Veterans Affairs Canada | Anciens Combattants Canada

June 2019

AUDIT OF MULTI-DISCIPLINARY CLINICS

Audit and Evaluation Division

Canada

Acknowledgements

The audit team gratefully acknowledges Veterans Affairs staff in the Service Delivery and Program Management Division as well as staff in Finance Division and the Federal Health Claims Processing Service contractor . Their contributions were essential to the success of this audit.

TABLE OF CONTENTS

1.0 BACKGROUND

The Health Care Benefits Program provides eligible Veterans and other qualified recipients with funding to access necessary health care benefits (also referred to as treatment benefits). The program is comprised of fourteen categories of benefits and services and within those categories, there are hundreds of individual treatment benefits which Veterans can access. In 2017–18, program expenditures totaled $299.6 Million and there were almost 79,000[1] Veterans accessing benefits. The program is administered by Veterans Affairs Canada (VAC) field office staff and through a third party health care processor with support from numerous areas within VAC. The program management unit is responsible for the management of the program. A brief overview of the benefits and services provided through each of the fourteen categories of Programs of Choice (POCs) is included in Appendix B.

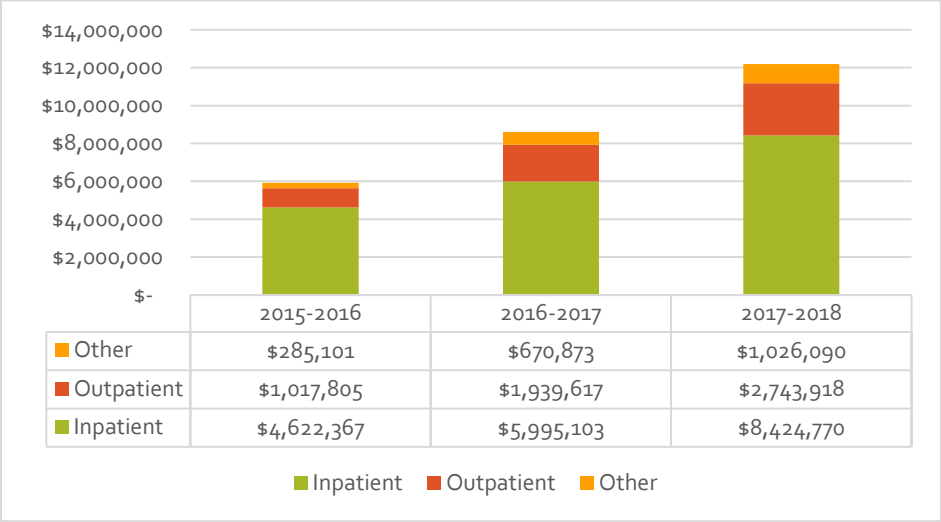
As part of the Health Care Benefits Program VAC introduced multi-disciplinary clinics (MDCs) in 2012 and they are included in POC 5 – Hospital Services. Multi-disciplinary clinics are comprised of various health professionals and para-professionals such as physicians, psychologists, physiotherapists, social workers, kinesiologists, and recreational therapists. The expectation is that the MDC staff provides a coordinated team approach to assessing and treating those with complex health problems and treatment objectives[2].

Initially, in 2012, there were four facilities registered and in 2014, the department began registering a broader range of facilities which provided integrated multi-disciplinary care to eligible Veterans and other clients.[3] As of March 31, 2019, there were 227 MDCs registered with the department with 55 additional applications for registration awaiting a decision. There have been 372 applications to the program in total with 86 applications declined. Of the clinics approved for registration with VAC, 185 are outpatient, 26 are inpatient, and 16 are combination clinics with both inpatient and outpatient services available. For inpatient treatment, Veterans reside at the facility for the duration of their treatment. Outpatient treatment requires no overnight stay.

MDC expenditures are increasing consistently year over year. As illustrated in Figure 1, total MDC expenditures in 2015-16 were approximately $6 million and by 2017-18 expenditures had increased to over $12 million.[4] Although MDC program costs have increased significantly, the cost per individual program recipient has remained fairly constant. The increase in program costs have been driven by volume, both in the number of MDC clinics and the number of individual program recipients.

