

June 2008

# VA HEALTH CARE

## Ineffective Controls over Medical Center Billings and Collections Limit Revenue from Third- Party Insurance Companies



G A O

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Highlights of [GAO-08-675](#), a report to congressional requesters

## VA HEALTH CARE

### Ineffective Controls over Medical Center Billings and Collections Limit Revenue from Third-Party Insurance Companies

#### Why GAO Did This Study

GAO previously reported that continuing problems in billing and collection processes at the Department of Veterans Affairs (VA) impaired VA's ability to maximize revenue from private (third-party) insurance companies. VA has undertaken several initiatives to address these weaknesses. GAO was asked to perform a follow-up audit to (1) evaluate VA billing controls, (2) assess VA-wide controls for collections, (3) determine the effectiveness of VA-wide oversight, and (4) provide information on the status of key VA improvement initiatives. GAO performed case study analyses of the third-party billing function, statistically tested controls over collections, and reviewed current oversight policies and procedures. GAO also reviewed and summarized VA information on the status of key management initiatives to enhance third-party revenue.

#### What GAO Recommends

GAO makes seven recommendations to improve VA's third-party billing and collection processes, including actions to improve (1) third-party billings, (2) follow up on unpaid amounts, and (3) management oversight of billing and collections. VA concurred with all seven recommendations and noted steps it is taking to address them. VA also expressed concerns with how GAO characterized its revenue enhancement and management oversight. GAO continues to believe its report overall fairly characterizes VA's actions to date.

To view the full product, including the scope and methodology, click on [GAO-08-675](#). For more information, contact Kay Daly, Acting Director, at (202) 512-9095 or [dalykl@gao.gov](mailto:dalykl@gao.gov).

#### What GAO Found

GAO's case study analysis of unbilled patient encounters at 18 medical centers, including 10 medical centers with low billing performance and 8 medical centers under VA's Consolidated Patient Account Centers (CPAC) initiative considered to be high performers, found documentation, coding, and billing errors and inadequate management oversight for approximately \$1.7 billion deemed unbillable in fiscal year 2007. Although some medical services are unbillable, such as service-connected treatment, management has not validated reasons for related unbilled amounts of about \$1.4 billion to assure that all billable costs are charged to third-party insurers. Because insurers will not accept improperly coded bills and they generally will not pay bills received more than 1 year after the date that medical services were provided, it is important that coding for medical services is accurate and timely. The 10 case study medical centers reported average days to bill ranging from 109 days to 146 days in fiscal year 2007 and significant coding and billing errors and other problems that accounted for over \$254 million, or 21 percent, of the \$1.2 billion in unbilled medical services costs. Although GAO determined that CPAC officials performed a more thorough review of billings, GAO's analysis of unbilled amounts for the 8 CPAC centers found problems that accounted for \$37.5 million, or about 7 percent, of the \$508.7 million in unbilled medical services costs.

In addition, GAO's VA-wide statistical tests of collections follow-up on unpaid third-party bills of \$250 or more identified significant control failures related to timely follow-up and documentation of contacts with third-party insurers on outstanding receivables. VA guidance requires medical center accounts receivable staff to make up to three follow-up contacts, as necessary, on outstanding third-party receivables. As shown in the table, GAO's tests identified high failure rates VA-wide as well as for CPAC and non-CPAC medical centers related to the requirement for timely follow up with third-party insurers on unpaid amounts. GAO's tests also found high failure rates associated with the lack of documentation of follow-up contacts.

**Estimated Control Failures on Timely Follow-up on Unpaid Bills of \$250 or More**

Required follow-up	VA-wide centers	CPAC centers	Non-CPAC centers
Initial	69%	36%	71%
Second	44%	23%	45%
Third	20%	22%	17%

Source: GAO tests of a VA-wide random probability sample.

Note: Failure rates are based on the lower bound of a two-sided, 95 percent confidence interval.

VA lacks policies and procedures and a full range of standardized reports for effective management oversight of VA-wide third-party billing and collection operations. Further, although VA management has undertaken several initiatives to enhance third-party revenue, many of these initiatives are open-ended or will not be implemented for several years. Until these shortcomings are addressed, VA will continue to fall short of its goal to maximize third-party revenue, thereby placing a higher burden on taxpayers.

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## Abbreviations

AR	accounts receivable
BPA	blanket purchase agreement
CBO	VHA Chief Business Office
CDE	Clinical Data Entry
CIDC	Clinical Indicators Data Capture
CPAC	Consolidated Patient Account Center
CPRS	Computerized Patient Record System
CPRS-R	Computerized Patient Record System-Reengineering
DOJ	Department of Justice
IT	information technology
NPRO	National Payer Relations Office
PFSS	Patient Financial Services System
POWER	Performance and Operations Web-Enabled Reports
RAP	Revenue Action Plan
RCET	Revenue Cycle Enhancement Team
RIDP	Revenue Improvement Demonstration Project
RISE	Revenue Improvements and Systems Enhancement
ROPE	Revenue Optimization Plan Enhancement
USC	United States Code
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Health Information Systems and Technology Architecture

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United States Government Accountability Office  
Washington, DC 20548

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June 10, 2008

The Honorable Bob Filner  
Chairman  
The Honorable Steve Buyer  
Ranking Member  
Committee on Veterans' Affairs  
House of Representatives

The Honorable Harry E. Mitchell  
Chairman  
The Honorable Ginny Brown-Waite  
Ranking Member  
Subcommittee on Oversight and Investigations  
Committee on Veterans' Affairs  
House of Representatives

The Department of Veterans Affairs (VA) provides health care to eligible veterans through a system of Veterans Health Administration (VHA) medical facilities that comprise one of the largest health care systems in the world. Over the past several years, we have reported that continuing weaknesses in VA billing processes and controls have impaired VA's ability to maximize the amount of dollars received by private insurance companies, commonly referred to as third-party insurers. VA third-party billing and collection operations are carried out through a nationwide network of 153 medical centers, 877 outpatient clinics, and 135 nursing homes, residential rehabilitation treatment programs, and readjustment counseling centers. During fiscal year 2007, about 5.6 million people received treatment in VA health care facilities for service-related as well as nonservice-related conditions and VA collections for health care services totaled nearly \$2.2 billion.

In September 2001, we testified that problems in VA's collection operations, including inadequate patient intake procedures for gathering insurance information, insufficient physician documentation of specific medical care provided, a shortage of qualified coders, and a lack of automated information, diminished VA's collections.<sup>1</sup> In May 2003, we

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<sup>1</sup> GAO, *VA Health Care: VA Has Not Sufficiently Explored Alternatives for Optimizing Third-Party Collections*, [GAO-01-1157T](#) (Washington, D.C.: Sept. 20, 2001).

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testified that VA had made improvements in these areas but operational problems, such as unpaid accounts receivable, missed billing opportunities, and billing backlogs, continued to limit the amount VA collects.<sup>2</sup> In July 2004, we reported that VA had increased collections of third-party insurer payments by 49 percent from \$540 million in fiscal year 2001 to \$804 million in fiscal year 2003.<sup>3</sup> However, we also found continuing weaknesses in the billing and collection processes at the three medical centers we visited that impaired VA's ability to maximize the amount of dollars paid by third-party insurance companies.

Over the past several years, Congress has provided funding for VHA medical information management system improvements. In fiscal year 2006, Congress directed VA to allocate \$10 million from its Medical Administration lump-sum appropriation of about \$2.86 billion to initiate a pilot program for comprehensive restructuring of the medical revenue cycle, including cash management and accounts receivable related to third-party billing and collection functions.<sup>4</sup> One of VA's initiatives to improve billing and collection functions was the establishment of a Consolidated Patient Account Center (CPAC) pilot program covering eight medical centers in Veterans Integrated Service Network (VISN) 6.<sup>5</sup>

This report responds to your request that we perform a follow-up audit of controls over VA's third-party billing and collection processes, including (1) an evaluation of the effectiveness of VA medical center billing processes at selected locations, (2) an assessment of VA controls for performing timely follow-up on outstanding third-party receivables, and (3) a determination of the adequacy of VA oversight of billing and collection processes. You also asked us to summarize the status of management initiatives currently underway at VA to improve third-party billing and collection processes.

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<sup>2</sup> GAO, *VA Health Care: VA Increases Third-Party Collections as It Addresses Problems in Its Collections Operations*, [GAO-03-740T](#) (Washington, D.C.: May 7, 2003.)

<sup>3</sup> GAO, *VA Medical Centers: Further Operational Improvements Could Enhance Third-Party Collections*, [GAO-04-739](#) (Washington, D.C.: July 19, 2004).

<sup>4</sup> H.R. Rep. No. 109-95, at 56 (May 23, 2005). *See also* H.R. Conf. Rep. No. 109-305, at 43 (Nov. 18, 2005); Military Quality of Life and Veterans Affairs Appropriations Act, 2006, Pub. L. No. 109-114, tit. II, 110 Stat. 2372, 2384-85 (Nov. 30, 2005).

<sup>5</sup> VHA has 21 VISNs that oversee medical center activities within their area, which may cover one or more states. VISN 6 covers North Carolina, parts of southern Virginia, and eastern West Virginia.

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To achieve our first objective, we used a case study approach to assess billing controls because VA does not have centralized data on third-party billings. For our case studies, we selected the 10 medical centers with the highest numbers of days to bill (lowest billing performance) and the 8 medical centers under the CPAC management initiative for regionalized billing and collection activity that were expected to be high performers. To achieve the second objective, we tested controls for timely collection follow-up and documentation of contacts on third-party bills using a VA-wide statistical sample, and stratified subsets of our VA-wide sample for CPAC medical centers and medical centers that were not under the CPAC initiative. Because you were interested in learning whether medical centers under CPAC had more effective controls over third-party billings and collections, we separately analyzed CPAC billing controls and separately tested third-party collection controls for CPAC medical centers. To address our third objective on VA management oversight capability, we reviewed management reports generated by key VA systems and interviewed medical center and VHA officials about their oversight procedures. We also obtained information on the status and targeted implementation dates of key management improvement initiatives, including two initiatives that were recently completed and six initiatives that were under way at the end of our field work.

In conducting our work, we interviewed management officials and reviewed applicable laws, regulations, and VA policies and procedures. We performed appropriate procedures to assure the reliability of data used in our work including data analysis, interviews of key officials, and review of VA procedures for assuring the reliability of data generated by key automated systems. We conducted our work from January 2007 through May 2008 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. A detailed discussion of our objectives, scope, and methodology is included in appendix I.

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## Results in Brief

Although VA has made some progress in improving third-party billings and collections since our 2004 report, our audit of VA fiscal year 2007 controls over third-party billings and collections found significant internal control weaknesses and inadequate management oversight that limited VA's ability to maximize third-party revenue. Our case study analysis of unbilled patient encounters at 18 case study medical centers found excessive

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average days to bill, coding and billing errors, and a lack of management oversight which raise questions about \$1.7 billion in unbilled amounts at the 18 locations. Although there are valid reasons why some medical services are not billable, including \$1.4 billion related to service-connected treatment, Medicare coverage, and the lack of private health insurance coverage,<sup>6</sup> medical center management did not always validate the reasons for these unbilled amounts. Further, because insurers will not accept improperly coded amounts and in many cases have national or regional contracts with VA that bar insurer liability for payment of bills received after a specified period of time, usually 1 year, but sometimes as little as 6 months, after the date that medical services were provided, it is important that coding for medical services is accurate and timely. The 10 medical centers we identified as having low billing performance reported average days to bill ranging from 109 days to 146 days in fiscal year 2007, compared to VA's goal of 60 days. We also found these centers had significant documentation, coding, and billing errors and performed little or no management oversight of the billing function. The use of inaccurate clinical service codes, late filing of claims, omissions in documentation, and other undefined reasons accounted for over \$254 million, or 21 percent, of the \$1.2 billion in total unbilled medical services costs at the 10 medical centers. The largest group of billing errors included \$25 million for which the billing time frame had expired. Our case study analysis of the eight medical centers under the CPAC initiative found that CPAC officials performed a more thorough review of the billing function. Our analysis of fiscal year 2007 unbilled amounts for the eight CPAC centers showed that CPAC centers' average days to bill ranged from 39 days to 68 days, compared to VA's 2007 goal of 60 days. CPAC centers' coding and billing errors, documentation errors, and other undefined reasons accounted for \$37.5 million, or about 7 percent, of medical services costs that were not billed to third-party insurance companies.

In addition, our VA-wide statistical tests of collection follow-up on unpaid third-party bills of \$250 or more identified significant problems related to timely follow-up and documentation of contacts with third-party insurance companies on actions to collect outstanding receivables. VA policy<sup>7</sup> requires medical center accounts receivable staff to make up to three follow-up contacts, as necessary, on outstanding third-party receivables.

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<sup>6</sup> Under 38 U.S.C. § 1729, VA is not authorized to collect these amounts from third-party insurers.

<sup>7</sup> VA Handbook 4800.14, *Medical Care Debts*, Section 4 (b) (1).

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Our statistical tests<sup>8</sup> of a stratified random sample of 260 fiscal year 2007 third-party bills identified a 69 percent failure rate VA-wide related to the requirement that accounts receivable staff perform the first follow-up on unpaid amounts within 45 days after the initial bill is generated. VA-wide failure rates for bills meeting the requirements for the second and third follow-ups were 44 percent and 20 percent, respectively. CPAC centers had a 36 percent failure rate for the required first follow-up, and a 23 percent and 22 percent failure rate for bills meeting the requirements for second and third follow-ups, respectively. The failure to make timely follow-up contacts and delays in initiating contacts with third-party insurance companies on unpaid amounts increase the risk that payments will not be collected, or that payments will be substantially delayed. Of the population of fiscal year 2007 billings valued at \$547.8 million that were used for our stratified random sample, VA collected \$260.1 million, or about 47 percent. Our analysis of accounts receivable aging data showed that \$37.5 million of the total \$600 million in receivables as of the end of fiscal year 2007 was over 1 year old. Further, VA policy<sup>9</sup> requires that accounts receivable staff include a comment for any adjustments<sup>10</sup> to decrease outstanding third-party bills. The policy requires that the explanation be clear and unambiguous and state the particular reason for the adjustment. Our tests of whether accounts receivable personnel adequately documented reasons for adjustments to decrease a bill found a failure rate of 38 percent VA-wide. Without clear documentation of the reasons for billing adjustments, VA management lacks the ability to monitor the validity of the adjustments. Further, documentation quality concerns undermine the reliability of trend information that is critical for effective management of third-party receivables.

