Audit Report

OFFICE OF THE INSPECTOR GENERAL

THIRD PARTY COLLECTION PROGRAM

Report No. 94-017 December 6, 1993

Department of Defense

Acronyms

AQCESS	Automated Quality of Care Evaluation Support System
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DFAS	Defense Finance and Accounting Service
FEHBP	Federal Employees Health Benefits Program
HMO	Health Maintenance Organization
MTF	Medical Treatment Facility

INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
400 ARMY NAVY DRIVE
ARLINGTON, VIRGINIA 22202-2884

December 6, 1993

MEMORANDUM FOR ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)
ASSISTANT SECRETARY OF THE NAVY (FINANCIAL MANAGEMENT)
ASSISTANT SECRETARY OF THE AIR FORCE (FINANCIAL MANAGEMENT AND COMPTROLLER)
AUDITOR GENERAL, DEPARTMENT OF THE ARMY

SUBJECT: Audit Report on the Third Party Collection Program (Report No. 94-017)

We are providing this report for your information and use. It discusses DoD medical treatment facility collections from health insurance plans for inpatient hospital costs incurred on behalf of insured military retirees and military dependents.

DoD Directive 7650.3 requires that all recommendations be resolved promptly. The Assistant Secretary of Defense (Health Affairs) had not provided comments to a draft of this report issued August 20, 1993. Therefore, we request that the Assistant Secretary provide comments on the recommendations and monetary benefits in the final report by February 4, 1994.

The courtesies extended to the audit staff are appreciated. If you have any questions on the report, please contact Mr. Michael A. Joseph, Program Director, at (804) 766-9108 or Mr. Michael F. Yourey, Project Manager, at (804) 766-3268. Copies of the final report will be distributed to the activities listed in Appendix G.

Edward R. Jones
Assistant Inspector General
for Auditing

Office of the Inspector General, DoD

Report No. 94-017 December 6, 1993
(Project No. 2LF-0052)

THIRD PARTY COLLECTION PROGRAM

EXECUTIVE SUMMARY

Introduction. United States Code, title 10, sec. 1095, allows DoD to collect from health insurance plans reasonable inpatient hospital costs incurred on behalf of insured military retirees and military dependents. The statute allows the military medical treatment facilities to collect from an insurance company, a medical service, or a health plan for reasonable inpatient hospital care costs. The program, designed to collect from third party payers, is known as the Third Party Collection Program (the Program). From January 1 through June 30, 1992, the 3 Military Departments collected about $32.3 million of the $86.8 million billed by their 108 medical treatment facilities. We audited the Program as implemented in the Navy and Air Force. The Army Audit Agency audited the Army Program. The Army Audit Agency results were not available in time to be included in this report.

Objectives. The objectives of the audit were to determine if medical treatment facilities effectively collect from health insurance plans for inpatient and outpatient hospital costs incurred on behalf of insured military retirees and military dependents; to follow up on recommendations made in IG, DoD, Report No. 90-105, "Third Party Collection Program," August 30, 1990; and to evaluate related internal controls.

We did not evaluate the effectiveness of the collection for outpatient services because DoD did not issue Program guidance for outpatient health care provided to insured military retirees and military dependents until March 10, 1993. Publishing the new instruction was delayed primarily due to the presidential moratorium on issuing new regulations.

Audit Results. Since 1987, DoD has significantly improved procedures and is effectively collecting from primary health insurance plans for inpatient hospital costs. However, DoD can still improve the collection process.

o Relatively few of the patients at DoD's medical treatment facilities are retirees or dependents covered by billable insurance, and a majority of those were being properly billed. However, projecting the results of our statistically selected sample shows that if the present trend continues, medical treatment facilities will not collect about $61.2 million from insurance companies for FYs 1994 through 1999 (Finding A). This is a repeat finding from IG, DoD, Report No. 90-105.

o Medical treatment facilities' procedures were not adequate to ensure the integrity of Program collections. As a result, they had no reasonable assurance that cash receipts were properly safeguarded (Finding B).

o Follow up on recommendations made in IG, DoD, Report No. 90-105 showed that management's actions were appropriate to meet the intent of 8 of the 13 recommendations. Although management took action on the other five recommendations, similar conditions still exist (Appendix D).

Internal Controls. The medical treatment facilities did not establish adequate procedures to identify all patients with health insurance coverage and to validate payments received. Further, the facilities did not establish adequate internal controls to separate duties associated with cash receipts. We consider the weaknesses to be material for the Office of the Assistant Secretary of Defense (Health Affairs). See Part I for the internal controls assessed and Findings A and B in Part II for details on the weaknesses.

Potential Benefits of Audit. Implementation of the recommendations will allow the medical treatment facilities to collect about $61.2 million in inpatient hospital costs for FYs 1994 through 1999, including $20.4 million identified in our August 1990 report that applies to that period. Appendix E summarizes the potential benefits resulting from the audit.

Summary of Recommendations. We recommended that the Assistant Secretary of Defense (Health Affairs) revise DoD Instruction 6010.15 to require medical treatment facility personnel to identify inpatients with insurance during the interview process and to establish a mandatory training program for Program administrators in the medical treatment facilities for validating payments based on patients' insurance coverage. We also recommended that the Assistant Secretary establish internal controls to separate accounting and collection duties related to third party collections.

Management Comments. The Acting Assistant Secretary of the Navy (Manpower and Reserve Affairs) commented on the recommendations addressed to the Assistant Secretary of Defense (Health Affairs). The complete text of the Acting Assistant Secretary's comments is in Part IV. As of November 30, 1993, the Assistant Secretary of Defense (Health Affairs) had not responded to the draft report. We request that the Assistant Secretary provide comments on the final report by February 4, 1994.

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This report was prepared by the Logistics Support Directorate, Office of the Assistant Inspector General for Auditing, Department of Defense. Copies of the report can be obtained from Secondary Reports Distribution Unit, Audit Planning and Technical Support Directorate, (703) 614-6303 (DSN 224-6303).

Part I - Introduction

Background

United States Code (U.S.C.), title 10, sec. 1095, allows DoD to collect, from health insurance plans, reasonable inpatient hospital costs incurred on behalf of insured military retirees and military dependents. The statute allows medical treatment facilities (MTFs) to collect from an insurance company, a medical service, or a health plan, the reasonable costs of inpatient hospital care incurred at an MTF to the extent that the insurer would pay if the services were provided by a civilian hospital. This program, designed to collect from third party payers, is known as the Third Party Collection Program (the Program).

