A STUDY TO DETERMINE THE BEST SYSTEM FOR INSURING THE MAXIMUM REIMBURSEMENT TO UNIVERSITY MEDICAL CENTER FOR SHARED SERVICES UTILIZED BY THE VETERANS ADMINISTRATION HOSPITAL, JACKSON, MISSISSIPPI

A Problem Solving Thesis

Submitted to the Faculty of

Baylor University In Partial Fulfillment of

Requirements for the Degree

of

Master of Hospital Administration

by

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Waco, Texas

August, 1971

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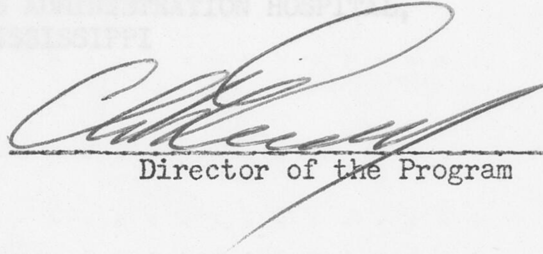

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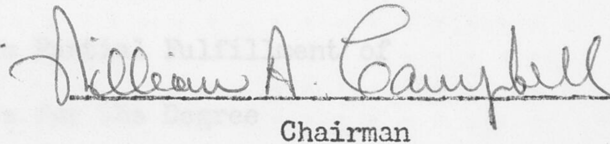

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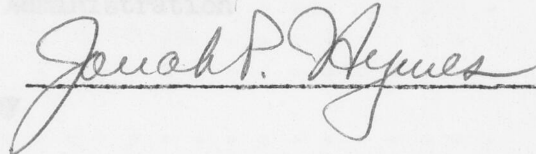

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ABSTRACT

A STUDY TO DETERMINE THE BEST SYSTEM FOR INSURING THE MAXIMUM REIMBURSEMENT OF UNIVERSITY MEDICAL CENTER FOR SHARED SERVICES UTILIZED BY THE VETERANS ADMINISTRATION HOSPITAL, JACKSON, MISSISSIPPI

A Problem Solving Thesis Submitted to the Faculty of Baylor University in Partial Fulfillment of the Requirement for the Degree of Master of Hospital Administration

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A detailed study was made of how requests at the Veterans Administration for shared services at the University of Mississippi Medical Center are initiated and processed, and how these services are rendered and charges recorded at UMC. Contracts, records, and agreements were reviewed and numerous interviews were conducted to gain knowledge and insight into the current program and future plans.

The present system, while permitting easy access to UMC services, was nonetheless noted to be characterized by lax administrative practices that do not account for all services performed. It was concluded that the best system for UMC is a gradual phasing-in of patient register numbers for all VA outpatients. This would permit full computerization of data for medical information and more accurate accounting measures. Clear, concise inter-hospital agreements, orientation of all personnel to procedures used, and an easily identifiable authorization stamp were general recommendations applicable to any system adopted.

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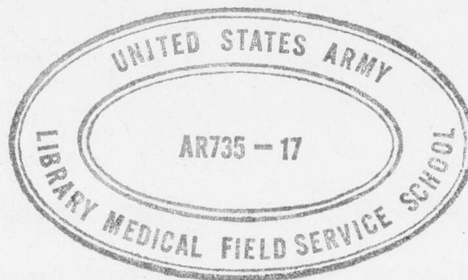

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CHAPTER I

INTRODUCTION

General Information

The general relationship of the Veterans Administration and medical schools officially began in 1946 primarily as a means of improving the quality of medical care of the veteran. In 1945 General Omar N. Bradley was named Administrator of Veterans Affairs, and he selected Army Major General Paul R. Hawley, formerly Chief Surgeon, European Theater of Operations, as Medical Director of the Veterans Administration (VA). At a meeting in Weisbaden, Germany, shortly after accepting the post of Administrator, General Bradley discussed with General Hawley the idea of linking a system of veterans hospitals with American medical education.[1] Their discussion may have been influenced by a recommendation of Presidential Advisor Bernard M. Baruch, who, in a letter to General Bradley, advised the establishment of effective VA ties with centers of medical education and skill and also suggested new VA hospitals be located accordingly.[2]

Dr. Paul T. Magnuson, noted orthopedic surgeon of Northwestern University Medical School, joined the VA medical program in 1945 as Acting Assistant Medical Director for Medical Research and Education. In his book, Ring the Night Bell, Dr. Magnuson relates that he had written to General Frank T. Hines, the previous Administrator of the VA, concerning the suggestion that Veterans Administration hospitals be built near established medical schools and that the deans of the medical schools staff the hospitals, putting in

chiefs of services, residents and interns.[3] Dr. Magnuson was recruited to the VA by the inducement that he would be permitted to help set up such programs. He personally visited several medical schools and gathered firm and enthusiastic support for the desired relationships. Deans' Committees, consultants, and residencies were a reality by March, 1946.[4] In 1948, Dr. Magnuson succeeded Dr. Hawley as Medical Director.