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<sup>8</sup> Our statistical tests were based on a 95 percent, 2-sided confidence interval. Because confidence intervals varied widely for our various control tests, we used a conservative estimate of our test results that is based on the lower bound of our confidence intervals.

<sup>9</sup> VHA Handbook 4800.14, *Write-Offs, Decreases, and Termination of Medical Care Collections Fund Accounts Third-Party Receivable Balances*, Appendix B.

<sup>10</sup> Accounts receivable staff reduce third-party receivables for a variety of reasons including, but not limited to, partial payments when the amount received is the full amount expected from the insurance carrier, the amount of payment received is the usual and customary amount received from the insurance company, or medical services are not covered under the insurance policy.

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Our review of VA and VHA policies and procedures, process walk-throughs, and interviews with VHA Chief Business Office (CBO)<sup>11</sup> officials and management officials at our case study medical centers determined that there were no formal VA policies and procedures for oversight of the third-party billing and collection processes. In addition, we found that VHA and medical centers have few standardized management reports to facilitate oversight. Because VA's health care billing and collection systems operate as stand-alone systems at each medical center, VA-wide reporting is dependent on numerous individual queries and data calls. These conditions contributed to inadequate monitoring and oversight of the third-party billing and collection processes. This raises concerns about adequacy of oversight over the \$1.7 billion in unbilled amounts at the 18 case study medical centers, including the hundreds of millions of dollars in unbilled amounts related to coding, billing, and documentation errors, and other reasons. The lack of formal VA policies for management oversight of third-party billings and collections also raises VA-wide concerns. Enhanced oversight would permit VA and medical center management to monitor trends and performance metrics, such as increases or decreases in unbillable amounts, and take appropriate management actions to help ensure that revenue from third-party insurers is maximized.

Since our July 2004 report, VA management has undertaken several initiatives to strengthen processes and controls over third-party billings and collections. For example, VA recently completed initiatives for (1) recruitment and retention of coders and health information managers and (2) updating VHA policy guidance related to third-party revenue. In addition, VA has six key strategic initiatives under way to enhance revenue from third-party insurers, including CPAC, a private-sector approach to revenue management that included consolidation of billing, collections, and payer analysis for eight medical centers in VISN 6. VA also initiated development of systems enhancements to improve medical procedure coding by capturing clinical data as a byproduct of the medical service encounter rather than capturing this information in a separate step. Further, VA has an effort under way to define current and end-to-end business processes in the revenue cycle as a basis for improving related systems and processes. VA also is attempting to negotiate national

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<sup>11</sup> VHA's CBO was established in April 2002 as the single accountable authority for the development of administrative processes, policy, regulations, and directives associated with the delivery of VA health benefit programs. VHA's CBO is composed of independent offices in the field that are dedicated to health benefits administration and revenue-related programs.

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contracts with major insurance companies to standardize billing information to facilitate collections. For example, VA established national blanket purchase agreements (BPA) for both coding and insurance identification and verification products and services. According to VA officials, the Revenue Contracts Program is currently working to establish BPAs for third-party billing and accounts receivable follow-up. Many of these initiatives are not yet fully implemented and others are open-ended without targeted implementation dates to help ensure that actions are completed and intended goals are met. Effective management oversight and implementation will be key to the success of these initiatives.

This report contains seven recommendations to VA aimed at strengthening key internal control activities over third-party billings and collections and improving management oversight. In comments on a draft of this report, VA concurred with all seven of our recommendations and provided information on steps it is taking to address them. VA also expressed concerns with how we characterized key findings related to revenue enhancement and emphasized significant progress it has made on third-party collections since 2004 as well as progress from management improvement initiatives. We believe our overall characterization of the potential for lost revenue as a result of our findings is accurate. However, we added clarifying language to indicate that \$1.4 billion of the \$1.7 billion in unbilled medical services at the 18 case study medical centers was classified as service-connected, Medicare coverage, or lack of private health insurance coverage. As discussed in our report, VA management has not validated whether the cited reasons for these unbilled amounts are properly supported to assure that all billable costs are charged to third-party insurers. In addition, VA stated that it has established significant levels of management oversight. Our report recognizes that VA has agency reporting requirements and data on days to bill, accounts receivable, and collections. However, we found that VA has not established policies and procedures for management oversight actions related to unbilled amounts and compliance with follow-up requirements for outstanding third-party receivables. We clarified issues raised by VA in its letter and addressed VA technical comments, as appropriate. VA's comments and our analysis are discussed in the Agency Comments and Our Evaluation section of this report. VA's comments are reprinted in appendix II.

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## Background

VA's mission is to serve America's veterans and their families and to be their principal advocate in ensuring that they receive medical care, benefits, and social support in recognition of their service to our nation. VA, headquartered in Washington, D.C., is the second largest federal

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department and operates the largest health care system in the United States. VA reported that as of September 30, 2007, it employed approximately 230,000 staff nationwide, including physicians, nurses, counselors, statisticians, computer specialists, architects, and attorneys. VA carries out its mission through three major line organizations – Veterans Health Administration (VHA), Veterans Benefits Administration, and National Cemetery Administration—and field facilities throughout the United States. During fiscal year 2007, VA provided health care services and benefits through a nationwide network of 153 medical centers, 877 outpatient clinics, and 135 nursing homes.

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### Third-Party Collections Authorized for Medical Care Related to Nonservice-related Conditions

The Veterans' Health Care Eligibility Reform Act of 1996<sup>12</sup> authorized VA to provide certain medical services not previously available to veterans with nonservice-related conditions. While VA in 1996 had authority to recover some of the cost of providing these additional benefits through billing and collecting payments from veterans' private health insurers (third-party collections), it was not authorized to keep these collections.<sup>13</sup> The Veterans Reconciliation Act of 1997, which was enacted as part of the Balanced Budget Act of 1997,<sup>14</sup> changed this by authorizing VA to collect and deposit third-party health insurance payments in its Medical Care Collections Fund, which VA could then use to supplement its medical care appropriations. As part of VA's 1997 strategic plan, VA predicted that collections of payments from third-party insurance companies, along with veteran copayments for medications, would cover the majority of costs of care for veterans with nonservice-related conditions. During fiscal year 2007, almost 5.6 million people received care in VA health care facilities, and VA collections for health care services totaled nearly \$2.2 billion.<sup>15</sup>

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<sup>12</sup> Pub. L. No. 104-262, § 101, 110 Stat. 3177, 3178 (Oct. 9, 1996)(*codified at* 38 U.S.C. § 1710).

<sup>13</sup> *See* Veterans' Health-Care Amendments of 1986, Pub. L. No. 99-272, tit. XI, § 19013, 100 Stat. 372, 382 (Apr. 7, 1986)(*codified, as amended, at* 38 U.S.C. § 1729). The 1986 statute authorized VA to seek reimbursement from third-party health insurance companies for the cost it incurred in providing medical care to insured veterans with nonservice-related conditions. Without specific authority to retain the third-party insurance payments it collected, however, VA was required to deposit these third-party collections in the General Fund of the U.S. Treasury.

<sup>14</sup> Pub. L. No. 105-33, tit. VIII, § 8023, 111 Stat. 251, 665 (Aug. 5, 1997)(*codified at* 38 U.S.C. § 1729A).

<sup>15</sup> VA collections for health care services include third-party collections as well as patient copayments for medical services.

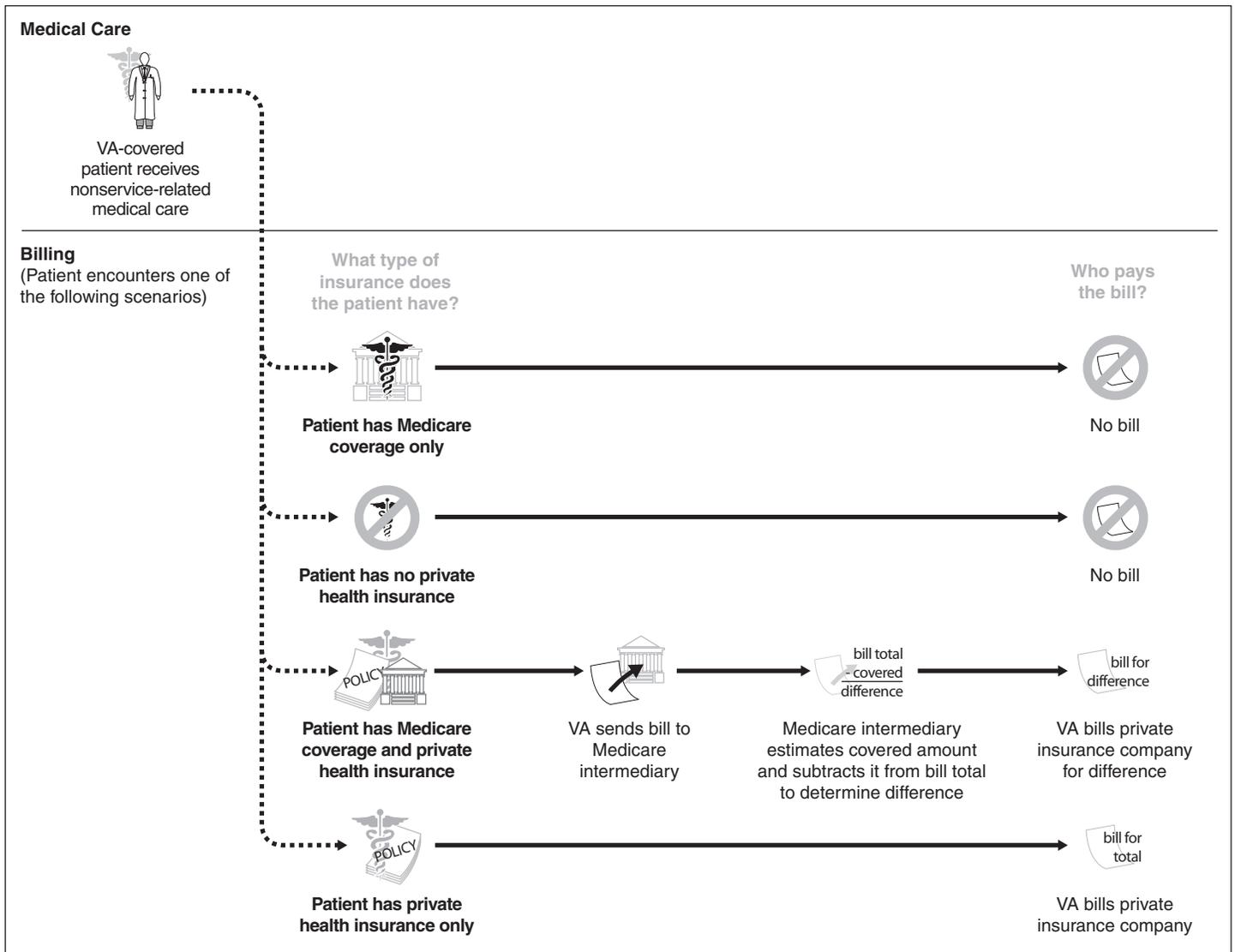
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As illustrated in figure 1, VA does not bill for health care services provided to veterans who have Medicare coverage only or veterans who have no private health insurance.<sup>16</sup> For veterans who are covered by both Medicare and private health insurance, VA prepares claims according to Medicare guidelines and sends the bill to a Medicare fiscal intermediary (contractor) who calculates the Medicare/patient responsibility and sends the bill to the private insurer for adjudication and payment. If the veteran is not eligible for health benefits under Medicare, but has private health insurance coverage, VA bills the third-party insurance company. In some situations, VA may not recognize that a veteran is eligible for Medicare benefits and sends the bill directly to the third-party insurance company. In these situations, the third-party insurer would determine that the veteran is eligible for Medicare coverage and would reject the bill and send it back to VA. VA updates the patient's file and then sends the bill to the Medicare contractor.

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<sup>16</sup> 38 U.S.C. § 1729. VA is subrogated to the rights of veterans for payments from third-party payers who are obligated to provide for (or pay the expenses of) the veterans' health services under a health plan contract. In addition to excluding uninsured veterans, this authority excludes veterans covered only by Medicare because the statutory definition for third-party payers specifically excludes Medicare, but does not exclude Medicare supplemental insurance policies obtained from private insurers.

**Figure 1: Overview of VA's Third-Party Billing Process**



Source: GAO analysis of VA policies, procedures, processes, and related law.

## VA Third-Party Revenue Cycle

Similar to most health care providers, VA uses a fee schedule consisting of “reasonable charges” for medical services based on diagnoses and procedures.<sup>17</sup> The fee schedule allows VA to more accurately bill for care

<sup>17</sup> Reasonable charges are defined as amounts that insurance companies would pay private sector health care providers in the same geographic area for the same services.

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provided. Documenting and coding the care provided and processing bills for each episode of care are critical to preparing accurate bills for submission to third-party insurers. As illustrated in figure 2, VA uses a process consisting of four key functions to collect from third-party insurance companies. The four functions cover the following actions.

