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

HUMAN RESOURCES DIVISION

OCTOBER 22, 1979

B-133044

The Honorable Max Cleland
Administrator of Veterans Affairs

The Honorable Patricia Roberts Harris
The Secretary of Health, Education,
and Welfare

Subject: Duplicate Payments for Medical Services by VA and Medicare Programs (HRD-80-10)

We have performed a limited review to determine the number of duplicate payments made by the Veterans Administration (VA) and the Medicare programs for certain medical services provided to veterans eligible for both programs.

We reviewed three VA medical service categories--unrestricted outpatient medical care, contract hospitalization with prior VA authorization, and kidney dialysis treatment. We made our review in Florida and California, where about 15 percent of U.S. veterans reside; many of them are eligible for both VA and Medicare benefits. We also briefly surveyed duplicate payments by VA and Medicaid programs. With the number of aged veterans increasing significantly each year, there will continue to be increases in the number of veterans who will have dual eligibility for receiving medical benefits.

The enclosure describes the results of our review. In our sample of about 800 dual-eligible veterans and about 4,600 claims, we found

--duplicate Medicare payments involving 153 veterans and 433 claims, amounting to more than $72,000, before voluntary refunds by providers totaling about $31,000 were deducted;

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--misapplied deductibles 1/ involving 77 veterans amounting to more than $3,100; and

--duplicate Medicaid claims involving 11 veterans and 27 claims amounting to about $1,700.

We estimate that duplicate payments, after deducting voluntary refunds and misapplied deductibles, exceeded $242,000 in Florida and $236,000 in California in 1976 for the three VA categories we reviewed. Our sample in Florida and California cannot be statistically projected nationally; however, because the Medicare and VA programs both operate under national program guidelines, it is likely that the practices we found during our review are occurring throughout the Nation. VA and Department of Health, Education, and Welfare (HEW) officials have taken action to recover the duplicate payments we found, but more needs to be done to prevent other duplicate payments.

We recommend that the Administrator of Veterans Affairs and the Secretary of HEW:

--Continue to recover the duplicate payments which we identified in Florida and California.

--Find out how frequently duplicate payments are occurring throughout the Nation, not only for the three VA medical service categories we reviewed, but for all medical service categories available to eligible veterans.

--Better coordinate their claims processing activities for patients who may be eligible for medical benefits from both programs.

--Identify dual-eligible individuals when they become eligible for both programs, perhaps by issuing unique identification cards or by adding a digit to their enrollment numbers.

1/A misapplied deductible occurs when Medicare and VA both pay a claim, with VA allowing the maximum on its fee schedule, and Medicare applying all or part of VA's payment to a beneficiary's part B deductible.

If VA and HEW efforts show that the duplicate payment problem is widespread and involves significant dollar amounts, we recommend that:

1. The Administrator of Veterans Affairs:

   --Consider changing VA's provider numbers and procedure codes to make them compatible with the Medicare program and to facilitate the identification of duplicate billings and duplicate payments.

   --Develop a standardized claim form which would require authorized providers to certify that no other Federal program would be billed for the same costs for the same services.

   --Issue timely reminders and sanctions to providers when dual billing and dual payments are found.

   --Initiate procedures to fully consider the possibility of dual eligibility each time authorization for medical service outside the VA's health care system is requested or renewed.

2. The Secretary of HEW direct the Administrator, Health Care Financing Administration, to require that Medicare intermediaries and carriers:

   --Whenever dual eligibility is indicated, determine whether VA has authorized payment or already paid for the services.

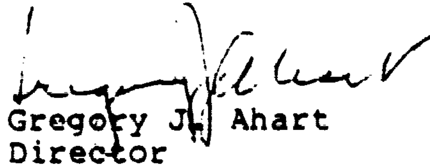
   --Regularly sample batches of claims and compare the information with VA records to determine if eligibility information is correct and detect duplicate payments.

We discussed our findings with responsible VA and Health Care Financing Administration officials and their comments have been incorporated where appropriate. These officials generally agreed with the facts and conclusions of the report and stated that they would take steps to attempt to resolve the problems we noted.

As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on action taken on our recommendations to the House Committee on Government Operations and the Senate Committee on Governmental Affairs not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

We are sending copies of this report to the Chairmen, House Committees on Appropriations, Government Operations, Ways and Means, and Veterans' Affairs; the Chairmen, Senate Committees on Appropriations, Governmental Affairs, Finance, and Veterans' Affairs; and the Director, Office of Management and Budget.

