Audit Report

OFFICE OF THE INSPECTOR GENERAL

PAYMENTS TO THE CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES

Report No. 96-092 April 3, 1996

Department of Defense

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Acronyms

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CMAC	CHAMPUS Maximum Allowable Charge
CPT	Current Procedural Terminology
OCHAMPUS	Office of CHAMPUS

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

April 3, 1996

MEMORANDUM FOR DIRECTOR, OFFICE OF THE CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES

SUBJECT: Audit Report on Payments to the Civilian Health and Medical Program of the Uniformed Services Providers (Report No. 96-092)

We are providing this report for your review and comment.

DoD Directive 7650.3 requires that all recommendations and potential monetary benefits be resolved promptly. Because the Office of the Civilian Health and Medical Program of the Uniformed Services did not comment on a draft of this report, we request that management provide comments on the final report by June 3, 1996.

We appreciate the courtesies extended to the audit staff. Questions on the audit should be directed to Mr. Michael A. Joseph, Audit Program Director, or Mr. James A. O'Connell, Senior Auditor, at (804) 766-2703. Copies of the final report will be distributed to the organizations listed in Appendix E. The audit team members are listed on the inside back cover.

Robert J. Lieberman
Assistant Inspector General
for Auditing

Office of the Inspector General, DoD

Report No. 96-092 **April 3, 1996**
(Project No. 4LF-0024)

Payments to the Civilian Health and Medical Program of the Uniformed Services Providers

Executive Summary

Introduction. During FY 1993, the Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) made payments totaling about $1.2 billion to civilian health care providers for outpatient services provided to eligible beneficiaries within and outside designated catchment areas. Of the $1.2 billion, about $149 million applied to claims submitted by providers within catchment areas (generally a 40-mile radius) for military treatment facilities in the CHAMPUS southeastern region. The southeastern region was one of six CHAMPUS regions (including the CHAMPUS Reform Initiative for California and Hawaii) with catchment area payments ranging from $63 million to $194 million.

Audit Objectives. The primary audit objective was to determine the validity of payments made by OCHAMPUS to civilian providers for outpatient services rendered to active duty dependents, retirees and their dependents, and survivors of deceased members of the uniformed services. The scope of audit was limited to payments to providers within catchment areas for military treatment facilities in the CHAMPUS southeastern region. We also reviewed the management control program as it applied to the primary audit objective.

Audit Results. While payments made by OCHAMPUS for outpatient services in the southeastern region were generally valid, the amounts paid were not always justified. Two conditions warranting management attention were identified during the audit.

o Providers in the southeastern region submitted and received payments on 476 claims (of 2,242 reviewed) for outpatient services at levels that exceeded services documented as being provided and for services not documented in patient medical records. As a result, we estimated that civilian health care providers in the CHAMPUS southeastern region may have been overpaid by about $10.9 million and CHAMPUS beneficiaries may have incurred unnecessary copayment costs of about $0.5 million during FY 1993 (Finding A).

o Institutional providers in the CHAMPUS southeastern region submitted 278 claims (of 2,242 reviewed) for technical component portions of outpatient services that were assigned miscellaneous procedure codes and paid at amounts billed by the provider, which exceeded maximum allowable rates or state prevailing rates for the services provided. As a result, we estimated that institutional providers in the CHAMPUS southeastern region were paid about $8.5 million in excess of allowable rates for services provided during FY 1993 and beneficiaries may have incurred unnecessary copayment costs of about $2.3 million (Finding B).

The OCHAMPUS management control program needs improvement, because we identified material weaknesses related to management controls over reimbursement of provider claims for outpatient services (Appendix A).

Recommendations in this report, if implemented, will result in CHAMPUS funds totaling about $116.4 million for FYs 1997 through 2002 being put to better use in the southeastern region and could reduce beneficiary costs for copayments by about $16.8 million during the same period. The potential monetary benefits shown here are for one of six CHAMPUS regions. We chose not to calculate and claim several multiples of the $116.4 million of the potential monetary benefits for the other five regions. However, it is unreasonable to assume the problems identified are not occurring in the other five regions. The recommendations will also strengthen the management control program. Appendix C summarizes the potential benefits of the audit.

Summary of Recommendations. We recommend establishing policy and procedures to provide for periodic on-site reviews of patient medical records, on a random sampling basis, to validate services performed by CHAMPUS providers. We also recommend revising policy to exclude diagnostic and other outpatient services, with applicable current procedural terminology codes, from the practice of assigning miscellaneous codes on institutional provider claims and limit reimbursement on such services to the technical portion of the allowable rate. Incorrect claims demonstrating a possibility of excessive or abusive trends by specific providers were submitted to OCHAMPUS for appropriate action.

Management Comments and Audit Response. The OCHAMPUS did not respond to the draft of this report. We understand that OCHAMPUS provided comments to the Office of the Assistant Secretary of Defense (Health Affairs) and the comments are being revised and coordinated. We request that OCHAMPUS provide comments on the final report by June 3, 1996. If we receive the original OCHAMPUS comments, we will consider them as comments to the final report.

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Part I - Audit Results

Audit Background

United States Code, title 10, section 1079 authorizes the Secretary of Defense to contract for medical care for spouses and children of members of the uniformed services who are on active duty for a period of more than 30 days. United States Code, title 10, section 1086 extends the authority of the Secretary of Defense to contract for medical care to include former members of the uniformed services and their dependents and survivors of former members. The program authorized by those sections is the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

CHAMPUS supplements direct medical care provided through military treatment facilities and is similar to private medical insurance programs. In the continental United States, eligible beneficiaries obtain prescribed medical care from civilian providers with the cost of such care being shared by CHAMPUS and the beneficiaries. All beneficiaries must meet a yearly deductible amount of $150 per person or $300 per family before CHAMPUS coverage begins. After the yearly deductible amount has been met, the beneficiary incurs a copayment of 20 or 25 percent of the CHAMPUS allowable cost depending on whether the beneficiary or the sponsor is active duty or retired. During FY 1993, the Office of CHAMPUS (OCHAMPUS) made payments totaling about $1.2 billion to civilian health care providers for outpatient services provided to eligible beneficiaries. Of the $1.2 billion, about $149 million applied to 1.3 million claims submitted by providers or beneficiaries within the catchment areas (generally a 40-mile radius) for military treatment facilities in the CHAMPUS southeastern region.