In November 1989, Public Law 101-189 amended U.S.C., title 10, sec. 1095, and provides that amounts collected from a third party payer for the costs of inpatient hospital care provided at an MTF of the uniformed services shall be credited to the appropriation supporting the operations and maintenance of the facility. Public Law 101-165, November 1989, requires DoD to audit how the collected funds were used at each MTF and also requires third party collections to be used at the MTF to directly increase the level of service. Public Law 101-510, November 1990, contains provisions to allow collections from third party payers for outpatient hospital care. However, due primarily to a presidential moratorium on new regulations, DoD did not issue outpatient guidance until March 10, 1993. Public Law 101-511, November 1990, provides that collections shall be made available to the local MTF, over and above their direct budget amounts, to be used to increase collections from third party payers.

Third party amounts claimed and actual collections for MTFs in the United States are shown below. Although the collection process can be improved, amounts claimed will generally exceed amounts collected for several reasons, including insurance coverage limitations, the beneficiary did not have an insurance policy in effect, or the MTF did not perform a precertification review.

Third Party Collection Program
January 1 - June 30, 1992

Military Department	Number of MTFs	Amounts Claimed (millions)	Amounts Collected (millions)
Army	33	$46.7	$16.6
Navy	23	17.9	4.8
Air Force	52	22.2	10.9
Total	108	$86.8	$32.3

Objectives

The objectives of the audit were to:

o determine if MTF Programs effectively collect from health insurance plans for inpatient and outpatient hospital costs incurred on behalf of insured military retirees and military dependents;

o follow up on recommendations made in IG, DoD, Report No. 90-105, "Third Party Collection Program," August 30, 1990; and

o evaluate MTF internal controls related to the Program.

Scope

Universe and Sample. From January 1 through June 30, 1992, 244,728 military retirees and military dependents were admitted to 108 MTFs (33 Army, 23 Navy, and 52 Air Force) in the United States (see Appendix A). We audited the Program as implemented by the Navy and the Air Force. For the 6 months, the Navy and the Air Force reported 14,312 Program claims totaling about $40.1 million and collections totaling about $15.7 million. Army Audit Agency audited the Army portion of the Program. The Army Audit Agency results were not available in time to be incorporated in this report.

A multistage sample methodology was used. See Appendix B for a description of the sample design. The sampling consisted of random selections of MTFs located in the United States and inpatient admissions for the 6 months, January 1 through June 30, 1992. As a result of the sampling process, we visited four Navy and five Air Force MTFs.

We randomly selected 250 of 18,166 inpatient admissions that were identified in the DoD Automated Quality of Care Evaluation Support System (AQCESS) for the 9 MTFs selected for review (see Appendix C). We sampled admissions for military retirees and their dependents and dependents of active-duty military personnel.

Audit Coverage. We reviewed medical record data to identify inpatients with health insurance and to identify billings associated with the inpatient admission. We determined whether the MTFs had obtained a signed insurance declaration form from each patient and confirmed with either the patient or the patient's sponsor and the patient's insurance carrier whether the patient had health insurance at the time of the admission. For valid claims that were not billed through the Program, we determined the collectible amounts through a review of applicable insurance plan coverage and through discussion with third party payer service representatives. We expanded our review of payment accuracy beyond the statistical sample due to weaknesses in MTF payment followup

procedures. We reviewed the accuracy of 101 third party insurance payments made through the Federal Employees Health Benefits Program (FEHBP) at 2 MTFs for calendar years 1991 and 1992.

We tested 150 inpatient records for 6 of 9 MTFs visited to verify the reliability of the AQCESS system and to confirm that inpatient admissions data were recorded in the AQCESS system. Our verification showed that the data base was accurate for the inpatient records tested. We visited two of three fiscal intermediaries and compared inpatient insurance information obtained from the AQCESS system to the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) data base maintained by the fiscal intermediaries to verify other health insurance information and inpatient admissions data.

We reconciled Program collections that were identified in quarterly and annual reports to MTF accounting records and reports and insurance payment logs. We compared insurance amounts billed for the inpatient admission to the amounts paid as identified in the inpatient's explanation of benefit. We contacted insurance carriers and verified the type of insurance plans and coverage available on the individual policies. For sampled beneficiaries age 65 and older, we confirmed Medicare enrollments with the Assistant Inspector General for Health Care Financing Audits, Department of Health and Human Services. We evaluated policies, procedures, and guidance implemented to administer and manage the Program. We also reviewed internal controls associated with the Program at the nine MTFs visited, including selected transactions and procedures in effect for FYs 1991 and 1992.

Limitation on Scope. We were unable to assess the effectiveness of the collection for outpatient services because DoD did not issue Program guidance for outpatient health care provided to insured military retirees and military dependents until March 10, 1993.

Audit Period, Locations, and Standards. This program audit was made from July 1992 through March 1993. The audit was made in accordance with auditing standards issued by the Comptroller General of the United States as implemented by the IG, DoD, and included such tests of internal controls as were considered necessary. Appendix F lists organizations visited or contacted during the audit.

Internal Controls

Controls Assessed. We evaluated MTFs' internal controls to ensure that MTFs were effectively collecting, from health insurance plans, inpatient hospital costs incurred on behalf of insured military retirees and military dependents. Specifically, we reviewed the procedures for identifying, documenting, and billing of insurance claims for inpatient hospital costs incurred on behalf of insured military retirees and military dependents. Additionally, we reviewed

procedures in effect at MTFs for handling and depositing cash receipts and for recording insurance payments on cash collection vouchers, accountable records, and reports.

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. Internal controls were not adequate to protect the interest of DoD. Procedures were not adequate to ensure that all inpatients with health insurance were identified. Additionally, MTF Program personnel were not adequately trained to evaluate the accuracy of insurance payments, nor were procedures in place to ensure that such validations were performed. Internal controls did not ensure that accounting and collection duties related to cash receipts were kept separate at the MTFs. The report recommendations, if implemented, will correct the internal control weaknesses. The monetary benefits of $40.8 million that can be realized by implementing the recommendations are described in Appendix E. A copy of the final report will be provided to the senior official responsible for internal controls within the Office of the Assistant Secretary of Defense (Health Affairs) (ASD[HA]).

Prior Audits and Other Reviews

IG, DoD, Report No. 90-105 found that ASD(HA) and the Military Department Surgeons General did not establish guidance and support to effectively implement the Program. Internal controls were not adequate to prevent waste, loss, and misuse of program collections, and did not ensure that reliable program data were provided. MTFs did not have procedures to identify and document inpatients with health insurance or to ensure that claims were correctly submitted to insurance companies. The report projected that MTFs would fail to collect approximately $318 million in FYs 1990 through 1994 from primary health insurance plans and approximately $192 million in FYs 1991 through 1995 from Medicare supplemental policies. The ASD(HA) and the Surgeons General concurred with all recommendations in the report but noted that the $192 million could not be collected until legislation was enacted to authorize collection from Medicare supplemental insurance policies.