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



Gregory J. Ahart
Director

Enclosure

DUPLICATE PAYMENTS FOR MEDICAL SERVICES BY VA AND MEDICARE PROGRAMS

BACKGROUND

The Federal Government administers several programs to help persons meet health care costs; many may be eligible for benefits from more than one program. As a result of this dual eligibility, a hospital's or physician's services may be paid for more than once. This report deals with duplicate payments for medical services provided to veterans eligible for Medicare and the Veterans Administration (VA) program. Duplicate payments involving the Medicaid and VA programs are also addressed briefly.

VA medical services are available to all veterans with service-connected disabilities and to eligible veterans with certain nonservice-connected conditions. The Medicare program provides protection to eligible persons (1) age 65 and older, (2) with chronic kidney disease, and (3) under age 65 who are disabled and have been entitled to Social Security or Railroad Retirement disability benefits for at least 2 years. Under Medicaid, the Federal Government shares with the States the costs of providing medical assistance to persons, regardless of age, whose income and resources are inadequate to pay for health care. Some of the same types of services are covered under the three programs.

VA

VA provides health care to eligible veterans. It administers the Nation's largest health care delivery system including 172 medical centers, 220 outpatient clinics, 91 nursing homes, and 16 domiciliaries. VA also relies on hospitals and physicians outside the VA system to provide professional services, medication, and supplies on a fee-for-service bas : at VA expense under certain conditions. There are several categories of medical service, including restricted and unrestricted outpatient medical care, outpatient prescriptions, contract hospitalization with and without prior VA authorization, contract kidney dialysis treatment, community nursing home care, and prosthetic devices.

Veterans generally are expected to use VA facilities and physicians. VA approves treatment outside the VA system if (1) justified for such reasons as the veteran's health status or hardship of travel or (2) needed medical service

is not available within a VA health care facility. VA issues Medical Treatment Information (ID) cards to veterans eligible for outpatient services from providers, such as community hospitals and physicians. VA also contracts directly with community hospitals to provide needed care to eligible veterans. Under VA's program, providers are paid by VA for medical services rendered after a proper bill is submitted. Authorized inpatient services are usually paid as billed by the provider, if the charges are reasonable. Payment for outpatient services is based on the relative medical care costs in each geographic area.

This report discusses three medical service categories under VA's program--unrestricted outpatient medical care, contract hospitalization (with prior VA authorization), and kidney dialysis treatment. The outpatient and contract hospital categories are large in terms of patients treated and dollars spent. The dialysis treatment category is relatively small in terms of the number of veterans treated, but the average cost for each veteran is large.

VA estimated that about 2.5 million veterans throughout the Nation are eligible for Medicare because they are at least 65 years old. Most veterans under 65 who need kidney dialysis treatment in freestanding centers or hospitals are eligible for Medicare after a 90-day waiting period. Also, certain disabled veterans under 65 are eligible for Medicare benefits.

Unrestricted outpatient medical care

VA reported nationally more than 331,000 outstanding ID cards for outpatient medical care during our review. Of these ID cards, 53 percent permitted veterans to receive unrestricted outpatient medical care. That is, veterans with a service-connected disability rating of at least 50 percent, are entitled to receive unrestricted outpatient medical services in a hospital, clinic, or physician's office for any medical condition except dental care. During fiscal year 1977 about 230,000 veterans used their ID cards at least once to receive outpatient medical care from the private sector; VA spent about $47 million for these services.

Contract hospitalization with prior VA authorization

An eligible veteran may be hospitalized in a community facility at VA expense if

(1) an emergency involving a service-connected condition arises,

(2) VA or other Federal facilities are not available, and

(3) delayed hospitalization would be hazardous to the veteran's life.

During fiscal year 1977 VA spent about $45 million nationwide for about 26,000 contract hospitalizations. This amount included both inpatient hospital services and physician services provided during the hospital stay.

Kidney dialysis treatment

During fiscal year 1977 about 1,200 veterans received kidney dialysis treatment from the private sector through VA contracts. Most had nonservice-connected conditions which had been approved for outpatient followup care after initial hospital treatment. Generally, treatment by a private provider was authorized by VA because either the veteran had problems traveling to a VA facility or the nearest VA facility was operating at capacity. During this period VA paid more than $20 million for contract dialysis treatments--about $17,000 for each veteran in fiscal year 1977.

MEDICARE

Medicare provides benefits in two ways to help eligible persons meet health care expenses:

--Part A, hospital insurance, financed by social security taxes, covers inpatient hospital services and certain postrelease care in skilled nursing facilities and patients' homes.