DoD Directive 5105.46, "Civilian Health and Medical Program of the Uniformed Services," December 4, 1974, established OCHAMPUS to administer and manage CHAMPUS. The Director, OCHAMPUS, has responsibility for organizing and managing OCHAMPUS to include contracting for and monitoring claims processing services necessary to carry out OCHAMPUS programs.

DoD Regulation 6010.8-R, "Civilian Health and Medical Program of the Uniformed Services," July 1991, prescribes guidelines and policies for administration of CHAMPUS. The regulation defines an authorized provider as an institution (for example, hospital, ambulatory surgery center, etc.), physician, or other individual professional provider, or other provider of services or supplies specifically authorized to provide benefits under CHAMPUS. Other providers of services or supplies include ambulance companies, independent laboratories, mammography suppliers, medical equipment and supply firms, pharmacies, and suppliers of portable X-ray services. Physicians and other individual professional providers bill for their services on a fee-for-service basis and are not employed by or under contract to an institutional provider.

The OCHAMPUS policy states that the preferred and primary method for reimbursement of individual health care professionals and other providers of outpatient services or supplies is the allowable charge method. The allowable charge for authorized care is the lower of the billed charge or the local CHAMPUS maximum allowable charge (CMAC). National CMAC levels are calculated for each procedure and are adjusted for localities using the same (or similar) geographical areas and the same geographic adjustment factors that are used for determining allowable charges under Medicare. CMACs are comprised of two component parts, the technical component covering operating costs including facilities and overhead, and the professional component covering services provided by health care professionals. CHAMPUS guidance provides for alternative methods of reimbursement but states that alternative methods may not result in reimbursement greater than the allowable charge method.

Audit Objectives

The primary audit objective was to determine the validity of payments made by OCHAMPUS to civilian providers for outpatient services rendered to active duty dependents, retirees and their dependents, and survivors of deceased members of the uniformed services. The scope of audit was limited to payments to providers within catchment areas for military treatment facilities in the CHAMPUS southeastern region. We also evaluated the management control program as it applied to the primary objective. See Appendix A for a discussion of the scope and methodology and management control program.

Finding A. Validity of Provider Claims

Providers in the CHAMPUS southeastern region submitted and received payment on claims for outpatient services at levels that exceeded services documented as being performed or for services that were not documented in patient medical records. CHAMPUS policies and procedures did not provide for validating the appropriateness of the levels of services or the actual performance of services claimed by providers. As a result, CHAMPUS may have overpaid providers in the southeastern region by about $10.9 million and CHAMPUS beneficiaries may have incurred about $0.5 million in unnecessary copayment costs on 1.3 million claims for services provided during FY 1993.

Procedures for Submitting, Processing, and Validating Claims

Submitting Claims. The annual American Medical Association, "Physicians' Current Procedural Terminology Manual," contains codes for reporting medical services performed by health care providers. Diagnostic, medical, surgical, and other health care services are identified by a five-digit current procedural terminology (CPT) code (see Appendix B for definitions of specific codes referenced in the report). The CPT codes are used by health care professionals and other providers in submitting claims for services rendered to CHAMPUS beneficiaries.

Processing Claims. The OCHAMPUS contracts with private firms, called fiscal intermediaries, to process claims and make payments to health care providers. The fiscal intermediaries are responsible for verifying beneficiary eligibility, checking for other beneficiary health insurance, denying noncovered benefits, checking for duplicate payments, paying valid claims, and issuing explanations of benefits* to beneficiaries. Claims submitted by health care professionals and other providers for services provided to eligible beneficiaries are normally paid on the basis of CPT codes billed.

The CHAMPUS Policy Manual (the Manual), volume II, chapter 4, section 1.1, July 18, 1983, states that payment should be made only for actual services rendered and documented in patient medical records; and that if documentation of billed services cannot be confirmed in patient medical records,

*Explanation of benefits - statement sent to both the provider and beneficiary showing services provided, other insurance payments, Government payment, beneficiary deductible and copayment, and reason for any charges not allowed.

payment should be denied. The Manual further states that it is the responsibility of the medical facility (provider) submitting a claim to substantiate that services were provided to the beneficiary.

Validating Claims. OCHAMPUS guidance requires fiscal intermediaries to validate claims to the extent that the provider submitting the claim is an authorized provider, the individual to which the services were provided is a valid beneficiary, and the services provided to the beneficiary were covered services. In addition, fiscal intermediaries or peer review groups are required to perform quality assurance and utilization reviews to ensure that services provided were medically necessary and to identify trends that might indicate overutilization or fraud and abuse. Intermediaries or peer review groups may request medical documentation supporting a claim during quality assurance or utilization reviews. However, periodic on-site (at provider locations) reviews of patient medical records and tracking of results to ensure the validity of claims submitted for payment are not required or performed.

Providers Submit and Receive Payment for Incorrect Claims

Providers in the CHAMPUS southeastern region submitted and received payments for claims that exceeded services documented as being provided and for services not documented in patient medical records. Figure 1 shows CHAMPUS and beneficiary payments, validated payment amounts, and overpayments associated with incorrect claims identified in our sample.