The value of the VA-medical school relationship has increased over the past twenty-four years. For the VA there has been a high quality of medical care for the veteran, particularly at the affiliated hospitals. Recruiting of VA medical staff and residents has been facilitated where the affiliation is strong. For the medical schools, the VA has been an important source of patients for teaching purposes. This has been increasingly important because the charity teaching patient has rapidly disappeared as third party plans proliferate.

Technological advances in medicine require new and often expensive equipment. Specialists knowledgeable in new procedures and techniques are often concentrated at a few places because of the need for this elaborate equipment and teams of assistants.

Medical schools often have such advanced medical resources. In this day of cooperation and sharing of resources, the VA finds itself less inclined to use its limited funds to open new services for which it has restricted use, and for which expensive equipment might become obsolete because of rapid technological advances. Congress has authorized the VA to purchase services, or to enter into exchange-of-use agreements with medical schools and teaching hospitals for specialized medical resources.[5] These agreements are intended to be a two-way street, and, indeed, many VA hospitals offer sophisticated services (such as cardiac catheterization, open heart surgery, and renal

dialysis) not generally available in the medical community. In most cases, however, the medical school teaching hospital has more to offer the veteran than the VA can offer the community hospital. Due to the nature of the operation of the medical school, there probably will always be more medical traffic in the direction of the medical school.

Hospital Setting and History

The University of Mississippi Medical Center, hereafter referred to as UMC, is located in Jackson, the state capital. It includes the School of Medicine, Graduate Studies in the Medical Sciences, School of Nursing, the Rowland Medical Library, various technological training programs and research laboratories, and the University Hospital. From a two-year school on the Oxford campus, the school moved to Jackson in 1955 and occupied a new eight-story building. This nucleus building, which contained the school and the hospital, was expanded with the completion of a nine-story research wing in 1963, and a nurse education building in 1964. A two-story diagnostic services wing was added in 1964, and then topped by two 20-bed private nursing units in 1968. At the same time, a modern circular children's hospital of four stories was opened. Currently, the children's hospital and connecting wing are receiving an additional floor. The 447 bed University Hospital serves as the major teaching unit for the school, and is also a general short term diagnostic and treatment center for the entire state in addition to being an acute general hospital for the immediate community.

The VA Hospital, Jackson, is a 498-bed hospital which occupied a new building in 1964 adjacent to the UMC campus. A short-term general medical-surgical hospital, it is a Deans' Committee hospital (see Definitions) and is accredited for residency training in most specialties except pediatrics and

obstetrics-gynecology. Currently, all residents are on a rotation basis from UMC. The hospital is also used for teaching medical students.

Conditions Prompting the Study

A combination of conditions has led to this study of the VA-UMC shared services relationship. Indirectly, the increase in size and complexity of operation of UMC has necessitated the application of more efficient business methods. There has been an increase in the number of third party payers with the demand for more comprehensive cost accounting. Some government grants have been eliminated, and other funding agencies have begun to require more detailed budget information. In 1969, a misunderstanding over reimbursement for a hospitalized VA patient led to a brief study of the relationship between the two institutions: the long-standing radiotherapy contract was reviewed, and a proposed contract was prepared for open heart surgery at UMC and certain laboratory studies and an ophthalmological procedure at the VA Hospital. This contract was forwarded to the VA central office for approval, but had not been signed by April, 1970. These actions are merely a beginning in recording the interhospital relationships for there remain many other procedures and studies that are not covered by the more formal agreements. The Director and Dean of UMC indicated an interest in providing for agreements that would obviate future misunderstandings. In early 1969, the Acting Director of the University Hospital submitted the problem for consideration of the United States Army/Baylor University program in Health Care Administration. The administrative and professional staffs of the VA Hospital were aware of the problem and gave their full support to the study.

Statement of the Problem

The problem is to determine the best system for insuring the maximum reimbursement of UMC for shared services utilized by the VA Hospital, Jackson, Mississippi.

Definitions

Shared service, as used in this paper, refers to any specialized medical service provided by one hospital and purchased by the other hospital.

Sharing (mutual use), in VA terminology, refers to certain advanced medical techniques and medical resources in a VA hospital, which are excess to the needs for VA patients and which are permitted to be used by non-veteran patients of the health service organization with whom a written agreement is held.[6]

Exchange of use of special medical resources refers to an agreement between a VA hospital and a particular health service organization whereunder VA resources may be used for non-veteran patients in exchange for use of their resources by VA patient.[7]

Deans' Committee hospital defines a VA hospital affiliated with a university teaching hospital. The Deans' Committee, a group of professors from the medical school and select representatives of the VA hospital, meet to discuss patient care and policy. The Deans' Committee approves VA staff and resident appointments.

An affiliated hospital is a VA hospital affiliated with a teaching hospital and having a Deans' Committee.

Unit history number is a register number assigned to each inpatient and outpatient at UMC. Generally referred to as a "UMC" number, it is

the key for entering and retrieving information from the computer for that patient.

Objectives

The three objectives that must be accomplished by this study in order to solve the problems are:

1. To analyze the present relationships between the VA Hospital and the UMC in the area of shared services.
2. To analyze the present system of administration of shared services at both the VA Hospital and UMC.
3. To discuss alternative methods of administrative control of shared services.