- Patient intake, which involves gathering insurance information and verifying that information with the insurance company as well as collecting demographic data on the veteran.
- Utilization review, which involves precertification of care in compliance with the veteran’s insurance policy, including continued stay reviews to determine medical necessity.
- Billing functions include properly documenting the health care services provided to patients by physicians and other health care providers. Based on physician documentation, the diagnoses and medical procedures performed are coded. VA then creates and sends bills to insurance companies based on the insurance and coding information obtained.
- Accounts receivable and collections, which involves processing payments from insurance companies and following up on outstanding or denied bills. In accordance with VA Handbook 4800.14, *Medical Care Debts*, VA accounts receivable staff at each medical center or other health care facility are required to follow up on unpaid reimbursable insurance cases.<sup>18</sup> For bills of \$250 or more, the first telephone or online follow-up is to be made within 45 days after the initial bill was generated. If necessary, a second follow-up should be initiated within 21 days of the first follow-up. If a third follow-up is necessary, it should be initiated within 14 days of the second follow-up. When a telephone or online follow-up is made, a comment briefly summarizing the contact with an appropriate follow-up date should be entered in the third-party joint inquiry menu in VHA’s Veterans Health Information Systems and Technology Architecture (VistA) system.<sup>19</sup>

If no payment is received within 7 days of the third follow-up, accounts receivable personnel are to refer the bill to the VA medical center senior management official responsible for collection of the bill, generally the

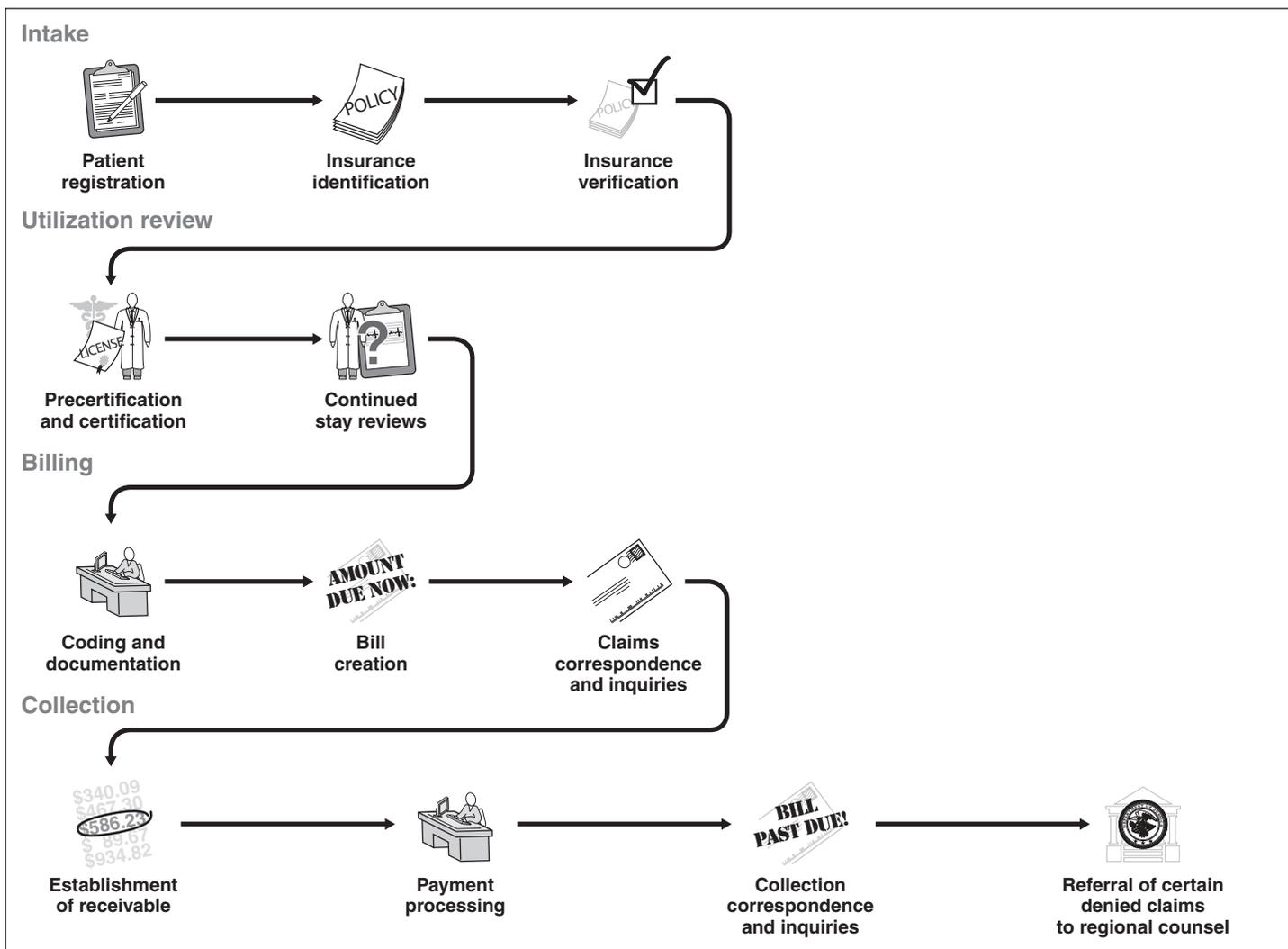
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<sup>18</sup> VA Handbook 4800.14, Section 4b, “Third-Party Receivables, Claims Follow-up.”

<sup>19</sup> VistA is a comprehensive medical records system. VistA includes an accounts receivable module that supports third-party billings and collections.

facility revenue manager. This official will determine the next appropriate action, including, after exhausting all required recovery efforts, possible referral to the VA regional counsel of jurisdiction for review and advice as to how to handle collection procedures. The regional counsel may forward problem cases to VA's General Counsel to review for possible litigation. Under guidance issued to VA by the Department of Justice (DOJ), VA may refer cases to DOJ for possible litigation.

**Figure 2: VA Third-Party Billing and Collection Process**



Source: GAO walkthroughs of medical center billing and collection processes and review of related policies and procedures.

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## VA Actions on Previously Reported Weaknesses in Third-Party Billings and Collections

Our July 2004<sup>20</sup> report documented continuing weaknesses in billing processes at the three medical centers tested that impaired VA's ability to maximize the amount of dollars paid by third-party insurance companies. For example, the medical centers did not always bill insurance companies in a timely manner and they did not always perform follow-up on unpaid receivables in accordance with VA policy. We identified insufficient resources and a lack of performance standards as major causes of these problems. Our 2004 report included several recommendations directed at improving billing and collection functions.

To improve the third-party billing function, we recommended that VA (1) perform a workload analysis of the medical center's coding and billing staff and (2) based on the workload analysis, consider making necessary resource adjustments. To address these recommendations, VA formed a work group and performed in-depth surveys at 148 medical facilities to determine whether the medical facilities had established and implemented productivity and accuracy standards that were recommended by VHA in 2002. The work group reported that the majority of the 148 facilities surveyed had implemented coding productivity standards and these standards were fairly consistent. In addition, the work group made several recommendations directed at maximizing coding productivity and assuring data quality. For example, the work group recommended that only qualified, competent coders be used and that noncoding duties related to assembly, analysis, preparation of coding records, and release of information be assigned to other staff. The work group also recommended that all coding must be completed through the national encoder software. In November 2007, VA issued Handbook, 1907.03, *Health Information Management, Clinical Coding Program Procedures*, which established a minimum bill coding accuracy standard of 95 percent and minimum standards (time frames) for coding productivity.<sup>21</sup>

Our 2004 report also made three recommendations directed at improving the third-party collection function. Specifically, we recommended that VA (1) reinforce to accounts receivable staff that they should perform the first follow-up on unpaid claims within 30 days of the billing date, as required by VA Handbook 4800.14, *Medical Care Debts*, and establish procedures for monitoring compliance; (2) reinforce the requirement for accounts

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<sup>20</sup> GAO, *VA Medical Centers: Further Operational Improvements Could Enhance Third-Party Collections*, [GAO-04-739](#) (Washington, D.C.: July 19, 2004).

<sup>21</sup> VA Handbook 1907.03, Sections 3 and 12.

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receivable staff to enter insurance company contact information and follow-up dates to better document follow-up actions; and (3) augment VA Handbook 4800.14 by specifying a date or providing instructions for determining an appropriate date for conducting second follow-up calls to insurance companies on unpaid amounts. To address these recommendations, VA modified and reissued VA Handbook 4800.14 to explain requirements for performing and documenting the first, second, and third follow-ups with third-party insurers. For example, for third-party accounts receivable greater than \$250, the reissued Handbook now requires the first follow-up to be made within 45 days<sup>22</sup> after the initial bill is generated. The second follow-up is to be made within 21 days after the first follow-up and the third follow-up is to be made within 14 days of the second follow-up. VA also provided training to staff on the policies included in VA Handbook 4800.14, which included the need for timely follow-up on outstanding third-party receivables as well as follow-up documentation requirements.

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## Case Study Medical Centers Had Billing Errors and Inadequate Oversight and Accountability

Our case study analysis of unbilled patient encounters at 18 medical centers, including 10 medical centers with low billing performance (based on reported days to bill) and 8 centers under VA's CPAC initiative that were expected to have high billing performance, found billing delays; coding, billing, and documentation errors; and a lack of adequate management oversight and accountability over approximately \$1.7 billion deemed to be unbillable in fiscal year 2007 by coding and billing staff. Although there are valid reasons why some medical services are not billable, including \$1.4 billion in service-connected treatment, Medicare coverage, and the lack of private health insurance coverage,<sup>23</sup> medical center management did not validate the reasons for the related unbilled amounts. Further, because third-party insurers will not accept improperly coded amounts and in many cases have national and regional contracts with VA that bar insurer liability for payment of bills received after more than a specified period of time, usually 1 year, after the date that medical services were provided, it is important that coding for medical services is

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<sup>22</sup> According to VA officials, the initial VA Handbook revision included the 30-day follow-up. However, with implementation of the Medicare verification process, and an evaluation of the third-party accounts receivable portfolio, VA determined that 45 days provided a more reasonable time for payment processing.

<sup>23</sup> Under 38 U.S.C. § 1729, VA is not authorized to collect these amounts from third-party insurers.

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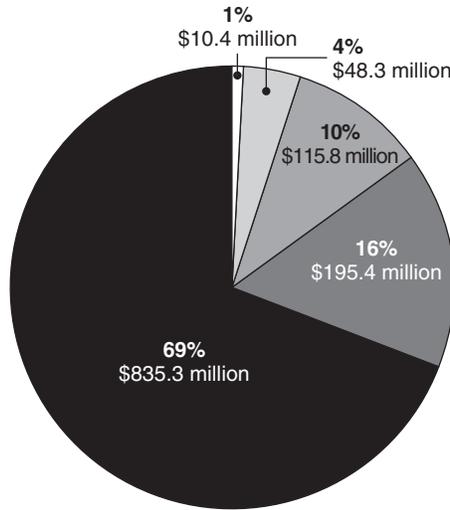
accurate and timely. Our analysis of VA billing data showed that VA has improved its average overall days to bill third-party insurance companies from 93 days in fiscal year 2003 to 64 days in fiscal year 2007. However, most of the 18 case study medical centers we audited exceeded VA's fiscal year 2007 goal of 60 average days to bill. In addition, our analysis found that coding and billing errors, omissions in documentation, and other undefined reasons for unbilled amounts accounted for hundreds of millions of dollars that were not billed to third-party insurance companies. Moreover, case study medical centers did not effectively use available management reports to monitor trends and performance metrics, such as increases or decreases in unbilled amounts.

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### Ten Medical Centers Had Billing Delays and Errors and Little or No Oversight of Their Billing Functions

The 10 medical centers with low billing performance included in our case study analysis reported average days to bill ranging from 109 days to 146 days in fiscal year 2007, compared to VA's goal of 60 days. The 10 centers also had a total of \$1.2 billion in unbilled medical services costs. To analyze case study medical center billing data by unbilled reason codes, we obtained medical center Reasons Not Billable reports and grouped unbillable reasons by major categories. Medical center Reasons Not Billable reports included over 100 reason codes and inconsistent reporting of other, undefined reasons. We discussed our groupings by category with VHA managers and obtained their agreement on our assignment of unbillable reasons by category. As illustrated in figure 3, our analysis of reasons not billable data for the 10 case study medical centers identified significant unbilled amounts for fiscal year 2007.

**Figure 3: Fiscal Year 2007 Unbilled Amounts by Reason for Ten Medical Centers with the Largest Elapsed Days to Bill**



- Documentation errors
- Coding and billing errors
- Service-connected not billable
- Other
- Nonservice-related not billable

Source: GAO analysis of 10 case study medical centers' Reasons Not Billable data.

There are valid reasons why VA does not bill for all medical services it provides. For example, VA's legal authority to seek reimbursement from third-party insurers for the cost of medical services does not extend to services provided to veterans who have medical conditions that are (1) service-connected, (2) covered only by Medicare, or (3) not covered under a private or other applicable health insurance plan.<sup>24</sup> Of the total \$1.2 billion in unbilled medical services costs at the 10 medical centers, service-connected (nonbillable) medical care accounted for nearly \$116 million, or 10 percent, and nonservice-related not billable amounts totaled \$835.3 million, or 69 percent, including \$170 million recorded as medical procedures performed for uninsured veterans and \$433 million recorded as attributable to medical services that were not covered by veterans'

<sup>24</sup> 38 U.S.C. § 1729.

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private health insurance. Managers at the 10 case study medical centers did not perform adequate reviews of the encounters assigned to these categories to ensure that billing clerks appropriately classified them. Coding and billing errors (\$48.3 million), documentation errors (\$10.4 million), and undefined other reasons (\$195.4 million) accounted over \$254 million, or 21 percent, of the \$1.2 billion in total unbilled medical services costs at the 10 medical centers. Coding and billing errors include incorrect clinical service codes and late filing of claims. The largest group of billing errors included \$25 million for which the billing time frame had expired. According to a VA official, VA has entered into national and regional contracts with many third-party insurance companies that bar insurer liability for payment of bills received after a specified period of time, usually 1 year, but sometimes as little as 6 months, after medical services were provided.<sup>25</sup> In addition, documentation errors accounted for more than \$10 million in unbilled amounts at the 10 medical centers. Documentation errors include the failure of certification personnel to provide documentation of physician and other health care provider certifications; health care provider errors, such as physicians failing to submit documentation of their services for coding; and veterans refusing to sign Authorization for Release of Protected Health Information forms.<sup>26</sup> Insurance companies will not pay for services unless they receive documentation that the physicians and health care providers are certified. The largest groups of documentation errors related to veterans not signing Release of Information forms due to privacy concerns (\$2.0 million) and insufficient or missing medical services documentation (\$6.4 million).

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<sup>25</sup> By law, VA has a right to seek reimbursement from third-party insurance companies for up to 6 years after it provided medical services to veterans with nonservice-connected conditions. 38 U.S.C. § 1729(b)(2)(C). However, according to a VA official, VA has entered into contracts with many insurers agreeing to a shorter recovery period in return for other health care provider contractual benefits, such as a higher reimbursement level. We did not independently verify the contractually limited billing periods for particular services provided or whether the billing periods had expired for the billable amounts associated with those services.