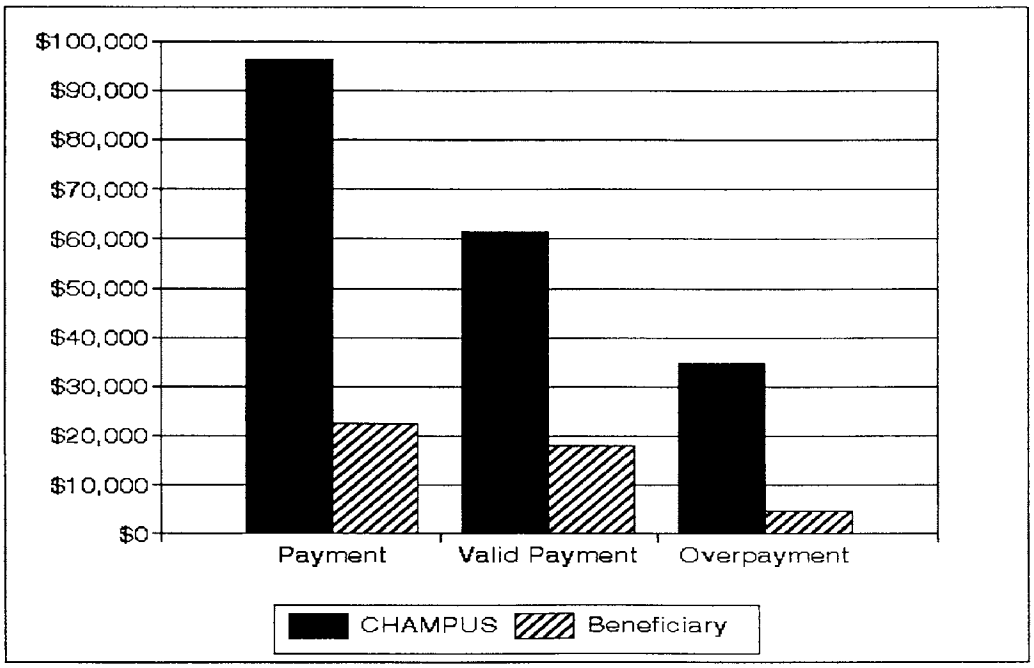

Figure 1. Overpayments on 476 Unsupported and Undocumented Claims

Of 2,242 claims reviewed in six catchment areas of the southeastern region, 476 claims were considered incorrect, resulting in CHAMPUS overpaying providers $34,638 and beneficiaries incurring $4,638 in unnecessary copayment costs. Of the 476 incorrect claims, 270 exceeded the level of services documented in patient medical records and 206 were for services not documented in patient medical records. Incorrect claims were not detected because CHAMPUS policy and procedures did not provide for periodic on-site review of medical records to validate the appropriateness of the levels of services or the actual performance of services claimed by providers.

Incorrect claims and overpayments were based on a statistical sample of 109 providers located within the six catchment areas selected for review. Levels of services, as documented in patient medical records, were compared to the levels of service reflected by the CPT codes billed by the providers. When necessary, we obtained the assistance of coding personnel at the local military treatment facility to determine CPT codes for the level of services performed. Based on sample results, we estimated that the total amount of overpayments to providers in the CHAMPUS southeastern region for FY 1993 was about $10.9 million and that beneficiaries incurred about $0.5 million in unnecessary copayment costs.

Documented Level of Services Provided. Of the 476 incorrect claims identified, 270 resulted from the provider billing for a CPT code that exceeded the level of service documented in the patient medical record. For our analysis of incorrect claims, we used the CPT code for one level of service below that billed by the provider unless the medical record clearly indicated a lower level of service. (Therefore, our estimates of overpayment are conservative.) The 270 incorrect claims resulted in providers being paid at least $8,671 in excess of the amounts justified by the services documented in patient medical records, and in CHAMPUS beneficiaries incurring about $1,231 in unnecessary copayments. Providers did not correctly bill based on the documented complexity of patient problems, negotiated provider payment rates, and length of patient visits.

Claims Based on Complexity of Patient Problems. The CPT codes for some services varied based on the complexity of patient problems and the degree of medical history, examination, and decisionmaking required (see Appendix B for definitions). In determining the correct level of service, we considered the complexity of patient problems and the medical evaluation documented in patient medical records. Incorrect claims in this category resulted from providers submitting claims for more complex patient problems and medical evaluations than were documented in patient medical records. For example, a provider submitted a claim for $90.00, on which the Government payment was $72.00, citing CPT code 99215 (moderate to highly severe problem, comprehensive history and examination, and highly complex medical decision) for a visit by a patient for possible otitis media (inflammation of the middle ear). The patient medical record noted that the patient had recurrent otitis media in the past and based on a brief examination was assessed with recurrent otitis media. The medical record clearly supported a billing no higher than CPT code 99212 (low severity problem, problem focused history and examination, and straightforward medical decision). The CMAC for CPT code 99212 was $30.00, which would have resulted in a Government payment

of $24.00 or $48.00 less than the amount paid. In addition, payment at the lower allowable amount would have resulted in the beneficiary's copayment being reduced from $18.00 to $6.00.

Claims Based on Negotiated Provider Payment Rate. Claims for some providers are made using rates individually negotiated with the fiscal intermediary based on the percentage of the CMAC the provider is willing to accept as full payment for services rendered. Our review indicated a possible trend for providers with negotiated rates to bill all services at the two highest level CPT codes resulting in CHAMPUS overpayments for services actually rendered. By billing at a higher level of service than actually provided, providers can offset revenues lost through acceptance of a negotiated rate. For example, a provider submitted a claim for $90.00 citing CPT code 99214 (moderate to severe problem, detailed history and examination, and moderately complex medical decision) for a follow-up visit by a patient being treated for stasis ulcers (open sore or lesion of the skin) on the lower extremities. The fiscal intermediary allowed $46.24, and based on the provider's negotiated rate of 80 percent, the Government payment was $37.00. Review of the patient's medical record showed evidence of a minimal history, a minimal examination, and continuation of local wound care, which would support a CPT code of 99212 (self-limited problem, problem focused history and examination, and straightforward medical decision). However, to be conservative we allowed CPT code 99213 (low to moderately severe problem, problem focused history and examination, and straightforward medical decision) with an allowable rate of $30.88, rather than the $46.24 allowed on CPT code 99214, resulting in a Government payment of $25.00 ($12.00 less than the amount paid). The beneficiaries copayment also would have been reduced by $3.00.