Criteria

Any proposed solution must meet the following standards before it can be considered the best available to UMC:

1. The solution must provide formal, fair, and accurate arrangements with the VA.
2. The solution must lessen misunderstandings between the two hospitals.
3. The solution selected must not impede obtaining services of UMC.
4. The solution selected must stimulate maximum compliance with the system by the professional and administrative personnel.

Factors Bearing on the Problem

The VA-teaching hospital relationship has, from its beginning, provided benefits to each partner that are, in part, difficult to quantify

and assign in terms of strict cost accounting. The VA provides an extension of teaching cases that enrich the medical student's exposure to additional and unusual conditions and diseases. It also permits the resident physician a broader ranger of cases for better training. Affiliation of a VA hospital with a university teaching hospital, particularly where there is a strong, active Deans' Committee, traditionally attracts a better caliber of physician to the VA staff and promotes a higher level of medical care in the hospital.[8] VA policy does not allow spending of monies to bring applicants for interview, but UMC has spent some its funds in recruiting a new Director of Medical Research for the VA Hospital. The VA uses many members of the UMC faculty as consultants. This arrangement not only gives the VA patients the benefit of consultation by the renowned physicians but affords some supplement in salary to the university faculty member.

Recently, UMC has been able to provide some small compensation to the VA staff physician who engages in teaching medical students. Both hospitals thus receive benefit from each other, and any attempt from UMC to push for monetary reimbursement for every possible quantifiable service performed for the VA would tend to damage the spirit of cooperation and mutual trust of the two institutions. This study and the resultant recommendations seek only to record and obtain reimbursement for those services performed by UMC in good faith for the VA. The VA wishes to properly and fairly provide reimbursement in the spirit of full compensation and fulfillment of its honest obligations.

Opposition by the medical staff to numbers and forms is frequently mentioned as a factor that might tend to sabotage any proposed method that would increase the use of identifying numbers or enhance a bureaucratic approach. Indeed, this may be true particularly if a method is unwieldy

or cumbersome. However, if a system is kept as simple as possible, is easily justified, and is explained to personnel using it, it will probably be accepted by the professional group.

Physicians have been known to shun administrative details, particularly if such details appear as unnecessary obstructions, but a new breed of physician is appearing—one who is brought up in a world of identifying numbers such as those for selective service, social security, credit cards, telephone dialing, and bank accounts. It is the era of the computer, and the physician recognizes its requirements.

Assumptions

Assumptions concerning this problem area:

1. That the VA will continue to have a need for specialized services available at UMC.
2. That the VA regulations will continue to authorize the purchase of specialized services from UMC.
3. That the bulk of shared services will continue to be provided by UMC.

Research Methodology

In order to obtain an in-depth knowledge of the nature, scope and implications of this problem, the author made two visits to the hospitals and conducted extensive interviews with the Director, numerous department or section chiefs, residents, clerks, technicians, and secretaries at UMC; and interviewed the Chief of Professional Services, the Chief Medical Administrator, residents, staff physicians, technicians, and clerks at the VA Hospital. The object of the personal interviews was to learn how the

present system works, its good and bad points, areas of misunderstanding and confusion, and how the system could be bypassed.

Laboratory tests, electroencephalograms, radiotherapy treatments and numerous other activities require different patterns of request, authorization, appointment, and completion. Almost all of these existing shared services were reviewed to compare similarities and differences and to detect weaknesses and strengths of the system.

Contracts, agreements, minutes of Deans' Committee meetings, inter-office memoranda, and policy files were reviewed at UMC. VA regulations, circulars, and manuals were also reserached in order to obtain background information and to determine intent and policy affecting both parties.

A survey of the literature was conducted to obtain insight into the history and philosophy of the VA-teaching hospital relationship. Some reports of the U.S. House of Representatives Committee hearings were scanned in order to examine the intent of Congress as regards the VA using shared services. Also, some general information on hospital shared services was reviewed; however, not much information specifically related to the problem was available.

Review of the Literature

A survey of available literature revealed many articles of a general nature on shared services but very little of a specific nature relative to a VA and teaching hospital. Mark S. Blumberg, in his report Shared Services for Hospitals, defines a shared service as "any service or product that a hospital purchases or obtains from an outside agency."[10]

The concept of utilizing shared services or an exchange of use approach has shown interest and rapid growth in the medical field. This trend is no doubt brought about by rapid technological advances with

resultant high costs for equipment and personnel. A general spirit of cooperation as reflected in comprehensive health planning, joint utilizations, and affiliations has flourished in the past few years. There are reports of small hospitals "hiring" larger hospitals to operate specific departments.[11] Problems occur with such joint operations particularly when hospitals want to take advantage of such arrangements and still preserve their independence.[12] Shared education and training programs appear to be easier to administer than patient care programs.[13]

Small hospitals can effect great savings by utilizing central geographic laboratories not only for equipment but in obtaining the services of clinical laboratory specialists.[14] Walter J. Rome has described the arrangement in Pittsburgh whereby the VA hospital utilizes a central chemistry laboratory at the University Health Center. Details of this cooperative venture were not given except that a committee of representatives of both hospitals meet periodically to divide the costs of operation of the shared central laboratory.[15]