The report contained five recommendations regarding collections from primary health insurance plans, six recommendations addressing DoD guidance and support for the Program, and two recommendations proposing legislation to authorize recoveries from Medicare supplemental insurance policies. Management reported to the Office of the Inspector General, DoD, that corrective actions were completed on all 13 recommendations and the case was closed.

In our current audit, we determined that management's actions were appropriate to meet the intent of 8 of the 13 recommendations. Although management took action on the other five recommendations, similar conditions still exist. Appendix D discusses the status of the five recommendations, related findings, and management comments.

Air Force Audit Agency, Report No. 8325113, "Medical Insurance Billings and Reimbursements in USAF Medical Facilities," July 31, 1989, stated that hospital personnel did not consistently identify inpatients with third party insurance or obtain insurance information from inpatients with health insurance. The report also stated that the hospitals did not adequately bill for covered hospital expenses and did not challenge questionable payments made by insurance companies. The report estimated that approximately $5.7 million was not collected at the 17 Air Force medical facilities reviewed. The report recommended improvements to inpatient insurance identification and to follow-up procedures for unresolved payments. The Air Force Surgeon General concurred with the report recommendations.

The Army Audit Agency is currently reviewing the Program within the Army (audit assignment numbers W2-300C, W2-300J, and W2-300N). The Army Audit Agency objective is to evaluate the management and oversight of the Program by the Army Medical Department.

Other Matters Of Interest

Public Law 101-165 requires that MTFs use collections from third party payers at the local level to increase the level of service. Public Law 101-511 provides that collections be made available to the MTF over and above their direct budget amount. The laws, therefore, were intended to provide an incentive for MTFs to collect from third party payers to increase the medical services provided and to encourage CHAMPUS patients to use military rather than civilian hospitals. DoD Instruction 6010.15, "Third Party Collection Program," March 7, 1991, implemented the public laws and requires third party collections to be made available to the MTF in addition to its direct budget authority.

The DoD Program Budget Decision 041, "Medical Operations," November 1990, identified Program budget reductions of $37.5 million for FY 1992. As a result, the Military Departments reduced their budgets and notified their respective MTFs that operation and maintenance appropriations were reduced accordingly. The reduction of MTF budgets had the effect of offsetting the intent of public law to make additional funds (collections) available to the MTFs to increase services. In FY 1993, the MTFs did not receive similar budget reductions.

At the nine MTFs visited, we verified that amounts collected through the Program were credited to the local MTF operation and maintenance appropriation. Collected amounts were available and were used to support each MTF's mission. However, we could not verify how much of the collected

amounts were directed to specific projects to increase the level of service and to recapture CHAMPUS work load. MTF personnel advised us that they did not separately account for amounts collected because Program collections were less than the amount their budgets were reduced. As a result, MTF personnel did not consider collections to be additional funds, but rather a substitute for appropriated funds that would have been available for routine MTF operations. For example, the Naval Hospital, Cherry Point, North Carolina, experienced a FY 1992 budget reduction of $141,000 but collected only about $23,000.

In an attempt to "sell" the Program to inpatients with health insurance and to increase collections at one MTF, MTF personnel advertised as Program benefits highly visible purchases such as new chairs in the waiting room or facility renovations. However, MTF personnel could not identify project expenses to Program collections. Advertising the benefits derived from collected funds may have made the inpatient more receptive to providing insurance information, but MTF personnel still believed collections were merely replacements for unfunded amounts that would have been available if the potential for third party collections did not exist.

Part II - Findings and Recommendations

Finding A. Collections From Health Insurance Plans

The medical treatment facilities could increase Program collections from health insurance companies for inpatient hospital costs incurred on behalf of insured military retirees and military dependents. Collection efforts were inadequate because procedures for identifying inpatients with billable insurance and for evaluating payments received were not adequate to ensure accurate processing of the accounts of inpatients with health insurance. Program personnel were not adequately trained in validating the accuracy of insurance payments. Additionally, the Military Health Services System does not provide incentives for its beneficiaries to participate in the Program. If Program improvements are not made, we estimate that the medical treatment facilities could fail to collect about $61.2 million from insurance companies for FYs 1994 through 1999.

Background

DoD Instruction 6010.15 establishes DoD's policy to collect from third party payers to the fullest extent allowed by law. ASD(HA) issues policy guidance and performs oversight to ensure that the Program is producing maximum collections. The Secretaries of the Military Departments provide any support necessary to effectively implement the Program and to ensure that adequate resources are devoted, personnel are fully trained, and support systems are functional. Each MTF commander is responsible for establishing an effective Program and for designating an individual to be responsible for Program operations.

Insurance Claim Processing

Inpatient Identification. MTF's were not adequately identifying inpatients with health insurance. Our review of 250 inpatient records for military retirees and military dependents showed that 40 admissions were covered by billable insurance. Of the 40, MTF personnel correctly identified the inpatients' insurance status on 32 admissions. Of the additional eight billable claims, six claims did not have the correct insurance status identified, in part because patients were not aggressively questioned by admission and discharge personnel. According to the six inpatients and other inpatients we interviewed, inaccurate data were provided because the inpatients were not sure what information was being requested. For example, the inpatients were not aware that Medicare supplemental insurance plans could be billed. For the other two cases, the inpatients identified their insurance coverage, but MTF personnel did not

process claims. Expanding the beneficiary interview with the inpatient or sponsor to include a discussion of the Program, of the legislative requirement for collection, and of the Program benefits should help acquire more accurate insurance information. Inpatients or sponsors should also be interviewed upon discharge to confirm insurance data received at admission. At discharge, inpatients or their sponsors are not likely to be as preoccupied with health care concerns.

Review of insurance plans and discussions with insurance personnel showed that about $11,500 could be collected when the additional eight claims are processed. Statistical projections of the sample show that potential payments from insurance companies for covered admissions not billed during the second and third quarters of FY 1992 totaled about $4.6 million, or an estimated $9.2 million for the fiscal year. Inflating this amount to represent FY 1993 funds, MTFs may not collect about $10.2 million annually due to unbilled insurance. The rate used to calculate the amount is based on the increase in the general medical care reimbursement rate from FY 1992 to FY 1993. If MTF work load remains at current levels, we estimate that about $61.2 million in reimbursements will be lost in FYs 1994 through 1999. We are claiming only $40.8 million in monetary benefits from this audit (Appendix E) due to the estimated savings claimed in IG, DoD, Report No. 90-105 for FYs 1994 and 1995.