[1] Veterans Affairs Canada Facts & Figures March 2018 Edition.
[2] How to Process Requests for Treatment/Intervention at Outpatient or Inpatient Multi-Disciplinary Clinics (MDCs), Effective August 2, 2017.
[3] Ministers News Release, October 30, 2012, Minister Steven Blaney Unveils Veterans Transition Action Plan and Ground-breaking Partnership with the Veterans Transition Program.
[4] VAC Statistics Directorate, request 1185 with data analysis by VAC Audit and Evaluation Division.

Figure 1 – Historical Spending for Multi-disciplinary Clinics
2015-2016 to 2017-18



	2015-2016	2016-2017	2017-2018
Other	$285,101	$670,873	$1,026,090
Outpatient	$1,017,805	$1,939,617	$2,743,918
Inpatient	$4,622,367	$5,995,103	$8,424,770

Source: VAC Statistics Directorate, request 1185 with data analysis by VAC Audit and Evaluation Division

2.0 AUDIT OBJECTIVES

The objectives of the audit were to determine whether:

- the controls for the registration process for MDCs were effective; and
- the controls for MDCs in the authorization, monitoring, and payment of services existed and were effective.

The audit excluded:

- The quality of the case manager decisions;
- The confirmation of services rendered at the MDC site; and
- The effectiveness of MDC services or specific treatment modalities.

Field work for this audit occurred between November, 2018 and April, 2019.

The audit findings and conclusions contained in this report are based on sufficient and appropriate audit evidence. This audit was conducted in conformance with the Institute of Internal Auditors' International Standards for the Professional Practice of Internal Auditing as supported by the results of the quality assurance and improvement program. The opinions expressed in this report are based on conditions as they existed at the time of the audit and apply only to the entity examined.

Additional information including the audit scope period, criteria, and methodology are provided in Appendix A.

3.0 AUDIT RESULTS

3.1 Multi-disciplinary Clinics Registration

3.1.1 Registration Process

When the MDC program was developed, VAC decided to implement a registration process to create a list of clinics that use an integrated, collaborative approach for the treatment of complex health conditions. Once an MDC has been registered, VAC field staff are able to refer Veterans to these clinics for integrated services.

VAC has a number of policies and supporting directives relating to MDC registration. These tools include a registration application package which outlines VAC's general expectations of registering MDC clinics; a Provider Claims Submission Agreement, which outlines the terms and conditions for providing and billing services for Veterans; and an MDC Clinics Provider Requirements document, which communicates the detailed MDC program requirements to interested applicants.

Clinics applying for registration submit their application to VAC's Federal Health Claims Processing Service contractor (FHCPS contractor) who reviews the application for completeness. When the package is complete, it is sent to VAC Program Management for review. Program Management reviews the application to determine whether it meets the required criteria. The decision (approved/denied) is forwarded by Program Management to the FHCPS contractor who sends a decision letter to the applicant. For approved clinics, a provider ID number for billing purposes is communicated in the letter.

The audit team reviewed all of the registration applications during the audit scope period for compliance with the established business processes. The audit found that overall the registration process had been adhered to. Minor deviations were noted and were brought forward by the audit team to program management for quality improvement purposes.

Although tools, guidance and policies exist, staff are challenged when making registration decisions. On paper, the application criteria appears straight forward. In practice, staff had difficulty applying the criteria and in ascertaining whether the applicants were in fact clinicians operating in an inter-disciplinary manner. Additionally, MDC applications are becoming more complex as clinics are offering a wide variety of treatments and modalities. Program staff were uncomfortable making decisions on clinic registration as they felt they lacked the medical and mental health expertise to make a determination on the adequacy of the proposed treatments for a clinic.