In 1966, Congress passed Public Law 89-785 which gave the VA the authority to enter sharing and exchange of use agreements with medical schools and certain hospitals.[16] This law appears to be an extension of other legislation such as the regional medical program. It has evoked some interest of the medical schools.[17] VA regulations that serve to implement this public law are the basis for the open heart surgery agreement between VA hospital and UMC. The VA had previously been permitted to contract for services outside VA hospitals; but this new legislation, for the first time, permitted some non-VA patients to utilize specialized medical resources of the VA hospital.[18]

Footnotes

[1]United States Congress, Committee of Veterans' Affairs, House Committee Print No. 170, VA Medical Program in Relation to Medical Schools (Washington, D.C.: Government Printing Office, 1970), p. 103.

[2]Ibid., p. 105.

[3]Paul B. Magnuson, Ring the Night Bell (Boston: Little, Brown, and Company, 1960), p. 269.

[4]U.S. Congress, VA Medical Program, p. 110.

[5]Veterans Hospitalization and Medical Services Modernization Amendments of 1966 Act, U.S. Code, Vol. XXXVIII, Secs. 5051-5053 (1966).

[6]U.S. Veterans Administration, Department of Medicine and Surgery, Sharing VA Resources, Facilities, Equipment and Personnel, Circular 10-67-86 (Washington, D.C., 1967).

[7]U.S. Veterans Administration, Department of Medicine and Surgery, Exchange of Use of Specialized Medical Resources. Circular 10-67-145 (Washington, D.C., 1967).

[8]U.S. Congress, VA Medical Program, pp. 232-251.

[9]U.S. Code, Vol, XXXVIII, Secs. 5053.

[10]Mark S. Blumberg, Shared Services for Hospitals (Chicago: American Hospital Association, 1966), p. 1.

[11]David S. Pomrinse and Bernard M. Weinstein, "Improvement of Medical Care Programs by Means of a New Type of Hospital Affiliation," American Journal of Public Health, LV (October, 1965), 1651.

[12]Carruth J. Wagner, "Association Concept Promotes Sharing, Preserves Independence," Hospitals, XLIII (16 March 1969), 47-52.

[13]"Johns Hopkins Medical School Joins Five Baltimore Hospitals in Pediatric Service," Hospitals, XXXVIII (1 August 1964), 110.

[14]R. G. Thomas, "Clinical Laboratory Service for Geographic Regions," Hospital Progress, XLVI (June, 1965), 88-92.

[15]"A Design for Shared Services," Hospitals, XLII (16 May 1968), 51.

[16]U.S. Code, Vol. XXXVIII, Secs. 5051-5053

[17]S. Richardson Hills, Chairman, "Report of the Education Advisory Committee to the Veterans Administration," Journal of Medical Education, XLIII (May, 1968), 648-654.

[18]U.S. Code, Vol. XXXVIII, Secs. 5051-5053

CHAPTER II

DISCUSSION

The Problem as It Exists at VA Hospital and UMC

A test or procedure performed at UMC for a VA patient originates with a physician at VA Hospital determining the need for a particular study that is not available at VA Hospital. His request for this special study must be approved by the Chief of Professional Services, the Chief Medical Administrator, and a specific clerk in the Business Office. Notice of approval is sent to the ward and to the laboratory in the case of laboratory studies. For the latter, the specimen is obtained, sent to the laboratory, and then transported to UMC. At UMC, the specimen is received at the main clinical laboratory or at any one of several special research laboratories. Since no unit history number is available, the clerk or technician in the laboratory completes a UH Form 01020 Charge Record (Appendix A), noting the patient's name, Social Security account number, and the designation "VA". Only authorized specimens are supposed to be sent over. Since VA Form 10-7078, Authorization and Invoice for Medical and Hospital Services (Appendix B), cannot be completed in time to accompany each specimen, there is no specific designation that indicates to UMC personnel that the test has been authorized. Frequently, physicians at the VA Hospital will personally contact a UMC laboratory and indicate that a test is authorized. Personnel are trusting and cooperative and, putting medical education and

patient care foremost, perform the requested study with little or no question. Later, it is often discovered that authorization for that test was not obtained. By that time, it is too late to investigate the circumstances, and UMC makes no attempt to collect.

For other special studies or procedures, the VA Business Office clerk makes an appointment in the specific clinic. In such cases, appropriate authorization is promptly sent to the UMC Business Office. Again, there is evidence that some special studies are performed and the charge slip is marked to identify "VA patient - - no charge." In some cases, these patients are VA patients for whom authorization could not be obtained and, in other cases, they may denote outpatients who require a different internal procedure at the VA. Indications are that some resident physicians are not familiar with the outpatient authorization procedure and bypass proper channels, obtaining studies "unofficially".

