

Audit



Report

OFFICE OF THE INSPECTOR GENERAL

**MILITARY-CIVILIAN HEALTH SERVICES
PARTNERSHIP PROGRAM**

Report Number 93-004

October 14, 1992

Department of Defense



INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
400 ARMY NAVY DRIVE
ARLINGTON, VIRGINIA 22202

October 14, 1992

MEMORANDUM FOR ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

SUBJECT: Audit Report on Military-Civilian Health Services
Partnership Program (Report No. 93-004)

We are providing this final report for your information and use. It addresses implementation of the Partnership Program and the controls over the validity of claims submitted by partnership providers. Comments on a draft of this report were considered in preparing the final report.

The Assistant Secretary of Defense (Health Affairs) concurred with all recommendations except Recommendation A.5. and proposed alternative corrective action that we consider responsive to the intent of this recommendation. We request an estimated date of completion for this alternative action. The Assistant Secretary withheld comments on monetary benefits pending consideration of data we provided on underpayments; therefore, we request that the Assistant Secretary of Defense (Health Affairs) provide comments on the monetary benefits claimed in this final report by December 14, 1992.

This audit disclosed three instances involving potential commissions of illegal acts, specifically, submission of false claims and collusion to submit false claims. This matter has been referred to the Office of the Assistant Inspector General for Investigations for possible criminal investigation.

The courtesies extended to the audit staff are appreciated. If you have any questions about this audit, please contact Mr. Michael A. Joseph at (804) 766-9108 or Mr. James H. Beach at (804) 766-3293. The planned distribution of this report is listed in Appendix G.

A handwritten signature in cursive script, reading "E. Jones", is positioned above the typed name.

Edward R. Jones
Deputy Assistant Inspector General
for Auditing

Enclosure

cc:
Secretary of the Army
Secretary of the Navy
Secretary of the Air Force

The following acronyms are used in this report.

- ASD(HA).....Assistant Secretary of Defense (Health Affairs)
- CCP.....Coordinated Care Program
- CHAMPUS.....Civilian Health and Medical Program of the
Uniformed Services
- CPT.....Current Procedural Terminology
- EOB.....Explanation of Benefits
- HSC.....Health Services Command
- MTF.....military treatment facility
- OCHAMPUS.....Office of the Civilian Health and Medical Program
of the Uniformed Services

Office of the Inspector General, DoD

AUDIT REPORT NO. 93-004
(Project No. 1FC-0044)

October 14, 1992

AUDIT REPORT ON
MILITARY-CIVILIAN HEALTH SERVICES PARTNERSHIP PROGRAM

EXECUTIVE SUMMARY

Introduction. The Military-Civilian Health Services Partnership Program was implemented in January 1988 as a component of DoD's Project Restore. This project was one means of addressing the rapid increase in costs of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The Partnership Program allows military treatment facility (MTF) commanders to negotiate agreements with civilian providers for the provision of CHAMPUS services on a discounted or fee schedule basis. These agreements allow the MTFs to more fully utilize their capacities, offset staff shortages, and reduce CHAMPUS costs. For FY 1991, there were about 1,400 active partnership agreements costing about \$110 million.

Objectives. The objective of the audit was to determine whether the Military-Civilian Health Services Partnership Program was effectively and economically integrating available military and civilian health care facilities, providers, support personnel, equipment, and supplies. We also evaluated associated internal controls.

Audit Results. Our audit showed that policies and procedures for selecting civilian providers and awarding partnership agreements were generally adequate. Although the Partnership Program was an effective means of meeting health care needs, improvements were needed.

o Decisions to use the Partnership Program were not adequately supported, and assurances did not exist that use of the Partnership Program was the most economical means of providing needed health care. Further, beneficiaries were not effectively notified of the Program. As a result, some agreements could not be adequately enforced, projected Government savings were overstated, and the potential of the Program to bring beneficiaries back to the MTFs was not fully exploited (**Finding A**).

o Effective procedures and controls had not been established to ensure the validity of claims submitted by partnership providers. Providers were overpaid by an estimated \$24 million for services provided during FY 1991 (**Finding B**).

Internal Controls. At some MTFs policies, procedures, and controls had not been established and at other locations were not effective to ensure proper preparation of cost analyses, enforcement of partnership agreements within the Army and Air Force, and validity of partnership claims. See Findings A and B for details on these weaknesses and page 5 for details on controls assessed.

Compliance with Laws and Regulations. The audit revealed three instances involving potential illegal acts by partnership providers that were referred for possible criminal investigation.

Potential Benefits of Audit. Recommendations in this report, if implemented, will result in improved internal controls, more effective administration and enforcement of agreements, and reduction of program costs by about \$24 million (see Appendix E). We have claimed savings for only 1 year because the extent of partnership usage under full implementation of the Coordinated Care Program (CCP) is not known. Estimated savings are not based on projections of future program claims, but are based on an assumption that the amount of claims will not drop significantly prior to full implementation of the CCP.

Summary of Recommendations. We recommended the issuance or revision of guidance to strengthen controls over administration and the enforcement of partnership agreements, performance of economic cost analyses, and validation of partnership claims.

Management Comments. The Assistant Secretary of Defense (Health Affairs) concurred with the findings and all recommendations except Recommendation A.5. and provided proposed alternative action which will satisfy the intent of that recommendation. We request an estimated date of completion for this alternative action. Comments on monetary benefits were withheld pending consideration on data relating to underpayments, therefore we request that the Assistant Secretary provide comments on the monetary benefits claimed in this final report. Comments are to be provided within 60 days of the date of this report. The responsiveness of comments by the Assistant Secretary of Defense (Health Affairs) is discussed in Part II of this report, and the complete text of the comments is included in Part IV.

TABLE OF CONTENTS

	<u>Page</u>
TRANSMITTAL MEMORANDUM	1
EXECUTIVE SUMMARY	i
PART I - INTRODUCTION	1
Background	1
Objectives	2
Scope	2
Internal Controls	3
Prior Audits and Other Reviews	3
Other Matters of Interest	4
PART II - FINDINGS AND RECOMMENDATIONS	7
A. Partnership Program Management	7
B. Validity of Partnership Claims	13
PART III - ADDITIONAL INFORMATION	19
APPENDIX A - Audit Sites, Audit Tests, and Audit Sample Projections	21
APPENDIX B - Economic Cost Analysis Example	25
APPENDIX C - Overbillings by Military Treatment Facility	29
APPENDIX D - McGuire Air Force Base Auditing Procedures	31
APPENDIX E - Summary of Potential Benefits Resulting from Audit	39
APPENDIX F - Activities Visited or Contacted	41
APPENDIX G - Report Distribution	43
PART IV - MANAGEMENT COMMENTS	45
Assistant Secretary of Defense (Health Affairs)	47

This report was prepared by the Logistics Support Directorate, Office of the Assistant Inspector General for Auditing, DoD. Copies of the report can be obtained from the information officer, Audit Planning and Technical Support Directorate, (703) 614-6303 (DSN 224-6303).

PART I - INTRODUCTION

Background

Program authorization and purpose. The Military-Civilian Health Services Partnership Program (Partnership Program) is authorized under United States Code, title 10, sec. 1096. This section authorizes the establishment of agreements for the sharing of resources between military treatment facilities (MTFs) and civilian health care providers. The Partnership Program, implemented in January 1988, is a component of DoD's Project Restore, which was designed as one means of addressing the rapid increase in costs of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Project Restore's basic premise was that, in some cases, health care services could be provided more cost-effectively within military health care facilities than through use of CHAMPUS in civilian facilities.

Program concepts. The Partnership Program allows MTF commanders to negotiate agreements with civilian providers for CHAMPUS services on a discounted or fee schedule basis with no beneficiary copayment. Partnership agreements may be either "external," military doctors practicing in civilian facilities, or "internal," civilian doctors practicing in military facilities. External agreements allow military doctors to take advantage of facilities and equipment that are not available at the MTFs. Internal agreements allow the MTF to more fully utilize its capacity and supplement its military personnel in areas that are understaffed. Within the continental United States for FY 1991, there were about 1,400 active partnership agreements, of which only 21 were external, costing about \$110 million.

Partnership Program's potential. The Partnership Program has the potential to decrease CHAMPUS costs by returning beneficiaries that have been receiving medical care in civilian facilities to the MTF for medical care at discounted provider rates. However, this essentially "free health care" has the potential for drawing back into the MTF that portion of the CHAMPUS eligible population that had not used CHAMPUS due to the required copayments. Active duty dependents are required to make a copayment of 20 percent, and other beneficiaries are required to make a copayment of 25 percent. Beneficiaries who had not used CHAMPUS because of the copayment, commonly referred to as the "Ghost Population," if attracted in large numbers, would significantly reduce expected CHAMPUS savings. Since CHAMPUS had not incurred any cost for the beneficiaries previously, their treatment by a partnership provider in the MTF would actually increase CHAMPUS costs. Thus, the Partnership Program could be successful in increasing beneficiary access to DoD health care, but unsuccessful in decreasing CHAMPUS costs and the overall cost of DoD health care.

Objectives

The objective of the audit was to determine whether the Military-Civilian Health Services Partnership Program was effectively and economically integrating available military and civilian health care facilities, providers, support personnel, equipment, and supplies. In addition, we evaluated internal controls over selecting civilian partners, developing cost analyses, awarding and administering contracts, and validating contract payments.