Claims Based on Length of Patient Visit. Claims for some CPT codes are based strictly on the length of the patient visit or the length of time the provider spent with the patient. Providers submitted claims and received payments for services based on the length of the patient visit, where review of medical records and appointment schedules did not support the length of patient visit claimed. For example, a provider submitted a claim for $120.00 citing CPT code 90844 (individual psychotherapy approximately 45 to 50 minutes), with an allowable charge of $96.60, resulting in a Government payment of $77.28. The patient's medical record showed only a one- to six-word comment on the provider's subjective and objective findings, assessment, and plan of treatment, which would make a 45- to 50-minute session questionable. In addition, our review of the provider's appointment schedule for the date in question showed that patient appointments had been scheduled every 15 minutes from 12:45 p.m. through 5:00 p.m., and that in four instances two patients were scheduled for the same 15 minute time period. Our review of appointment schedules for other dates of service showed that scheduling appointments every 15 minutes was routine, which made billing in excess of 45 minutes questionable. Based on the limited documentation in the patient's medical record and the scheduled length of the patient's appointment, a billing no higher than CPT code 90843 (individual psychotherapy approximately 20 to 30 minutes) could be supported. Although CHAMPUS guidance provided a lower procedure code, 92850 (individual psychotherapy less than 20 minutes), we used CPT code 90843, to be conservative. CPT code 90843 had an

allowable charge of $62.90, which would have resulted in a Government payment of $50.32 or $26.96 less than the amount paid on the claim and a reduction of about $7.00 in the beneficiaries copayment.

Documentation of Services Provided. CHAMPUS payments on 206 incorrect claims, totaling $25,967, were made for services not documented in patient medical records. The 206 claims also resulted in CHAMPUS beneficiaries incurring about $3,407 in copayments. We identified as incorrect those claims that had an absence of documentation in the patient medical records indicating that the patient was seen on the date in question, and the absence of any evidence that the patient had scheduled an appointment on that date. For example, a provider submitted a claim for CPT 90862 (pharmacologic management with no more than minimal psychotherapy) for services performed on July 20, 1993. The Government paid $28.35 on the claim. Our review of the patient's medical record showed no evidence of a visit on July 20, 1993, or on any other date in 1993; and according to the office appointment calendar the provider saw no patients on July 20, 1993. In the absence of supporting documentation, the Government overpaid the provider $28.35.

Conclusion

The lack of policy and procedures for periodic on-site reviews of medical records to validate medical documentation supporting provider claims allowed providers to receive payment for higher levels of service than actually provided or for services that were not provided. We recognize that the overpayments on individual claims are not significant dollar amounts; however, the volume of claims processed results in a significant cumulative effect. As a result, in FY 1993 CHAMPUS overpaid an estimated $10.9 million for health care for beneficiaries in the southeastern region and CHAMPUS beneficiaries may have incurred unnecessary out-of-pocket costs of $0.5 million for copayments. Establishing policy and procedures for periodic on-site reviews of medical records to validate services performed by providers, and for tracking of review results to serve as a basis for additional followup reviews, could result in CHAMPUS funds totaling about $65.4 million being put to better use over a 6-year period in the southeastern region. While policy and procedures providing for periodic validation of provider claims might result in substantial recoupments in extreme cases, the primary benefit would be the deterrent effect that a potential review would have on provider billing practices.

Recommendations for Corrective Action

A. We recommend that the Director, Office of the Civilian Health and Medical Program of the Uniformed Services establish policy and procedures to:

1. perform periodic on-site reviews of patient medical records, on a random sampling basis, to validate services claimed; documented; and performed by providers,

2. track the results of records reviews for providers identified as submitting excessive numbers of incorrect or undocumented claims, and

3. initiate appropriate corrective action and additional followup reviews for providers identified as submitting excessive numbers of incorrect or undocumented claims.

Management Comments Required

The OCHAMPUS did not respond to the draft of this report. We understand that OCHAMPUS provided comments to the Office of the Assistant Secretary of Defense (Health Affairs) and the comments are being revised and coordinated. We request that OCHAMPUS provide comments on the final report by June 3, 1996. If we receive the original OCHAMPUS comments, we will consider them as comments to the final report.

Finding B. Institutional Provider Claims for Outpatient Services

Institutional providers in the CHAMPUS southeastern region submitted claims for technical component portions of outpatient services that were paid at amounts exceeding the CMAC or applicable prevailing State rate for the services provided. OCHAMPUS policies and procedures for the processing of claims by the fiscal intermediaries did not provide adequate controls to ensure that outpatient services included in claims submitted by institutional providers were not assigned miscellaneous procedure codes and that payments were not made in excess of the CMAC or prevailing State rate. As a result, CHAMPUS institutional providers in the southeastern region may have been paid about $8.5 million more than was appropriate, based on the CMACs or prevailing State rates for the services provided during FY 1993. In addition, CHAMPUS beneficiaries may have incurred about $2.3 million in unnecessary copayment costs.