Radiotherapy patients and x-ray diagnostic patients are scheduled by appointments. Cross-verification of authorization and treatments/service performed is made by clerks in radiology and VA with resultant complete accuracy in reimbursement. Radiotherapy is the only study performed under formal contract. X-ray diagnostic studies are a more recent addition. Studies on two to three outpatients per day were undertaken to assist in relieving the overworked, lone radiologist at the VA.

VA patients referred to the Allergy Clinic have appointments made by a VA Business Office clerk. On their first visit at UMC, these patients are issued a unit history number. This number is used for all services performed in connection with their outpatient visits. At the end of the month, a computer print-out by name, service performed, and charge is

made available for both VA and UMC business office personnel. All personnel concerned with this method express warm praise for the ease and accuracy of verification of services performed.

The only inpatients involved in the shared services arrangements are certain heart patients who receive their evaluation and workup at the VA Hospital and, when ready, are scheduled for admission to UMC for open heart surgery. The cardiovascular surgeons who perform the surgery are consultants at the VA and conduct the pre-operation evaluation at the VA Hospital as part of their consultation services. This arrangement has been satisfactory and has presented no serious difficulties or misunderstandings except in one instance when a VA patient was admitted as an emergency to UMC. Authorization for admission was not obtained prior to the patient's being admitted, and this omission resulted in some controversy over payment. A proposed contract between VA and UMC for open heart surgery is under final review and, if approved, will provide for VA to reimburse UMC for all hospital charges in connection with the admission up to a designated amount per patient. There are no professional fees involved, for such cases are considered to be a part of the teaching program. Terms of this proposed contract have already been applied in several cases.

Cardiac catheterizations are performed on VA patients as an outpatient service of the Heart Station, UMC. Scheduling and reimbursement for this service has presented no problems. The VA Hospital is in the process of establishing a comprehensive catheter laboratory but currently has no cardiologist on its staff.

The proposed agreement for open heart surgery includes two services to be provided by the VA for UMC patients. These are a laboratory procedure,

phenotyping for hyperlipoprotenemia, and cyclecryotherapy, an ophthalmology procedure. The latter has been performed as an outpatient procedure at least once, and the former has not yet become a reality because the equipment is not available.

Unstructured interviews with several residents who had rotated through the VA Hospital and with VA staff physicians revealed that permission to obtain laboratory studies or other procedures at UMC is readily obtained. The system at the VA Hospital for obtaining such permission, while presenting some delay, at least has never been considered a roadblock to obtaining studies that would be in the best interest of the patient or would be of teaching of research benefit. VA policy and approach appears to be a most cooperative one. Screening is designed to prevent any misuse of funds, and only budgetary limitations restrict permission for requested studies. Despite this spirit of cooperation, some residents are not familiar with the system, or not willing to accept the minor delays, bypass the system. This tendency to bypass the system results in tests being performed at UMC for which there is no authorization and thus no reimbursement.

There are some studies obtained at UMC laboratories that are performed under specific research grants or funds. Many of these grants are federally sponsored. If charges were made to the VA, such action would result in unauthorized use of government funds. There is no evidence that these unauthorized charges are being made; however, generally it would be considered a better business procedure if any accounting were kept of the number of such tests performed.

At UMC, when a laboratory specimen from the VA is received at the main laboratory, it is entered in a log book and marked "VA." The log book is used for those studies without a unit history number. Results are posted

in the book and reports returned to the VA. Some studies are not done in the main laboratory but are sent to specialized laboratories in other areas such as the research building. In some cases, blood specimens from the VA are carried directly to the laboratory concerned. At most of the clinics where VA patients are examined, appointments are made by the VA Business Office clerk, a ward nurse or other official. Occasionally, a VA patient appears at a clinic with a note from a physician at the VA requesting some specialized study. At times, the technician is instructed not to bill the VA. The technician may or may not complete a UHC Form 01020, Charge Record. If it is completed, it is marked "VA — no charge."

At the end of each month, the UMC Business Office clerk begins to gather information concerning charges to VA for that month. The clerk collects the computer print out for the allergy clinic patients, the assorted charge slips, and sometimes a list of patients seen and services rendered for certain clinics. In addition, she goes to the main laboratory to check the log book for VA charges. She compares all of these bits of information with the copies of VA Form 10-7078, which indicates authorization for services performed for the VA. At times, the clerk at UMC is unable to verify that services were actually performed as authorized. Statements are not rendered unless verification is made. There are always charge clips for which authorization is not available. These go without reimbursement since it is assumed they were performed without authorization. No specific accounting is made of this category of services. Some of the technicians or clerks in the various clinics/laboratories where studies are performed indicate a lack of instruction in verifying authorization and in preparing charge records. All are aware that some sort of authorization is required but few are familiar with VA Form 10-7078 or know the procedure of telephone verification with the VA Business Office. Usually the requesting doctor is queried concerning

authorization, and his affirmative answer is accepted without question. This is not meant to imply that the physician intentionally evades responsibility for proper procedures; however, he may be unwilling to follow the proper procedures for obtaining authorization because of his unfamiliarity with them.