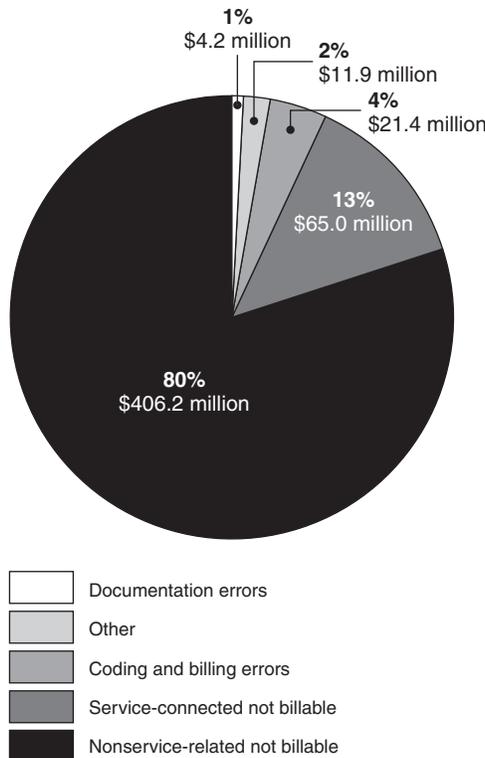
<sup>26</sup> The Health Insurance Portability and Accountability Act of 1996 (HIPAA), as implemented by the HIPAA Privacy Rule, establishes federal privacy standards for the use and disclosure of an individual's protected health information. *See* Pub. L. No. 104-191, § 264, 110 Stat. 1936, 2033-34 (Aug. 21, 1996); 45 C.F.R. pt. 164 subpt. E ("privacy of individually identifiable health information"). To comply with HIPAA, health care providers and health insurance companies often require patients to sign release forms authorizing limited use and disclosure of the protected health information for specified purposes, such as payment for health care.

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## **Eight Medical Centers under CPAC Had Better Billing Performance and Performed More Oversight of Unbilled Amounts**

The CPAC centers' fiscal year 2007 average days to bill ranged from 39 days to 68 days, compared to VA's goal of 60 days. In fiscal year 2007, the eight CPAC centers accounted for over \$508.7 million in unbilled amounts. As illustrated in figure 4, service-connected reasons accounted for about \$65 million, or 13 percent, and nonservice-related, unbillable reason codes accounted for the largest portion—about \$406.2 million, or 80 percent, of the total \$508.7 million unbilled third-party amounts for the 8 medical centers under CPAC. Coding and billing errors, documentation errors, and other reasons accounted for \$37.5 million, or about 7 percent, of medical services costs that were not billed to third-party insurance companies. CPAC officials told us they perform some analysis of unbillable amounts. For example, CPAC officials stated that they review unbillable codes they consider to be at high risk of error. If a particular unbillable code increased from month-to-month, they investigated the cause of the increase and took appropriate action to mitigate the problem. A detailed discussion of CPAC management oversight is presented later in this report.

**Figure 4: Fiscal Year 2007 Unbilled Amounts by Reason for Eight Medical Centers under CPAC**



Source: GAO analysis of 8 CPAC case study medical centers' Reasons Not Billable data.

## Medical Centers Have Not Followed VA Policy for Timely Follow-up and Documentation on Unpaid Third-Party Receivables

Our analysis of VA's accounts receivable aging data as of September 25, 2007, showed that VA had approximately \$600 million in outstanding third-party receivables of which over \$148 million, or about 25 percent, was more than 120 days old. It is important that VA actively pursue unpaid amounts by making timely follow-up contacts with third-party insurance companies because the older a receivable, the less likely it is to be collected. Moreover, uncollected third-party receivables place an added burden on taxpayers because additional amounts would need to be covered by annual appropriations to support the same level of service to veterans. In addition, our statistical tests found high internal control failure rates related to medical centers' lack of adherence to VHA requirements for timely, properly documented follow-up on unpaid bills that had been sent to third-party insurance companies. Management officials at several of the medical centers tested in our statistical sample

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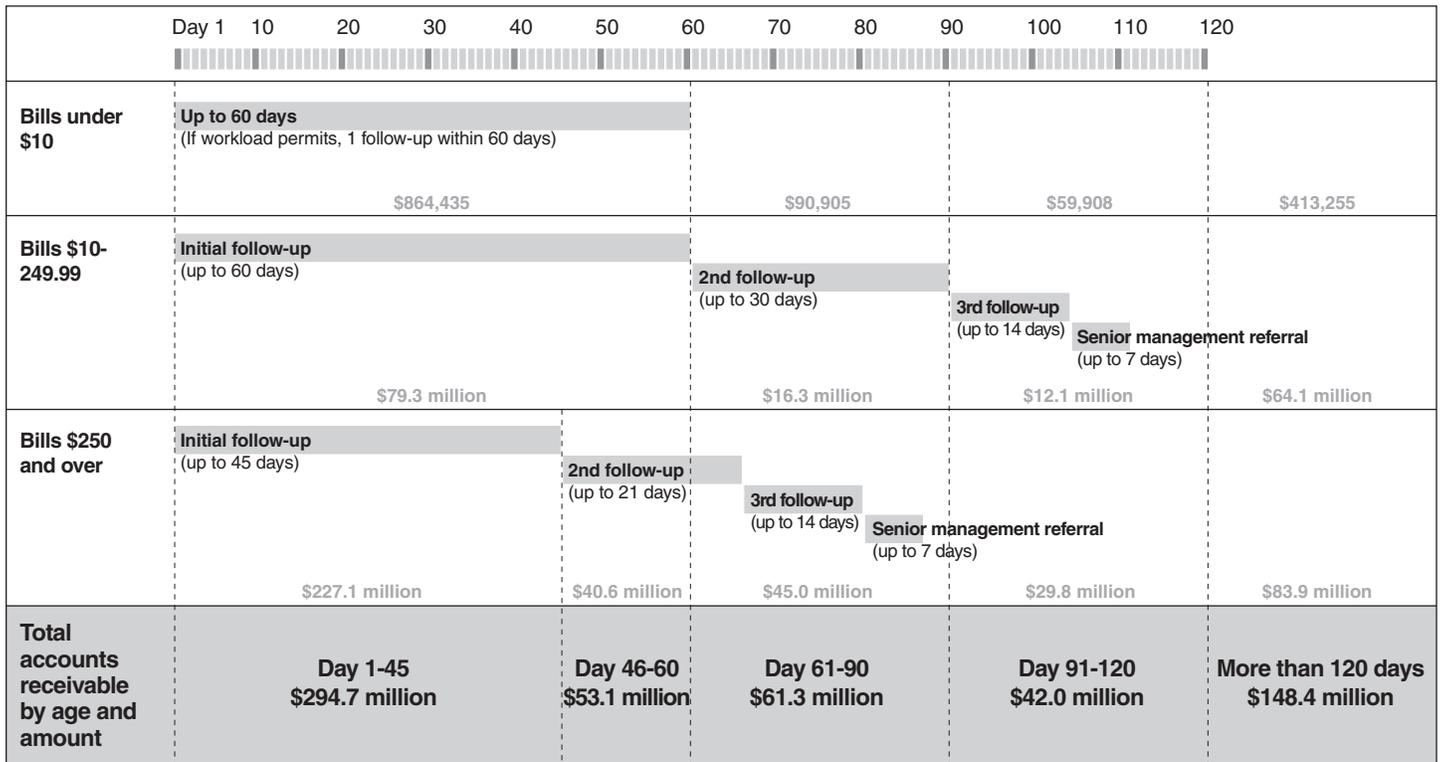
attributed their high follow-up failure rate to inadequate staffing. However, we found that a lack of management oversight at the medical centers as well as at the VHA management level contributed to the control weaknesses we identified.

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### VA Has Hundreds of Millions of Dollars in Uncollected Receivables from Third-Party Insurers

Our analysis of VA's accounts receivable aging data as of September 25, 2007, identified approximately \$600 million in outstanding third-party receivables. As shown in figure 5, about \$295 million of this total was less than 45 days old. Of the remaining \$305 million, over \$148 million, or 49 percent, was more than 120 days old. We focused our analysis on bills of \$250 or more—the largest category of third-party receivables. For example, uncollected receivables related to bills of \$250 or more represented over \$426 million, or 71 percent, of the approximately \$600 million in outstanding receivables at the end of fiscal year 2007. Although about \$227 million of the over \$426 million in receivables related to bills of \$250 or more were less than 45 days old and did not yet require initial follow-up, the remaining \$199 million, or 47 percent, was subject to VA follow-up action on unpaid amounts, and nearly \$84 million had remained uncollected for 120 days from the date of the initial bill. Timely follow-up is critical because the older a receivable, the less likely it is to be collected. As was the case with billings, we found that the case study medical centers had limited procedures in place to monitor the collections process. Further, the lack of follow-up documentation undermines the reliability of trend information needed to effectively manage third-party receivables.

**Figure 5: Analysis of VA's Third-Party Accounts Receivable as of September 25, 2007**



Source: GAO analysis of VA third-party accounts receivable aging data maintained in VistA.

Our analysis of accounts receivable aging data showed that \$37.5 million of the total \$600 million in receivables as of the end of fiscal year 2007 was over 1 year old, including \$17 million related to bills of \$250 or more.

## VA Medical Centers Failed Control Tests for Timely Follow-up on Unpaid Receivables

Our statistical tests of VA-wide data on controls for follow-up by accounts receivable personnel on unpaid amounts of \$250 or more billed to third-party insurers found significantly high failure rates. VA Handbook 4800.14, *Medical Care Debts*, requires follow-up on unpaid accounts receivable, as necessary, to collect unpaid third-party receivables.<sup>27</sup> The first follow-up for debts of \$250 or more is required within 45 days after the initial bill

<sup>27</sup> VA Handbook, 4800.14, Section 4, "Third-Party Receivables Under Fiscal Activity Jurisdiction."

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was generated. If necessary, the second follow-up is to be made within 21 days of the initial follow-up and the third follow-up is required within 14 days of the second follow-up. The follow-up requirement does not apply once a receivable is either collected in full, partially paid and contractually adjusted to a zero balance, or contractually adjusted to zero with no payment. Our test of timely follow-ups considered a bill to be closed and no longer subject to follow-up on the date the bill was paid in full or decreased to zero. We randomly selected a sample of 260 third-party insurer bills from a population of \$547.8 million in fiscal year 2007 billings for medical services. Of the \$547.8 million, our analysis showed that VA collected \$260.1 million, or about 47 percent.

We generally report our statistical results as point estimates that fall within confidence intervals. Our 95 percent confidence interval means that if you were to determine an estimate for 100 different random samples, 95 out of 100 times, the estimate would fall within the confidence interval. In other words, the true value is between the lower and upper limits of the confidence interval 95 percent of the time. Point estimates provide a useful indicator of the effectiveness of controls for our VA-wide tests, which included a total of 260 bills. However, our tests of CPAC and non-CPAC medical subsets of our sample involved fewer bills and the confidence intervals were much wider. When this is the case, we generally focus on the lower bound of our confidence interval as a more conservative estimate of the effectiveness of controls. Our point estimates for each of our tests and the upper and lower bounds of our confidence intervals are included in appendix I. The following discussion focuses on conservative estimates of our test results based on the lower bound of our 95 percent confidence intervals.

For example, table 1 shows that conservative estimates, based on the lower bound of our confidence intervals, indicate that VA controls for timely follow-up were ineffective. For example, the conservative approach for our VA-wide tests shows that medical center collections staff failed the control for timely initial follow-up after 45 days from the bill date at least 69 percent of the time. Similarly, our conservative estimate indicates that CPAC medical center personnel failed this control test for timely initial follow-up based on 60 bills in our sample subset at least 36 percent of the time and non-CPAC medical center personnel failed this control test based on 200 bills in this subset at least 71 percent of the time.

Because the universe of unpaid bills subject to requirements for second and third follow-ups was smaller, the confidence intervals for these tests were greater. However, the same conservative approach for our estimates

of control failures for the second and third follow-ups continues to show significant failure rates. For example, based on our tests, we estimate that VA-wide control failures related to required second and third follow-ups on unpaid third-party bills were at least 44 percent (based on a subset of 109 bills) and 20 percent (based on a subset of 55 bills), respectively. We estimate that CPAC medical center control failures related to required second and third follow-ups on unpaid third-party bills were at least 23 percent (based on a subset of 40 bills) and 22 percent (based on a subset of 21 bills), respectively. In addition, we estimate that non-CPAC medical center control failures related to required second and third follow-ups on unpaid third-party bills were at least 45 percent (based on a subset of 69 bills) and 17 percent (based on a subset of 34 bills), respectively.

**Table 1: Estimated Failure Rates for Controls on Timely Follow-up on Unpaid Third-Party Insurer Receivables Totaling \$250 or More**

Required follow-up	VA-wide medical centers	CPAC medical centers	Non-CPAC medical centers
Initial, 45 days	69%	36%	71%
Second, 21 days after 1st contact	44%	23%	45%
Third, 14 days after 2nd contact	20%	22%	17%

Source: GAO tests of VA-wide random probability sample of third-party accounts receivable data.

Note: Failure rates are based on the lower bound of our two-sided, 95 percent confidence interval.

Our analysis of our actual test results for the third-party insurer bills included in our statistical sample showed that results varied by medical center. For example, for several medical centers all, or nearly all, of the bills in our statistical sample failed control tests for timely first follow-up on unpaid amounts within 45 days. Conversely, there were several medical centers in our sample that performed timely first follow-up on all of the bills we tested. The actual test results for the first follow-up for all of the bills in our statistical sample are presented by VISN in appendix III.

In our interviews of management officials at several of the medical centers included in our statistical sample, the officials attributed their high follow-up failure rate to inadequate staffing. As noted previously, in response to recommendations in our 2004 report, VA shifted nonrevenue functions from billing and collections staff to other medical center personnel to provide greater focus on the revenue function.

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## VA Medical Centers Failed Control Tests for Recording Details of Follow-up Contacts

Our statistical tests of VA-wide data on controls for documenting details of follow-up contacts on unpaid amounts billed to third-party insurers also found significantly high failure rates. VA Handbook 4800.14, Medical Care Debts, requires medical center accounts receivable staff to document a summary of their contacts with third-party insurance companies as well as the first and last name of the insurance company representative and the representative's title, position, and phone number.<sup>28</sup> Documentation of contact detail is important because it enables VA to quickly identify billing problems and take appropriate action to resolve them. However, for several of the bills in our sample, accounts receivable personnel just noted "AR follow-up," or they left this data field blank.

As shown in table 2, our test results based on the lower bound of our confidence intervals indicate that controls for proper documentation of follow-up contacts on unpaid amounts with third-party insurers were ineffective. For example, using this conservative approach for our VA-wide tests, we estimate that medical center collections staff failed the control test for proper documentation of first follow-up contacts at least 72 percent of the time based on a sample of 97 bills. Similarly, our conservative estimate indicates that CPAC medical center personnel failed this control at least 38 percent of the time (based on 36 bills in this subset) and non-CPAC medical center personnel failed this control test at least 74 percent of the time (based on 61 bills in this subset). Table 2 shows that conservative estimates of contact documentation failures related to the second and third follow-ups are also significantly high, indicating that controls for all of our related tests were ineffective. Our tests of the requirement for documenting the second follow-up contact were based on 41 bills VA-wide, 14 bills for CPAC medical centers, and 27 bills for non-CPAC medical centers. Our tests of the documentation requirement for the third follow-up were based on 18 bills VA-wide, 8 bills for CPAC medical centers, and 10 bills for non-CPAC medical centers.