Institutional Provider Claims for Services

Institutional providers submit claims for services classified as either institutional or noninstitutional. Claims classified as institutional are for inpatient services and cover operating costs associated with the treatment of the primary diagnosis resulting in the patients stay in the institution. Institutional claims are paid under the diagnosis related group-based payment system, which uses average rates based on the normal length of stay for procedures forming a specific diagnostic related group to reimburse institutions for the resources that should be provided to patients based on the complexity of care required. Claims classified as noninstitutional are for the professional component charges associated with both inpatient and outpatient services and technical component charges associated with outpatient services (for example, ambulatory surgery, diagnostic laboratory and radiological procedures, emergency room treatment, etc.). Noninstitutional claims may also cover facility charges for the use of certain institution facilities (for example, operating room, recovery room, etc.) associated with either inpatient or outpatient services that are not covered under diagnostic related group or technical component allowable rates. Claims for outpatient services by institutional providers in this report pertain only to technical component charges.

Submitting Institutional Provider Claims for Outpatient Services. Institutional providers submit claims for outpatient services on a Uniform Bill-82 or -92 form, either electronically or in hard copy. The claims show services provided, CPT codes if applicable, applicable revenue codes identifying the departments providing services, and amounts billed. Technical component charges for outpatient services provided by nurses, technicians and other healthcare personnel, medical supplies, and drugs and biologicals, which cannot

be self-administered, are appropriate for submission and payment on the Uniform Bill-82 or -92 form. Institutional providers are to use Health Care Financing Administration form 1500 to bill CHAMPUS for the professional services component of care provided on an inpatient or outpatient basis. Professional services included on the Uniform Bill-82 or -92 form should show the appropriate professional services revenue code, indicating submission as noncovered charges to be billed separately on Health Care Financing Administration form 1500.

Processing Institutional Provider Claims for Outpatient Services. When claims submitted on Uniform Bill-82 or -92 forms were received by the fiscal intermediary, all claimed services, except properly coded professional services, were assigned miscellaneous codes that OCHAMPUS established for facility charges. Facility charges do not have applicable CPT codes, therefore, miscellaneous codes were established for tracking purposes. Further, miscellaneous codes established for facility charges appropriately billed on Uniform Bill-82 or -92 forms have no established CMACs or prevailing State rates. Therefore, all charges, except properly identified professional component charges, submitted on Uniform Bill-82 or -92 claim forms from institutional providers were paid as billed, with no regard to CMACs or prevailing State rates. Professional services included on the Uniform Bill-82 or -92 and properly coded with a professional services revenue code were flagged as noncovered and disallowed.

Overpayments on Outpatient Claims by Institutional Provider

Institutional providers in the CHAMPUS southeastern region submitted claims in FY 1993 on Uniform Bill-82 or -92 forms that included the technical component portions of outpatient services, and received payments for those services that exceeded the applicable CMAC or prevailing State rate. Of 2,242 claims reviewed, 309 were billings from institutional providers that were paid as billed and resulted in the institutional provider receiving payments that exceeded CMACs or prevailing State rates for the services provided by about $58,211.

The claims were for ambulatory surgery and other outpatient services including diagnostic services, such as laboratory procedures, X-rays, and other radiological procedures.

Ambulatory Surgery. Of the 309 claims paid in excess of CMACs or prevailing State rates, 31, totaling $25,549, were for ambulatory surgery (surgical procedures performed in a hospital or ambulatory surgery clinic that do not require inpatient admission). Effective November 1, 1993, OCHAMPUS revised its policies and procedures on payment of claims for ambulatory surgery from reimbursement based on billed charges to reimbursement using prospectively determined rates based on standardized national cost data. Our limited review of FY 1995 claims payment data contained in the CHAMPUS data base showed that the revised policy had been

implemented and has resulted in significant reductions in the CHAMPUS cost for ambulatory surgery. The OCHAMPUS implementation of the revised policy eliminated the overpayment problem, therefore, we excluded ambulatory surgery claims from our projected estimate of total claims paid in excess of CMACs or prevailing State rates.

Other Outpatient Services. The remaining 278 claims were for other outpatient services, primarily diagnostic services, such as laboratory procedures, x-rays, and other radiological procedures. Services provided on the claims were assigned miscellaneous codes by the fiscal intermediaries and paid at billed rates that exceeded the CMACs or prevailing State rates for the services provided. Figure 2 shows CHAMPUS and beneficiary payments, validated payment amounts, and overpayments associated with the 278 claims.