Scope

Audit coverage. We reviewed the 190 partnership agreements in effect during FY 1991 at 14 MTFs that were selected using stratified random sampling. We analyzed the integration of civilian providers into the MTF with respect to military staff, facilities, and equipment. In addition, we determined the equipment, support personnel, and supplies to be furnished by civilian providers under partnership agreements.

We reviewed policies, procedures, and controls on selecting civilian providers, developing cost analyses, awarding and administering agreements, and validating provider claims. We reviewed documentation applicable to the selecting, awarding, and monitoring of partnership agreements from program implementation in January 1988 to the dates of individual activity reviews in 1991 and 1992.

We reviewed and analyzed CHAMPUS Health Care Summary reports for selected catchment areas^{1/} in order to determine the overall effectiveness of the Partnership Program in reducing CHAMPUS costs. In addition, we analyzed the composition of beneficiaries treated under the Partnership Program to determine whether individual beneficiaries were drawn back to the MTF from regular CHAMPUS care.

At each sampled MTF, we selected a random statistical sample of the most recent paid claims to determine the validity of provider claims. Our sample included 1,717 claims, totaling \$102,500, of 50,323 claims, totaling \$2.6 million, processed for the MTFs included in our review. Services billed by the provider on each randomly selected claim, as shown on the monthly Explanation of Benefits (EOB) listings, were compared to those documented in beneficiaries' medical records. Services documented in the

^{1/} A catchment area includes all of the covered population in a geographic area that is eligible to report to the military health care facility in that area.

beneficiary medical record were reviewed by a representative of the MTF who made a determination of the applicable Current Procedural Terminology (CPT) code that should have been billed. Technical assistance was provided by the Quantitative Methods Division of the IG, DoD, on selection and projection of our statistical sample. Details on the sample are provided in Appendix A.

Audit period and standards. This performance audit was performed from April 15, 1991, to February 20, 1992. The audit was made in accordance with the auditing standards issued by the Comptroller General of the United States as implemented by the IG, DoD, and accordingly included such tests of internal controls as were considered necessary. Detailed information on apparent overbillings by partnership providers has not been included in this report because of the potential for possible criminal investigations. Activities visited or contacted during this audit are listed in Appendix F.

Internal Controls

Controls assessed. At the 14 MTFs and higher level headquarters, we evaluated internal controls over selecting civilian health care providers, developing cost analyses, awarding and administering contracts, and validating claims submitted by partnership providers.

Internal control weaknesses. The audit identified material internal control weaknesses as defined by Public Law 97-255, Office of Management and Budget Circular A-123, and DoD Directive 5010.38. Established policies and procedures did not provide adequate guidance on the preparation of cost analyses and on the terms of partnership agreements necessary for enforcement within the Army and Air Force. In addition, at some MTFs adequate policies, procedures, and controls had not been established and at other locations were not being enforced to ensure that Partnership Program providers submitted claims and received payment for only those services actually provided. Recommendations in Findings A and B, if implemented, will correct these weaknesses. We have determined that an estimated \$24 million in potential monetary benefits can be realized by implementing Recommendations B.1. through B.4. A copy of the final report will be provided to the senior official responsible for internal controls within the Office of the Secretary of Defense.

Prior Audits and Other Reviews

Air Force Audit Agency "Report of Audit on Health Care Services Obtained Under Contracts and Agreements," Project No. 0325111, June 13, 1991, states:

- o Air Force MTFs used more costly partnership agreements to expand outpatient services rather than contracting for medical services under the Alternate Use of CHAMPUS Funds Program,

- o partnership agreements for outpatient care were not always achieving the primary goal of reducing CHAMPUS costs because of high negotiated rates, and

- o Air Force MTFs could save one-half or more of the cost of partnership agreements by hiring or contracting with civilian health care providers for services within the MTF.

Management officials agreed with the findings and recommendations and issued revised guidance within the Air Force on use of partnership agreements and the negotiation of lower partnership rates.

Air Force Audit Agency "Report of Audit on Review of Billing Procedures for Partnership Providers," Project No. 0325114, September 10, 1991, states that internal controls over billings by partnership providers needed strengthening. Specifically, the audit found that:

- o The Air Force Surgeon General had not developed procedures to familiarize or inform partnership providers on:

- o how to bill for different levels of treatment or new versus established beneficiaries,

- o what ancillary services and supplies could be provided by the MTF, and

- o what billing rates should be used.

- o At 11 of 19 MTFs reviewed, the required MTF quarterly reviews of EOB forms either were not completed or were not completed effectively, and when overpayments were identified, they were not elevated for recoupment action.

Management nonconcurred with the report's inference that the Air Force has the responsibility to instruct CHAMPUS partnership providers on how to bill for services; however, recommended corrective actions were implemented.

Other Matters of Concern

Coordinated Care Program. Under the Coordinated Care Program (CCP), MTF commanders will be responsible for ensuring that health care funds (including CHAMPUS funds) and MTF resources are allocated and expended in such a manner that all catchment area beneficiaries' health care needs are met. According to Assistant Secretary of Defense (Health Affairs) [ASD(HA)] officials, the Partnership Program under the CCP is envisioned as being used by MTF commanders as an interim measure

for providing health care until long-term health care can be contracted for and provided. Cost analyses will still be needed to determine whether use of the Partnership Program is more cost-effective than referring beneficiaries to civilian providers under CHAMPUS.

Monitoring billings. MTF commanders currently have little incentive to monitor civilian provider billings under the Partnership Program because monitoring uses MTF resources but does not provide financial benefit to the MTF. Funds recouped on partnership claims are provided to the Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS), not the MTF. However, under the CCP concept, the monitoring of partnership billings will be essential to the MTF in meeting its health care responsibilities and in controlling its overall health care budget. Overpayments on partnership claims will lessen the MTF's fiscal capability for providing health care to MTF beneficiaries. As discussed in Finding B of this report, there are substantial overbillings by partnership providers. Because it appears that the incentives to MTFs will be increased under the CCP concept, we are not making a recommendation on this point.

Patient-level accounting. Deriving the cost information needed to prepare accurate cost analyses for comparing Partnership Program costs, individual beneficiary costs, and CHAMPUS costs will be difficult due to the lack of a patient-level accounting system. MTFs use the Medical Expense Performance Reporting System, which gives the average cost for certain procedures but does not allow the MTF to track daily health care expenditures or to determine the actual costs involved in treating a beneficiary. Under the CCP, MTF commanders will be responsible for the allocation of their physical and fiscal resources in order to meet all health care needs of the beneficiaries within the MTF's catchment area. A patient-level accounting system is needed to provide MTF commanders with a more efficient means of monitoring and allocating resources. We did not make a recommendation on this subject because the complexities of patient level accounting were beyond the scope of this audit.

PART II - FINDINGS AND RECOMMENDATIONS

A. PARTNERSHIP PROGRAM MANAGEMENT

Decisions to use the Partnership Program were not adequately supported, and assurances did not exist that use of the Partnership Program was the most economical means of providing needed health care. Further, beneficiaries were not effectively notified of the Program. Established policies and procedures did not provide adequate guidance on the consideration of and methodology to be used in the evaluation of alternative means of providing needed health care, factors to be included in cost analyses, provisions needed in agreements for effective management, and effective notification of beneficiaries. As a result, some agreements could not be enforced, projected CHAMPUS savings were overstated, and the potential of the Partnership Program to bring beneficiaries back to the MTFs was not fully exploited.

DISCUSSION OF DETAILS

Partnership Program Guidance

DoD Instruction 6010.12, "Military-Civilian Health Services Partnership Program," October 22, 1987, prescribes policies, procedures, and standards for implementing the Partnership Program. The Instruction also included a sample agreement. Before entering into each partnership agreement, commanders of MTFs are required to determine that use of the Partnership Program is more economical to the Government than obtaining needed health care services in the civilian community through the CHAMPUS program. The instruction further prescribes that before a partnership agreement may be implemented, the commander of the MTF involved shall submit the proposed agreement to the Director, OCHAMPUS, or designee and the Surgeon General of the appropriate Military Department, or designee for approval.

Department of the Army. There is no Army regulation to implement DoD Instruction 6010.12; however, the U.S. Army Health Services Command (HSC), "Memorandum For: Commanders, HSC Medical Centers/Medical Activities," January 29, 1988, implemented the Partnership Program in the Army. The approval authority for partnership agreements has been delegated to Headquarters, U.S. Army; HSC; and the CHAMPUS Fiscal Intermediary (private insurance company) serving the area where the MTF is located. Agreements forwarded to the HSC for approval must include estimates of cost savings; an overall net savings to the Government must be demonstrated. Further, HSC guidance required that agreements submitted for approval not deviate from the model agreement in DoD Instruction 6010.12.

Department of the Navy. Naval Medical Command Instruction 6320.29, "Military-Civilian Health Services Partnership Program," March 3, 1988, defines management responsibilities and procedures for implementing DoD Instruction 6010.12. The Instruction prescribes that when an MTF is unable to provide health care using existing resources, MTFs should consider use of partnership agreements after determining that other, more cost-effective alternatives are not feasible. MTFs are required to obtain written approval from their respective geographical naval medical command and the CHAMPUS Fiscal Intermediary before a partnership agreement can be implemented. Also, the Instruction requires that MTFs publicize the availability of partnership agreements to CHAMPUS-eligible beneficiaries. Enclosure 2 of the Naval Instruction contains a sample partnership agreement, which allows the MTF to insert the necessary provisions needed to monitor and enforce the agreement.