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<sup>28</sup> VHA Handbook, 4800.14, Section 4 (b) (2).

**Table 2: Estimated Failure Rates for Documenting Details of Follow-up Contacts on Unpaid Third-Party for Bills of \$250 or More**

Required comment	VA-wide medical centers	CPAC medical centers	Non-CPAC medical centers
Initial, 45 days	72%	38%	74%
Second, 21 days after 1st contact	59%	42%	58%
Third, 14 days after 2nd contact	35%	47%	26%

Source: GAO tests of VA-wide random probability sample of third-party accounts receivable data.

Note: Failure rates are based on the lower bound of our two-sided, 95 percent confidence interval.

In addition to documenting the details of follow-up contacts, collections personnel are required to adequately document the reasons for adjustments to decrease billed amounts in order to perform proper monitoring and oversight of accounts receivable personnel and to assess whether these adjustments were appropriate. Specifically, VHA Handbook 4800.14, *Write-Offs, Decreases, And Termination of Medical Care Collections Fund Accounts Third-Party Receivable Balances*, requires that accounts receivable staff provide an explanation for adjustments made to decrease third-party bills.<sup>29</sup> The Handbook requires that the explanation provide clear and unambiguous reasons for the decrease adjustment and provides several suggested comments that are considered adequate explanations for the adjustments.

Our tests of whether accounts receivable personnel adequately documented reasons for adjustments to decrease billed amounts found a VA-wide failure rate of 44 percent, as shown in table 3. Although the upper bound of our 95 percent, 2-sided confidence interval indicates that VA-wide estimated control failures could be over 50 percent, a conservative analysis based on the lower bound of our 2-sided confidence interval indicates that controls were ineffective for all categories of our tests in this area. Our tests for this control included a sample of 260 bills VA-wide, 60 bills for CPAC medical centers, and 200 bills for non-CPAC medical centers. Decreases made without appropriate explanations leave no audit trail or explanation of the reasons why an account receivable was decreased to zero. As a result, VA medical center management has limited data available to determine whether the adjustment was appropriate or if further collection action is needed. Moreover, without this information,

<sup>29</sup> VHA Handbook 4800.14, Appendix B.

medical center management cannot perform necessary oversight to assure that third-party revenues are maximized.

**Table 3: Estimated Failure Rates for Controls over Decreases in Billed Amounts of \$250 or More with No Explanation or an Ambiguous Explanation**

Test results	VA-wide medical centers	CPAC medical centers	Other medical centers
Estimated failure rates	38%	16%	39%

Source: GAO tests of VA-wide random probability sample of third-party accounts receivable data.

Note: Failure rates are based on the lower bound of our two-sided, 95 percent confidence interval.

## VA Lacks Policies and Procedures for Assuring Adequate Oversight of Third-Party Billings and Collections

Our review of VA and VHA policies and procedures, process walk-throughs, and interviews of VHA Chief Business Office (CBO)<sup>30</sup> officials and management officials at our case study medical centers determined that there are no formal policies and procedures for oversight of the third-party insurer billing and collection processes by medical centers or VHA. In addition, we found that medical centers and VHA have few standardized management reports to facilitate oversight. Because VA's health care billing and collection systems operate as stand-alone systems at each medical center, VA-wide reporting is dependent on numerous individual queries and data calls. As a result, we found little or no monitoring and oversight of the third-party billing and collection processes. This raises concerns about adequacy of oversight over the \$1.7 billion in unbilled amounts at the 18 case study medical centers, including the hundreds of millions of dollars in unbilled amounts related to coding, billing, and documentation errors, and other undefined reasons. The lack of formal VA policies for management oversight of third-party billings and collections also raises VA-wide concerns.

Enhanced oversight would permit VHA and medical center management to monitor trends and performance metrics, such as increases or decreases in unbillable amounts.

<sup>30</sup> CBO was established in April 2002 as the single accountable authority for the development of administrative processes, policy, regulations, and directives associated with the delivery of VA health benefit programs. CBO is composed of independent offices in the field that are dedicated to health benefits administration and revenue-related programs.

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## Case Study Medical Centers Performed Little or No Monitoring of Third-Party Insurer Billing and Collection Activity

Although VA has not established formal policies and procedures for oversight of third-party insurer billings and collections, officials at the 18 case study medical centers told us they perform some oversight. For example, officials at all 10 of the case study medical centers with low billing performance indicated that they perform limited oversight of unbilled amounts with no documentation and insufficient documentation reason codes. None of the officials we interviewed provided us documentation of their monitoring or oversight procedures. According to our interviews, oversight procedures varied by medical center. For example, one medical center official told us that she performs a monthly review of the insufficient documentation and no documentation reason codes. A second medical center official told us that a review of the codes had not yet been performed in fiscal year 2008, but that quarterly reviews usually have been performed. Another medical center official told us that she randomly selects between three and six bills per coder that were designated as unbillable for documentation reasons and reviews them for accuracy. Further, an official at a fourth medical center told us that she sees a potential risk that a billing clerk could clear out a billing backlog by inappropriately assigning reasons not billable codes to medical procedures waiting to be billed. While it is unlikely that this would occur, such a problem would only be detected if proper reviews were being performed by medical center management. None of the officials at the 10 medical centers indicated that their reviews included any of the other reasons not billable, such as service-connected medical services or medical services not covered by third-party insurance companies. As illustrated previously in figure 3, documentation errors, the focus of the 10 medical centers we reviewed, made up only 1 percent of the total amount not billed by the 10 medical centers during fiscal year 2007. Without reviewing all of the patient services deemed to be unbillable, the 10 medical centers do not have reasonable assurance that their unbilled amounts are accurate and appropriate. Further, officials at three case study medical centers that were also in our VA-wide sample for testing collection follow-up told us they performed little or no monitoring of collection follow-up activity because existing management reports did not facilitate their oversight.

Although CPAC also lacked formalized policies and procedures for management oversight of unbilled amounts, CPAC officials told us that they reviewed unbilled amounts assigned to reason codes they consider to have a high risk of error. However, CPAC officials did not provide us any documentation of their oversight and monitoring procedures. For example, CPAC officials told us that they perform weekly reviews of unbilled amounts assigned to the service-connected reason not billable code. If doubt exists as to whether the patient's condition is actually

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service-connected, quality assurance personnel send the medical services record to the facility where the bill was generated for further review. This provides management assurance that the encounters not billed for that reason are appropriately classified. The officials said they also prepare trend analyses for three types of documentation errors—no documentation, insufficient documentation, and not a billable provider. The officials said they also do some review of coding and billing errors. CPAC officials stated that if a particular unbillable code is increasing from month-to-month, they investigated the cause of the increase and took appropriate action to mitigate the problem. According to CPAC officials, experienced medical coders in their Quality Assurance Division review the diagnosis codes for service-connected patient encounters for reasonableness and documentation of the medical condition.

At the eight CPAC medical centers, oversight of the collection process consists of supervisory reviews. For example, supervisors in the collections follow-up department perform quality reviews of clerks. A clerk is tested every 2 weeks until the clerk receives two consecutive reviews with no exceptions. The clerk is then reviewed monthly. The reviews involve testing five claims for proper follow-up.

We found that medical centers have few standardized management reports to facilitate oversight. Our analysis of medical center Reasons Not Billable reports found that these reports consist of a list of over 100 reason codes for unbillable amounts that are not summarized by major categories, such as the five categories we identified, to facilitate management review and decision making.

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## VA Lacks Policies and Procedures and Reporting Mechanisms for Oversight of Third-Party Billings and Collections

Our review of VA and VHA policies and procedures and our interviews with CBO officials determined that VA lacked formal policies and procedures for oversight of the billing and collections processes related to third-party insurers. In addition, we found that VA and VHA have few standardized management reports to facilitate oversight. For example, our review of CBO reports found that these reports generally consist of data on VA-wide days to bill, accounts receivable, and collections. VHA CBO does not generate detailed performance reports by medical center, and it does not review unbilled amounts.

Limitations in management reporting relate to VHA systems design. For example, VistA operates as a stand-alone system at each medical center. As a result, VHA's CBO does not have direct access to medical center data, and it would need to use data calls to obtain medical center data for

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monitoring and oversight. Consequently, VHA developed the Performance and Operations Web-Enabled Reports (POWER) system as a data warehouse for VistA data and information to provide some additional management information capability. However, as a data warehouse POWER does not provide a full range of standard management reports needed for oversight, and obtaining management information from POWER for oversight and monitoring purposes would necessitate numerous individual management queries and data compilations.

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## VHA Has Undertaken Several Initiatives to Increase Third-Party Revenue

In response to long-standing weaknesses in third-party billing and collection processes, VA undertook several initiatives aimed at increasing revenue from third-party billings and collections. According to VA documentation, the improvement initiatives were developed by engaging key VHA leaders and other stakeholders in a comprehensive review of revenue cycle business process activities, from patient intake and insurance verification through billing and collection as well as planning and implementation efforts. As discussed previously, we assessed controls for coding and billing accuracy and collection follow-up for medical centers under the CPAC pilot initiative. However, we did not evaluate the six ongoing initiatives, some of which are open ended or will not be completed for several years. Effective management oversight and implementation will be key to the success of these initiatives. The following section summarizes recently completed VA initiatives, including improvements in recruitment and retention of coders and updates of key VHA policy guidance. Ongoing initiatives include six key strategic initiatives for increasing third-party revenue.

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### Recently Completed Revenue Enhancement Initiatives

The following two VHA initiatives to enhance third-party revenue were completed in 2006 and 2007.

**Recruitment and Retention of Coders and Health Information Managers.** Over the past several years, VHA has pursued improvements in the capture of medical charges and clinical documentation to enhance third-party collections. The first of three improvements, completed in December 2006, resulted in implementation of a plan to improve recruitment and retention of coders and health information managers within VHA through reclassification of employee positions in Office of Personnel Management occupation series 675, medical record technicians, and series 669, medical record administrators, from regular civil service positions to unique hybrid health-care civil service positions. The position reclassifications, which were effective on December 6, 2006, removed

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many hiring delays and provided opportunities for employee special advancement for professional achievement while in VA service. As of October 2007, VHA had 2,024 employees in the 675 medical record technician job series and 430 employees in the 669 medical record administrator job series.

**Updated VHA Policy Guidance.** VHA updated its policy guidance on coding staff qualifications, accurate coding and documentation of medical services, and closing dates for reporting these data for performance measures and corporate management reporting. The updated guidance was incorporated in the following VHA policy documents during 2006 and 2007.

- VHA Directive 2006-026, *Patient Care Data Capture*, dated May 5, 2006, contains requirements for capture of all outpatient encounters, inpatient appointments in outpatient clinics, and inpatient billable services. This directive also requires that each clinic is set up with appropriate Decision Support System identifiers to help ensure the accuracy of coding for patient care encounters.<sup>31</sup>
- VHA Directive 2006-035, *Surgical Case Coding*, dated May 30, 2006, provides policy for surgical code assignments based on International Classification of Diseases (9th Revision) Clinical Modification and Current Procedural Terminology (4th Edition). The policy also notes recent software changes and reiterates VHA policy on accurate capture of coded data within the surgical package, including requirements for qualified coding staff, accurate source documentation, and timely and accurate entry of codes. In addition, the directive makes VISN directors responsible for ensuring that the Surgery Version 3.0 software patch is installed on all medical centers' VistA systems in accordance with nationally distributed software packages. The directive also makes medical center directors responsible for ensuring that surgical coding is conducted by qualified staff using the Update/Verify Procedure/Diagnosis Codes option within the surgery package or using an encoder that is interfaced with the surgery package for entry of coded procedures and diagnoses for all surgeries.<sup>32</sup>
- VHA Directive 2007-030, *Closeout of Veterans Health Administration Corporate Patient Data Files, Including Quarterly Inpatient Census*,

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<sup>31</sup> VHA Directive 2006-026, Sections 1 and 2.

<sup>32</sup> VHA Directive 2006-035, Sections 1 through 4.

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dated September 27, 2007, changed the close out date to ensure that all corporate data are available when extracted for performance measures and other corporate reporting needs. Accordingly, this directive requires inpatient coding to be completed no later than the 14th day following patient discharge and outpatient coding to be completed no later than 14 days after the outpatient visit.<sup>33</sup>

VHA Handbook 1907.03, *Health Information Management, Clinical Coding Program Procedures*, dated November 2, 2007, as previously discussed, establishes minimum standards for coding productivity, including specific time frames for completing bill coding for various medical services, and a minimum 95 percent coding accuracy standard. The Handbook also includes suggested coding staffing requirements, coding staff qualifications, coding contract services, and coding function efficiencies.<sup>34</sup>

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## VA Has Six Key Strategic Initiatives Under Way To Enhance Third-Party Revenue

In October 2005, VHA's Revenue Optimization Plan Enhancement (ROPE) work group identified six key strategic initiatives for improving revenue performance. Many of these initiatives represented continuing actions that were previously initiated under VHA's Revenue Action Plan (RAP)—the predecessor to ROPE. The first initiative is targeted for completion in May 2008. As of the end of our field work in April 2008, VA had not provided target dates for full implementation of the other five initiatives. A brief overview of the six initiatives and their current status follow.

**Revenue Improvement Demonstration Project (RIDP).** The RIDP (outlined in congressional reports discussing the fiscal year 2006 appropriation for VHA's medical administration account)<sup>35</sup> was established to further advance revenue performance within a single VISN and develop a comprehensive national revenue model by integrating contractor-supported process modeling and business reengineering efforts. According to VA documents, CPAC was selected to be the host of this demonstration project because the objective was seen as a complimentary effort to the CPAC initiative that was already under way. The RIDP initiative was

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<sup>33</sup> VHA Directive 2007-030, Sections 2 and 4.

<sup>34</sup> VA Handbook 1907.03, Sections 12, 13, and 5, respectively.

<sup>35</sup> See H.R. Conf. Rep. No. 109-305, at 43 (Nov. 18, 2005); H.R. Rep. No. 109-95, at 56 (May 23, 2005); Military Quality of Life and Veterans Affairs Appropriations Act, 2006, Pub. L. No. 109-114, tit. II, 110 Stat. 2372, 2384-85 (Nov. 30, 2005).