--Part B, supplementary medical insurance, financed by enrollee premiums and Federal contributions, covers physician services, outpatient hospital services, outpatient X-ray and laboratory services, durable medical equipment needs, ambulance service, prosthetic devices, and home health care. Part B enrollees are required to incur $60 in covered medical expenses before payment may be made by the program each calendar year; this is called the "medical insurance deductible." After the deductible expenses are incurred by the enrollee, Medicare generally pays 80 percent of the reasonable charges of additional

covered services for the rest of the year. The other 20 percent is the beneficiary's responsibility and is called coinsurance.

The Health Care Financing Administration (HCFA), Department of Health, Education, and Welfare (HEW), is responsible for administering Medicare. HCFA has contracted with public and private organizations to review and pay claims submitted by providers. Organizations handling claims for hospital services are called intermediaries; organizations handling claims for physicians' services are called carriers. Intermediaries almost always reimburse hospitals directly; carriers, however, reimburse patients for claims in about half the cases, because physicians are permitted by law to either send the claim directly to the carrier (an assigned claim) or bill the beneficiary (an unassigned claim), who in turn submits a claim based on an itemized paid or unpaid bill to the carrier.

During fiscal year 1977 about 33 million claims totaling $14.9 billion were paid under part A; about 110 million claims totaling $5.9 billion were paid under part B.

MEDICAID

Medicaid, which is administered at the Federal level by HCFA, reimburses the States for 50 to 78 percent of medical costs incurred by individuals unable to pay for such care. Medicaid is used only after other medical insurance has been exhausted. Each State is responsible for operating its own program, but each is required by law to provide: inpatient and outpatient hospital services, laboratory and X-ray services, physicians' services, skilled nursing home care, and home health care services. A State may choose to provide other services. About 10 percent of those eligible for Medicare are also eligible for Medicaid. Most States have arranged to pay for the part B coinsurance on behalf of these beneficiaries.

SCOPE OF REVIEW

This review was made to determine the extent to which duplicate payments may have been made by Medicare and VA for medical services provided to veterans eligible for both programs.

We made our detailed review in Florida and California, where about 15 percent of U.S. veterans reside, and many veterans are eligible for both VA and Medicare benefits.

We selected a random sample of 1,812 veterans and found that 834 were eligible for both VA and Medicare benefits during calendar year 1976. For the 834 veterans, 4,625 claims totaling about $1.6 million had been paid by VA to the physicians and hospitals which provided medical treatment. Using VA, Medicare, and Medicaid program data, we developed information for calendar year 1976 on duplicate billings, duplicate payments, and refunds. We also developed some information concerning services provided during fiscal years 1975 and 1977.

Our review was made at HCFA and VA headquarters in Washington, D.C.; HCFA regional offices in Atlanta, Georgia, and San Francisco, California; VA Clinics of Jurisdiction responsible for paying medical claims submitted to VA in Bay Pines, Florida, and San Francisco, California; the VA Outpatient Clinic in Los Angeles, California; and the VA Medical Center in Miami, Florida.

We also visited the responsible Medicare fiscal intermediaries and carriers in California and Florida and the State Medicaid agencies in Sacramento, California, and Tallahassee, Florida.

DUPLICATE PAYMENTS BY VA AND MEDICARE OCCURRED FREQUENTLY

Duplicate payments by VA and Medicare for patients with dual eligibility occurred frequently during calendar year 1976 in the three medical service categories at the locations included in our review.

In reviewing about 4,600 claims involving about 800 veterans with dual eligibility, we found

--duplicate Medicare payments involving 153 veterans and 433 claims, amounting to over $72,000 before voluntary refunds by providers totaling about $31,000 were deducted;

--misapplied deductibles 1/ involving 77 veterans, amounting to over $3,100; and

--duplicate Medicaid claims involving 11 veterans and 27 claims amounting to about $1,700.

1/A misapplied deductible occurs when Medicare and VA both pay a claim, with VA allowing the maximum on its fee schedule and Medicare applying all or part of VA's payment to the beneficiary's part B deductible.

We estimate that the duplicate payments and misapplied deductibles incurred during 1976 for these three VA categories, after deducting voluntary refunds, exceeded $242,000 in Florida and $236,000 in California. Our work in Florida and California cannot be statistically projected nationally. However, because the Medicare and VA programs both operate under national program guidelines, it is likely that the practices we found in Florida and California occur throughout the Nation.

PAYMENT LIMITATIONS IMPOSED BY VA AND MEDICARE REGULATIONS

VA and Medicare program regulations limit payments for medical services when the other program also provides payment.