Department of the Air Force. The Air Force Surgeon General is responsible for implementing the Partnership Program within the Air Force. There is no Air Force regulation implementing the Partnership Program; however, the Air Force Surgeon General has published guidance through letters and messages. Supplemental guidance, dated January 13, 1989, from the Surgeon General directs that all partnership agreements negotiated at more than 70 percent of the CHAMPUS prevailing rate be approved by the Major Command Surgeon General and that agreements negotiated at or below 70 percent of the CHAMPUS prevailing rate can be approved by the MTF Surgeon General.

Partnership Program Management

Decisions to use the Partnership Program were not adequately supported and assurances did not exist that use of the Partnership Program was the most economical means of providing needed health care. MTFs entered into partnership agreements without evaluating alternative types of health care. Cost analyses either were not performed or when performed, did not include all costs associated with the Partnership Program. In addition, partnership agreements entered into by the MTFs did not include sufficient provisions needed for monitoring and enforcing agreements. After entering into agreements, MTFs did not effectively notify beneficiaries of Partnership Program availability. Further, once agreements were effective, MTFs did not adequately monitor partnership billings. Due to weaknesses in management controls, DoD lacked assurance that the Partnership Program was reducing CHAMPUS costs.

Alternative health care. Before entering into partnership agreements, MTFs did not adequately determine that the Partnership Program was the most economical means of providing health care. Guidance issued by the Military Departments required that MTFs consider use of partnership agreements after determining that other more cost-effective alternatives, such as civilian hire, Department of Veterans Affairs and DoD sharing

agreements, inter- and intra-Service support agreements, or contract services, were not feasible. However, DoD guidance on the Partnership Program did not establish requirements and methodology to be used in evaluating other potentially more cost-effective means of providing necessary health care. As a result, only 1 of the 14 MTFs visited had documentation showing that alternative forms of health care had been considered before partnership agreements were made. Without the evaluation of alternative health care, DoD and the Military Departments had no assurance that the partnership agreements entered into by MTFs were the most cost-effective means of providing needed health care.

Cost analyses. MTFs had not adequately prepared cost analyses showing that the partnership agreements were more cost-effective than use of regular CHAMPUS providers. Once alternative health care sources are evaluated, MTFs are required by Military Department guidance to show that each proposed partnership agreement is more economical than use of CHAMPUS providers outside the MTFs. However, guidance had not been issued on a cost analysis format or on the various cost factors that should be considered in cost analyses. Of the 190 agreements reviewed, 65 (34 percent) did not have required supporting cost analyses. For the cost analyses supporting the other 125 agreements, 53 (42 percent) did not include the reduction for CHAMPUS copayments when computing the Government cost, and 110 (88 percent) did not include the incremental increases in facility ancillary and administrative costs. The exclusion of the CHAMPUS copayment and incremental ancillary and administrative cost increases overstated savings derived from the use of the Partnership Program (see Appendix B).

Use of accurate workload data is necessary to adequately support the need for the Partnership Program and to ensure the accuracy of projected savings resulting from use of the Program. Our review of MTF cost analyses showed that estimated work load and savings were not accurate. At one MTF, the analysis compared the estimated annual Government cost without a partnership agreement to the annual Government cost of the partnership, showing an estimated annual savings to the Government of about \$1.2 million. However, our review of the analysis showed that the estimated monthly partnership work load, instead of the annual work load, was used in computing the annual Government cost of using the Partnership Program. When we used the estimated annual workload figure in the analysis for determining the annual partnership cost, the results showed a loss of about \$682,000 to the Government. In addition, the analysis did not account for the CHAMPUS copayment and the increased facility ancillary and administrative costs, which if included would have shown a further increase in the loss to the Government.

Partnership agreements. Partnership agreements entered into by Army and Air Force MTFs did not contain sufficient provisions needed to effectively monitor and enforce the agreements. We

attributed the absence of provisions to inadequate DoD and Service guidance. Our review showed that agreements entered into by Army and Air Force MTFs often did not specify, for the health care provider, the negotiated discount CHAMPUS rate, the hours and days of work, and the support personnel and equipment to be provided. Agreements entered into by Navy MTFs generally contained the provisions shown above, because Navy higher commands had provided guidance allowing inclusion of those provisions. The provisions assisted the Navy MTFs in effectively monitoring and enforcing agreements.

Army and Air Force guidance required MTFs to utilize the sample agreement contained in DoD Instruction 6010.12. The inability to include additional provisions in agreements reduced the ability of the Army and the Air Force MTFs to effectively monitor and enforce agreements. For example, unless discounted CHAMPUS rates are contained in signed agreements, the Government may experience difficulties in recouping monies paid for billings exceeding the negotiated rate. Also, hours of work and support equipment and personnel to be provided need to be specified in agreements to ensure that the provider will satisfy the beneficiary demands necessitating the partnership agreement. Further, hours of work needed to be specified in order to prevent partnership providers from violating the Dual Compensation Act^{2/}.

Providers were often employed by MTFs under the Partnership Program as well as under separate contract. At one MTF, a group provider had some employees who worked as partnership providers and other employees who worked as contract providers during the same work days and hours. The partnership agreement with the group provider did not specify which employees would work specific hours. Although our review disclosed no violation, that is, no employee was being paid as a partnership provider and contract provider for identical work hours, the facility had no assurance that providers were not in violation of the Dual Compensation Act. Also, the propensity for dual billings by the group provider was increased.

When entering into group partnership agreements, MTFs did not maintain accurate listings of all group providers practicing at the MTFs, and the providers were not required to sign individual agreements. Without individual agreements or a signed addendum to group agreements showing individual CHAMPUS provider numbers, MTFs could not effectively monitor provider work load and billings. Further, CHAMPUS would have no assurance that reimbursements made under the Partnership Program were for services performed by CHAMPUS approved providers. For example, when submitting partnership claims, one group provider's billing clerk recorded only the group CHAMPUS identification number on

^{2/} United States Code (annotated), title 5, section 5533, the "Dual Compensation Act" states that an individual is not entitled to receive basic pay for more than an aggregate of 40 hours on more than one Federal job.

the claims. The CHAMPUS fiscal intermediary processing the claims recorded and paid the claims under the identification number of only one provider in the group. This procedure increased the difficulty of monitoring partnership billings, work load, and quality assurance.

Notification of beneficiaries. MTFs did not adequately advertise the availability of the Partnership Program. The basic premise of the Partnership Program was to reduce CHAMPUS expenditures by encouraging CHAMPUS beneficiaries to use the MTFs for their health care. Our review at 12 MTFs showed that only 5 had established procedures that would adequately inform CHAMPUS beneficiaries of the availability and advantages of the Partnership Program. From our review of the MTFs' staffing levels and from discussions with MTF personnel, we determined that the Partnership Program was used primarily to offset military provider shortages and to handle the MTFs normal beneficiary work load. This use of the Partnership Program may tend to increase CHAMPUS health care costs, because a portion of the cost for the treatment of the MTF work load would be shifted from MTF funds to CHAMPUS funds. This possibility was further supported by our analysis of beneficiaries seen by partnership providers at the 14 MTFs. Of the beneficiaries using the Partnership Program, 58 percent were active duty dependents who would not normally seek CHAMPUS care if services were available at the MTF. To verify whether active duty dependents would be prone to use CHAMPUS, we contacted 53 sample patients at 11 MTFs (contacts were not made at the 3 survey sites). Of the active duty dependents contacted, 29 (55 percent) stated that in the absence of the Partnership Program, they would not have sought treatment through CHAMPUS. The dependents stated they would have waited until treatment could be received at the MTF or they would have gone to the emergency room to obtain treatment. To significantly decrease CHAMPUS expenditures, MTFs must inform catchment area beneficiaries utilizing CHAMPUS of the Partnership Program availability and advantages.

RECOMMENDATIONS FOR CORRECTIVE ACTION

We recommend that the Assistant Secretary of Defense (Health Affairs) revise DoD Instruction 6010.12, "Military-Civilian Health Services Partnership Program," to require that:

1. Proposed partnership agreements be compared with other means of providing health care, such as direct hire, contract services, or resource sharing, to ensure that partnership agreements are the most efficient and cost-effective means of obtaining needed services. The methodology to be used in the evaluation should be included in the guidance.

2. Economic cost analyses are performed for proposed partnership agreements. The analyses will include at a minimum, validated military treatment facility workload data, reductions for beneficiary copayments, increased ancillary costs, and added administrative costs.

3. Partnership agreements include negotiated discount Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) rates, days, and hours of work and personnel and equipment to be furnished by the health care provider.

4. Military treatment facilities obtain individual signed agreements from all health care providers or addendums to group agreements signed by all providers under the group.

5. Beneficiaries using CHAMPUS be notified by the catchment area military treatment facility of the availability and benefits of the Partnership Program in order to maximize the beneficiaries' return to military treatment facilities for health care.

MANAGEMENT COMMENTS

The Assistant Secretary of Defense (Health Affairs) concurred with Finding A and Recommendations A.1., A.2., A.3., and A.4. and provided an estimated completion date of December 1, 1993. The Assistant Secretary nonconcurred with Recommendation A.5. responding that DoD Instruction 6010.12, paragraph E.4.i. states that commanders of military treatment facilities shall encourage beneficiaries to use services available under partnership agreements. Alternative action proposed by the Assistant Secretary was to issue a letter to the Secretaries of the Military Departments reemphasizing the importance of notifying beneficiaries of the availability of partnership providers and the benefits that military dependents can realize by using them.