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divided into two major phases. The first phase was an operational assessment of revenue cycle functions in order to create additional cash flow and to assist with the development of a model that could be replicated nationally. The second phase of RIDP has two parts – Parts A and B. Part A, which was completed during fiscal year 2007, covered phase 1 implementation and benefit realization. Under Part A, a revenue cycle processing environment was established, staff and leadership received training in new processes and techniques, and transition and permanence activities were completed. Part B, which was scheduled to be completed in May 2008, covers transition monitoring and sustainability.

**Clinical Data Entry(CDE).** According to VA officials, CDE was developed to improve the currently existing Clinical Indicators Data Capture (CIDC) VistA software. CIDC was not implemented nationally because of concerns related to the provider-patient interaction and provider productivity. However, functional requirements and software design were to be revisited so that expanded clinician involvement could be included. According to VA, the expected outcome of CDE is twofold—first, to recommend software that can be designed to automatically capture clinical data as a by-product of the clinical encounter instead of as an extra step, and second, to accommodate revenue capture of high-volume/dollar procedures that are being performed, but not billed in VistA. CDE was targeted for completion in May 2007. However, upon extensive work with clinicians, the project team concluded that a fundamental change was required in the Computerized Patient Record System (CPRS) in order to effectively accomplish the project goal. According to VA information technology officials, the CDE design recommendations and accompanying business flow diagrams will be included as a part of Computerized Patient Record System Reengineering, referred to as CPRS-R. An implementation date for this initiative has not yet been determined.

**National Revenue Contracts Office.** According to VA, the National Revenue Contracts Office initiative is designed to leverage VHA's size and financial purchasing power to develop national relationships for both payer agreements and contracts for vendors who provide support for revenue cycle activities. The National Payer Relations Office (NPRO) is currently pursuing strategies to effectively manage relationships with third-party insurance companies. VHA's first national payer agreement, with Aetna, was completed in 2007 and a second national agreement with United Healthcare is expected to be effective May 2008. According to VA officials, the National Payer Relations Office has completed 78 regional agreements and is currently working on negotiating an additional 10 agreements.

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According to VA officials, a Revenue Contracts Program component was established under NPRO to improve management of vendors used to support VHA revenue cycle activities by developing better rates and consistency in payment terms, expectations, and performance standards. VA hopes that this Program will ensure more consistent terms and conditions for frequently used revenue cycle contracts. For example, VA established national Blanket Purchase Agreements (BPA) for both coding and insurance identification/verification products and services. According to VA officials, the Revenue Contracts Program is currently working on establishing BPAs for third-party billing and accounts receivable follow-up. As of the end of our field work in April 2008, VA had not provided us with a target date for completing BPAs for third-party billing and accounts receivable follow-up.

**Revenue Improvements and Systems Enhancement (RISE) Plan.** A major driver in VA's revenue optimization strategy is a Patient Financial Services System (PFSS) project directed by Congress, which seeks to remedy significant business process and technology issues in VA's revenue-related financial systems.<sup>36</sup> Building on the initial PFSS project and to continue ongoing improvement efforts, the VHA CBO chartered a RISE project team. RISE is part of the VistA modernization action program. The primary objective of RISE is to provide comprehensive tools for seamless sharing of required administrative and clinical information to support billing and related revenue activities across the enterprise. The four goals of the RISE plan are (1) defining a clear vision for revenue cycle activities across VHA, (2) replacing or enhancing aspects of current integrated billing and accounts receivable systems, (3) improving all related business processes by implementing structured IT support systems while delivering automated tools to improve revenue cycle efficiency, and (4) identifying process improvements for VHA that drive improvement in revenue cycle activities while leveraging enhanced IT support systems.

According to VA officials, the RISE team is currently developing detailed short- and long-term business process and technology strategies in all areas of the revenue program. The RISE team is also developing accompanying documentation that defines end-to-end processes and that will form the requirements for the framework of the overall system

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<sup>36</sup> In the conference report accompanying its fiscal year 2002 appropriation, VA was directed to begin a demonstration project of a patient financial services system installed and operated by a contractor. H.R. Conf. Rep. No. 107-272, at 56 (Nov. 6, 2001); *see also* H.R. Rep. No 107-159, at 11 (July 25, 2001).

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improvement initiative. This document will include (1) a vision and scope document which defines services and capabilities required from the future state revenue system and (2) a business case, which incorporates process definitions; a program governance structure to oversee operations; a communications plan for the business program; and definitions to identify requirements for a new end-to-end revenue system. As of the end of our field work in April 2008, VA had not provided us with a targeted implementation date for this initiative.

**Revenue Cycle Enhancement Reviews.** VHA has implemented an initiative to identify opportunities to further enhance revenue potential using Revenue Cycle Enhancement Teams (RCET). On-site reviews and development of corrective action plans are ongoing. The objective of this initiative is to identify available operational opportunities and provide recommendations to improve overall cash flow. A review team consists of VHA subject matter experts who are deployed to lower performing facilities to assess core revenue cycle functions, including patient intake and insurance verification, utilization review, coding, billing, and accounts receivable. The methodology employed by the team in completing reviews includes a combination of data analysis and on-site observation of activities.

Following the on-site review, the team provides an action plan to the facility that outlines tasks that need to be completed within the next 90 days and participates in conference calls to ensure completion of all identified action items. VHA CBO reported that it had completed reviews at 30 facilities (through January 2008) and that those facilities have generally increased revenue collections following these reviews. As of the end of our field work in April 2008, VA did not have a list of planned visits, and it had not provided us with a targeted implementation date for this initiative.

**Consolidated Patient Account Centers (CPAC).** CPAC is based on a private sector model that is tailored for VHA's specific requirements. The CPAC model consists of a stand-alone, regionalized billing and collection activity supported by remote utilization review, data validation, and customer service functions that are organizationally aligned with the consolidated center. CPAC is being developed in three phases. Phase I, which focused on designing a work flow model and new organizational structure within a pilot VISN-VISN 6, operating as CPAC—was completed September 30, 2006. In fiscal year 2006, CPAC reported that it achieved 99 percent of its targeted collections, increasing total VISN 6 collections by

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approximately \$10 million over fiscal year 2005. In fiscal year 2007, CPAC reported that it achieved 110 percent of its targeted collection, increasing total VISN 6 collections by \$23 million over fiscal year 2006.

Phases II and III address expansion of the CPAC pilot program. Phase II, which includes moving the consolidated center into a new physical plant to support workflow models developed in Phase I as well as expansion of existing operations to service an additional VISN and is scheduled for completion by the end of fiscal year 2008. Phase III addresses national expansion. VHA is currently working on a VA-wide implementation strategy based on experiences from the CPAC pilot in VISN 6. As of the end of our field work in April 2008, VA had not provided us with targeted implementation dates for Phase III.

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## Conclusions

Although VA has made some progress in improving policy guidance and processes for billing and collecting medical care receivables from third-party insurers, medical centers have significant, continuing weaknesses in controls over coding, billing, and collections follow-up that prevent VA from maximizing hundreds of millions of dollars in potential revenue from third-party insurance companies. The fundamental weaknesses are a lack of proper processing of billing information, inadequate follow-up on unpaid third-party accounts receivable, and inadequate management oversight by medical center and VA management. Unless VA effectively addresses these weaknesses, it will continue to use higher amounts of appropriations from the General Fund of Treasury to provide medical care to the nation's veterans than otherwise would be necessary, thereby placing a higher burden on taxpayers.

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## Recommendations

We recommend that the Secretary of Veterans Affairs require the medical centers to take the following seven actions to maximize revenue from third-party insurer billings and collections.

First, to assure that all amounts that should be billed to third-party insurers are billed in an accurate and timely manner, we recommend that the Secretary take the following two actions.

- Establish procedures requiring medical center management to perform and document detailed monthly reviews of patient encounters determined to be nonbillable by coding staff to ensure they are properly coded.

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- Establish procedures requiring medical center management to develop and use management reports on medical center performance with respect to accuracy and timeliness of billing performance and take appropriate corrective action.

Second, to assure timely follow-up and documentation of unpaid third-party billings, we recommend that the Secretary take the following three actions.

- Establish a process requiring medical centers to monitor their accounts receivable staffs' adherence to the requirement in VA Handbook 4800.14, *Medical Care Debts*, to follow-up on outstanding third-party accounts receivable within specified time frames.
- Establish a mechanism requiring medical centers to monitor their accounts receivable staff adherence to VA Handbook 4800.14, *Medical Care Debts*, which requires documenting a brief summary of all follow-up contacts, including information on when a payment will be made or why a payment was not made.
- Establish a process requiring medical centers to confirm that accounts receivable staff are following the requirement in VHA Handbook 4800.14, *Write-Offs, Decreases, And Termination of Medical Care Collections Fund Accounts Third-Party Receivable Balances*, to provide a specific explanation for any adjustments to decrease third party accounts receivable from third-party insurers.

Third, to assure effective VA-wide oversight of billings and collections with regard to third-party insurers, we recommend that the Secretary take the following two actions.

- Require VHA to establish a formal VA-wide process for managing and overseeing medical center billing performance, including development of standardized reports on unbilled amounts by category.
- Establish procedures requiring periodic VHA-wide assessments by the Chief Business Office to document whether medical center staff are performing timely and accurately documented follow-up on outstanding third-party accounts receivable, as required in VHA Handbook 4800.14.

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## Agency Comments and Our Evaluation

On May 22, 2008, the Secretary of Veterans Affairs provided written comments on a draft of this report. VA officials concurred with all seven of our recommendations and provided information on steps it is taking to address them. However, VA's letter stated that our report overstated findings related to the potential for lost revenue to the government and inadequate levels of oversight. VA's letter also stated that our conclusion on collections improvement minimizes the significant gains VA has made and that several improvement initiatives were so successful that they have been designated as ongoing.

With regard to VA's comment that we overstated findings related to the potential for lost revenue to the government, we added language to our report to indicate that \$1.4 billion of the \$1.7 billion in unbilled medical services at the 18 case study medical centers were classified as service-connected, Medicare coverage, or lack of private health insurance coverage. However, as noted in our report, although certain medical services are not billable, such as service-connected treatment, VA management has not validated reasons for these unbilled amounts to assure that all billable costs are charged to third-party insurers. Further, we focused on unbilled amounts related to coding, billing, and documentation errors and other undefined problems as a basis for making recommendations for increasing third-party revenues. In this regard, we identified \$291.5 million in unbilled amounts due to errors at the 18 case study medical centers.

With regard to VA's statement that it has established significant levels of oversight, our report noted that VA has agencywide data on days to bill, accounts receivable, and collections. However, we found that VA has not established policies and procedures for management oversight of unbilled amounts or compliance with follow-up requirements for outstanding third-party receivables. Further, although POWER generates metrics for several performance indicators, these metrics do not provide VA with the full range of management reports needed to adequately monitor unbilled amounts and compliance with follow-up procedures. VA concurred with our recommendation to establish oversight of unbilled amounts and compliance with follow-up procedures and described systems enhancements and improved monitoring activities that it expects will address the problems related to billings, collections, and oversight we identified.

With regard to VA's comment that it made significant gains in collecting third-party revenue since fiscal year 2004, there are a number of factors that need to be considered to measure the extent of VA's success. For

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example, VA also experienced an increase of 500,000 patients that were treated at VA medical centers during the 4-year period. In addition, the rate of inflation for medical care over the last 4 fiscal years and changes in inpatient and outpatient mix would need to be considered. Further, VA's efforts to address billing backlogs over the 4-year period could have also contributed to the increased revenue. This type of analysis was outside the scope of our audit and would require further study to determine the impact of these factors on VA's collection gains. Despite VA's increased third-party collections, our work showed there is a significant opportunity to increase revenue from third-party insurers by (1) correcting errors that have prevented appropriate billings to third-party insurers and (2) performing timely and effective follow-up on unpaid receivables.

VA's statement that several initiatives to enhance third-party revenue were so successful that they have been designated as ongoing implies that target dates for completion are not necessary. We support the concept of ongoing efforts for continuous improvement in operations. However, three of the six initiatives were begun in 2002 and have encountered significant slippage and refocusing under revised management plans. For example, initiatives related to Clinical Data Entry, the National Revenue Contracts Office, and CPAC began under the Revenue Action Plan (RAP), which was approved in July 2002. These initiatives were later incorporated under the Revenue Optimization Plan Enhancement (ROPE) plan in 2005. In addition, the RISE plan for revenue-related system enhancements was initiated under ROPE. Targeted implementation dates and milestones will be key to assisting management in overseeing these initiatives to assure that intended goals are accomplished within reasonable time frames.

Finally, VA officials informed us at the conclusion of our audit that they revised their follow-up requirements for third-party receivables to require increased focus on unpaid high-dollar amounts and provide more flexibility in follow-up time frames for smaller dollar amounts. For example, VA's revised policy will focus on collection follow-up for amounts of \$1,500 and above within 45 days of the billing date. However, the revised policy would extend the date for the first follow-up for bills from \$250 to \$1,500 to be within 60 days of the initial bill. Going forward, it will be important for VA to oversee and monitor the implementation of the new policy as part of its management oversight process in order to determine if the new policy is achieving intended results and, if not, to perform additional analysis and make appropriate policy changes to assure effective follow-up on unpaid third-party bills.

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VA also provided technical comments and corrections which we have addressed in our report, as appropriate. VA's comments are reprinted in appendix II.

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As agreed with your offices, unless you announce its contents earlier, we will not distribute this report until 30 days from its date. At that time we will send copies of this report to interested congressional committees; the Secretary of Veterans Affairs; the Acting Secretary of Health, Veterans Health Administration; the VHA Chief Business Officer; and the Director of the Office of Management and Budget. We will make copies available to others upon request. In addition, this report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

Please contact me at (202) 512-9095 or [dalykl@gao.gov](mailto:dalykl@gao.gov), if you or your staff have any questions concerning this report. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report are acknowledged in appendix IV.



Kay L. Daly  
Acting Director  
Financial Management and Assurance

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# Appendix I: Objectives, Scope, and Methodology

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Pursuant to requests from the Chairman and Ranking Minority Member of the House Committee on Veterans' Affairs and the Chairman and Ranking Minority Member of the Subcommittee on Oversight and Investigations, we performed a follow-up audit of controls over VA's third-party billing and collection processes, including (1) an evaluation of the effectiveness of VA medical center billing processes at selected locations, (2) an assessment of medical centers' adherence to VA policies for performing timely follow-up on unpaid accounts receivable and proper documentation of follow-up contacts, and (3) a determination of the adequacy of VA oversight of billing and collection processes. In addition, we summarized the status of management initiatives undertaken to improve third-party billing and collection processes.