Medicare program regulations state that when VA has authorized inpatient hospital services to be furnished outside the VA system at VA expense, Medicare benefits will not be available. If reimbursement has been made by Medicare and it later finds that VA has paid or will pay for the same service, the Medicare benefit is to be treated as an overpayment. For physicians' services, Medicare regulations state that (1) when treatment under a VA program has been authorized, Medicare will not make payment, nor can the services paid for by VA be counted toward the part B deductible and (2) where the veteran does not request authorization from VA, Medicare may make payment under part B. Also, according to Medicare regulations, when a physician treats a Medicare patient and files a Medicare claim directly with a carrier, he/she is agreeing to accept Medicare's reasonable charge as full payment.

VA regulations state that, when medical services are paid by other sources, including Medicare and Medicaid, VA may supplement the payment, but only up to the total amount it would have paid if VA had received the entire bill in the first place.

According to VA and Medicare regulations, VA clearly has primary responsibility for claims submitted by dual-eligible veterans, and Medicare should only be billed and pay for medical service not authorized by VA.

OUR METHODOLOGY

To determine whether claims for medical care submitted to both VA and Medicare during 1976 were duplicates, we matched

(1) the veteran's name and social security number,

(2) the date(s) of medical service,

(3) the provider (hospital, physician, or group of physicians) that rendered the service, and

(4) the medical procedures performed.

If all elements matched but only one program paid the claim, we considered it a dual-processed claim. We only considered a claim to have resulted in a duplicate payment when VA paid the maximum allowed on its fee schedule and Medicare paid part or all of the same bill. We considered the Medicare payment to be the duplicate because VA is the primary payer.

After we identified a duplicate payment, we submitted appropriate claim information to both VA and Medicare to determine if a refund or other adjustment had been made.

EXTENT OF DUAL ELIGIBILITY

As shown below, in our sample many of the veterans eligible for the three VA medical service categories were also enrolled in Medicare. The services or benefits available through VA for contract hospitalization, outpatient services, and kidney dialysis treatment were basically the same as the Medicare benefits.

	Veterans eligible for VA and Medicare medical benefits					
	Florida			California		
VA service category	Number in sample	Number with dual eligibility	Percent	Number in sample	Number with dual eligibility	Percent
Outpatient medical care	523	232	44.4	758	319	42.1
Contract hospitalization	278	140	50.4	155	76	49.0
Kidney dialysis treatment	22	14	63.6	65	48	73.8

We recognize that these States are popular retirement locations and the percentage of veterans with dual eligibility may be higher than in other areas. However, with the number of aged veterans increasing significantly nationwide each year, the number of dual-eligible veterans in other States will continue to increase.

DUPLICATE PAYMENTS FOUND DURING OUR REVIEW

Significant percentages of the dual-eligible veterans in our sample received medical services which resulted in one or more duplicate payments during the sample period. The table below illustrates the magnitude of this problem in Florida and California for the three service categories we examined:

Duplicate Payments Found During Our Review of Three Medical Service Categories

	Outpatient services		Contract hospitalization		Kidney dialysis treatment		
	Florida	California	Florida	California	Florida	California	Total
Veterans with dual eligibility	232	319	140	76	14	48	829
Veterans receiving care which resulted in duplicate payments	22	52	44	17	-	18	153
Percent	9.5	16.6	31.4	22.4	-	37.5	18.4
Claims paid by VA for dual-eligible veterans	1,630	1,706	355	137	105	692	4,625
VA claims resulting in duplicate payments	85	230	53	25	-	55	448
Percent	5.2	13.5	14.9	18.2	-	8.0	9.7
Amount paid by VA for dual-eligible veteran care	$63,932	$69,314	$205,011	$83,789	$140,554	$1,052,038	$1,612,638
Amount paid by Medicare for duplicate payments	$2,021	$5,271	$30,488	$10,960	-	$23,292	$72,134
Percent	3.2	8.0	14.8	13.1	-	2.2	4.5
Medicare claims resulting in duplicate payments	53	231	56	25	-	68	433

The average annual duplicate payment for each veteran in our 1976 sample was: $100 for each outpatient, $679 for each contract hospitalization, and $1,370 for each kidney dialysis patient.

Although some duplicate payments we found were quite small, others were sizable:

--A California outpatient had bills submitted to VA and Medicare for medical services totaling $1,144; VA paid $1,102. The Medicare carrier paid $523 to the beneficiary, and the Medicare intermediary paid the hospital $46--$569 for the same services.