AUDIT RESPONSE

The intent of Recommendation A.5. was to provide added assurance that all beneficiaries within a catchment area are made aware of the availability of partnership providers and the benefits that beneficiaries might derive from their use. We consider the alternative action proposed by the Assistant Secretary of Defense (Health Affairs) to be responsive to the intent of our recommendation and request an estimated date of completion.

B. VALIDITY OF PARTNERSHIP CLAIMS

Partnership providers received payments for claims that exceeded services provided and for services not documented in patients' official medical records. DoD and Military Department guidance did not provide adequate procedures to ensure the validity of partnership claims or payments. In addition, some MTFs had no guidance on the appropriate medical procedure codes for selected services and other MTFs had guidance that was not clear on appropriate codes to use. As a result, partnership providers were overpaid an estimated \$24 million during FY 1991.

DISCUSSION OF DETAILS

Submission of claims. The Physicians' Current Procedural Terminology Manual, published annually by the American Medical Association, contains a list of CPT codes for reporting medical services and procedures performed by physicians. Each procedure or service is identified by a five-digit CPT code. The CPT codes identify medical, surgical, and diagnostic services. The CPT codes are used by Partnership Program providers to bill for services rendered to beneficiaries.

Processing claims. OCHAMPUS contracts with Fiscal Intermediaries to process claims and make payments to health care providers. It is the responsibility of the Fiscal Intermediaries to pay claims submitted for CHAMPUS-eligible beneficiaries based on the CPT codes billed. CHAMPUS funding of the Partnership Program is restricted to providing CHAMPUS-authorized benefits to eligible beneficiaries through CHAMPUS-authorized providers. Claims submitted to the Fiscal Intermediary must be identified as a partnership claim. The Fiscal Intermediaries are responsible for paying negotiated rates, performing Defense Eligibility Enrollment Reporting System reviews of beneficiaries, checking for other beneficiary health insurance coverage, denying noncovered benefits, checking for duplicate payments, and issuing EOBs to beneficiaries. The EOB notifies the beneficiary of the amount of the claim, the services performed, whether the services are covered benefits, and the amount paid to the provider.

CHAMPUS Policy Manual, volume II, chapter 4, section 1.1, (the Manual) states that payment should be extended only for actual services rendered and documented in official medical records and that if documentation of billed services cannot be confirmed in official medical records, payment should be denied. The Manual further states that it is the responsibility of the medical facility to substantiate that services were provided to the beneficiary.

Validation of claims. DoD Instruction 6010.12 does not provide guidance on the validation of claims submitted by Partnership Program providers. Consequently, each Military Department has issued guidance that differs in methodology and scope on validating and auditing partnership claims.

Department of the Army. U.S. Army HSC Memorandum 310-2d, January 29, 1988, requires that partnership claims be submitted to the Fiscal Intermediary through the MTF or that the MTF develop a system for randomly auditing the providers' records and CHAMPUS EOBs to ensure that the provider has billed CHAMPUS for actual services rendered at the proper negotiated rates. No guidance was provided on the methodology to be used by the MTFs in accomplishing audits of partnership claims.

Department of the Navy. Bureau of Medicine and Surgery message 3C21/0002.A, September 13, 1991, requires MTFs to implement a system for conducting periodic audits of processed claims, but does not specify the frequency and percentage of claims to be audited. The message further defines what is considered an effective audit program and some of the discrepancies to watch for.

Department of the Air Force. Air Force Surgeon General/Health Affairs message 132230Z, January 1989, requires that 5 percent of all processed partnership claims be audited and gives specifics on the areas to audit, such as appropriate level of service and new versus established beneficiary. Audit summaries are to be forwarded to OCHAMPUS.

Overpayments. Partnership providers received payments for claims that exceeded services provided and for services not documented in beneficiaries' official medical records. Of 1,717 claims reviewed at 14 MTFs, 984 (57 percent) claims resulted in overpayments. For our sample claims, partnership providers were overpaid \$22,619. In contrast, our sample claims included 49 claims with underbillings totaling \$388.

Our determination of improper billings and overpayments was based on a statistical sample of the latest month's EOB listings at each MTF reviewed. With the assistance of an MTF coder, levels of service provided, as documented in the beneficiaries' official medical records, were compared with the CPT codes billed by partnership providers. Overall, our review of claims and medical records showed that from 18 to 90 percent of the claims reviewed at sample MTFs resulted in the provider being overpaid (see Appendix C). Based on the sample results, we estimated that the total amount of overpayments on partnership claims for FY 1991 was about \$24 million.

Level of services provided. Of the 984 improper claims identified, 853 resulted from the provider billing for a CPT code that exceeded the level of service documented in the beneficiaries' official medical records. The claims resulted in

providers receiving \$10,994 in excess of the amounts authorized for services documented. For example, a provider billed code 90020, new patient, comprehensive service, and was paid \$97.65 for the service provided. Our review of the beneficiary's official medical record showed that the service should have been billed as code 90040, established patient, brief service, with a payment of \$18.76. In this case, billing at a higher level of service code, commonly referred to as "upcoding," resulted in the provider receiving an overpayment of \$78.89. Additionally, follow-up services were frequently billed as extended services, although the medical narrative supported only brief services, which resulted in overpayments of more than \$23 per follow-up service.

Documentation of services provided. A total of \$11,625 on 137 claims was found to be billed for services not documented in the beneficiaries' official medical records. For example, a provider was paid \$96.60 for an initial comprehensive consultation; however, we could find no record to show that the beneficiary had an appointment with the provider or had received treatment. At one MTF, providers were maintaining medical narratives in their own private files but were not putting the narratives into the beneficiaries' official medical records. Copies of the narratives were obtained by the MTF representative assisting in our review and were placed in the official medical records. With this documentation in the official medical records, we considered the applicable claims valid.

Auditing of claims. MTFs did not have adequate audit guidance and procedures to verify that narratives in the medical records supported CPT codes billed. Of the 14 MTFs included in our audit, 2 had not performed audits of Partnership Program claims, and only 2 had established audit procedures and guidance that required review of medical records to validate services billed. Audits performed by 10 other MTFs verified only that providers billed at negotiated rates, beneficiaries kept appointments, and providers performed services of some type. Instead of questioning claims and requesting reimbursement for overpayments, audit procedures at one MTF returned medical records to providers to have narratives expanded to reflect billings. When improper billings were found at other MTFs, only two MTFs expanded their audits to determine the total amount of overpayments. However, those MTFs had not performed a sufficient number of audits to significantly lower the instances of improper billing. Lack of guidance and confusion on recoupment procedures significantly limited collections from providers in those cases where procedures were adequate to identify overpayments.

During our review of MTF audit procedures, a prevalent concern voiced by MTF personnel was the lack of personnel experienced in CPT coding. The MTF at McGuire Air Force Base implemented procedures that allowed claim audits by personnel not experienced in CPT coding. Procedures contained in an operating instruction issued by the MTF required audits of partnership claims on a

quarterly basis to include at least 5 percent of all claims for each partnership provider. The instruction also required a 100-percent review of claims for any provider if 10 percent of the sample claims showed excessive charges. In addition, the operating instruction included a level of care decision matrix and an audit criteria sheet (see Appendix D) that allowed the individual performing the MTF audit to determine whether the billed CPT code accurately reflected the level of care documented in the beneficiaries' official medical records. DoD-wide implementation of similar procedures would help eliminate many of the excessive billing practices disclosed by our audit.

Coding of services claimed. Use of CPT codes for services that exceeded actual service rendered could enable providers to increase total earnings that were decreased by accepting negotiated rates. Partnership providers often used the same CPT codes consistently, regardless of services rendered. Guidance on new and established patient codes either had not been provided to MTFs or the guidance was not clear, which allowed the providers to bill the more costly new patient code.

At one MTF, a provider consistently billed the new patient code the first time the provider treated a beneficiary regardless of how many times the beneficiary had been treated at that clinic. An emergency room partnership billed new patient codes because patient records were not available in the emergency room. The new patient CPT code provides for a higher billing rate to compensate for additional time required of the provider to obtain a personal and medical background on the patient. When a patient has been treated in a clinic previously, these data are already available and no additional work is required of the provider.

Improper use of the new patient CPT code results in providers receiving additional monies to which they are not entitled. More definitive guidance was needed on the CPT codes that are acceptable for office visits and consultations and the differentiation between new and established patient billings to ensure proper payments to providers.

Other billing irregularities. We identified the following minor billing irregularities for which we are making no recommendations.

- o Beneficiary treatment performed by physicians in training (residents) was billed at provider rates. The OCHAMPUS has lower provider rates for services not rendered by a licensed provider.

- o Residents were treating beneficiaries without a licensed provider being present and were signing medical narratives.

- o Partnerships billed beneficiaries for ancillary services, such as x-rays, lab tests, and diagnostic tests performed by MTF medical technicians.

- o Some medical records contained narratives signed by a provider other than the one who submitted the claim.

Conclusion. The lack of adequate guidance and internal audit procedures allowed Partnership Program providers to be paid for claims that exceeded services rendered and for services not documented in beneficiaries' medical records. As a result, CHAMPUS overpaid an estimated \$24 million for health care rendered under the Partnership Program during FY 1991. Implementation of the following recommendations will result in an estimated cost avoidance of \$24 million for FY 1993.