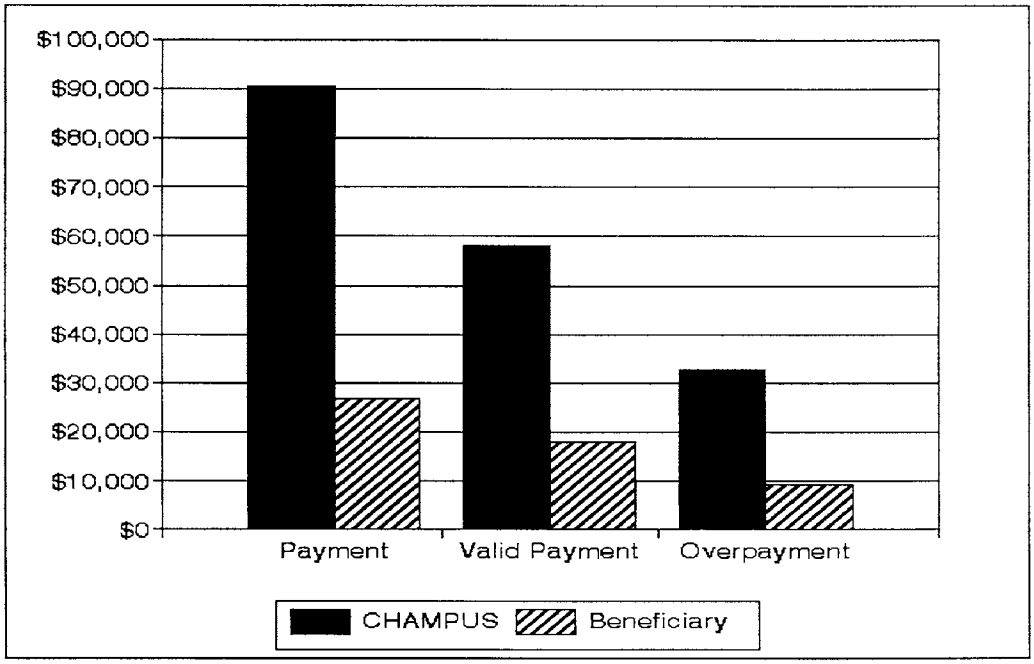

Figure 2. Claims Paid Over Allowable Rates

The 278 claims, resulted in CHAMPUS overpayments of $32,662 and beneficiary overpayments of $9,015. Charges billed and allowed on claims from institutional providers for outpatient services exceeded the technical component maximum allowable amounts, and on 127 of the 278 claims exceeded the combined maximum allowable amounts for both technical and professional components. For example, an institutional provider submitted a claim for outpatient services provided to a beneficiary that included charges for a whole body bone scan (CPT code 78306), a computerized tomography scan of the thorax with contrast (CPT code 71260), a complex computer manipulation (CPT code 78890), a chest X-ray with two views (CPT code 71020), and a radionuclide diagnostic test (CPT code 78990). The institutional provider billed a total of $1,557.80 for the services. Although the institutional provider

submitted the proper CPT codes for each service, the fiscal intermediary coded the services billed on the claim with miscellaneous codes and allowed the entire amount. As a result, the Government paid $1,168.35 for the services provided to the beneficiary. Using the technical component CMACs, applicable to the appropriate CPT codes for the services provided, would have produced a total allowable amount of $563, of which the Government would have paid $422. Therefore, coding the services with miscellaneous codes and allowing the total amounts billed by the institutional provider resulted in an allowable amount that exceeded the technical component CMACs by $995 ($1,168 - $563). The Government overpaid $746. Further, allowing the entire billed amount resulted in a total allowable amount that exceeded the combined maximum allowable amount of $873 for the technical and professional components of the services billed. Coding the services with miscellaneous codes and paying billed amounts resulted in the beneficiary incurring $249 of unnecessary copayment costs.

Conclusion

CHAMPUS was incurring excessive costs for the technical component portion of outpatient services obtained through institutional providers because services billed on Uniform Bill-82 or -92 forms were being coded with miscellaneous codes by the fiscal intermediary and reimbursed based on billed charges. Revised OCHAMPUS policy to prevent outpatient services with applicable CPT codes from being assigned miscellaneous codes and limit reimbursement for such services to the technical component CMAC or prevailing State rate could result in CHAMPUS funds of about $51 million, for the southeastern region, being put to better use over a 6-year period. In addition, copayment costs for CHAMPUS beneficiaries could be reduced by about $13.8 million over the same 6-year period.

Recommendations for Corrective Action

B. We recommend that the Director, Office of the Civilian Health and Medical Program of the Uniformed Services revise policy to:

1. prohibit the fiscal intermediaries from assigning facility charge miscellaneous codes to institutional provider claims for outpatient services with current procedural terminology codes and

2. limit reimbursement for outpatient services to the technical component portion of the Civilian Health and Medical Program of the Uniformed Services maximum allowable charge or prevailing state rate.

Management Comments Required

The OCHAMPUS did not respond to the draft of this report. We understand that OCHAMPUS provided comments to the Office of the Assistant Secretary of Defense (Health Affairs) and the comments are being revised and coordinated. We request that OCHAMPUS provide comments on the final report by June 3, 1996. If we receive the original OCHAMPUS comments, we will consider them as comments to the final report.

Part II - Additional Information

Appendix A. Audit Process

Scope

Claim Submission and Payment. We reviewed the submission and payment of 2,242 claims for services provided during FY 1993 by 109 providers located within six catchment areas in the CHAMPUS southeastern region. The Government payments on the 2,242 claims totaled $568,351. We selected the catchment areas, providers, and claims reviewed using statistical sampling techniques (details are in Sampling Methodology). For the claims selected, we reviewed, as applicable:

- o CHAMPUS Data Information System data on payment of the claim,
- o patient medical records for the beneficiary to which the claim applied,
- o provider appointment schedules,
- o detailed billing data from the provider,
- o CMAC listings for the applicable localities and time period, and
- o prevailing State rate schedules for the applicable localities and time period.

We also reviewed OCHAMPUS policies and procedures applicable to the processing of claims by fiscal intermediaries in effect from October 1992 through September 1995.

Use of Computer-Processed Data. We performed limited tests on the reliability of computer-processed data contained in the CHAMPUS Data Information System on a claim-by-claim basis. To the extent that we reviewed the computer-processed data, we concluded that they were sufficiently reliable to be used in meeting our audit objectives.

Audit Period, Standards, and Locations. We performed this economy and efficiency audit from July 1994 through November 1995 in accordance with auditing standards issued by the Comptroller General of the United States, as implemented by the Inspector General, DoD. We included tests of management controls considered necessary.

Methodology

We obtained procedure codes and amounts claimed, allowed, and paid by the Government from the CHAMPUS data base for all sampled claims. We compared the procedure codes claimed by the provider to documentation in the patient medical record to make a determination on the validity of the claim. If documentation in the patient medical record supported all procedures and levels of service claimed by the provider, we considered the claim correct. In those instances where the documentation in the patient medical record did not show any services provided on the claimed date of service or did not support a procedure or level of service claimed, we considered the claim incorrect. Institutional provider claims for outpatient services paid as billed, based on assigned miscellaneous codes, were considered incorrect if reimbursement exceeded the applicable CMAC or prevailing State rate for the outpatient services provided. A claim with multiple procedures may have had procedures that were determined to be correct, unsupported, undocumented, and paid over the allowable, in which case we categorized the claim as the problem having the largest dollar impact on the Government payment for reporting purposes.