Given these challenges, processing registration applications involves significant effort for VAC staff. Staff frequently needed additional information or clarification from applicant clinics to ensure and document that all criteria are met. As a result, some applications were not being processed in a timely manner. A file review of processed applications found that decisions on application registration took an average of 98 days and, as of December 31, 2018, there were 55 application awaiting a registration decision. Those unprocessed applications had been awaiting decision an average of 156 days. The registration process has been described by staff as a frustrating administrative procedure for both the applicant and staff suggesting improvements are required. The audit team noted that one application for registration was approved during the audit scope period.

It is important to note that individuals and clinics can claim for services even though they have not registered as an MDC with VAC. In this situation, claims are processed under POC 12. The audit team looked to identify potential providers that were claiming for services under POC 12 without having gone through the MDC registration process. The review noted instances where clinics appeared to have been offering multi-disciplinary services under POC 12.

3.1.2 Monitoring

Registration of a clinic is granted at a point in time, and there is no mechanism to ensure clinics continue to meet requirements. For example, VAC does not monitor and update changes in clinic services, programs, or changes in health care professionals. Some clinics may not be providing the services they initially registered for. VAC program staff, field staff, and health care professionals all expressed concern over the lack of monitoring clinics' ongoing eligibility. All felt a monitoring and quality review process for registered clinics is important and the registration process should include an expiry date to ensure periodic review.

The MDC clinic registration process requires improvement but to implement stronger controls could require more resources. The benefits of registering MDCs needs to be examined in light of the challenges discussed above. Improvements to the process such as set expiry dates, facility site reviews, health care professional expertise, and a more detailed registration form need to be considered. Consideration should also be given to the cost/benefit of registering and monitoring multi-disciplinary clinics.

Recommendation 1

It is recommended that the Director General, Service Delivery and Program Management, with support from Finance Division, strategically review the registration process, considering that additional guidance and controls are needed.

Management Response:

Service Delivery and Program Management agrees with this recommendation. Program Management had recognized these challenges and prior to the audit established a working group tasked with identifying and addressing these concerns. A detailed action plan was provided to Audit and Evaluation for audit follow up.

Target Completion Date: July 2020

3.2 MDC Treatment Authorization and Payment

Treatments provided at MDCs must be preauthorized by a VAC case manager. Case managers use a system called Client Service Delivery Network[5] (CSDN) to manage a Veteran's treatment. Among other things, CSDN houses a Veteran's case plan, progress notes, reports, and authorized treatment details.

Once an MDC treatment has been authorized by the VAC case manager, he or she forwards the authorization details to the FHCPS contractor who sets up the authorized treatment details in the Federal Health Claims Processing Service (FHCPS)[6].

Once the treatment has been set up, the provider is notified of the details of the authorized plan and is provided with billing instructions. The majority of providers claim for these services electronically via the FHCPS Provider Portal. Using the Portal, the provider inputs data into specific fields for the service rendered and the payment is made. Alternatively, providers can claim for services using paper invoices, the details of which are manually entered into FHCPS by the FHCPS contractor and the payment is made.

The audit team examined whether the VAC case managers and the FHCPS contractor adhered to the Business Process that outlines the MDC treatment authorization process. The audit team conducted file reviews, directly observed system authorizations and payments, and interviewed staff from both VAC and the FHCPS contractor . In general, we found that both VAC and the FHCPS contractor were adhering to the requirements of the Business Process. Some minor deviations were noted and these were communicated to program management for quality improvement.

3.2.1 Controls over dollar and frequency limits

VAC offers a variety of treatment benefits, of which MDC treatments are one (under POC 5). There are also many other health related treatment benefits that fall under POC 12 - Related Health Services that are closely tied to the provision of MDC treatments. These POC 12 benefits include treatments and services offered by a wide range of clinicians such as dieticians, chiropractors, psychologists, physiotherapists,

[5] The Client Service Delivery Network (CSDN) is an information system used by VAC staff to assist in the delivery of services to Veterans, including Veteran's benefits and case management.
[6] The Federal Health Claims Processing Service (FHCPS) is the FHCPS contractor 's system to manage the payment of claims for health treatment benefits on behalf of VAC.

social workers, and massage therapists. These clinicians may also provide services while working as part of an MDC.