RECOMMENDATIONS FOR CORRECTIVE ACTIONS

We recommend that the Assistant Secretary of Defense (Health Affairs) revise DoD Instruction 6010.12 to:

1. Require performance of periodic statistical sampling audits of Partnership Program claims, to include:

- a. Verification of the dates of service billed by providers.

- b. Verification of the individual providing the services according to the beneficiary's official medical record.

- c. Comparison of medical procedures billed with services documented in the beneficiaries' medical records.

- d. Verification of payment at authorized negotiated rates.

2. Require review of all claims during the audit period for providers found to have an error rate in excess of 10 percent on periodic statistical sampling audits.

3. Require initiation of recoupment actions on any overpayments identified during periodic audits of partnership claims.

4. Establish guidance on the appropriate use of new and established patient codes and recoupment procedures.

MANAGEMENT COMMENTS

The Assistant Secretary of Defense (Health Affairs) concurred with Finding B and all recommendations and provided an estimated completion date of December 1, 1993. The Assistant Secretary withheld comments on monetary benefits pending receipt and

consideration of data requested on underbillings and cited an Air Force Audit Agency report indicating that 17.7 percent of claims filed were underpaid.

AUDIT RESPONSE

The Air Force Audit Agency report cited by the Assistant Secretary of Defense (Health Affairs) showed that 4,082 of 23,101 (17.7 percent) claims filed by providers were paid by the Fiscal Intermediaries at rates lower than the prevailing rate for a specific level of service. The requested data that we provided to the Assistant Secretary on underbillings identified in our audit pertained to instances where the military treatment facility coder felt that the provider could have been justified in billing a higher level of service. Our audit identified only 49 instances of such potential underbillings, which equated to less than 3 percent of the 1,713 claims reviewed and represented less than .4 percent of the total dollar value of claims reviewed. Consideration of the insignificant underbillings would have little effect on the projected amount of potential overpayments cited in this report; therefore, we request that the Assistant Secretary of Defense (Health Affairs) provide comments indicating concurrence or nonconcurrence with monetary benefits cited in this final report.

PART III - ADDITIONAL INFORMATION

APPENDIX A - Audit Sites, Audit Tests, and Audit Sample Projections

APPENDIX B - Economic Cost Analysis Example

APPENDIX C - Overbillings by Military Treatment Facility

APPENDIX D - McGuire Air Force Base Auditing Procedures

APPENDIX E - Summary of Potential Benefits Resulting from Audit

APPENDIX F - Activities Visited or Contacted

APPENDIX G - Report Distribution

APPENDIX A: AUDIT SITES, AUDIT TESTS, AND AUDIT SAMPLE PROJECTIONS

Audit Sites

An OCHAMPUS information memorandum, April 8, 1991, showed that there were 1,397 partnership agreements in effect at 156 MTFs. We randomly selected one MTF from each of the Military Departments for review during the survey phase of the audit. Based on the survey results, and using a table of random numbers, we selected 12 additional MTFs from a May 14, 1991, list of Partnership System Hospitals obtained from the Office of the Assistant Secretary of Defense (Health Affairs). We reviewed all partnership agreements in effect at the selected MTFs. MTFs selected for review included:

Dwight David Eisenhower Army Medical Center, Fort Gordon, GA
Fitzsimons Army Medical Center, Aurora, CO
Bayne-Jones Army Community Hospital, Fort Polk, LA
Fox Army Community Hospital, Redstone Arsenal, AL
Ireland Community Hospital, Fort Knox, KY
Moncrief Army Community Hospital, Fort Jackson, SC
Winn Army Community Hospital, Fort Stewart, GA
Naval Hospital, Camp Pendleton, CA*
Naval Hospital, Naval Air Station, Jacksonville, FL
Naval Hospital, San Diego, CA
Air Force Systems Command Regional Hospital, Eglin Air Force
Base, FL
U.S. Air Force Hospital, Robins Air Force Base, GA
U.S. Air Force Hospital, Tinker Air Force Base, OK
380th Medical Group, Plattsburg, NY
U.S. Air Force Clinic, McGuire Air Force Base, NJ

* Naval Hospital, Camp Pendleton, was dropped from the sample because at the time of our scheduled review, it had no active partnership agreements.

Audit Tests

We statistically sampled partnership claims processed for each selected MTF, as shown on the most recent months' EOB listing. Our sample included 1,717 of 50,323 claims processed for the sample MTFs during the selected months. MTF personnel determined the appropriate CPT codes for services documented in the beneficiaries' medical records, and those codes were compared to the CPT codes billed by the partnership providers. We considered claims as overbilled if billed CPT codes indicated a higher level of service than that shown in the medical record or if the medical record did not show any services performed on the date billed.

APPENDIX A: AUDIT SITES, AUDIT TESTS, AND AUDIT SAMPLE PROJECTIONS
 (cont'd)

Audit Sample Projections

We used a two-stage sampling methodology to project overbillings for the Partnership Program for FY 1991. In the first stage, we selected a random sample of MTFs as shown previously under "Audit Sites." For the second stage, we selected a random sample of claims from the monthly data on claims processed for the MTFs selected in the first stage. The results of that procedure are shown in Appendix C.

To make projections for the total Partnership Program, we used post stratification methodology to analyze payment data received from OCHAMPUS for October 1990 through September 1991. The strata used were based on the total amount allowed on claims for partnership services in 131 catchment areas because of the wide variation in dollar volume. The statistical methodology and formulation were extracted from Section 5.10 of "Elementary Survey Sampling," by Scheaffer/Mendenhall/Ott, 4th Edition.

Table 1 below gives the stratified universe data for the Partnership Program claims used for projections. Table 2 gives the corresponding sampled universe data and audit results, and table 3 gives the results of statistical projections.

Table 1 - Universe Data

<u>Strata</u>	<u>Criteria (Millions)</u>	<u>Number of Catchment Areas*</u>	<u>Number of Claims</u>	<u>Dollar Amount Allowed</u>
I	>\$2.0	17	1,167,398	\$ 50,564,075
II	>\$1.0 and ≤\$2.0	22	719,157	30,758,150
III	>\$.5 and ≤\$1.0	24	389,108	17,247,849
IV	≤\$.5	68	292,410	12,240,983
Totals		<u>131</u>	<u>2,568,073</u>	<u>\$110,811,057</u>

* Data were classified by catchment area; sample MTFs were drawn from these areas. Of the 14 MTFs 13 represent whole catchment areas; McGuire Air Force Base MTF represents a portion of the 14th catchment area. Projections are based on dollar strata levels and are statistically valid.

APPENDIX A: AUDIT SITES, AUDIT TESTS, AND AUDIT SAMPLE PROJECTIONS
(cont'd)

Table 2 - Sampled Universe And Results

Strata	Universe For Sample Sites			Reviewed		Overbilled	
	MTFs	Claims	Dollars	Claims	Dollars	Claims	Dollars
I	3	201,120	\$ 9,134,467	396	\$ 36,008	180	\$ 8,239
II	3	108,136	4,040,668	454	14,748	272	2,778
III	6	85,100	3,930,758	654	41,834	423	10,091
IV	2	12,912	585,585	213	9,910	109	1,511
Totals	<u>14</u>	<u>407,268</u>	<u>\$17,691,478</u>	<u>1,717</u>	<u>\$102,500</u>	<u>984</u>	<u>\$22,619</u>

Table 3 - Projections

Strata	Number of Claims Overbilled	Dollar Amount Overbilled
I	530,582	\$11,303,073
II	430,847	5,414,754
III	251,675	3,703,763
IV	149,626	3,485,910
Totals	<u>1,362,730</u>	<u>\$23,907,500</u>

Margin of error with
90-percent confidence
level

± 128,619 (9.4 percent)	± \$ 6,324,418 (26.5 percent)
----------------------------	----------------------------------

Range of values:	Number of Claims Overbilled	Dollar Amount Overbilled
Minimum values	1,234,111	\$17,583,082
Maximum values	1,491,349	\$30,231,918

APPENDIX B: ECONOMIC COST ANALYSIS EXAMPLE

Typical MTF Cost Analysis

CHAMPUS Cost Estimate

<u>CPT CODE</u> <u>1/</u>	<u>CHAMPUS Rate</u> <u>1/</u>	<u>Estimated Beneficiary Work Load</u>	<u>CHAMPUS Cost</u>
XXXX	\$80.00	100	\$ 8,000.00
XXXX	\$75.00	200	15,000.00
XXXX	\$50.00	200	<u>10,000.00</u>
Total CHAMPUS Cost			<u>\$33,000.00</u>

Partnership Cost Estimate

<u>CPT Code</u>	<u>CHAMPUS Rate</u>	<u>Negotiated Rate (70 percent)</u>	<u>Estimated Beneficiary Work Load</u>	<u>Partnership Cost</u>
XXXX	\$80.00	\$56.00	100	\$ 5,600.00
XXXX	\$75.00	\$52.50	200	10,500.00
XXXX	\$50.00	\$35.00	200	<u>7,000.00</u>
Total Partnership Cost				<u>\$23,100.00</u>
Estimated Government Savings From Partnership				<u>\$ 9,900.00</u>

The estimated Government savings shown in the table above would have been substantially reduced if the MTF had included the effect of the CHAMPUS copayment (20 percent for active duty dependents and 25 percent for retirees). If the incremental cost increases (X-rays, lab tests, etc.) that the MTF would incur through the use of the Partnership Program were taken into account, then the estimated savings to the Government would be further decreased. The effects of considering copayments and incremental cost increases on estimated Government savings are demonstrated in our cost analysis model shown on the following page. The model uses an average Government cost per visit under a primary diagnosis that would include the most frequently billed CPT codes used in the typical MTF cost analysis shown above and includes the effect of copayments. Incremental ancillary costs and usage factors used in the model represent composite data obtained from several MTFs.