Medicare Enrollee Identification. At one MTF, we expanded our review and tested claims processed for inpatients age 65 and older. We found that Program personnel did not determine if inpatients were enrolled in Medicare and billed an insurance company for primary rather than supplemental health benefits. As a result, the insurance company reimbursed the MTF $140,741 for 24 admissions rather than the Medicare entitlement of $15,648. This overpayment occurred because the MTF did not bill at the required Medicare deductible rate of $652 per hospital admission. Had the insurance company known the patients were enrolled in Medicare, the insurance company would have paid only supplemental or secondary benefits, and the overpayments could have been avoided. During our audit debrief, we reported the overpayment of about $125,093 to the MTF commander. We did not reduce our potential monetary benefits by the $125,093 overpayment because IG, DoD, Report No. 90-105 included the amount of the overpayment in its computation of potential monetary benefits. Additionally, the overpayments were not part of the statistical samples and are therefore not projectable.

Insurance Billing Evaluations

Insurance Payments Validation. The MTFs received inaccurate payments in 4 of the 32 billable admissions identified by Program personnel. Because the four improper payments were isolated instances related to FEHBP claims at two MTFs, we did not attempt to project the results. However, we expanded our review to include FEHBP claims. At six of nine MTFs, Program personnel did not validate amounts paid by insurance companies. Program clerks did not

contact insurance companies to determine the basis for the payment or to verify that proper amounts were received in accordance with the inpatient's plan. Program personnel at the remaining three MTFs validated the payments.

We reviewed third party payments made by FEHBP plans at two of the six MTFs that did not validate payments. At one MTF, 82 of 85 payments for FY 1992 were incorrect, totaling a net underpayment of about $26,400. At the other MTF, a similar review of 16 claims identified 13 incorrect payments for FY 1991 totaling a net underpayment of about $13,800. The $40,200 net underpayment went undetected because Program personnel did not follow up and did not validate the insurance payments. Program personnel informed us that they resubmitted the claims to insurance companies to resolve the inaccurate payments and that they would establish procedures to review insurance payments. We have not increased our potential monetary benefits to include the underpayments of about $40,200 on the 95 validated claims because IG, DoD, Report No. 90-105 included underpayments in the projections of Program collections.

During our validation of insurance payments at one of the two MTFs, we found that procedures were not adequate to ensure that claims were processed for all admissions. As a result, 125 claims for about $383,000 during FY 1992 were processed but not mailed to the insurance companies. Program personnel advised us that because their time was limited they did not follow up on prior admissions; therefore, billing omissions went undetected. A suspense file would assist Program personnel to track claims produced. We provided the list of 125 claims to the MTF Program personnel, who billed the insurance companies on the admissions.

Program Personnel Training. Program personnel are not trained to handle the complexities of validating payments for health insurance claims. To determine a proper payment, Program and insurance company personnel must understand and agree upon the type of coverage and then determine the amount of reasonable and proper payment. Determining a proper payment also requires Program personnel to know the various types of health plans and payment policies (for example, deductibles and co-payments), and generally understand how insurance companies and health maintenance organizations (HMOs) relate to one another and the Military Health Services System.

For example, an admission involving a medical emergency for a retired inpatient with health insurance was not paid by the insured's HMO because the MTF was not a designated HMO facility. Representatives of the HMO told us that the medical emergency admission at a nonparticipating hospital would be paid if the inpatient prepared a statement explaining the emergency and the necessity for being admitted to the MTF. We notified Program personnel of our follow up, and they requested the patient to prepare a statement in order to rebill the HMO.

Inpatient Participation. The Military Health Services System does not provide an incentive to inpatients with health insurance to participate in the Program collection process. Free medical care is provided in the MTFs to military retirees and military dependents regardless of whether they have health

insurance. Inpatients treated at MTFs are not at risk for amounts not paid by insurance companies. As a result, inpatients have no incentive to provide accurate insurance information when requested by MTF admissions personnel or to ensure that amounts paid by insurance companies to MTFs are proper. In contrast, patients who are admitted to civilian hospitals for treatment are responsible for billed amounts not covered by their insurance plans. Because the patient is financially obligated to pay the noncovered amounts, the patient becomes involved in monitoring insurance payment amounts. When improper payments are made by insurance companies to MTFs, Program personnel resolve the difference without assistance from the insured inpatient.

Inpatients were often not knowledgeable about their insurance coverage because they had always received free medical care at the MTF or because they believed their participation in the Program to be voluntary. Other inpatients were reluctant to provide insurance information that was not related to benefits earned as a result of their military service, and expressed concern that participating in the Program would ultimately increase their insurance rates and cause them to lose their health insurance. We are not making a recommendation on inpatient deductibles and co-payments at MTFs because such issues would require policy decisions outside the scope of the audit.

Recommendations, Management Comments, and Audit Response

We recommend that the Assistant Secretary of Defense (Health Affairs) revise DoD Instruction 6010.15, "Third Party Collection Program," March 7, 1991, to:

1. Require medical treatment facility personnel to interview inpatients during both the admission and discharge process to obtain complete insurance information. During the interview, medical treatment facility personnel should discuss legislative requirements, the benefits of the Third Party Collection Program, and the types of insurance plans subject to collection, and should ascertain Medicare enrollment status for patients age 65 and older.

2. Establish necessary internal controls to ensure compliance with Third Party Collection Program requirements to bill and collect the maximum amount allowed by law. As a minimum, the controls should establish:

a. Mandatory training programs for medical treatment facility Program personnel covering the validation of payments for various types of insurance plans.

b. Procedures to validate the accuracy of insurance payments by considering health plan deductibles, co-payments, and any other pertinent insurance information.

c. A suspense system to monitor and verify the status of insurance claims.

Management Comments. The Acting Assistant Secretary of the Navy (Manpower and Reserve Affairs) commented on the recommendations addressed to the Assistant Secretary of Defense (Health Affairs). The complete text of the Acting Assistant Secretary's comments is in Part IV. As of November 30, 1993, the Assistant Secretary of Defense (Health Affairs) had not responded to the draft report.

Audit Response. We request that the Assistant Secretary of Defense (Health Affairs) provide comments to the final report by February 4, 1994.

Finding B. Medical Treatment Facilities Internal Controls

The medical treatment facilities Program procedures were not adequate to ensure the integrity of Program collections. The condition occurred because the medical treatment facilities had not implemented internal controls to separate cash collection and accounting duties related to cash receipts. Additionally, at two of the medical treatment facilities visited, amounts collected were not reconciled with deposit and accounting records. As a result, reasonable assurance did not exist that amounts collected were adequately safeguarded against fraud, waste, loss, or mismanagement.