--A Florida hospital patient had bills submitted to VA totaling $5,345; VA paid the full amount. The Medicare intermediary and carrier were billed for $5,345. The Medicare intermediary paid the hospital $4,836, and the Medicare carrier paid the beneficiary $264--a total of $5,100.

--A San Francisco veteran incurred bills of $14,012 for kidney dialysis treatment; VA paid the full amount. The Medicare intermediary paid $8,962 to the hospital and the Medicare carrier paid a physician $336--a total of $9,298 for the same treatments.

In addition to the $72,132 of Medicare duplicate payments made during the sample period, we found additional duplicate payments amounting to $24,430 occurred during 1975 and 1977. These duplicate payments involved some of the same veterans with dual eligibility and the same categories of medical service as in our sample year. In most cases the veteran continued to receive medical care from the same provider for more than 1 year. This would indicate that once a duplicate payment practice starts, and the same provider continues to treat the veteran over a period of time, the duplicate payment problem may continue.

As discussed on page 12, some funds spent for duplicate payments were later refunded to one of the programs. However, we believe a serious duplicate payment problem exists for the three service categories in Florida and California. Furthermore, we believe the duplicate payment problem may be widespread because (1) veterans are eligible to receive medical treatment under several other service categories through both VA and Medicare, (2) the providers' invoices for these other service categories are processed for payment the same way--without safeguards to detect duplicate payments--as the

three service categories reviewed, and (3) according to HCFA and VA officials, the practices and controls in Florida and California are similar to those in other States.

Medicare usually paid claims before VA

The table below shows that when duplicate billing occurred, the Medicare intermediary or carrier paid the claim before or at the same time 1/ as VA in about two-thirds of the cases.

Comparison of Timing in Paying Claims Between VA and Medicare Intermediaries or Carriers

	Outpatient	Contract hospitalization
Total VA invoices involved in duplicate payments	315	78
Number VA paid first	108	24
Number Medicare intermediary or carrier paid first	130	38
Number paid at the same time	77	16
Percent of claims Medicare intermediary or carrier paid first or at the same time	65.7	69.2

Duplicate payments related to both hospital services and physician services

We analyzed the duplicate payments in the outpatient and contract hospitalization service categories 2/ to determine the numbers and dollar amounts of the claims submitted

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1/A claim was considered to have been paid at the same time when the two programs paid it within 14 days of each other or during the same month.

2/No comparative analysis of kidney dialysis duplicate payments was made because of the relatively small number in our sample.

for hospital services and physician services. We found that of 309 duplicate claims involving $48,839, Medicare interme-diaries paid $35,171 on 60 claims for hospital services. The other $13,668 had been paid by Medicare carriers on 249 claims for physician services. As shown in the following table, only one Medicare intermediary duplicate payment involving $153 was received by a veteran. On the other hand, veterans received $8,824--about 65 percent of the Medicare carrier duplicate payments.

Recipients of Medicare Duplicate Payments
During Calendar Year 1976

	Medicare part A			Medicare part B			Total
	Hospital	Veteran	Total	Physician	Veteran	Total	parts A and B
Claims relating to outpatient services	24	1	25	59	144	203	228
Claims relating to contract hospitalization	35	-	35	14	32	46	81
Total duplicate claims - outpatient services and contract hospitalization	59	1	60	73	176	249	309
Amount related to outpatient services	$ 811	$153	$ 964	$2,109	$4,318	$6,427	$ 7.392
Amount related to contract hospitalization	34,207	-	34,207	2,109	4,318	7,241	41,488
Total amount	$35,018	$153	$35,171	$4,844	$8,824	$13,668	$48,839

VA almost always made direct payment to the hospitals and physicians for both outpatient services and contract hospitalizations. As summarized above, Medicare interme-diaries also generally paid hospitals directly for services rendered. In our sample, however, Medicare carriers usually sent payments to the beneficiaries for services rendered by physicians. Also in about 23 percent of the physicians' service claims, the Medicare carrier or intermediary im-properly applied the VA payment to the part B deductible. Some duplicate payments occurred because of these different billing and payment practices.

The example below illustrates the confusion of two par-ties billing two programs for the same service. A physician billed VA $754 for outpatient services rendered from December 1975 through November 1977, and VA paid $691. The veteran

billed the Medicare carrier for the same amount and services, and he was sent a check for $449, while $35 and $57 were applied to the 1976 and 1977 part B deductibles. A duplicate payment under these circumstances would be even more difficult to detect than when the physician billed two programs for the same service.