See footnotes on next page.

APPENDIX B: ECONOMIC COST ANALYSIS EXAMPLE (cont'd.)

Audit Cost Analysis Model

CHAMPUS Cost Estimate

<u>Estimated Work load</u>	<u>Average Government Cost Per Beneficiary Visit</u> ^{2/}	<u>Total Government Cost</u>
500	\$68.33	<u>\$34,166.65</u>

Partnership Cost Estimate

<u>CPT Code</u>	<u>CHAMPUS Rate</u>	<u>Negotiated Rate (70 Percent)</u>	<u>Estimated Beneficiary Work load</u>	<u>Partnership Costs</u>
XXXX	\$80.00	\$56.00	100	\$ 5,600.00
XXXX	\$75.00	\$52.50	200	10,500.00
XXXX	\$50.00	\$35.00	200	<u>7,000.00</u>
Total Professional Service Costs				\$23,100.00
MTF Incremental Ancillary Costs:				
X-rays (500 beneficiaries x 1.5 ^{3/} x \$4.50 ^{4/})				3,375.00
Lab Tests (500 beneficiaries x 2 ^{3/} x \$5.50 ^{4/})				5,500.00
Miscellaneous Supplies ^{5/}				<u>500.00</u>
Total Partnership Cost				<u>\$32,475.00</u>
Estimated Government Savings From Partnership				<u>\$1,691.65</u>

^{1/} The CPT Codes and CHAMPUS rates are not intended to represent specific medical services from locations visited. The data were generated for use in this model only.

^{2/} This cost information can be obtained from the Outpatient Professional Services (Section IV) Average Government Cost Per Visit, contained in the CHAMPUS Health Care Summary by Primary Diagnosis report for the MTF's catchment area. This cost includes the effect of the CHAMPUS copayment.

^{3/} This number represents the average usage factor for beneficiaries provided service by physicians in a particular specialty. The usage factor can be determined by analyzing the specialty work load for a period and the number of ancillary services (X-rays, lab tests, etc.) ordered during that period.

APPENDIX B: ECONOMIC COST ANALYSIS EXAMPLE (cont'd.)

4/ This cost represents the actual cost to the MTF for an X-ray or a lab test. These costs are available from the supply section of the MTF. The X-ray, lab equipment, and personnel services are fixed costs of the MTF. Since the concept of the Partnership Program is to bring beneficiaries utilizing CHAMPUS back into the MTF, then only the incremental cost of the increase in the number of X-rays, lab tests, etc., ordered by the supply section as a result of the influx of partnership beneficiaries should be considered in the cost analysis.

5/ The cost for supplies represents the additional daily clinical supplies used as a result of having a partnership provider practice in a clinic. The amount of additional supplies used can be determined from discussions with clinic personnel, and the actual cost of the additional supplies is available in the MTF supply section.

APPENDIX C: OVERBILLINGS BY MILITARY TREATMENT FACILITY

<u>Location</u>	<u>Claims Reviewed</u>		<u>Claims Overbilled</u>		<u>Percentage Overbilled</u>	
	<u>Number</u>	<u>Amount</u>	<u>Number</u>	<u>Amount</u>	<u>Number</u>	<u>Amount</u>
Eglin Air Force Base, FL	157	\$ 15,469	66	\$3,953	42.0	25.6
Fitzsimons Army Medical Center, CO	133	16,573	68	3,467	51.1	20.9
Fort Gordon, GA	132	4,384	37	642	28.0	14.6
Fort Jackson, SC	54	5,352	40	1,547	74.1	28.9
Fort Knox, KY	161	6,077	103	1,317	64.0	21.7
Fort Polk, LA	131	3,292	114	691	87.0	21.0
Fort Stewart, GA	161	4,287	132	819	82.0	19.1
McGuire Air Force Base, NJ	123	3,849	86	825	69.9	21.4
Naval Hospital Jacksonville, FL	106	3,966	46	819	43.4	20.7
Plattsburg Air Force Base, NY	99	3,723	89	1,436	89.9	38.6
Redstone Arsenal, AL	128	10,080	96	4,611	75.0	45.7
Robins Air Force Base, GA	114	6,187	20	75	17.5	01.2
Naval Hospital San Diego, CA	102	6,420	24	769	23.5	12.0
Tinker Air Force Base, OK	<u>116</u>	<u>12,841</u>	<u>63</u>	<u>1,648</u>	54.3	12.8
 Totals	 <u>1,717</u>	 <u>\$102,500</u>	 <u>984</u>	 <u>\$22,619</u>		

APPENDIX D: MCGUIRE AIR FORCE BASE AUDITING PROCEDURES

DEPARTMENT OF THE AIR FORCE
USAF Clinic McGuire (MAC)
McGuire AFB, NJ 08641-5300

SGR OPERATING INSTRUCTION 168-3

11 June 1991

Medical Administration

INTERNAL PARTNERSHIP PROGRAM AUDIT

1. **PURPOSE:** To outline the procedures required for conducting an Internal Partnership Audit. This operating instruction applies to all individuals assigned to the Patient Administration Office and other auditors as appointed.

2. **GENERAL:**

a. Audits must be performed on at least a quarterly basis. The audits are conducted on at least 5 percent of the paid internal partnership claims received during the quarter on each partnership. If 10% or more of the 5% sample show evidence of excessive charges, then a 100% audit will be performed by an independent contractor paid for by the partner, or the current audit results (based on the 5% sample) will be used as a basis to determine overcharge per claim.

b. The audits will be conducted on the quarters ending in the months of March, June, September, and December. All Explanation of Benefits (EOBs) dated during the month the quarter ends, must be received before the audit can be conducted. This may on occasion take you 3 - 4 weeks into the next quarter.

3. **PROCEDURES:**

a. When you receive the monthly Partnership EOB Summary from the Fiscal Intermediary (FI), separate the summary by partnership. The EOB Summaries will then be further separated into two categories for filing, active and inactive.

(1) Active file: EOB Summaries you are currently receiving from the FI that have not been audited. File the summaries behind the respective provider's place card.

(2) Inactive files: EOB Summaries that have previously been audited are kept in this file. The EOBs from the last two audits must be kept on hand, all other EOBs will be destroyed, unless a readjustment of the claim is pending. Once adjustment has been made, the EOBs may be destroyed. Because the EOBs contain the sponsor's social security number, they are governed by the Privacy Act and must be destroyed accordingly.

b. Once all EOB Summaries have been received and separated by partner, locate and add the monthly totals together, then multiply by 5% to get the number of records which must be audited. Go through the summary, randomly selecting the EOBs to be used for the audit. List on a separate sheet of paper the patient's name, sponsor's SSAN, date of service, and procedure code.

APPENDIX D: MCGUIRE AIR FORCE BASE AUDITING PROCEDURES
(cont'd)

c. After you have completed the listings of individuals' records which you will be auditing, the medical records must be pulled and compared to the Partnership Program Audit Checklist (attachment 1). There are seven required items on the checklist. All must be met. Additional items may be added to the checklist, as necessary.

d. In the audit process, determining the level of care and what criteria needs to be met to be considered a specific level of care are the most difficult. To aid you in determining these two factors, the Partnership Program Audit Level of Care Decision Matrix (attachment 2), the Partnership Program Audit Criteria Sheet (attachment 3), and the Partnership Program Audit Level of Service (attachment 4) were developed. If, after reviewing the record and attachments 2 through 4, you still have questions concerning the level of care, they should be directed to the Chief, Clinic Services.

e. One of the questions on the audit checklist is whether care was billed above the allowable charge. As the FI for this region has a system to preclude payment over the negotiated rate, we are more concerned with verifying that the payment has been reduced than with the amount of the charge. The new EOB Summary has no statement to this effect, so you should confirm that payments have been reduced by randomly selecting billed CPT codes, obtaining the CHAMPUS allowable from the CHAMPUS Fee Schedule, and then multiplying by the negotiated percentage for that partner. After confirming that payments have been reduced, you will identify any overcharges by determining if the level of care has been inappropriately upgraded, if the patient has been inappropriately billed as new vs. established, or if CHAMPUS was knowingly billed for non-allowed services.

f. If a visit cannot be validated, RMO must be notified to subtract that visit from the total visits reported for the month in question.

g. After completion of the audit, you will need to do a finalized report to the Director, Base Medical Services (DBMS), using a format similar to the Audit Report Letter (attachment 5). After the DBMS reviews and signs, approving the audit report, the original signed report will be filed in the Partner's MOU folder, with copies provided to OCHAMPUS/POA, ATTN: Partnership Project Officer, Aurora, CO 80045-6900 and to the Partner. The copy provided to the Partner will have a cover letter attached similar to the Audit Notification Letter (attachment 6). File a copy of this cover letter in the MOU folder as well.

h. If, of the 5% audited, more than 10% show evidence of excessive charges, the cover letter to the Partner should include the paragraph informing them of the requirement for the 100% audit or alternative determination of overcharges to CHAMPUS in accordance with the Partnership Agreement Support Document.