Background

Program Controls. Internal controls are intended to provide reasonable assurance that program goals and objectives are met; that resources are adequately safeguarded and efficiently used; and that reliable data are obtained, maintained, and reported. Internal control standards are prescribed by the Comptroller General of the United States and are set forth in the 1983 publication, "Standards for Internal Controls in the Federal Government." The standards specify that management is responsible for controls and that internal controls should not be looked upon as separate, specialized systems within an organization. Management should use internal controls as an integral part of each system, to regulate and guide organization operations.

General Accounting Office, Title 7 Fiscal Guidance, "Policy and Procedures Manual for Guidance of Federal Agencies," February 1990, chapter 5, specifies that persons handling cash receipts are not allowed to participate in accounting or operating functions related to billing for services, controlling accounts receivable and subsidiary ledgers, preparing and mailing statements of balances due, or adjusting amounts due. Separating the duties reduces the opportunity to misuse cash receipts and to use the accounting records to conceal improper or illegal activities.

DoD Accounting Manual 7220.9M, October 1983, implements Title 7 and establishes internal control requirements for DoD. The manual requires DoD organizations to maintain internal controls and prescribes internal control techniques that DoD organizations should design and implement in all accounting systems.

Separation of Duties

MTFs had not implemented internal controls to separate cash collection duties from accounting duties related to cash receipts. Insurance checks should only

be received by an authorized collection agent who is not responsible for recording and reviewing the appropriateness of the insurance payments. Nonseparation of duties allows an individual to control an entire business transaction and provides an opportunity to misuse government funds or to conceal improper or illegal transactions. At eight of the nine MTFs visited, personnel were both collection agents and Program clerks who controlled or could control entire insurance collection transactions. MTF personnel were responsible for billing, receiving, and depositing amounts paid by insurance companies for inpatient stays at MTFs. The same personnel were also responsible for determining the appropriateness of payments and for writing off uncollectible accounts receivables. For the ninth MTF, Program personnel performed all collection and accounting duties; however, the personnel were not allowed to deposit checks that they received.

Reconciliation of Collections

At two of the nine MTFs visited, Program personnel did not reconcile collections with deposits and accounting and financial records to ensure all receipts were properly deposited and reported. At one of the MTFs, our reconciliation verified that FY 1992 Program collections were deposited with the disbursing officer and accurately reported on accounting and finance documents. At the other MTF, 32 percent of completed cash collection vouchers were not available. Cash collection vouchers are prepared by the disbursing offices as a receipt for monies collected from third parties for deposit. As a result, the MTF did not attempt, nor was it possible, to reconcile collected and deposited amounts with the records on file at the MTF. Ultimately, we were able to reconcile the accounts by visiting the disbursing office at Bangor, Washington, to acquire copies of collection vouchers. Periodic reconciliations provide necessary confirmation that collected amounts are deposited and properly reported. Program personnel at all MTFs should reconcile deposits with insurance payments to ensure accuracy of deposits with insurance payments.

Centralized Collections

We visited the Headquarters, Defense Finance and Accounting Service (DFAS), Washington, D.C., and determined that DFAS could collect and process third party insurance payments for the MTFs. A representative of the Disbursing and Travel Division, DFAS, stated that MTFs could use the U.S. Treasury Department-sponsored "lock box" system, allowing insurance payments to be sent to a centrally located commercial bank directly from the health insurance plans. The bank would process payments and would credit the MTFs' operation and maintenance accounts overnight. The lock box system for processing Program collections would eliminate the need for MTFs to handle checks and would provide quicker access to amounts collected. An explanation of benefits paid should be forwarded to the billing MTF for use by Program personnel to validate the payment amount.

As a result of our discussion with the DFAS representative, ASD(HA) Program and DFAS representatives met to discuss the potential use of the lock box system for Program collections. Use of an independent collection agent such as the lock box system would ensure that collecting and accounting duties are separate. Using the lock box system would be effective even in smaller MTFs where separating collection and accounting duties may not have been practical because of limited staffing. The DFAS representative also informed us that in many cases the Treasury Department pays the cost of setting up the lock boxes.

Recommendations, Management Comments and Audit Response

We recommend that the Assistant Secretary of Defense (Health Affairs):

1. Direct medical treatment facilities to perform monthly reconciliations of amounts collected with deposited amounts and with accounting and financial records.

2. Establish procedures with the Defense Finance and Accounting Service to use lock boxes for collecting Third Party Collection Program payments. Lock box procedures should require explanations of benefits prepared by the insurance companies to be provided to Third Party Collection Program officials at the military treatment facilities.

Management Comments. The Acting Assistant Secretary of the Navy (Manpower and Reserve Affairs) commented on the recommendations addressed to the Assistant Secretary of Defense (Health Affairs). The complete text of the Acting Assistant Secretary's comments is in Part IV. As of November 30, 1993, the Assistant Secretary of Defense (Health Affairs) had not responded to the draft report.

Audit Response. We request that the Assistant Secretary of Defense (Health Affairs) provide comments to the final report by February 4, 1994.

Part III - Additional Information

Appendix A. Universe of Medical Treatment Facility Inpatient Admissions (January 1 through June 30, 1992)

This appendix shows the universe of MTF inpatient admissions for three stratum used to select a statistical sample. For additional details, see Appendix B.

MTF Location*	Total Admissions
Stratum I	
Lackland AFB, TX	10,836
San Diego, CA	10,453
Walter Reed AMC, Washington, DC	10,382
Madigan AMC, WA	9,246
Tripler AMC, HI	9,245
Brooke AMC, TX	8,792
Fitzsimons AMC, CO	8,056
Portsmouth, VA	7,840
William Beaumont AMC, TX	7,748
Bethesda, MD	6,409
Eisenhower AMC, GA	5,723
Travis AFB, CA	4,703
Oakland, CA	4,387
Wright-Patterson AFB, OH	4,128
Keesler AFB, MS	4,054
Andrews AFB, MD	3,102
Scott AFB, IL	2,576
Total Stratum I	117,680
Stratum II	
Womack AMC, NC	7,141
Fort Hood, TX	6,580
Fort Campbell, KY	4,590
Fort Carson, CO	4,166
Fort Benning, GA	3,888
Fort Belvoir, VA	3,607
Jacksonville, FL	3,257

See footnote and acronyms at end of appendix.