Treatments under POC 12 have limits on the dollar values that VAC will pay and the frequency of treatments it will allow. For example, a Veteran on Prince Edward Island can access 20 physiotherapist visits per year at a set fee of $55/session. In contrast, MDC services are managed under POC 05, and there are no set frequency or dollar limits for these services. Costs for MDC treatments (inpatient, outpatient, and the various reports) vary widely. There is no guidance for VAC case managers, and they expressed some challenges with referring Veterans to MDC treatments without any guidance on frequencies or appropriate rates.

In addition to there being no set limits or guidance, a case manager's delegated authority to authorize these treatments also has no set dollar limit.

Where no set limits exist over theses MDC services, we would expect greater controls over payment and monitoring to mitigate the increased risks associated with these services. As outlined in the subsequent section, there are significant gaps in these controls.

3.2.2 Key controls over payments for multi-disciplinary services

After MDC treatment benefits have been authorized by the VAC case manager, the treatment is provided to the Veteran by the relevant MDC provider. As mentioned, the MDC provider submits a claim for payment to VAC in one of two ways: a paper invoice is submitted to the 3rd party payment processing centre or the provider submits the claim details (a prescribed set of fields) directly into the FHCPS contractor 's FHCPS Portal. We were advised that the majority of providers submit their claims electronically via the Portal.

The audit examined the following key controls and the related observations are noted in the subsequent paragraphs. The audit reviewed whether

- the provider claimed more than the amount authorized by the case manager and
- VACs payment verification processes sufficiently addressed the risks associated with the lack of limits over the MDC services.

Payments in excess of authorized amounts

When the MDC provider submits its claim for service via the Portal, it directly populates pre-determined fields within the FHCPS contractor 's FHCPS portal. These fields include the Veteran's identification number, the treatment authorization number, the number of occurrences, the treatment service date, and the amount. The claim gets applied to the authorization that had been previously set up in FHCPS by the FHCPS contractor based on the instructions from the VAC case manager. The audit team

expected the system to have built-in controls to limit a claimed amount to the dollar value authorized by the case manager. This control is especially important given that POC 5 treatments have no prescribed frequency or dollar limits.

The audit team conducted interviews with the FHCPS contractor and VAC finance staff and performed a detailed file review. The audit found that for claims paid through the portal, the FHCPS contractor system has no mechanism to limit the claimed service to the dollar amount that was authorized by the VAC case manager. Further, our file review found 5/48 (10.4%) instances where the claimed amount exceeded the authorized amount. None of these instances was in excess of $2,500.

Although there are no controls limiting the dollar value of the claims, there are controls built into the system around the date of service and the number of occurrences. The audit test found these controls to be working to an extent; however, they are not as effective as they could be.

There is a lack of consistency and a lack of billing instruction when it comes to setting up the number of occurrences for the authorization and claiming against those authorized occurrences. For example, **[Redacted]** [7]. Providers are able to claim for services for up to 18 months after the date of service, which allows a large time period for providers to continue to claim and for potential errors to occur.

Payment verification processes

Payment verification becomes increasingly important where a control environment has limited prepayment expenditure controls. There were two key payment verification processes examined in this audit:

- VAC's payment verification for individual treatments and
- VAC's monitoring for potential duplicate payments.

Payment verification at the treatment level requires that someone confirms that the service was rendered in accordance with the authorization and at the negotiated price. The audit found that the payment system is not set up to allow VAC to confirm these details.

As claims are submitted directly to the FHCPS contractor, **[Redacted]** [7].

There are two levels of post payment review for all POC treatment benefits: work conducted by the FHCPS contractor 's audit team and analyses conducted by VAC's finance division. The audit team interviewed key stakeholders to determine what post

[7] Protected from disclosure in accordance with the provisions of the Access to Information Act s.16(2)(c)

payment work is done specifically with regards to MDC transactions. The audit team found that post payment verification specific to MDCs is limited. This is due primarily to MDC transactions ranking low from a risk-based planning perspective as it represents a small portion of the total treatment benefits expenditures.