Carolyn L. Hanson
CAROLYN L. HANSON, MEGT, USAF
NCOIC, Patient Administration

6 Atch

1. Partnership Audit Checklist
2. Decision Matrix
3. Audit Criteria
4. Levels of Service
5. Audit Report Letter
6. Audit Notification Letter

PARTNERSHIP PROGRAM AUDIT CHECKLIST

ITEMS TO BE AUDITED	YES	NO
1. Does the record have an entry for the date of the EOB?		
2. Does the EOB data agree with the documentation in the record? Level of care versus level billed? New patient versus established patient rate?		
3. Is care billed above the allowable charge or negotiated rate? Is the Fiscal Intermediary automatically reducing payment to the negotiated rate?		
4. Are visits properly documented in the records (SOAP or other format approved by the medical facility)?		
5. Were all visits submitted to RMO for inclusion in ROP or MEPRS reports?		
6. Was treatment/care CHAMPUS authorized? If not, was the care preapproved as supplemental/cooperative care by SGH?		
7. Were support personnel (if included in billing) authorized? Was their fee within CHAMPUS allowances?		

Atch 1

**PARTNERSHIP PROGRAM AUDIT
 LEVEL OF CARE DECISION MATRIX**

LEVEL	TIME	HISTORY	EXAMINATION	JUDGMENT	TREATMENT	CRITERIA
BRIEF	1 - 10 MINUTES	PROBLEM FOCUSED	PROBLEM FOCUSED	STRAIGHT FORWARD DECISION MAKING	MINOR	7 OF 7
LIMITED	10 - 20 MINUTES	EXPANDED PROBLEM FOCUS	EXPANDED PROBLEM FOCUS	STRAIGHT FORWARD DECISION MAKING	SIMPLE	8 OF 9
INTERMEDIATE	20 - 30 MINUTES	DETAILED	DETAILED	LOW COMPLEXITY	LOW TO MODERATE	9 OF 10
EXTENDED	30 - 45 MINUTES	COMPREHENSIVE	COMPREHENSIVE	MODERATE COMPLEXITY	COMPLICATED	11 OF 12
COMPREHENSIVE	45 + MINUTES	COMPREHENSIVE	COMPREHENSIVE	HIGH COMPLEXITY	HIGH	12 OF 13

**PARTNERSHIP PROGRAM AUDIT
 CRITERIA SHEET**

STATUS & CRITERIA TO BE MET	BRIEF 7 OF 7	LIMITED 8 OF 9	INTER MEDIATE 9 OF 10	EXTENSIVE 10 OF 12	COMPRE HENSIVE 12 OF 13
NEW PATIENT CPT	99201	99202	99203	99204	99205
ESTABLISHED PNT CPT	99211	99212	99213	99214	99215
COMPLAINTS/SYMPOMS (S)	X	X	X	X	X
DURATION AND/OR COURSE OF ILLNESS (S)		X	X	X	X
DETAILS OF ILLNESS (S)			X	X	X
REVIEW OF SYSTEMS (S)				X	X
PAST HISTORY (S)				X	X
FAMILY HISTORY (S)					X
BLOOD PRESSURE (S)	X	X	X	X	X
TEMPATURE(S)	X	X	X	X	X
PULSE (S)	X	X	X	X	X
LIMITED EXAM (ONE AREA) (0)	X	X			
LIMITED EXAM (TWO OR MORE AREA) (0)			X	X	X
COMPLETE EXAM (WITH PELVIC) (0)					X
LAB & X-RAY VALUE & FINDINGS (A)		X	X	X	X
DIAGNOSIS/PROBLEM (A)	X	X	X	X	X
TREATMENT/INJECTION ADVICE (P)	X	X	X	X	X

APPENDIX D: McGUIRE AIR FORCE BASE AUDITING PROCEDURES
(cont'd)

LEVELS OF SERVICE

BRIEF: Pertaining to the evaluation and treatment of a condition requiring only an abbreviated history and examination. Supervised by a physician, but not necessarily requiring his/her presence.

EXAMPLES: Evaluation of patient with subconjunctival hemorrhage, acute tonsillitis, or minor trauma. Review of minor trauma or recent x-ray report and abbreviated discussion with patient. Concurrent hospital care for a minor secondary diagnosis.

LIMITED: Pertaining to the evaluation of a limited acute illness or to the periodic reevaluation of a problem including an interval history and examination, the review of effectiveness of past medical management, the ordering and evaluation of appropriate diagnostic tests, the adjustment of therapeutic management as indicated, and the discussion of findings and/or medical management.

EXAMPLES: Treatment of an acute respiratory function, review of internal history, physical status, and control of a diabetic patient, review of mental status findings, or review of hospital course, studies, orders and chest examination of a patient with rheumatic heart disease recovering from congestive heart failure, revision of orders, and limited exchange with nursing staff.

INTERMEDIATE: Pertaining to the evaluation of a new or existing condition complicated with a new diagnostic or mental status finding, diagnostic tests and procedures, the ordering of appropriate therapeutic management, or formal conference with the patient, family, or hospital staff regarding patient medical management or progress.

EXAMPLES: Evaluation of a patient with arteriosclerotic heart disease, detailed intensive review of an adequate therapeutic program: involving a detailed interval history and physical examination, and ordering of appropriate diagnostic tests and discussion of new therapeutic management, or reviewing school reports, developmental exams, and/or psychometric tests in conference with parents of a child with recurrent school problems.

EXTENDED: Services requiring an unusual amount of effort or judgment including a detailed history, review of medical records and examinations, and a formal conference with patient, family, or staff or a comparable diagnostic and/or therapeutic service.

EXAMPLES: Reexamination of neurological findings, detailed review of hospital studies and course, review of results of diagnostic evaluation, performance of a detailed examination, and a thorough discussion of physical findings, lab results, x-ray exams, diagnostic conclusions and recommendations for treatment of complicated chronic pulmonary disease.

COMPREHENSIVE: Providing an in-depth evaluation of a patient with a new or existing problem requiring the development or complete reevaluation of medical data. Includes the recording of chief complaint(s), present illness, family history, medical history, personal history, system review, a complete physical examination, and the ordering of appropriate diagnostic tests and procedures.

APPENDIX D: McGUIRE AIR FORCE BASE AUDITING PROCEDURES
(cont'd)

FROM: SGR

Date

SUBJ: Quarterly Partnership Audit (1 Jul - 30 Sep 90)

TO: SG

1. A quarterly partnership audit was performed on 5% of the number claims submitted by (name.of.partnership). The audit compared Explanation of Benefits (EOBs) submitted by (partner) and processed by CHAMPUS with the individuals' medical records.

2. The audit was conducted using policies and procedures set forth by HQ USAF and HQ MAC. Our audit confirms that the Fiscal Intermediary's computer program is automatically reducing payment to the negotiated rate for this partner. Our audit findings have been reviewed for clinical consistency by our Chief, Clinic Services. Administrative items have been reviewed for appropriateness by our Patient Administration staff.

3. Listed below are the discrepancies found during the audit.

<u>NAME</u>	<u>SSAN</u>	<u>DISCREPANCY(including.overcharge.amount)</u>
WILLIAMS, Sheryl	111-22-2233	Established patient billed as new patient, intermediate service billed as comprehensive. +\$20.50

4. After completion of the audit, it was found that service for 12 patients was incorrectly billed at a higher level, and that 3 established patients were billed as new patients, resulting in total overcharges to CHAMPUS of \$365.00.

CAROLYN L. HANSON, MSgt, USAF
NCOIC, Patient Administration

1st Ind, SG

TO: SGR

Approved/Disapproved.

STEVEN L. COLEMAN, Col, USAF, MSC
Director of Base Medical Services

Atch 5

APPENDIX D: McGUIRE AIR FORCE BASE AUDITING PROCEDURES
(cont'd)

(Appropriate Letterhead)

(Doctor's Name, Address)

(Date)

Dear Doctor Whatsis

We have just completed an audit of the claims submitted by you, under the Partnership Program, over the past quarter. A copy of the audit report is attached.

During the audit we check to ensure that the terms of the Memorandum of Understanding are being met, with regard to the proper annotation of the medical record, the assignment of proper procedure codes for care given, and that established patients are not billed as new patients.

After completion of the audit, the following discrepancy(ies) was/were noted:

<u>NAME</u>	<u>SSAN</u>	<u>DISCREPANCY(INCLUDE AMOUNT CHARGED. +/-)</u>
Walter Hickman	222-22-3443	Limited service billed as extended +\$20.00

On the above discrepancy(ies) please note that these visits appear to be for a lower level of service than was billed for. We ask that you review your billing procedures and criteria for level of service with your staff to preclude future problems. Please take appropriate action to correct the billing error(s) by corresponding directly with the fiscal intermediary and providing this office a copy of your correspondence. Your cooperation in this matter will be greatly appreciated. Our Patient Administration staff is available to assist you and your office with any questions regarding the partnership program. Please contact us at (609) 724-2246 if we can be of any help.

(USE THE FOLLOWING PARAGRAPH AS APPROPRIATE)

We are required to audit 5% of the EOBs quarterly. In accordance with Department of Defense directives, if more than 10% of those audited show excessive charges, we are required to obtain a 100% audit of the claims for the quarter in question. Please inform us whether you wish to have an independent audit, paid for by your office, or if you wish us to determine the overcharge for the quarter based on the percentage error rate and average overcharge for the 5% audited.

Your continued participation in the military-civilian health services partnership program is appreciated.