Appendix A. Universe of Medical Treatment Facility Inpatient Admissions (January 1 through June 30, 1992)

MTF Location*	Total Admissions
Stratum II (cont'd)	
Charleston, SC	3,195
Fort Sill, OK	3,090
Fort Stewart, GA	3,089
Fort Riley, KS	2,630
Fort Knox, KY	2,590
Camp LeJeune, NC	2,563
Fort Polk, LA	2,311
Eglin AFB, FL	2,278
Pensacola, FL	2,253
Fort Leonard Wood, MO	2,247
Bremerton, WA	2,189
Camp Pendleton, CA	2,142
MacDill AFB, FL	2,028
Fort Rucker, AL	2,001
Fort Jackson, SC	1,925
Elmendorf AFB, AK	1,861
Fort Meade, MD	1,819
Offutt AFB, NE	1,654
March AFB, CA	1,616
Fort Huachuca, AZ	1,565
Fort Eustis, VA	1,529
Colorado Springs, CO	1,518
Langley AFB, VA	1,476
Luke AFB, AZ	1,448
Fort McClellan, AL	1,334
Davis-Monthan AFB, AZ	1,299
Fort Wainwright, AK	1,292
Orlando, FL	1,223
Millington, TN	1,222
Maxwell AFB, AL	1,133
Fairchild AFB, WA	1,022
Fort Lee, VA	1,013
Sheppard AFB, TX	1,007
Barksdale AFB, LA	952
Beaufort, SC	859
West Point, NY	845

See footnote and acronyms at end of appendix.

Appendix A. Universe of Medical Treatment Facility Inpatient Admissions (January 1 through June 30, 1992)

MTF Location*	Total Admissions
Stratum II (cont'd)	
Fort Dix, NJ	791
Minot AFB, ND	765
Newport, RI	687
Great Lakes, IL	661
Tyndall AFB, FL	632
Corpus Christi, TX	630
Total Stratum II	101,613
Stratum III	
Homestead AFB, FL	1,182
Twentynine Palms, CA	1,064
Kirtland AFB, NM	1,023
Redstone Arsenal, AL	994
Cherry Point, NC	993
Shaw AFB, SC	955
Vandenberg AFB, CA	880
Oak Harbor, WA	878
Hill AFB, UT	834
Nellis AFB, NV	792
Dover AFB, DE	747
Fort Irwin, CA	743
Whiteman AFB, MO	700
F.E. Warren AFB, WY	696
Dyess AFB, TX	687
Mountain Home AFB, ID	683
Groton, CT	668
Lemoore, CA	661
Ellsworth AFB, SD	642
Fort Leavenworth, KS	633
Cannon AFB, NM	631
Seymour Johnson AFB, NC	630
Patrick AFB, FL	598

See footnote and acronyms at end of appendix.

Appendix A. Universe of Medical Treatment Facility Inpatient Admissions (January 1 through June 30, 1992)

MTF Location*	Total Admissions
Stratum III (cont'd)	
Tinker AFB, OK	549
Holloman AFB, NM	540
Little Rock AFB, AR	513
Patuxent River, MD	484
Moody AFB, GA	472
Beale AFB, CA	463
Altus AFB, OK	463
Robins AFB, GA	437
Grand Forks AFB, ND	425
Fort Monmouth, NJ	424
Edwards AFB, CA	408
Griffiss AFB, NY	398
K.I. Sawyer AFB, MI	383
Laughlin AFB, TX	273
Columbus AFB, MS	252
Reese AFB, TX	189
Adak, AK	184
Plattsburgh AFB, NY	149
McConnell AFB, KS	115
Total Stratum III	25,435
Total Admissions at 108 MTFs	244,728

*Navy hospitals are designated by location only.

Acronyms

AMC Army Medical Center
AFB Air Force Base

Appendix B. Statistical Sample Methodology and Nonstatistical Calculation

Statistical Sample Methodology. We used a multistage sample design from a universe of 122,699 patient admissions at 23 Navy and 52 Air Force MTFs for the period January 1 through June 30, 1992. The Quantitative Methods Division, IG, DoD, designed the sample and combined the 11 MTF peer groups into 3 overall strata. Peer groups categorize MTFs by bed size and case mix (complexity of care). The sample used a 95-percent confidence level and employed stratification to get optimum precision for dollars given the nature of the universe and the resources available. The Quantitative Methods Division randomly selected three MTFs from each stratum, and auditors made statistically random selections of patient admissions at the nine MTFs visited.

At the nine MTFs visited, we selected 250 of 18,166 patient admissions. The projection of Program collections for medical care provided to military retirees and military dependents with primary health care insurance was based on various conditions identified by the audit. The conditions used in the estimates are inpatient admissions. The estimates involved two types of admissions: those billed and for which the correct amount was collected, and those not billed for which reimbursement is due. The Quantitative Methods Division excluded eight inpatient admissions from the sample results before computing the projected collections because the eight involved the quality of claims processed rather than whether the admission was collectible or not.

We identified 40 of 250 admissions that were covered by billable insurance. Of the 40, MTF admission personnel correctly identified billable insurance on 32 patient admissions. We found an additional eight billable insurance claims. The Quantitative Methods Division projected 3,016 admissions (confidence interval from 1,048 to 4,984 admissions) with unbilled collections valued at about $4.58 million, assuming that all eligible admissions with insurance had been identified, processed, and paid. The monetary benefits are the value of the claims that were not collected but that could have been collected. The margin of error of the estimate is from $4.167 million to $4.992 million, with $4.579 million being the midpoint of that interval.

Nonstatistical Calculation. Using the projected value of unbilled collections of about $4.6 million for 6 months, we estimated about $9.2 million for FY 1992. We inflated this estimated amount by 10.84 percent to $10.2 million. We determined the 10.84 percent increase by comparing the FY 1992 standard DoD Program billing rate of $701 to the FY 1993 billing rate of $777 for medical care services. We used the $777 rate because it was the most comparable of 13 variable billing rates established by DoD in FY 1993 to the FY 1992 billing rate. To be conservative, we did not inflate the estimated collection numbers beyond the FY 1993 amount. If MTF workload remains at its current level for FYs 1994 through 1999, we estimate that about $61.2 million (6 X $10.2 million) in collections will be lost.

Appendix C. Non-Active Duty Admissions (January 1 through June 30, 1992)

MTF Location	Peer Group Category[1]	Stratum[2]	Number of Admissions	Sample Size
Navy				
Oakland, CA	MC1	I	4,387	45
Camp Pendleton, CA	CH8	II	2,142	26
Great Lakes, IL	CH8	II	661	26
Cherry Point, NC	CH3	III	993	12
Total			8,183	109
Air Force				
Keesler Air Force Base, MS	MC2	I	4,054	45
Scott Air Force Base, IL	MC1	I	2,576	45
Elmendorf Air Force Base, AK	CH7	II	1,861	26
Nellis Air Force Base, NV	CH3	III	792	12
Whiteman Air Force Base, MO	CH3	III	700	13
Total			9,983	141
Total Navy and Air Force			18,166	250

[1]Abbreviations used by the Military Department to identify medical treatment facilities. MC is medical center; CH is community hospital. Numbers represent size of the facility.
[2]MTFs were assigned to one of three strata-based peer groups.