The MDC treatment delivery model allows for the potential of duplicate claims where the registered MDC claims for a Veteran's treatment using its MDC provider number and the individual clinician also claims for that same service using its provider number, usually under POC 12. The audit sought to conduct data analyses to identify potential duplicate claims. However, there were data limitations that restricted audit's ability to conduct meaningful analyses. **[Redacted]**.[7] .

There are weaknesses around the control framework for MDC services. Controls around pre-payment and post-payment require strengthening.

Recommendation 2

It is recommended that the Director General of Service Delivery and Program Management, in collaboration with the Finance Division, improves the control framework for the authorization and payment of multi-disciplinary clinics services, including implementing treatment benefit limits, pre and post-payment controls, and the use of data analytics.

Management Response:

Service Delivery and Program Management agrees with this recommendation. Program Management had recognized these challenges and prior to the audit established a working group tasked with identifying and addressing these concerns. A detailed action plan was provided to Audit and Evaluation for audit follow up.

Target Completion Date: June 2020

3.3 Audit Conclusion

The audit team identified the need for additional controls over the registration, authorization and payment for multi-disciplinary clinics. The audit identified compliance with business processes but this was not sufficient to manage the risks associated with the lack of limits for multi-disciplinary clinics services. The risk of inaccurate or erroneous payments is not managed to an acceptable level and additional controls are required.

[7] Protected from disclosure in accordance with the provisions of the Access to Information Act s.16(2)(c)

Appendix A - Audit Criteria and Methodology

The audit scope included MDC program activities over the 12 month period from September 1, 2017 to August 31, 2018. Specifically, the audit included:

- MDC provider registration applications received during that time period;
- Authorization of and payments for MDC services rendered during that time period; and
- An analysis of POC 12 transactions to identify trends, unregistered clinics, and duplicate payments during that time period.

Objective	Criteria
1. To determine whether the controls for the registration of multi-disciplinary clinics (MDCs) / providers are effective.	A. Employees have access to appropriate and sufficient tools (e.g. industry best practices, work methodologies and operating procedures) to discharge their responsibilities for registration decisions (approvals/denials). B. MDC provider registration form/process is adhered to. C. Provider registration decisions are processed in a timely manner.
2. To determine whether the controls for multi-disciplinary clinics in the authorization, monitoring and payment of services exist and are effective.	A. Authority is formally delegated and delegated authority is aligned with individuals' responsibilities. B. Authorization process is adequate and appropriately adhered to by VAC employees. C. Authorization process is adequate and appropriately adhered to by the third party contractor. D. Controls are in place to ensure accuracy of transaction coding and processing. E. MDC status reports are submitted to VAC, provide sufficient information, and are correctly coded for billing (Assessment reports, Progress reports, End of treatment report.)

* The audit team confirmed that all of the above criteria were met unless otherwise stated in this audit report.

Methodology

Methodology	Purpose
Interviews	Interviews were conducted with stakeholders involved in the processing of treatment benefits. VAC field staff were interviewed (11) to gain an understanding of the authorization process for MDC treatments. Third party processing staff were also interviewed in regards to the provider registration, claims processing and government business audit processes. VAC senior management and program management were interviewed to discuss governance, controls and challenges related to the registration of MDC's and the authorization and payment of services by MDCs. Audit team also interviewed VAC Finance staff to gain an understanding of the post payment verification processes for MDCs and duplicate payments.
Direct Observation	Direct observation was conducted for each of the primary steps of the MDC process. VAC staff (3) at a field office were observed using the electronic client management system and processes to create an Authorization for MDC services. FHCPS contractor staff (2) were observed creating the electronic approval and notification process informing the service provider of the specific services approved. The final step was observed at the third party processing site where the audit team observed the matching of the submitted claim to the authorized treatment and the release of payment.
Documentation Review	Documentation was reviewed to determine the governance of MDCs and whether VAC employees have access to the appropriate tools and training (guidance, methodologies, and procedures) for assessing MDC applications, authorization, monitoring, and payments to MDCs. Documentation was compiled, reviewed, and analysed for the provider registration process for MDC's. The audit