We obtained allowable amounts from listings of CMACs and prevailing State rates furnished by the fiscal intermediary. We calculated correct Government payment amounts using claims processing procedures contained in OCHAMPUS Manual 6010.24-M, "CHAMPUS Operations Manual: Fiscal Intermediary," June 1, 1992, through change 66, August 14, 1995. Our calculations considered other insurance and third party payments, correct allowable amounts, and beneficiary deductible and copayment amounts.

Statistical Sampling Methodology

The following statistical sampling methodology was used during the audit.

Sampling Plan

Sampling Purpose. The purpose of the statistical sampling plan was to estimate the numbers and dollar values of overpaid, undocumented, and unsupported claims made by CHAMPUS providers and the numbers and dollar values of the claims to CHAMPUS beneficiaries.

Universe Represented. The original audit universe was defined as payments to CHAMPUS providers for FY 1993 outpatient services in 120 U.S. catchment areas as of February 1994. However, due to limited resources and access to the data that needed to be reviewed, we reviewed only the catchment areas in the southeast region.

Sampling Design. A three-stage sample design was used to estimate the numbers and dollar values of overpaid, undocumented, and unsupported claims made by CHAMPUS providers and the numbers and dollar values of the claims to CHAMPUS beneficiaries. Of the 120 catchment areas, 24 were selected for review. In the first stage of the design, we stratified the catchment areas into three strata and selected the catchment areas, using a simple random sample without replacement. Because of limited resources and access to data, we limited the number of catchment areas reviewed to 6 southeastern region catchment areas of the 24 catchment areas originally selected to be reviewed. In the second stage of the design, the providers were selected within catchment areas. We divided the providers into two strata and selected them using a simple random sample with replacement within each strata. In the third stage of the sample design, we selected claims within the sampled providers. The claims were selected using a simple random sample without replacement. Although the original weights were applied in calculating the projections, they represent the southeast region only.

Sampling Results

Statistical projections of the sample data at the 90-percent confidence level are as follows.

Table A-1. Projected Number of Overpaid, Undocumented, or Unsupported Claims for Providers in the Southeast Region

	Lower Bound	Point Estimate	Upper Bound
Overpaid Claims	18,906	65,966	113,026
Undocumented Claims	27,943	77,053	126,163
Unsupported Claims	35,256	94,291	153,326

We are 90 percent confident that the total number of overpaid claims lies between 18,906 and 113,206, undocumented claims lies between 27,943 and 126,163, and unsupported claims lies between 35,256 and 153,326.

Table A-2. Projected Dollar Value (Millions) of Overpaid, Undocumented, and Unsupported Claims for Providers in the Southeast Region

	Lower Bound	Point Estimate	Upper Bound
Overpaid Claims	$2.511	$8.480	$14.450
Undocumented Claims	2.782	7.723	12.665
Unsupported Claims	1.207	3.188	5.169

We are 90 percent confident that the total value of overpaid claims lies between $2.511 million, and $14.450 million, undocumented claims lies between $2.782 million and $12.665 million, and unsupported claims lies between $1.207 million and $5.169 million.

Table A-3. Projected Number of Overpaid, Undocumented, and Unsupported Claims for Providers in the Southeast Region for Beneficiaries

	Lower Bound	Point Estimate	Upper Bound
Overpaid Claims	15,715	53,853	91,991
Undocumented Claims	17,868	51,551	85,234
Unsupported Claims	30,118	85,420	140,722

We are 90 percent confident that the total number of overpaid claims lies between 15,715 and 91,991, undocumented claims lies between 17,868, and 85,234 and unsupported claims lies between 30,118, and 140,722.

Table A-4. Projected Dollar Value (Millions) of Overpaid, Undocumented, and Unsupported Claims for Providers in the Southeast Region for Beneficiaries

	Lower Bound	Point Estimate	Upper Bound
Overpaid Claims	$0.574	$2.261	$3.947
Unsupported Claims	0.070	0.505	0.940

We are 90 percent confident that the total value of overpaid claims lies between $0.574 million and $3.947 million and unsupported claims lies between $0.070 million and $0.940 million. There is insufficient statistical evidence to adequately project undocumented claims dollars for beneficiaries.

Management Control Program

DoD Directive 5010.38, "Internal Management Control Program," April 14, 1987, requires DoD organizations to implement a comprehensive system of management controls that provide reasonable assurance that programs are operating as intended and to evaluate the adequacy of the controls.

Management Controls Assessed. We reviewed OCHAMPUS implementation of the management control program as it applied to the processing and payment of provider claims.

Adequacy of Controls. The audit identified material management control weaknesses as defined by DoD Directive 5010.38. Management controls were not adequate to ensure that excessive costs were not incurred due to submission of unsupported claims and payment of claims in excess of established allowable amounts. Recommendations, if implemented, will correct the identified weaknesses. Appendix C summarizes the potential benefits associated with correcting the material management control weaknesses. A copy of the final report will be provided to the senior official responsible for management controls within the Office of the Secretary of Defense and OCHAMPUS.

Adequacy of Management's Self-evaluation. OCHAMPUS had implemented a management control program covering all aspects of operations. Vulnerability assessments and management control reviews applicable to processing and payment of CHAMPUS claims are performed by the fiscal intermediaries. Management control weaknesses and recommendations are reported to OCHAMPUS and are tracked by the OCHAMPUS Program Integrity Branch. Management control weaknesses identified in this report were not identified by management control reviews because validation of medical documentation supporting provider claims was not covered in the assessable unit for claims processing.