We used as our criteria applicable law and VA policy, as well as our *Standards for Internal Control in the Federal Government*<sup>1</sup> and our *Internal Control Management and Evaluation Tool*.<sup>2</sup> To assess the control environment at our test locations, we obtained an understanding of VA processes and controls over the third-party revenue cycle. We performed walk-throughs of these processes at several medical centers. We interviewed management officials at selected medical centers about their management oversight and accountability procedures over third-party billings and collections. We also reviewed applicable VA program guidance and local policies and procedures at selected test locations and interviewed officials about their billing and collection processes and controls. In addition, to assure the reliability of data and information used in this report, we reviewed VA documentation and interviewed key officials. We also reviewed VA procedures for assuring the reliability of data and information generated by key VA systems used in the third-party billing and collection processes, including VHA's Veterans Health Information Systems and Technology Architecture (VistA) and Performance and Operations Web-Enabled Reports (POWER) systems.

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<sup>1</sup> GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999). This document was prepared to fulfill our statutory requirement under 31 U.S.C. 3512 (c), (d), commonly known as the Federal Managers' Financial Integrity Act of 1982, to issue standards that provide the overall framework for establishing and maintaining internal control.

<sup>2</sup> GAO, *Internal Control Management and Evaluation Tool*, [GAO-01-1008G](#) (Washington, D.C.: August 2001). This document was prepared to assist agencies in maintaining or implementing effective internal control and, when needed, to help determine what, where, and how improvements can be implemented. Although this tool is not required to be used, it is intended to provide a systematic, organized, and structured approach to assessing the internal control structure.

To determine if the third-party revenue offices at our 18 case study locations had adequate management oversight and accountability for assuring timely and accurate billings, we obtained and reviewed management reports, including (1) Reasons Not Billable Summary and Detailed reports and (2) Elapsed Days to Bill performance reports. We compiled data from the Reasons Not Billable reports into a database and established categories of reasons not billed for further analysis. We coordinated with VHA officials on the identification of reasons not billed categories. We interviewed medical center revenue officials at the 10 case study medical centers with low billing performance and at CPAC, for the 8 CPAC case study medical centers, about their management oversight and accountability procedures. Table 4 shows the two groups of case study medical centers we examined and performance data on days to bill and unbilled amounts for each location.

**Table 4: Medical Centers Covered in Examination of Third-Party Billing Processes**

Medical center location	Average number of days to bill as of September 30, 2007	Unbilled amount as of September 30, 2007 (in millions)
<b>Ten medical centers with largest number of days to bill</b>		
North Texas Health Care System	109	\$ 233.3
West Los Angeles, California	110	139.4
Washington, D.C.	110	167.0
San Francisco, California	116	123.4
South Texas Health Care System	121	156.8
Columbus, Ohio	122	34.7
Marion, Indiana	122	56.2
Northern California Health Care System	123	151.2
Lebanon, Pennsylvania	134	119.2
Pacific Islands	146	23.4
<b>Subtotal</b>		<b>\$1,205.3</b>
<b>Eight medical centers under CPAC</b>		
Asheville, North Carolina	46	\$ 39.8
Beckley, West Virginia	37	16.3
Durham, North Carolina	68	66.5
Fayetteville, North Carolina	47	24.4
Hampton, Virginia	49	39.4
Richmond, Virginia	54	175.9
Salem, Virginia	49	81.3

<b>Medical center location</b>	<b>Average number of days to bill as of September 30, 2007</b>	<b>Unbilled amount as of September 30, 2007 (in millions)</b>
Salisbury, North Carolina	55	65.0
<b>Subtotal</b>		<b>\$508.7</b>
<b>Total</b>		<b>\$1,714.0</b>

Source: GAO analysis of medical center billing performance data.

We selected a VA-wide statistical sample of billing records to assess whether medical center accounts receivable personnel were adhering to VA policy for timely follow-up with private insurance companies on unpaid third-party receivables. From the universe of fiscal year 2007 collections activity, we stratified the billing records into one stratum for bills from CPAC and one stratum from all other VA medical centers. We randomly selected 60 bills from the CPAC stratum and 200 from the stratum for the rest of VA. We designed this sample for control testing with a 5 percent tolerable error rate so that if there were no errors in one of the strata, we would be able to conclude with 95 percent confidence that the billing records for that stratum were statistically compliant.

Our random sample of 260 bills included medical centers from each of the 21 VISNs. We used our statistical sample to assess the population of follow-up contacts for receivables greater than \$250 that were outstanding for at least 45 days at any point during fiscal year 2007. We explain the results of our statistical sample in terms of control attributes related to adherence to VA policy guidance for (1) performing timely initial and subsequent follow-up, as appropriate, on unpaid amounts, (2) whether accounts receivable personnel properly documented follow-up contacts, and (3) whether accounts receivable staff properly documented reasons why adjustments to decrease billed amounts were made. We present our statistical results as (1) our projection of the estimated error overall (failure rate) and for each control attribute as point estimates and (2) the 95 percent, two-sided, confidence intervals for control failure rates. Our 95 percent confidence interval means that if you were to determine an estimate for 100 different random samples, 95 out of 100 times, the estimate would fall within the confidence interval. In other words, the true value is between the lower and upper limits of the confidence interval 95 percent of the time. We generally report our statistical results as point estimates that fall within confidence intervals. However, because confidence intervals varied widely for our various control tests, we focused on the lower bound of our confidence intervals as a conservative estimate of our test results. As additional information, we present our

detailed test results below, including the point estimate and the upper and lower bound of our 95 percent confidence intervals. Table 5 shows our detailed test results for timely follow-up on unpaid third-party bills totaling \$250 or more.

**Table 5: Estimated Failure Rates for Controls on Timely Follow-up on Unpaid Third-Party Insurer Receivables Totaling \$250 or More**

Required follow-up	VA-Wide	CPAC medical centers	Non-CPAC medical centers
	Estimated failure rate and 95%, 2-sided confidence interval	Estimated failure rate and 95%, 2-sided confidence interval	Estimated failure rate and 95%, 2-sided confidence interval
Initial, 45 days	75% (69% to 80%)	48% (36% to 61%)	77% (71% to 83%)
Second, 21 days after 1st contact	54% (44% to 64%)	38% (23% to 54%)	57% (45% to 68%)
Third, 14 days after 2nd contact	34% (20% to 50%)	43% (22% to 66%)	32% (17% to 51%)

Source: GAO tests of a VA-wide random probability sample of third-party accounts receivable data.

Notes: Failure rates for the second and third follow-up contacts exclude bills that were paid before the dates required for these follow-up contacts. These follow-up contacts represent subsets of our sample; thus, the confidence interval (margin of statistical error) is wider. Similarly, CPAC and non-CPAC medical center results represent subsets of our VA-wide sample and also have wider margins of statistical error.

Table 6 shows the detailed results of our tests of VA-wide controls for documenting the details of follow-up contacts made with third-party insurers.

**Table 6: Estimated Failure Rates for Documenting Details of Follow-up Contacts on Unpaid Third-Party Bills of \$250 or More**

Required comment	VA-wide	CPAC medical centers	Non-CPAC medical center
	Estimated failure rate and 95 percent, 2-sided confidence interval	Estimated failure rate and 95 percent, 2-sided confidence interval	Estimated failure rate and 95 percent, 2-sided confidence interval
Initial, 45 days	81% (72% to 89%)	56% (38% to 72%)	85% (74% to 93%)
Second, 21 days after 1st contact	77% (59% to 90%)	71% (42% to 92%)	78% (58% to 91%)
Third, 14 days after 2nd contact	65% (35% to 88%)	88% (47% to 99.7%)	60% (26% to 88%)

Source: GAO tests of a VA-wide random probability sample of third-party accounts receivable data.

Notes: Failure rates for the second and third follow-up contacts exclude bills that were paid before the dates required for these follow-up contacts. These follow-up contacts represent subsets of our sample; thus, the confidence interval (margin of statistical error) is wider. Similarly, CPAC and non-CPAC medical center results represent subsets of our VA-wide sample and also have wider margins of statistical error.

Our tests of whether accounts receivable personnel adequately documented reasons for adjustments to decrease billed amounts found a VA-wide failure rate of 44 percent, as shown in table 7.

**Table 7: Failure Rates for Controls over Decrease Adjustments with No Explanation or an Ambiguous Explanation**

Test results	VA-wide	CPAC medical centers	Other medical centers
Estimated failure rate	44%	25%	46%
95 percent, 2-sided confidence interval	(38% to 51%)	(15% to 38%)	(39% to 52%)

Source: GAO tests of VA-wide random probability sample of third-party accounts receivable data.

Notes: Tests for CPAC and non-CPAC medical center results represent subsets of our VA-wide sample and, therefore, have wider margins of statistical error in our confidence intervals

To assess VA management oversight of third-party billing and collection processes, we interviewed medical center and CPAC management officials at our case study locations and reviewed available data and reports used by these managers. Three of our 10 case study locations with low billing performance and CPAC were also included in our statistical tests of

collection follow-up procedures. We also reviewed related VA and VHA policies and available VHA CBO management reports. In addition, we interviewed VHA officials about their oversight procedures, including limitations in systems reporting capabilities.

To follow up on management initiatives undertaken to improve third-party billings and collections, we obtained and reviewed information and interviewed VA managers on the objectives, status, and targeted completion dates for eight major initiatives. We did not evaluate the initiatives or independently assess the information provided by VA officials. However, we evaluated billing controls and tested compliance with controls for accounts receivable follow-up for the medical centers under the CPAC pilot initiative.

We briefed VA managers at our test locations and VA headquarters, including VA medical center directors, VA headquarters information resource management and property management officials, and VHA's Chief Business Officer on the details of our audit, including our findings and their implications. On April 30, 2008, we requested comments on a draft of this report. We received comments on May 22, 2008, and have summarized those comments in the Agency Comments and Our Evaluation section of this report. We conducted our audit work from January 2007 through May 2008 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

# Appendix II: Comments from the Department of Veterans Affairs



THE SECRETARY OF VETERANS AFFAIRS  
WASHINGTON  
May 22, 2008

Ms. Kay L. Daly  
Acting Director  
Financial Management and Assurance Team  
U. S. Government Accountability Office  
441 G Street, NW  
Washington, DC 20548

Dear Ms. Daly:

The Department of Veterans Affairs has reviewed your draft report, ***VA HEALTH CARE: Ineffective Controls over Medical Center Billings and Collections Limit Revenue from Third-Party Insurance Companies*** (GAO-08-675) and concurs with your recommendations.

We believe the report's "Highlights" page does not adequately explain to the reader that 83 percent (\$1.42B) of the \$1.7B reviewed as unbillable for these 18 medical centers is for care that is either service-connected or cannot be billed because of the type of insurance policy (HMO, Medicare) or type of visit. For the 10 test sites aside from the Consolidated Patient Accounts Center (CPAC), 79 percent (\$951.1M) of the \$1.2B reviewed as unbillable is for care that is either service-connected or cannot be billed to an insurance because of the type of insurance policy (HMO, Medicare) or type of visit. For the CPAC, 93 percent (\$471.2M) of the \$508.7M reviewed as unbillable is for care that is either service-connected or cannot be billed to an insurance carrier because of the type of insurance policy or visit. We believe this lack of information leads to the overstated conclusion about potential lost revenue to the government.

Contrary to GAO's determination that "*VA has not yet established effective management oversight of VA-wide third-party billing and collection operations,*" VA has established significant levels of such oversight operations. Specifically, VA has established industry standard performance metrics for senior level oversight (Gross Days Revenue Outstanding, Days to Bill, Accounts Receivable over 90 Days and Total Collections), which are reported on a monthly basis to VA's senior managers during the Monthly Performance Review. Additionally, VA facility and network directors have performance standards they must meet for revenue cycle metrics. Facility Compliance and Business Integrity Office (CBI) programs complement oversight monitoring by providing independent validation of existing controls. VHA Directive 1030, *Compliance and Business Integrity (CBI) Program*, requires CBI to evaluate and assess policies, procedures,

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Ms. Kay L. Daly

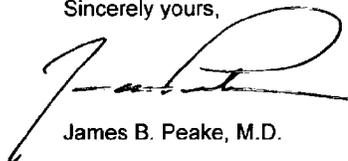
systems, and control environments the VHA Chief Business Office has established

GAO's conclusion regarding collections improvement minimizes the significant gains VA has made. Specifically, since fiscal year (FY) 2004, VA's Medical Care Cost Fund (MCCF) total collections increased from \$1.7B to \$2.2B in FY 2007 (a 29.4 percent increase), and the third-party component of these collections increased from \$960,000 to \$1.26M (a 31.3 percent increase). During this same time period, VA's national third-party average days to bill improved from 68.7 to 63.9 days. Finally, VA has continued to improve its management of accounts receivable as evidenced by the fact that only 28 percent of accounts receivable are over 90 days compared to 31.2 percent at the end of FY 2007.

Several initiatives to enhance third-party revenue were so successful that they have been designated as ongoing; however, GAO's report summarizes these efforts as open-ended or not to be implemented for several years. In particular, revenue assist team visits and national payer relations efforts have dramatically improved revenues and, therefore, VA will continue them for subsequent years. Other initiatives such as the Revenue Improvements and Systems Enhancement project and Consolidated Patients Accounts Centers are longer term initiatives due to their large scope involving funding, systems changes and organizational impact.

The enclosure provides more detailed comments to your draft report, action plans to implement the recommendations, and needed technical corrections. Thank you for the opportunity to comment on your draft report.

Sincerely yours,



James B. Peake, M.D.

Enclosure

Enclosure

DEPARTMENT OF VETERANS AFFAIRS (VA)  
COMMENTS TO  
GOVERNMENT ACCOUNTABILITY OFFICE (GAO)  
DRAFT REPORT:  
***VA HEALTH CARE: Ineffective Controls over Medical Center Billings and  
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GAO-08-675

To assure that all amounts that should be billed to third-party insurers are billed in an accurate and timely manner, GAO recommends that the Secretary take the following two actions:

- Establish procedures requiring medical center management to perform and document detailed monthly reviews of patient encounters determined to be non-billable by coding staff to ensure they are properly coded.
- Establish procedures requiring medical center management to develop and use management reports on medical center performance with respect to accuracy and timeliness of billing performance and take appropriate corrective action.

Concur: Amounts billed to third-party payers should be performed in an accurate and timely manner including reviewing patient accounts determined to be non-billable and using reports to monitor accuracy and timeliness of billing performance.