Methodology	Purpose
	team assessed the decision tools used for provider registration. Delegated authority instruments and authority levels/limits were reviewed to determine alignment with individual's responsibilities and if departmental delegation authorization processes are adhered to.
File Review	Three distinct file reviews were conducted: The population of MDC provider registration applications processed during the audit scope period (25) was reviewed to assess whether processes were adhered to and whether decisions were made in a timely manner. The population of unprocessed registration applications outstanding as of the date of audit field work (55) was reviewed to assess timeliness and to determine the reasons for any delays. A sample of authorized MDC services (48) was reviewed to determine whether controls were effective over the authorization, monitoring, and payment of services.
Data Analysis	Audit team conducted various analyses on POC 5 and POC 12 data to determine whether there were any duplicate payments. Audit team conducted various analyses on the POC 5 data of transactions to identify any unusual patterns or trends.

Appendix B – Overview of the Programs of Choice[8]

1. **Aids for Daily Living -** devices and accessories designed to assist in the activities with everyday tasks, such as walking and bathroom aids. The costs of necessary repairs to this equipment are also covered.

2. **Ambulance Services and Health Related Travel -** ambulance services required for an emergency situation or a specified medical condition. The program also includes coverage for costs related to travel when receiving treatment benefits.

3. **Audio (Hearing) Services -** equipment and accessories related to hearing impairment, such as hearing aids, telephone amplifiers, infrared devices, hearing aid accessories and dispensing/fitting fees.

4. **Dental Services -** basic dental care and some pre-authorized comprehensive dental services. Examples of eligible services and benefits are exams, fillings and dentures.

5. **Hospital Services -** treatment services in an acute care, chronic care or rehabilitative care hospital. As these services are generally a provincial responsibility, costs for these services are normally covered by VAC only if they relate to a condition for which a client holds disability entitlement.

6. **Medical Services -** services provided by a licensed physician for a condition for which a recipient holds disability entitlement. It also covers the cost of medical examinations, treatment or reports specifically requested by VAC. For most VAC recipients, physician services are the responsibility of the provincial health care insurance programs.

7. **Medical Supplies -** medical and surgical equipment and supplies normally used by an individual in a non-hospital setting. Examples of eligible benefits include bandages and incontinence supplies.

8. **Nursing Services -** services provided by a registered nurse or a qualified licensed/certified nursing assistant. Examples of eligible services include foot care, the administration of medications, application of dressings and counselling Veterans or caregivers in the use of medical supplies.

9. **Oxygen Therapy (Respiratory Equipment) -** oxygen and accessories, including the rental or purchase of respiratory supplies and equipment.

10. **Prescription Drugs** - drug products and other pharmaceutical benefits to those who have demonstrated a medical need and have a prescription from a health professional authorized to write a prescription in that province. Standard benefits and special authorization benefits are included in this program.

[8] Veterans Affairs Canada Programs of Choice.

11. **Prosthetics and Orthotics -** prostheses, orthoses, and other related accessories. Repairs to equipment are obtained under this program.

12. **Related Health Services -** services provided by licensed health professionals. In many cases, the service must be prescribed by a physician in order to be approved by VAC. Examples of eligible services include occupational therapy, physiotherapy, and massage therapy.

13. **Special Equipment -** special equipment required for the care and treatment for eligible recipients. Benefits must be prescribed by a doctor, and in many cases supported by the recommendation of another health professional. VAC may also provide coverage for home adaptations or modifications (i.e., wheelchair ramps, door widening) to accommodate the use of the special equipment in the home. Examples of eligible equipment include hospital beds, wheelchairs and lifts.

14. **Vision (Eye) Care -** eye examinations, lenses, frames and accessories to correct sight impairments as well as low-vision aids.