Appendix D. Unresolved Issues From IG, DoD, Report No. 90-105

Collections from Primary Health Insurance Plans

Prior Finding. MTFs were not collecting from primary health insurance plans for inpatient hospital costs incurred on behalf of insured military retirees and military dependents. We projected that MTFs would fail to collect approximately $318 million from insurance companies for FYs 1990 through 1994.

Recommendations A.1.a., A.1.b., and A.1.c. We recommended that the Military Department Surgeons General direct commanders at MTFs to fully implement and resource the Program. To fully implement the Program, MTFs needed to establish procedures to:

o identify inpatients who have insurance coverage, and document that inpatients have been questioned about insurance coverage;

o correctly prepare and submit claims to insurance companies, and

o resolve open claims and claims that were unpaid or partially unpaid for inappropriate reasons.

Management Comments. The Surgeons General concurred with the recommendations and agreed to initiate corrective actions and procedures when ASD(HA) issued guidance addressing the areas covered in the audit report.

Current Status. The Surgeons General issued guidance to MTF commanders on patient identification, claims preparation, and claims resolution. However, we found that the same conditions exist because the MTFs did not identify and bill all billable insurance and the MTFs did not validate payments received. Finding A documents the results of our review.

DoD Guidance and Support for the Program

Prior Finding. The Surgeons General and MTFs did not have sufficient DoD guidance and support to effectively implement and manage the Program. Consequently, policies and procedures used to implement the Program were inadequate and inconsistent.

Recommendation B.1.a. We recommended that ASD(HA) develop and issue a DoD instruction that provides specific policies, procedures, and responsibilities for implementing the Program.

Management Comments. ASD(HA) concurred with the finding and recommendation and published DoD Instruction 6010.15, "Third Party Collection Program," on March 7, 1991.

Current Status. DoD Instruction 6010.15 met the intent of our recommendation. However, we found that the same condition still exists, requiring revision and better implementation of the Instruction.

Legislation to Authorize Recoveries from Medicare Supplemental Insurance Policies

Prior Finding. Only 7 of the 25 MTFs visited were collecting from Medicare supplemental insurance policies for the cost of inpatient care for insured military retirees and military dependents. As a result, the MTFs collected only $46,600 for FY 1988 and the first quarter of FY 1989. We projected that, with appropriate legislation and guidance, MTFs can collect approximately $191.9 million from Medicare supplemental insurance policies for FYs 1991 through 1995.

Recommendation C.2. We recommended that ASD(HA) issue appropriate guidance requiring MTFs to collect from Medicare supplemental insurance policies if legislation is enacted.

Management Comment. ASD(HA) concurred with the finding, and stated that a draft legislative proposal was being circulated to authorize MTFs to collect from Medicare supplemental insurance policies and that, if legislation was enacted, ASD(HA) would issue appropriate guidance.

Current Status. Legislation was enacted and DoD Instruction 6010.15, issued March 7, 1991, requires MTFs to collect from Medicare supplemental insurance policies. The corrective action met the intent of our recommendation but additional effort is needed to resolve problems associated with billing third party insurance for Medicare-eligible beneficiaries. Finding A discusses the details of our review.

Appendix E. Summary of Potential Benefits Resulting From Audit

Recommendation Reference	Description of Benefit	Amount and/or Type of Benefit
A.1.	Program Results. Proper identification of billable admissions could result in additional collections of $40.8 million for FYs 1996 through 1999.	Recurring benefits from additional collections by MTFs of about $40.8 million.* (Appropriation 97X0130)
A.2.	Program Results. Revising guidance to establish procedures will improve Program's effectiveness.	Additional collections included in A.1.
B.1.	Improved internal controls.	Nonmonetary.
B.2.	Improved internal controls.	Nonmonetary.

*We claimed only $40.8 million of the $61.2 million estimated undercollection. The difference of $20.4 million was not claimed as potential monetary benefits in this report because it overlapped the amounts claimed for FYs 1994 and 1995 in IG, DoD, Report No. 90-105.

Appendix F. Organizations Visited or Contacted

Office of the Secretary of Defense

Office of the Secretary of Defense (Health Affairs), Washington, DC
Office of the Deputy General Counsel (Personnel and Health Policy), Washington, DC

Department of the Army

Headquarters, U.S. Army Audit Agency, Alexandria, VA
  Western Region, U.S. Army Audit Agency, San Antonio, TX

Department of the Navy

Office of the Chief, Bureau of Medicine and Surgery, Washington, DC
Naval Hospital, Camp Pendleton, CA
Naval Hospital, Cherry Point, NC
Naval Hospital, Great Lakes, IL
  Naval Air Station, Glenview Clinic, Chicago, IL
Naval Hospital, Oakland, CA
Personnel Support Activity, Puget Sound, WA
  Personnel Support Detachment, Bangor, WA

Department of the Air Force

Office of the Surgeon General of the Air Force, Bolling Air Force Base, DC
Keesler Medical Center, Keesler Air Force Base, Biloxi, MS
United States Air Force Medical Center Scott, Scott Air Force Base, IL
3rd Medical Center, Elmendorf Air Force Base, AK
351st Strategic Hospital, Whiteman Air Force Base, MO
554th Medical Group, Nellis Air Force Base, NV

Defense Organizations

Headquarters, Defense Finance and Accounting Service, Washington, DC
Office of the Civilian Health and Medical Programs of the Uniformed Services, Aurora, CO

Non-Defense Federal Organizations

House Subcommittee on Defense, Committee on Appropriations, Washington, DC
Office of Management and Budget, Washington, DC
Division of Insurance Audit, Office of Inspector General for Auditing, Office of Personnel Management, Arlington, VA
Assistant Inspector General for Health Care Financing Audits, Office of the Inspector General, Department of Health and Human Services, Baltimore, MD

Non-Defense Organizations

Electronic Data Systems Corporation, Alexandria, VA
Uniformed Services Benefit Plans, Inc., Columbus, IN
Wisconsin Physicians Service, Madison, WI