Other than the one formal contract for radiotherapy and the proposed contract for open heart surgery, there are no well-documented agreements concerning terminology and fees for other studies. There is a single page fee schedule (Appendix C) for some procedures dated September 15, 1969. Copies of this schedule were observed in some clinics, but all copies were not dated, and it was reported from the outpatient clinic and laboratory that some fees had been changed. There was evidence that some agreements were made by individuals in laboratories or clinics but were never confirmed in writing or submitted for approval at any UMC administrative office. UMC charges to the VA are usually the low, local charge or basic cost for that service or may be below cost if the VA indicates that by regulation it can pay no more than a specific amount for that particular service. The contract for radiotherapy only notes a routine charge of ten dollars per visit. On new patients, there is a need to obtain ordinary diagnostic type x-ray films for localization purposes. Since diagnostic x-rays are available at the VA, the VA will not reimburse UMC for such films. It would be totally impractical for a radiotherapy patient to interrupt his treatment session to return to the VA for such x-rays. The contract could be rewritten to include a slightly higher fee for first visits. This higher fee would include costs of necessary localization films and also computer charges which are a new addition to radiotherapy.

The allergy clinic arrangement was an informal agreement and there

now remains some disagreement over just what an initial visit includes as to laboratory tests and other adjunct studies. Such informal arrangments, while executed in good faith, later lead to misunderstandings when the staff changes and interpretations vary. The fact that such misunderstandings occur indicates a need for clear-cut agreements approved by hospital administration and copies circulated to appropriate sections so that all areas concerned are aware of specific terms of the agreement. Unit or section standard operating procedures could reflect such agreements as indicated.

Alternative Solutions to the Problem

Present System Strengthened

The present system could be continued with some modifications that would strengthen it and close some loopholes. VA-authorized laboratory studies could all bear an easily-recognized, unique stamp. Such a marking could be publicized among UMC laboratories to encourage greater enforcement of a policy to perform only authorized tests. Orientation of personnel concerning business procedures relative to outpatient charges would be of benefit. Orientation of resident physicians, especially when they report to the VA Hospital, would keep them informed of procedures and the necessity for procuring authorization for work performed at UMC. More funneling of laboratory studies through the VA laboratory could be made in an effort to enter laboratory work on the computer and eliminate the use of charge record slips for monthly billing. If laboratory workload warrants, the VA laboratory could connect with the UMC computer using a cathode ray tube terminal to obtain laboratory results more promptly. Within the VA, the system of approving laboratory requests could be simplified by giving the laboratory budgetary

authority to approve any studies that had professional approval. This simplified procedure would keep all laboratory requests routed through the laboratory and would eliminate time-consuming procedures of billing by individual patient name. The UMC Business Office clerk should have all pertinent information sent to her promptly. She should not be expected to leave her desk to track down information.

Advantages.--Making few changes in the system would lessen complaints of users and make changes more acceptable. Centralizing laboratory requests and authorizations at the VA laboratory would permit more efficient operation and better control of laboratory studies performed outside the VA.

Disadvantages.--The moderate success of the present system depends on much personal contact between clerks, technicians, and secretaries. While such personal interest is commendable, no sound system should rely on the presence of specific individuals for proper functioning. One VA Business Office clerk who has been instrumental for years in assuring smooth functioning of the current system is retiring in the near future. Her replacement may not be as dedicated or as familiar with all the personal contacts necessary for proper functioning of the system. The assortment of methods of recording information at UMC leads to inefficiency in one operation of the Business Office. The system was probably valid when the hospital and operation was small but, as the hospital has grown and as accounting procedures have become more complex due to third party requirements for cost accounting, present methods are inadequate to meet the new demands.

Require unit history number for all procedures/tests

Just as the VA allergy clinic patients are interviewed and are

given a unit history number, so could all other VA patients seen at UMC be given such a number. Either patients could be routed by the outpatient desk, or the private admission desk at the rear entrance of the hospital could be authorized to interview and issue unit history numbers to these patients. The latter method would relieve the load on the outpatient desk and would be more convenient to the VA patients going to radiotherapy and x-ray since usually they use the rear entrance. The only problem arises with laboratory specimens, but this could be solved by issuing one unit history number to the VA laboratory for use on all specimens sent to UMC. It may be possible for UMC to add the Social Security number as used by the VA or some partial identification so that the computer bank of information would have clinical value in addition to business value. The addition of the Social Security account number would be especially helpful if the VA laboratory had a cathode ray tube terminal for instant retrieval of laboratory information as is used at UMC. Verification of authorization would still be necessary, and some easily-recognizable sign should be adopted and publicized.

Advantages.—This system enables all patient information to be entered into the computer. It further meets the hospital's goal to improve its business methods, is much more efficient and professional and will provide better verification of data for cost accounting. A copy of the applicable computer print-out could be made available to both business offices to aid and simplify in preparing statements and payments. Information as to clinic visits and laboratory studies performed would be readily available to those who have a need for it and its preparation would not require the time and effort of any individuals. The success of

this system would not depend as much on specific clerks and secretaries since much of the monthly required information is accumulated and tabulated by machine. Computerization permits manipulation of data for additional statistical studies if such are desired.