- Review of Encounters Determined to Be Non-Billable  
In November 2007, the Veterans Health Administration (VHA) issued VHA Handbook 1907.03, *Health Information Management, Clinical Coding Program Procedures* that established minimum bill coding accuracy standards and provided procedures for conducting coding reviews for many different purposes including coding for third-party billing. VA will supplement this guidance by developing new procedures for specifically monitoring reasons not billable codes due to documentation and coding that are entered into the billing system.
- Timeliness and Accuracy of Billing Performance  
With regard to the accuracy of billing, VA has a systems enhancement in progress to standardize reason not billable codes that staff uses when reviewing episodes of care. When complete, this systems enhancement will prohibit facilities from adding locally developed reason codes, which make monitoring billing compliance difficult for managers. To monitor more effectively medical center management's accuracy of billing, VA will also publish guidance for supervisors to review the reasons not billable report on a

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monthly basis and take appropriate actions to ensure accurate use of the reasons not billable codes.

**To assure timely follow-up and documentation of unpaid third-party billings, GAO recommends that the Secretary take the following three actions:**

- Establish a process requiring medical centers to monitor their accounts receivable staffs' adherence to the requirement in VA Handbook 4800.14, Medical Care Debts, to make follow-ups on outstanding third-party accounts receivable within specified timeframes.
- Establish a mechanism requiring medical centers to monitor their accounts receivable staff adherence to VA Handbook 4800.14, Medical Care Debts, which requires documenting a brief summary of all follow-up contacts, including information on when a payment will be made or why a payment was not made.
- Establish a process requiring medical centers to confirm that accounts receivable staff are following the requirement in VHA Handbook 4800.14, Write-Offs, Decreases, And Termination of Medical Care Collections Fund Accounts Third-Party Receivable Balances, to provide a specific explanation for any adjustments to decrease accounts receivable from third-party insurers.

**Concur:** In an effort to understand low compliance rates with follow-up standards, VA researched industry norms and conducted a review of its current third-party accounts receivable portfolio, including stratification by age and dollar amount of the receivable, to determine the average age at time of first collection as well as average dollar amount collected. This analysis, plus the estimated cost to generate a bill and perform the necessary follow-up activities to collect outstanding receivables indicated that changes were necessary to current follow-up guidelines to ensure they are both reasonable and consistent with industry practice. Moreover, VA believes it is important to focus efforts on higher-dollar, more collectible claims. As a result of the above analysis, VA proposed new guidelines that include more stringent follow-up standards on the highest-dollar claims, which are the smallest number of outstanding receivables, but represent

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the largest dollar amount of outstanding receivables. Additionally, these new standards provide more flexibility relative to follow-up for low-dollar claims, which represent the highest number of outstanding receivables. The rationale for this stratification is to ensure claims that normally process within a certain period of time are not targeted for follow-up prior to normal processing cycles and that follow-up resources are spent on receivables that will produce the maximum return on the time invested. Based on this review and with approval of senior management, VA issued revised guidance for third-party follow-up to the field on April 28, 2008. VA believes this revised guidance, which we shared with GAO prior to publication of its report, should assist facilities in meeting follow-up standards based on prioritizing follow-up first on higher dollar receivables and then on those accounts with lower values.

• **Monitoring of Accounts Receivable Follow-up**

VA agrees that a standard process and mechanism to monitor staff adherence to accounts receivable follow-up requirements is necessary. Therefore, VA has developed several system enhancements, which when complete, will assist field staff in thoroughly monitoring both the timeliness and accuracy of accounts receivable follow-up according to published guidelines. As part of these systems enhancements, reports will be generated on follow-up actions to determine staff compliance with requirements. In FY 2008, Financial Quality Assurance Managers located in each Veterans Integrated Service Network (VISN) began monthly audits of follow-up based on a sample of accounts receivable and provide this information to facility management in an effort to track compliance and take corrective actions as needed.

• **Monitoring of Account Adjustments**

VA agrees it is critical to ensure processes are in place to monitor staff adherence with guidelines to performing adjustments on accounts receivable. VA recently published instructions to field supervisors requiring them to conduct monthly reviews in order to ensure these transactions are accurate and appropriately documented. Supervisors are required to share the review with facility Compliance Officers for monitoring and appropriate action.

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(Continued)

**To help assure effective VA-wide oversight of billings and collections with regard to third-party insurers, GAO recommends the Secretary take the following two actions:**

- **Require VHA to establish a formal VA-wide process for managing and overseeing medical center billing performance, including development of standardized reports on unbilled amounts by category.**
- **Establish procedures requiring periodic VHA-wide assessments by the Chief Business Office to document whether medical center staff are performing timely, accurately documented follow-up on outstanding third-party accounts receivable, as required in VHA Handbook 4800.14.**

Concur: VA agrees with the need to ensure oversight of third-party billings and collections and has several activities already in-progress. As described in the response to recommendation number one above, VA is developing a systems enhancement to implement a standard list of reasons not billable for staff to use when reviewing and processing potentially billable episodes of care. Additionally, this systems enhancement will prohibit facilities from adding locally developed reason codes, which make monitoring billing compliance difficult for managers. Second, VA will publish guidance for supervisors to review the reasons not billable report on a monthly basis and take appropriate actions to ensure accurate use of the reasons not billable codes. Finally, VA will implement a periodic data call to review the use of the reasons not billable at a national level in order to take necessary corrective actions.

With regard to compliance with published follow-up guidelines for accounts receivable, as noted under recommendation 2 above, VA Financial Quality Assurance Managers located in each VISN conduct monthly audits of follow-up based on a sample of accounts receivable and provide this information to VA-wide management in an effort to track compliance and take corrective actions as needed.

A joint work group of the VHA business program offices, comprised of the Chief Business Office (CBO), Chief Finance Office, Chief Compliance and Business

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Integrity Office (CBI), and Health Information Management was established in January 2007 and meets routinely to address jointly business quality improvement, business integrity, and strengthening of internal control environments. Further, these offices all participate in national level business improvement activities through the National Leadership Board Business Performance Improvement Committee (NLB BPIC) established in 2007 by the VHA Under Secretary for Health. Through these forums and others, CBI and CBO continue to collaborate to enhance the control environment for business operations.

# Appendix III: Actual Test Results for Timely First Follow-up on Unpaid Bills with Third-Party Insurers

Table 8 lists our actual test results for timely first follow-up on unpaid third-party billings by medical centers within each VISN. As noted at the end of the table, 183 of the 260 bills in our stratified random sample failed this control test.

**Table 8: Actual Control Test Results Related to the Requirement for Initial Collections Follow-up**

Medical center number	Medical center location	Number of bills tested	Number of bills with untimely first follow-up
<b>Veterans Health Administration: VISN 1: VA New England Healthcare System</b>			
650	Providence, Rhode Island	1	1
402	Augusta, Maine	2	2
523	Boston Health Care System, Jamaica Plain Campus, Massachusetts	2	1
689	Connecticut Health Care System, West Haven Campus	1	0
405	White River Junction Regional Office, Vermont	1	1
<b>Veterans Health Administration: VISN 2: VA Healthcare Network Upstate New York</b>			
528	Western New York Healthcare System at Buffalo	6	6
<b>Veterans Health Administration: VISN 3: Veterans Integrated Service Network</b>			
526	Bronx, New York	1	1
630	Manhattan Campus of the NY Harbor Health Care System	3	3
632	Northport, New York	1	1
<b>Veterans Health Administration: VISN 4: VA Stars &amp; Stripes Healthcare Network</b>			
503	Altoona, Pennsylvania	1	1
542	Coatesville, Pennsylvania	1	1
595	Lebanon, Pennsylvania	2	2
642	Philadelphia, Pennsylvania	2	1
646	Pittsburgh Health Care System, University Drive Division, Pennsylvania	5	5
460	Wilmington Regional Office, Delaware	1	1
<b>Veterans Health Administration: VISN 5: VA Capitol Health Care Network</b>			
512	Maryland Health Care System, Baltimore	3	1
613	Martinsburg, West Virginia	2	2
688	Washington, D.C.	3	3
<b>Veterans Health Administration: VISN 6: VA Mid-Atlantic Health Care Network</b>			
637	Asheville, North Carolina	9	4
517	Beckley, West Virginia	5	3
558	Durham, North Carolina	11	4
565	Fayetteville, North Carolina	7	3
590	Hampton, Virginia	6	4

**Appendix III: Actual Test Results for Timely  
First Follow-up on Unpaid Bills with Third-  
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<b>Medical center number</b>	<b>Medical center location</b>	<b>Number of bills tested</b>	<b>Number of bills with untimely first follow-up</b>
652	Richmond, Virginia	8	4
658	Salem, Virginia	6	2
659	Salisbury, North Carolina	8	5
<b>Veterans Health Administration: VISN 7: VA Southeast Network</b>			
508	Atlanta VAMC, Decatur, Georgia	1	1
521	Birmingham VAMC, Alabama	1	0
557	Dublin, Georgia	1	1
509	Augusta, Georgia	1	0
534	Charleston, South Carolina	1	1
544	Columbia, South Carolina	1	0
<b>Veterans Health Administration: VISN 8: VA Sunshine Healthcare Network</b>			
516	Bay Pines Health Care System, Florida	3	2
546	Miami Health Care System, Florida	2	1
672	Caribbean Health Care System, San Juan Puerto Rico	2	0
673	Tampa, Florida	5	4
573	North Florida/South Georgia Health Care System, Gainesville, Florida	2	0
548	West Palm Beach, Florida	4	2
<b>Veterans Health Administration: VISN 9: VA Mid South Healthcare Network</b>			
581	Huntington, West Virginia	5	5
596	Lexington, Kentucky	1	1
603	Louisville, Kentucky	3	0
614	Memphis, Tennessee	4	3
621	Mountain Home, Tennessee	3	2
626	Tennessee Valley Health Care System, Nashville, Tennessee	4	4
<b>Veterans Health Administration: VISN 10: VA Healthcare System of Ohio</b>			
541	Cleveland, Ohio	1	1
<b>Veterans Health Administration: VISN 11: Veterans In Partnership</b>			
655	Saginaw VAMC, Michigan	2	0
515	Battlecreek VAMC, Michigan	1	0
583	Indianapolis, Indiana	2	2
506	Ann Arbor Health Care System, Michigan	2	1
550	Illiana Health Care System, Danville, Illinois	1	1
610	Northern Indiana Health Care System – Marion Campus, Marion, Indiana	3	3

**Appendix III: Actual Test Results for Timely  
First Follow-up on Unpaid Bills with Third-  
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<b>Medical center number</b>	<b>Medical center location</b>	<b>Number of bills tested</b>	<b>Number of bills with untimely first follow-up</b>
<b>Veterans Health Administration: VISN 12: VA Great Lakes Health Care System</b>			
578	Hines, Illinois	2	2
585	Iron Mountain, Michigan	1	1
537	Jesse Brown, Chicago, Illinois	1	1
<b>Veterans Health Administration: VISN 15: VA Heartland Network</b>			
589	Kansas City, Missouri	7	4
657	St. Louis, Missouri – John Cochran Division	9	8
<b>Veterans Health Administration: VISN 16: South Central VA Health Care Network</b>			
502	Pineville, Louisiana	2	2
598	Central Arkansas Veterans Health Care System, Little Rock, Arkansas	2	2
586	Jackson, Mississippi	2	2
580	Houston VAMC, Texas	2	0
635	Oklahoma City, Oklahoma	2	2
667	Shreveport VAMC, Louisiana	1	0
629	Southeast Louisiana Veterans Health Care System, New Orleans, Louisiana	1	1
<b>Veterans Health Administration: VISN 17: VA Heart of Texas Health Care Network</b>			
674	Central Texas Health Care System, San Antonio, Texas	11	11
549	North Texas Health Care System, Dallas, Texas	17	15
<b>Veterans Health Administration: VISN 18: VA Southwest Health Care Network</b>			
504	Amarillo Health Care System, Texas	3	0
756	El Paso Health Care System, El Paso, Texas	3	3
501	New Mexico Health Care System, Albuquerque	1	1
644	Phoenix, Arizona Health Care System	5	5
<b>Veterans Health Administration: VISN 19: Rocky Mountain Network</b>			
554	Eastern Colorado Health Care System, Denver, Colorado	3	0
660	Salt Lake City Health Care System, Salt Lake City, Utah	3	3
<b>Veterans Health Administration: VISN 20: Northwest Network</b>			
463	Alaska Health Care System and Regional Office, Anchorage	4	2
531	Boise, Idaho	2	2
663	Puget Sound Health Care System, Seattle, Washington	3	1
<b>Veterans Health Administration: VISN 21: Sierra Pacific Network</b>			
640	Palo Alto Health Care System, California	1	1
662	San Francisco, California	2	2
570	Central California Health Care System, Fresno, California	1	1

**Appendix III: Actual Test Results for Timely  
First Follow-up on Unpaid Bills with Third-  
Party Insurers**

<b>Medical center number</b>	<b>Medical center location</b>	<b>Number of bills tested</b>	<b>Number of bills with untimely first follow-up</b>
612	VA Northern California Health Care System	1	1
654	Sierra Nevada Health Care System, Reno, Nevada	1	1
<b>Veterans Health Administration: VISN 22: Desert Pacific Healthcare Network</b>			
600	Long Beach Health Care System, California	1	0
664	San Diego Health Care System, San Diego, California	1	1
<b>Veterans Health Administration: VISN 23: VA Midwest Health Care Network</b>			
618	Minneapolis, Minnesota	1	1
636	Omaha Division - VA Nebraska Western Iowa Health Care System	6	6
438	Sioux Falls Regional Office, South Dakota	2	2
656	St. Cloud, Minnesota	1	1
568	Black Hills Health Care System, Fort Meade, South Dakota	1	1
<b>Total</b>		<b>260</b>	<b>183</b>

Source: GAO tests of VA-wide data on the requirement for medical center accounts receivable personnel to perform initial follow-up on unpaid third-party receivables.

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# Appendix IV: GAO Contact and Staff Acknowledgments

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## GAO Contact

Kay Daly, (202) 512-9095, or [dalykl@gao.gov](mailto:dalykl@gao.gov)

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## Acknowledgments

In addition to the contact named above, Gayle L. Fischer, Assistant Director; F. Abe Dymond, Assistant General Counsel; Carl S. Barden; Deyanna J. Beeler; Francine DelVecchio; Lauren S. Fassler; Jason Kelly; Amanda K. Miller; Matthew L. Wood; and Matthew P. Zaun made key contributions to this report.

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