Hospitals refunded duplicate payments more often than physicians

After determining how frequently Medicare intermediaries and carriers made duplicate payments, we developed information on the extent to which voluntary refunds were made to negate them. Most voluntary refunds in our sample--both in terms of numbers of claims and dollar amounts--came from hospitals. The refunds to VA or Medicare, however, were not always for the entire amount of the duplicate payment. The numbers of claims and amounts voluntarily refunded by physicians and veterans were negligible.

Outpatient services

In Florida, where we found 22 duplicate payment claims for outpatient services totaling $2,021, one voluntary refund amounting to $26 was made by a hospital.

In California, where we found 52 duplicate payment claims totaling $5,371, five voluntary refunds were made, amounting to $315. Three of the refunds totaling $249 came from hospitals; the two others, totaling $66, were made by physicians.

Contract hospitalization

This medical service category, in addition to having the most duplicate payments in dollar amounts, also had the most voluntary refunds. In California where we found 17 duplicate payments amounting to $10,960, five refunds totaling $4,472 were made. Of these refunds, $4,447 came from four hospitals; a $25 refund was made by a physician.

In Florida, where we found $30,488 of duplicate payments involving 44 Medicare claims, there were 18 voluntary refunds totaling $17,399. Of this total, all refunds except one totaling $159 were made by hospitals. According to Medicare intermediary officials, the Florida hospitals included in our review routinely bill all potential sources of payment for medical services simultaneously, and then refund to one or more of the sources the amounts that they determine to be overpayments. This practice partly explains

why so many voluntary refunds were made by hospitals; however, billing two or more Federal programs for the same services does not seem proper.

Kidney dialysis treatment

We found no duplicate payments for kidney dialysis treatments in Florida, but in California there were 17 duplicate payment claims totaling $23,292. Of these, six refunds amounting to $9,011 were made. Five refunds, totaling $8,962 and involving one patient, were made by a hospital; the other $49 refund was made by a physician.

CONCLUSIONS

About 43 percent of the duplicate payments ($31,223 of $72,132) we found in our sample were voluntarily refunded to VA or Medicare before we identified them in our review. However, of the $31,223, only $298, involving five claims, was refunded by physicians. This ratio is significant because over 80 percent of the duplicate payment claims we found involved physicians or groups of physicians. Hospitals usually have more sophisticated accounting systems and controls than physicians or groups of physicians, and we do not mean to imply that physicians knowingly did not refund duplicate payments to VA or Medicare. Based on the information we developed, however, it appears that when a physician or group receives a duplicate payment, it is not likely to be detected and refunded.

HCFA and VA officials at one hospital have initiated action to recover the duplicate payments we found for which voluntary refunds have not been made.

Based on our sample, we estimated that duplicate payments, after voluntary refunds, totaled about $221,600 in Florida and about $194,000 in California in 1976.

SOME DUPLICATE PAYMENTS RESULTED IN MISAPPLIED DEDUCTIBLES

Persons enrolled under Medicare part B are required to incur $60 in covered medical expenses each calendar year before payment may be made by the program; this is called the "medical insurance deductible." After the enrollee incurs the deductible, Medicare generally pays 80 percent of the reasonable charges for additional covered services for the rest of the year. Medicare regulations state that amounts paid by VA for medical services cannot be counted toward the

part B deductible; applying the VA payment in this way is referred to as a "misapplied deductible." The table below summarizes the extent to which misapplied deductibles occurred in the three medical service categories we reviewed:

Misapplied Deductibles in Three Service Categories

	Florida	California	Total
Outpatient services			
Veterans enrolled in Medicare part B	232	319	551
Veterans with misapplied deductible	12	48	60
Percent	5.2	15.0	10.9
Amount of misapplied deductible	$432	$1,837	$2,269
Contract hospitalization			
Veterans enrolled in Medicare part B	113	61	174
Veterans with misapplied deductible	7	4	11
Percent	6.2	6.6	6.3
Amount of misapplied deductible	$399	$168	$507
Kidney dialysis			
Veterans enrolled in Medicare part B	14	48	62
Veterans with misapplied deductible	-	6	6
Percent	-	12.5	9.7
Amount of misapplied deductible	-	$328	$328

Although the average amount for each misapplied deductible was not large, the overall effect of this practice could be sizable. For example, based on our 1976 sample we estimated that

--in Florida about $17,400 and $3,700 in misapplied deductibles occurred in outpatient services and contract hospitalizations, respectively, and

--in California misapplied deductibles amounted to almost $40,500 in outpatient services, about $1,400 in contract hospitalization, and about $640 in kidney dialysis treatments.