Disadvantages.--Use of this system requires more change which, at least initially, would lead to some confusion among the users. Obtaining history numbers would be an added requirement for those VA patients now going to radiotherapy and x-ray. This additional requirement could be classified as a minor inconvenience for them although use of the private admission desk at the rear entrance would ease this inconvenience considerably.

The VA laboratory would have some additional work in logging all specimens and verifying the monthly computer print-out for the Business Office. Giving the VA laboratory responsibility for budgeting authorization might necessitate changes within the VA Hospital, but any added burden to the laboratory would be offset by reduced requirements in the business office.

Modified unit history number system

Either as a substitute or as a matter of making changes more slowly to permit data processing and other services more time to accomodate them, the system of utilizing unit history numbers might be phased in over a period of a year or two. The VA laboratory might first be assigned one unit history number for use on all laboratory specimens sent to UMC. Since reimbursement is now rather complete for radiotherapy and x-ray, these areas could be phased in latter when data processing is prepared to assume a greater volume of data.

Advantages.—This modified system would put the weakest part of the present system under closer control immediately and would permit those parts now functioning well to be phased-in as data processing and other services could be expanded to receive them. Less radical, sudden change might be better accepted by those using the system.

Disadvantages.—This proposal does not immediately utilize the most professional and efficient system that is available. This alternative also involves change which would meet resistance in some areas.

Summary

The discussion has considered in detail each facet of the system at the VA Hospital whereby a request for service in initiated, authorized, arranged, and eventually paid for. It has also reviewed areas at UMC where services are performed and the operation of the current accounting method within UMC.

The present system with some modifications was offered as the first alternative solution to the problem. The obvious advantage of this system is simplicity; minimal change would be required; yet greater control over the program would be provided. The major disadvantage is that little improvement is made toward increased efficiency and business professionalism. The potentials of the computer are not fully realized, and in time the system would require modification.

In complete opposition is the second alternative. It utilizes the unit history number to the fullest extent, thus permitting full computerization of all data. While not necessarily beneficial to medical information, this alternative would provide for a professional business system with increased efficiency. The chief disadvantage is that institution of this

system requires more extensive changes in the current operation.

A third alternative represents a more moderate or medial approach in that the unit history number would be phased-in. The function now most difficult to control—laboratory studies—would be added first by issuing the VA laboratory a unit history number to be used for all laboratory studies. Other services would add unit history numbers as the data processing and other sections could adjust to the increased load. This alternative has the advantage of a smooth transition to a professional, efficient system but with less drastic, immediate change. The major disadvantage is that slow transition does not permit improvement at a pace consistent with the potential of the UMC business staff.

CHAPTER III

CONCLUSIONS

Conclusions

Based on the information presented and analyzed in this study, it is concluded that the third alternative, a gradual phasing-in of a system utilizing unit history number with other general measures, is the best system for assuring maximum reimbursement to UMC for shared services utilized by the VA.

Recommendations

It is recommended that:

1. The VA proceed to investigate methods for implementing a plan whereby its laboratory manages all studies being referred to UMC. This plan should include one UMC unit history number for all specimens and a standard, easily identifiable authorization stamp or mark on all request slips.

2. The UMC and VA institute orientation programs to acquaint all staff with the details of requesting, verifying, and obtaining shared services. Additionally, UMC should provide guidance to clerks and technicians involved with servicing VA patients (or their laboratory specimens) in the proper method of completing Charge Record forms. The term "all staff" is intended

to include physicians, for their understanding and cooperation are essential to smooth operation of any system.

3. The UMC study the list of services now being performed for the VA and make appropriate additions or corrections. The list should include the Division Performing Code and the Type of Service Code as is specified on UH Form 01020, Charge Record, or as would be entered on the computer. When the complete list has been properly staffed through all appropriate departments, it should be returned to the Office of Hospital Administration which will then consult with the VA. Any disagreements over fee reimbursement can be negotiated by the Hospital Director, who is influenced by the policy of the Deans' Committee and the UMC Director and Dean. All agreements should be kept on file in Hospital Administration, but copies should be readily available at appropriate areas of the hospital. Major procedures such as open heart surgery and radiotherapy will require more formal agreements or contracts under VA regulations.

4. The UMC and VA should conduct an annual review of all contracts and agreements. This action will assure that charges are timely and in keeping with Congressional intent that reimbursement be fair and reasonable.

5. The UMC study how best to phase-in the use of unit history numbers for all VA outpatients so as to effect an orderly, reasonable transition with a minimum of confusion and inconvenience.