Sincerely

STEVEN L. COLEMAN, Col, USAF, MSC
Director of Base Medical Services

1 Atch
Audit Report and Questionable EOBs

cc: Fiscal Intermediary

Atch 6

APPENDIX E: SUMMARY OF POTENTIAL BENEFITS RESULTING FROM AUDIT

<u>Recommendation Reference</u>	<u>Description of Benefit</u>	<u>Amount and/or Type of Benefit</u>
A.1. thru A.5.	Improved internal controls to ensure effective and economical program usage.	<u>Nonmonetary</u>
B.1. thru B.4.	Improved internal controls to ensure the validity of provider claims and reduced CHAMPUS costs.	<u>Funds Put To Better Use</u> Savings for the FY 1993 Defense Health Program appropriation are estimated at \$24 million.*

* Savings are claimed for 1 year only and are based on the assumption that the amount of overpayments will be the same as calculated for FY 1991.

)

)

)

APPENDIX G: REPORT DISTRIBUTION

Office of the Secretary of Defense

Assistant Secretary of Defense (Health Affairs)
Assistant Secretary of Defense (Public Affairs)
Comptroller of the Department of Defense

Department of the Army

Secretary of the Army
Inspector General
Auditor General, U.S. Army Audit Agency

Department of the Navy

Secretary of the Navy
Assistant Secretary of the Navy (Financial Management)
Auditor General, Naval Audit Service

Department of the Air Force

Secretary of the Air Force
Assistant Secretary of the Air Force (Financial Management
and Comptroller)
Auditor General, Air Force Audit Agency

Defense Agencies

Director, Defense Contract Audit Agency
Director, Defense Logistics Agency
Director, Defense Logistics Studies Information Exchange
Director, National Security Agency
Inspector General, Defense Intelligence Agency

Other Defense Activities

Office of Civilian Health and Medical Program of the
Uniformed Services

Non-DoD

Office of Management and Budget
U.S. General Accounting Office
NSIAD Technical Information Center
NSIAD Director for Logistics Issues

**Chairman and Ranking Minority Member of the following
Congressional Committees and Subcommittees:**

Senate Subcommittee on Defense, Committee on Appropriations
Senate Committee on Armed Services
Senate Committee on Governmental Affairs

APPENDIX G: REPORT DISTRIBUTION (cont'd)

Chairman and Ranking Minority Member of the following
Congressional Committees and Subcommittees: (cont'd)

House Committee on Appropriations
House Subcommittee on Defense, Committee on Appropriations
House Committee on Armed Services
House Committee on Government Operations
House Subcommittee on Legislation and National Security,
Committee on Government Operations

PART IV: MANAGEMENT COMMENTS

Assistant Secretary of Defense (Health Affairs)

MANAGEMENT COMMENTS: ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

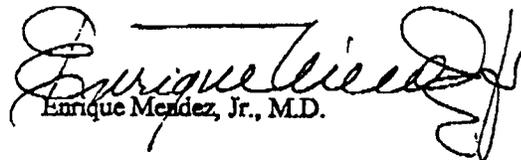
SEP 21 1992

MEMORANDUM FOR THE INSPECTOR GENERAL

Subject: Draft Audit Report on Military-Civilian Health Services Partnership Program (Project No. IFC-0044)

Thank you for the opportunity to comment on the Draft Audit Report regarding our Partnership Program. Your thorough look at this program and your insightful recommendations are useful tools for us to use in deciding the future of this program. I will direct a moratorium be placed on all new agreements. Agreements that will expire during the moratorium may be extended, but only under terms no less favorable to the government than the expiring agreement. A joint Health Affairs and Military Services work group will be formed to study the program in light of your findings. A complete revision of DoD Instruction 6010.12 will follow the receipt of this work group's recommendations. The moratorium will be lifted upon completion of the revised DoD Instruction.

I trust that our comments on your findings and recommendations will assist you in completing your report (see attached). If you have any questions regarding our input, please feel free to contact LTC Robert Campbell directly at (703) 695-3331. Please extend my thanks to your project team for their hard work.


Enrique Mendez, Jr., M.D.

Attachments:
As stated

MANAGEMENT COMMENTS: ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS) (cont'd)

**COMMENTS ON DRAFT AUDIT REPORT:
REPORT ON MILITARY-CIVILIAN HEALTH SERVICES PARTNERSHIP
PROGRAM**

PROJECT NO. 1FC-0044

FINDING: A. Partnership Program Management.

Partnership Program Guidance.	CONCUR.
Partnership Program Management.	CONCUR.
Alternative Health Care.	CONCUR.
Cost Analysis.	CONCUR.
Partnership Agreements.	CONCUR.
Notification of Beneficiaries.	CONCUR.

RECOMMENDATIONS:

A.1. CONCUR.

Corrective Action Planned: DoD Instruction 6010.12, "Military-Civilian Health Services Partnership Program," paragraph E.4.b (2), will be revised to include a methodology to be used for evaluating the cost effectiveness of providing health care services. The methodology will compare the Partnership Program with other means of obtaining services, such as direct care, contract services and resource sharing.

Estimated Completion Date: December 1, 1993.

A.2. CONCUR.

Corrective Action Planned: DoD Instruction 6010.12, "Military-Civilian Health Services Partnership Program," paragraph E.4.a, (2) will be revised to require an economic cost analysis be performed. As a minimum, the analysis will include impacts on beneficiary copayments, and the marginal increases expected in ancillary service and administrative costs.

Estimated Completion Date: December 1, 1993.

A.3. CONCUR.

Corrective Action Planned: DoD Instruction 6010.12, "Military-Civilian Health Services Partnership Program," paragraph F, will be revised to require that partnership agreements include negotiated discount rates from the CHAMPUS allowable, the specific days and hours of work, and the personnel, equipment and ancillary services to be furnished to the provider by the MTF.

Estimated Completion Date: December 1, 1993.

MANAGEMENT COMMENTS: ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS) (cont'd)

A.4. CONCUR.

Corrective Action Planned: DoD Instruction 6010.12, "Military-Civilian Health Services Partnership Program," paragraph F, will be revised to require that all agreements be signed by individual providers. This will also apply to group agreements. Each individual in a group agreement must sign the agreement before he or she is allowed to provide service.

Estimated Completion Date: December 1, 1993.

A.5. NON CONCUR.

Reason for nonconcurrence: DoD Instruction 6010.12, "Military-Civilian Health Services Partnership Program," paragraph E.4.i. states that commanders of military treatment facilities shall encourage beneficiaries to use the services available under partnership agreements.

Proposed Alternative Recommendation: Recommend a letter be sent to the Secretaries of the Military Departments reemphasizing the importance of notifying beneficiaries of the availability of partnership providers and the benefits that can be realized by them through their use.

FINDING: B. Validity of Partnership Claims.

Validation of Claims.	CONCUR.
Overpayments.	CONCUR.
Level of Services Provided.	CONCUR.
Documentation of Services Provided.	CONCUR.
Auditing of Claims.	CONCUR.
Coding of Services Claimed.	CONCUR.

RECOMMENDATIONS:

B.1. CONCUR.

Corrective Action Planned: DoD Instruction 6010.12, "Military-Civilian Health Services Partnership Program," paragraph E.4., will be revised to require periodic statistical sampling audits of claims. These audits will include verification of the dates of service, verification of inclusion of services in the medical record, a comparison of billed services to the medical record, and verification that payments were made at authorized rates.

Estimated Completion Date: December 1, 1993.

MANAGEMENT COMMENTS: ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS) (cont'd)

B.2. CONCUR.

Corrective Action Planned: DoD Instruction 6010.12, "Military-Civilian Health Services Partnership Program," paragraph E.4., will be revised to require a 100% audit of claims filed by providers found to have an error rate exceeding 10 % on periodic statistical sampling audits.

Estimated Completion Date: December 1, 1993.

B.3. CONCUR.

Corrective Action Planned: DoD Instruction 6010.12, "Military-Civilian Health Services Partnership Program," paragraph E.4., will be revised to require the initiation of recoupment actions on instances of overpayments to providers.

Estimated Completion Date: December 1, 1993..

B.4. CONCUR.

Corrective Action Planned: DoD Instruction 6010.12, "Military-Civilian Health Services Partnership Program," paragraph E.4., will be revised to provide guidance on the appropriate use of new and established patient codes and on recoupment procedures.

Estimated Completion Date: December 1, 1993.

MONETARY BENEFITS.

The report states that CHAMPUS may have overpaid approximately \$24 million to partnership providers during FY 1991. This projection was based on sample data obtained from 14 MTFs. However, the sample data shown in the report did not include any instances of underbilling. A similar study by the Air Force Audit Agency (referenced in the DoD IG report), was published in September, 1991. The subject report was titled "Review of Billing Procedures for Partnership Program Providers." The AFAA study reviewed all claims filed during July through September 1990, from 19 Air Force installations (23,101 claims). The results reported by the AFAA showed that 17.7% of the claims filed were underpaid. A request for information on number of claims and amounts of claims that were underpaid has been made to the DoD IG Project Director. Further comments regarding the monetary benefits will be issued after consideration of requested information.

LIST OF AUDIT TEAM MEMBERS

Shelton R. Young, Director, Logistics Support Directorate
Michael A. Joseph, Program Director
James H. Beach, Project Manager
Gene P. Akers, Team Leader
I. Eugene Etheridge, Team Leader
Carolyn A. Swift, Auditor
Carla R. Vines, Auditor
Mary J. Gibson, Auditor