Appendix G. Report Distribution

Office of the Secretary of Defense

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

Department of the Army

Secretary of the Army
Auditor General

Department of the Navy

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

Department of the Air Force

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

Defense Agencies

Director, Defense Contract Audit Agency
Director, Defense Finance and Accounting Service
Director, Defense Logistics Agency
Director, Defense Logistics Studies Information Exchange
Director, National Security Agency
Inspector General, Defense Intelligence Agency

Non-Defense Organizations

Office of Management and Budget
U.S. General Accounting Office
- National Security and International Affairs Division, Technical Information Center
- National Security and International Affairs Division, Defense and National Aeronautics and Space Administration Management Issues
- National Security and International Affairs Division, Military Operations and Capabilities Issues

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

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

Department of the Navy Comments

DEPARTMENT OF THE NAVY
OFFICE OF THE SECRETARY
WASHINGTON, D C. 20350-1000

1 NOV 1993

MEMORANDUM FOR DEPARTMENT OF DEFENSE ASSISTANT INSPECTOR GENERAL FOR AUDITING

Subj: DRAFT AUDIT REPORT ON THE THIRD PARTY COLLECTION PROGRAM (PROJECT NO. 2LF-0052) - INFORMATION MEMORANDUM

Per Tab A, the Department of the Navy (DON) response is provided at Tab B.

We generally agree with the draft report findings and recommendations. However, we do not concur with recommendation B-2. Centralizing the collection function with a lock box at the Defense Finance and Accounting Service (DFAS) would cause the medical treatment facilities to lose direct control over the management of the third party receivables. Additionally, thousands of manhours would be expended tracking insurance payments between the third party payer and DFAS.

DOROTHY M. MELETZKE
Assistant Secretary of the Navy
(Manpower and Reserve Affairs)
Acting

Tab A - DODIG memo of 20 Aug 93
Tab B - DON response to draft audit report

Copy to:
NAVINSGEN
NAVCOMPT (NCB-53)

Department of the Navy Response

to

DODIG Draft Report of August 20, 1993

on

Third Party Collection Program
Project No. 2LF-0052

Finding A:

The medical treatment facilities (MTFs) were not properly collecting from health insurance companies for inpatient hospital costs incurred on behalf of all insured military retirees and military dependents. Collection efforts were inadequate because procedures for identifying patients with billable insurance and for evaluating payments received were not adequate to ensure accurate processing of all inpatients with insurance. Program personnel were not adequately trained in validating the accuracy of insurance payments. Additionally, the Military Health Services System (MHSS) does not provide incentives for its beneficiaries to participate in the program. If program improvements are not made, we estimate that MTFs could fail to collect about $61.2 million from insurance companies for FYs 1994 through 1999. Although we estimate the effect of not correcting deficiencies to be $61.2 million, we only claimed $40.8 of potential monetary benefits for FYs 1996 through 1999 because the remaining $20.4 million is included in benefits claimed in IG, DoD, Report No. 90-105 for FYs 1994 and 1995.

Recommendation A-1:

We recommend that the Assistant Secretary of Defense (Health Affairs) revise DoD Instruction 6010.15, "Third Party Collection Program," 7 March 1991, to:

- Require medical treatment facility personnel to interview inpatients during both the admission and discharge process to obtain complete insurance information. During the interview, medical treatment facilities personnel should discuss legislative requirements, the benefits of the Third Party Collection Program, and the types of insurance plans subject to collection and should ascertain Medicare enrollment status for patients age 65 or older.

DON COMMENTS ON DODIG DRAFT AUDIT REPORT NO. 2LF-0052 "THIRD PARTY COLLECTION PROGRAM," AUGUST 20, 1993

DON Position:

Concur, with the following comments:

a. A complete interview upon admission, which covers all the areas of the recommendation, would preclude the need to interview the patient during the discharge process. In the event that the insurance information upon admission is not complete due to the inability of the patient to provide it, and it cannot be obtained from a family member at that time, then a discharge interview would be appropriate.

b. Since the services are precluded from billing Medicare, the MTFs must determine if patients age 65 or older hold medical insurance policies that are Medicare supplements. The federal regulations under 32 CFR Part 220, authorize MTFs to bill the Medicare supplemental third party payer for the deductible amount of an inpatient visit that Medicare would not pay.

Recommendation A-2:

We recommend that the Assistant Secretary of Defense (Health Affairs) revise DoD Instruction 6010, "Third Party Collection Program," 7 March 1991, to:

a. Establish necessary internal controls to ensure compliance with Third Party Collection Program requirements to bill and collect the maximum amount allowed by law. As a minimum, the controls should establish:

1. Mandatory training programs for medical treatment facility program personnel covering the validation of payments for various types of insurance plans.

2. Procedures to validate the accuracy of insurance payments by considering health plan deductibles, co-payments, and any other pertinent insurance information.

3. A suspense system to monitor and verify the status of insurance claims.

DON Position:

Concur. Per DoD Instruction 6010.15 of 10 March 1993, the responsibility for training resides with DoD. The BUMED Instruction 7000.7 of 10 August 1993, covers the procedures for validating accuracy of insurance payments. A suspense system is

DON COMMENTS ON DODIG DRAFT AUDIT REPORT NO. 2LF-0052 "THIRD PARTY COLLECTION PROGRAM," AUGUST 20, 1993

in place which uses the DoD aging of accounts receivable report required by the DoD instruction. Each MTF must use this report to verify the status of insurance claims.

Finding B:

MTF program procedures were not adequate to ensure the integrity of program collections. The condition occurred because MTFs had not implemented internal controls to separate cash collection and accounting duties related to cash receipts. Additionally, amounts collected were not always reconciled with deposit and accounting records. As a result, reasonable assurance did not exist that amounts collected were adequately safeguard against fraud, waste, loss, or mismanagement.

Recommendation B-1:

We recommend that the Assistant Secretary of Defense (Health Affairs) direct MTFs to perform monthly reconciliations of amounts collected with deposited amounts and with accounting and financial records.

DON Position:

Concur. The Resource Management Handbook (NAVMED P-5020) provides the required accounting guidance for the separation of cash collection and accounting duties related to cash receipts. The NAVMED P-5020 also requires that amounts collected be reconciled with deposit and accounting records monthly.

Recommendation B-2:

We recommend that the Assistant Secretary of Defense (Health Affairs) establish procedures with the Defense Finance and Accounting Service (DFAS) to use lock boxes for collecting Third Party Collection Program payments. Lock box procedures should require explanations of benefits prepared by the insurance companies to be provided to Third Party Collection Program officials at the MTF.

DON Position:

Do not concur. Centralizing the collection function with a lock box at DFAS would cause the MTFs to lose direct control over the management of the third party receivables, and thousands of manhours would be expended tracking insurance payments between the third party payer and DFAS.

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