MEDICAID MAY SUPPLEMENT VA/MEDICARE DUPLICATE PAYMENTS

We found some California veterans were eligible to receive medical benefits from Medicaid (known as Medi-Cal in California) as well as from VA and Medicare. In some cases Medicaid supplemented VA/Medicare duplicate payments by paying the coinsurance applicable to a Medicare beneficiary.

Ninety-five of the 1,026 veterans in our California sample were eligible under Medicaid for at least 1 month between August 1976 and February 1978. Of these, 71 were also enrolled under Medicare during this period and therefore were eligible to receive medical benefits through three Federal programs. Fifteen of these 71 veterans received payments for medical care from both VA and Medicare.

We also found that 11 of the 71 veterans received medical care for which duplicate payments were made by Medicaid. For these veterans 27 duplicate claims totaling $1,692 were paid by Medicaid, in addition to the $6,026 paid by Medicare for these same services.

Most of the Medicaid duplicate payments we found related to one veteran receiving kidney dialysis treatments. VA and Medicare were each billed $6,947 for services provided from June through October 1976. VA paid $6,945; Medicare paid $5,500; and Medicaid paid $1,402. The total overpayment of $6,902 could have been averted if VA had been the only payer.

Any procedures or safeguards to prevent VA/Medicare duplicate payments should also address the possibility of Medicaid duplicate payments.

REASONS DUPLICATE PAYMENTS OCCURRED

The duplicate payments discussed in this report occurred for several reasons. We found a serious duplicate payment problem involving Medicare and VA, and corrective action should be taken. VA and Medicare officials stated that they cannot rely exclusively on providers and/or beneficiaries to submit medical claims to the appropriate Federal program.

It may be unrealistic to expect that duplicate billings and duplicate payments can be eliminated completely. However, without significantly changing the procedures, forms, or processing activities of either program, we believe improvements to minimize these practices are possible.

Several questionable practices cause or contribute to the duplicate payment problems. These practices and our recommendations for corrective action are discussed below.

Medicare intermediaries/carriers could do more to minimize duplicate payments

Medicare regulations state that when services are provided without charge by a VA facility or VA physician, or when VA authorizes payment to a hospital or physician outside the VA health care system, the services are not reimbursable through Medicare.

When claims are submitted to Medicare carriers/intermediaries for beneficiaries also covered by VA, documentation must be provided to show that VA was contacted and has not authorized payment. However, we found the Medicare carriers/intermediaries have no way to determine when a Medicare beneficiary is an eligible veteran unless the provider or the patient has indicated dual eligibility.

We found cases where dual eligibility information had been omitted and caused duplicate payments. On the other hand, we found cases where even when dual eligibility information was provided, duplicate payments still occurred because often the Medicare intermediary or carrier did not attempt to determine whether VA had authorized payment for the same medical service.

Providers are not following
VA and Medicare regulations

Both VA and Medicare regulations state that VA should be billed when a provider has determined that a patient is eligible to receive medical benefits under both Federal programs. A provider cannot unknowingly bill both Federal programs for the same medical service, because (1) with an assigned Medicare claim a form must be completed and signed by both the patient and the provider and (2) to bill VA, the patient must show an ID card or otherwise indicate VA eligibility to the provider. For an assigned claim, the provider usually takes positive action to bill both programs at about the same time.

VA is the primary source of payment for dual-eligible veterans, and providers, once having accepted responsibility to treat dual-eligible patients, generally, should bill VA for authorized services and only bill Medicare for services not covered by VA.

Providers employ questionable
billing practices

We were told by VA hospital officials that the Florida hospitals included in our review routinely bill all sources of payment for which a patient is eligible, keep the first payment received, and refund the other(s). In our opinion, this practice is improper because unrefunded duplicate payments and related additional administrative expenses may result.

Some physicians customarily billed all sources of payment for which a patient was eligible and kept a combination of the payments received. For example, a Florida physician billed VA and Medicare $755 each for a series of office visits by one patient; the Medicare carrier paid him $224, and VA paid him $690. The physician eventually refunded $159 to VA, leaving himself a combined reimbursement of $755, the original amount billed. This physician later submitted another bill to the Medicare carrier for some of the same services and received another $167, which he did not refund.

In cases like this one, when a provider alters the amount(s) billed and/or the date(s) of medical treatment, it appears that the provider is attempting to receive larger payments than entitled to under the VA and/or Medicare programs.