APPENDIX A

UH FORM 01020, CHARGE RECORD

PATIENT SERVICE

CHARGE

RECORD

UNIVERSITY HOSPITAL
JACKSON, MISSISSIPPI

UH FORM 01020

WRITE IN PATIENT NAME IF ADDRESSOGRAPH PLATE IS NOT USED

PATIENT NUMBER (4-9)				PERSON REQUESTING (27-29)		PERSON PERFORMING (30-32)	
DATE SERVICE PERFORMED (11-16)	MO. / DA. / YR.			BUSINESS OFFICE ONLY (33-34)		BUSINESS OFFICE ONLY (35)	
DIVISION REQUESTING (17-19)		DIVISION PERFORMING (20-22)		SERVICE AMOUNT (36-40)		QUANTITY ADMIN. (41-43)	
TYPE OF SERVICE CODE (23-26)				TIME IN (44-47)		TIME OUT (48-51)	

DATA PROCESSING

APPENDIX B

VA FORM 10-7078, AUTHORIZATION AND INVOICE FOR MEDICAL AND HOSPITAL SERVICES

VETERANS ADMINISTRATION

AUTHORIZATION AND INVOICE FOR MEDICAL AND HOSPITAL SERVICES

ISSUING OFFICE	1. DATE OF ISSUE (Month, day, year)	
	2. VETERAN'S FIRST NAME -MIDDLE INITIAL -LAST NAME	
TO –	3. ADDRESS	
	4. VETERAN'S CLAIM NO. C-	4A. SOCIAL SECURITY NO.
	5. AUTHORIZATION VALID	
	FROM	TO

PART I – SERVICES AUTHORIZED

6. SERVICES SHOWN BELOW ARE AUTHORIZED FOR THE PERIOD INDICATED IN 5 ABOVE. SEE SPECIAL PROVISIONS ON REVERSE SIDE.			7. FEE $
8. FEE SCHEDULE OR CONTRACT	9. AUTHORITY	9A.	10. ESTIMATED AMOUNT $
11. FISCAL SYMBOLS 36__________0160.001		12. AUTHORIZED BY (Name and title)	

PART II – INVOICE

13. DATE(S) OF SERVICE			14. DESCRIPTION OF SERVICE (If services furnished are identical to those authorized, enter the remark "As authorized above" in this column. Otherwise, itemize services.)	15. FEE CLAIMED
MONTH	DAY	YEAR	SERVICE	AMOUNT
				$

Individual or organization rendering service, enter billing date and total amount claimed. (Continue billing on reverse if necessary.)	16. BILLING DATE	17. TOTAL CLAIMED→	$

PART III – FOR VA USE ONLY

ADMINISTRATIVE CERTIFICATION	AUDIT BLOCK		
Payment of this claim will not cause payee to exceed maximum amount allowed. Services have been furnished as authorized or medically approved except as stated below.	AMOUNT DUE	DATE	VOUCHER AUDITOR
	$		
(Signature, title, and date)	REMARKS		

VA FORM MAR 1965 10-7078

EXISTING STOCK OF VA FORM 10-7078, MAR 1962, WILL BE USED.

ORIGINAL 1

APPENDIX C

FEE BASIS AGREEMENTS WITH UNIVERSITY MEDICAL CENTER

FEE BASIS AGREEMENTS WITH UNIVERSITY MEDICAL CENTER

September 15, 1969

Procedure		Fee	Unit
Open Heart Surgery			
Electronystagmograph		$ 25	each
Heart Catheterization		$ 250	
Hemodialysis	- Chronic	$ 150	/treatment
	- Acute	$ 325	/treatment
Cobalt Therapy		$ 10	/treatment
Speech Therapy		$ 8	/visit
GI Series, Upper		$ 25	/series
with small bowel		$ 40	
Barium Swallow		$ 30	each
Barium Enema		$ 25	each
with air contrast		$ 30	
Esophogram		$ 20	each
Cholecystography with oral dye		$ 20	each
Tremogram		$ 30	each
Motor Nerve Conduction Study		$ 10	each
Laryngeogram		$ 25	each
Allergy Clinic		$ 5.20	/treatment
LABORATORY:			
Immuno-electrophoresis		$ 15	each
Osmolarity, Urine and/or Serum		$ 2	each
Serum Magnesium		$ 6	each
Plasma Cortisol Level		$ 15	each

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BIOGRAPHICAL SKETCH

Colonel Mims C. Aultman He attended public schools there and then entered Emory Junior College in 1945. He received a Bachelor of Arts degree from Emory University, Atlanta, Georgia, in 1949. His professional education was obtained at the Medical College of Georgia, Augusta, where he received his Doctor of Medicine in 1953. After a rotating internship and one year of internal medicine residency at University Hospital, Augusta, he was commissioned in the United States Army and entered active duty in 1955 as a first lieutenant. Following two years of active service, he returned to civilian life in order to complete a residency in internal medicine at the Medical College of Georgia Hospitals. In 1959 he again returned to active duty and has had continuous military service since that time.

Military assignments have included U.S. Army Hospitals at Fukuoka and Camp Zama, Japan; USA Dispensary and USA Hospital, Frankfurt, Germany; U.S. Martin Army Hospital, Ft. Benning, Georgia; Surgeon, 2nd Infantry Division, Korea; Chief, Professional Services, Headquarters First U.S. Army; and Commanding Officer, 12th Evacuation Hospital, Vietnam. He has attended the basic and career courses at the Medical Field Service School, the associate course at the USA Command and General Staff College, the U.S. Air Force Primary Course in Aerospace Medicine, and the U.S. Army/Baylor University Program in Health Care Administration. His awards include the Army Commendation Medal and the Legion of Merit.