The provider numbers registered by each program are different; therefore, matching claims submitted to the two programs by one provider is difficult. To further complicate this situation, some providers have been issued more than one provider number under each Federal program because often a different number is used for each office location from which a provider practices medicine. In other cases, a provider may use one provider number for his individual practice and another provider number as a member of a group practice. Again, matching claims in these instances is a difficult task even for the most sophisticated internal control systems of Medicare carriers.

Each program uses different procedure codes to identify medical services. For example, an office visit in the Medicare program has a different code number than an office visit in VA. Due to these different codes it is time-consuming and difficult to match claims submitted to the two programs.

Another common practice which makes detecting duplicate payments a difficult chore is batching of several medical services provided over a period of time on one bill. For example, a patient was treated eight times by one physician over a 10-month period. The provider billed VA for these services on eight bills and billed the Medicare carrier for the same services on one bill. There is nothing wrong with batching services on one bill to conserve processing costs; when providers do not batch the services similarly for both programs, detecting duplicate payments is difficult.

Patients and providers receive duplicate payments

VA generally pays only providers for services rendered to eligible veterans. However, the law permits Medicare carriers to either pay providers or reimburse beneficiaries for physician services. As discussed earlier, it is difficult to detect duplicate payments when a provider receives payment from both programs. We found this problem is compounded when one program pays the provider and the other reimburses the patient.

In one case, a California veteran filed 22 claims with the Medicare carrier for services received over 2 years and the carrier reimbursed him about $1,000. The physician who provided the services billed VA for $2,067 for the same services, and VA paid him $1,654.

In cases like this the physician may be paid twice--by the patient and by VA. The instructions on veterans' outpatient ID cards clearly state that the veteran is not expected to pay a fee in addition to the amount paid by VA. The instructions also advise the physician to bill VA directly.

RECOMMENDATIONS

We recommend that the Administrator of Veterans Affairs and the Secretary of HEW:

--Continue to recover the duplicate payments which we identified in Florida and California.

--Find out how frequently duplicate payments are occurring throughout the Nation, not only for the three VA medical service categories we reviewed, but for all medical service categories available to eligible veterans.

--Better coordinate their claims processing activities for patients who may be eligible for medical benefits from both programs.

--Identify dual-eligible individuals when they become eligible for both programs, perhaps by issuing unique ID cards or adding a digit to their enrollment numbers.

If VA and HEW efforts show that the duplicate payment problem is widespread and involves significant dollar amounts, we recommend that:

1. The Administrator of Veterans Affairs:

   --Consider changing VA's provider numbers and procedure codes to make them compatible with those used by the Medicare program and to facilitate the identification of duplicate billings and duplicate payments.

   --Develop a standardized claim form which would require authorized providers to certify that no other Federal program would be billed for the same costs for the same services.

   --Issue timely reminders and sanctions to providers when dual billing and dual payments are found.

--Initiate procedures to fully consider the possibility of dual eligibility each time authorization for medical service outside the VA's health care system is requested or renewed.

2. The Secretary of HEW direct the Administrator, HCFA, to require that Medicare intermediaries and carriers:

--Whenever dual eligibility is indicated, determine whether VA has authorized payment or already paid for the services.

--Regularly sample batches of claims and compare information with VA records to determine if eligibility information is correct and detect duplicate payments.

VA AND HCFA OFFICIALS' COMMENTS

VA and HCFA officials generally agreed with our findings and conclusions and told us they would attempt to resolve the duplicate payment problems. Officials of both organizations acknowledged that until our review they had not been aware of the extent of duplicate payments.

VA officials stated that they could not respond specifically to our recommendations until more nationwide information had been developed and analyzed. According to HCFA officials, they could not comply with some of our recommendations until they had obtained information on VA's recordkeeping and claims processing systems for comparison. They stated, however, that it would be difficult to develop national standards and procedures because of the wide variance of fees, billing practices, and recordkeeping methods employed by physicians and hospitals nationwide.

VA and HCFA officials expressed a willingness to meet with each other to discuss the duplicate payment problems and to exchange pertinent information to determine how frequently duplicate payments occur nationwide in all VA fee-for-service medical programs. HCFA officials pointed out, however, that Medicare carriers and intermediaries in fiscal year 1977 paid more than $20 billion for hospitals' and physicians' services, that eligible veterans comprise only a fraction of Medicare beneficiaries, and that the costs to implement some of our recommendations might exceed the benefits. We agree that major changes would not be appropriate for the VA or Medicare programs' claims processing or payment systems until sufficient nationwide data are developed and analyzed by VA and HEW to determine the extent of the duplicate payment problem.