Appendix B. Definitions

CPT Codes

Code	Definition
71020	Radiological examination, chest, single view, frontal
71260	Computerized axial tomography, thorax, with contrast material
78306	Nuclear medicine, bone and or joint imaging, whole body
78890	Generation of automated data: interactive process involving nuclear physician and/or allied health professional personnel; simple manipulations and interpretation, not to exceed 30 minutes
78990	Provision of diagnostic radionuclide
90843	Individual psychotherapy approximately 20 to 30 minutes
90844	Individual psychotherapy approximately 45 to 50 minutes
90862	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
99212	Office or other outpatient visit for evaluation and management of an established patient, which requires two of three components: a problem focused history, a problem focused examination, or straightforward medical decisionmaking.
99213	Office or other outpatient visit for evaluation and management of an established patient, which requires two of three components: a problem focused history, a problem focused examination, or low complexity medical decisionmaking.
99214	Office or other outpatient visit for evaluation and management of an established patient, which requires two of three components: a detailed history, a detailed examination, or moderate complexity medical decisionmaking.
99215	Office or other outpatient visit for evaluation and management of an established patient, which requires two of three components: a comprehensive history, a comprehensive examination, or high complexity medical decisionmaking.

Nature of Presenting Problem

A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. The five types of presenting problems are:

Minimal - problem that may not require the presence of the physician, but service is provided under the physician's supervision.

Self-limited - problem that runs a definite and prescribed course, is short in nature and is not likely to permanently alter health status; or it has a good prognosis with management/compliance.

Low severity - problem where the risk of continued ill health without treatment is low; there is little to no risk of mortality without treatment; and full recovery without functional impairment is expected.

Moderate severity - problem where the risk of continued ill health without treatment is moderate; there is moderate risk of mortality without treatment; and uncertain prognosis or increased probability of prolonged functional impairment.

High severity - problem where the risk of continued ill health without treatment is high to extreme; and there is a moderate to high risk of mortality without treatment or high probability of severe prolonged functional impairment.

Levels of Patient History

Problem focused - chief complaint; brief history of present illness or problem.

Expanded problem focused - chief complaint; brief history of present illness; problem pertinent system review.

Detailed - chief complaint; extended history of present illness; extended system review; pertinent past family and/or social history.

Comprehensive - chief complaint; extended history or present illness; complete system review; complete past, family and social history.

Levels of Examination

Problem focused - an examination that is limited to the affected body area or organ system.

Expanded problem focused - an examination of the affected body area or organ system and other symptomatic or related organ systems.

Detailed - an extended examination of the affected body area(s) and other symptomatic or related organ system(s).

Comprehensive - a complete single system specialty examination or a complete multi-system examination.

Levels of Medical Decisionmaking

Four types of medical decisionmaking are recognized. To qualify for a given type of decisionmaking, two of three elements must be met or exceeded:

Straight forward - minimal number of diagnoses or management options; minimal amount and complexity of data to be reviewed; or minimal risk of complications, morbidity, or mortality.

Low complexity - limited number of diagnoses or management options; limited amount and complexity of data to be reviewed; or low risk of complications, morbidity, or mortality.

Moderate complexity - multiple number of diagnoses or management options; moderate amount and complexity data to be reviewed; or moderate risk of complications, morbidity, or mortality.

High complexity - extensive number of diagnoses or management options; extensive amount and complexity of data to be reviewed; or high risk of complications, morbidity, or mortality.

Appendix C. Summary of Potential Benefits Resulting From Audit

Recommendation Reference	Description of Benefit	Amount and Type of Benefit
A.1., A.2., and A.3.	Improved management controls over the validity of claims paid by CHAMPUS fiscal intermediaries. CHAMPUS cost avoidance.	Funds put to better use for the Defense Health Program Appropriation for FYs 1997 through 2002 are estimated at $65.4 million.
B.1. and B.2.	Improved management controls over payment of institutional provider claims for outpatient services. CHAMPUS cost avoidance.	Funds put to better use for the Defense Health Program Appropriation for FYs 1997 through 2002 are estimated at $51 million.

Appendix D. Organizations Visited or Contacted

Office of the Secretary of Defense

Office of the Assistant Secretary of Defense (Health Affairs)
Director, Office of the Civilian Health and Medical Program of the Uniformed Services, Aurora, CO

Department of the Army

Headquarters, U.S. Army Medical Command, Fort Sam Houston, TX
Noble Army Community Hospital, Fort McClellan, AL

Department of the Navy

Office of the Chief, Bureau of Medicine and Surgery/Surgeon General, Washington, DC
Naval Hospital Jacksonville, Naval Air Station, Jacksonville, FL
Naval Hospital Orlando, Naval Training Center, Orlando, FL

Department of the Air Force

Office of the Surgeon General of the Air Force, Bolling Air Force Base, Washington, DC
45th Medical Group Hospital, Patrick Air Force Base, FL
96th Medical Group Hospital, Eglin Air Force Base, FL
653rd Medical Group Hospital, Robins Air Force Base, GA

Non-Government Organizations

Wisconsin Physicians Service, Madison, WI
Various civilian health care providers

Appendix E. Report Distribution

Office of the Secretary of Defense

Under Secretary of Defense (Comptroller)
  Deputy Chief Financial Officer
  Deputy Comptroller (Program/Budget)
Assistant Secretary of Defense (Health Affairs)
  Director, Office of the Civilian Health and Medical Program of the Uniformed Services
Assistant to the Secretary of Defense (Public Affairs)
Director, Defense Logistics Studies Information Exchange

Department of the Army

Auditor General, Department of the Army

Department of the Navy

Assistant Secretary of the Navy (Financial Management and Comptroller)
Auditor General, Department of the Navy

Department of the Air Force

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

Defense Organizations

Director, Defense Contract Audit Agency
Director, Defense Logistics Agency
Director, National Security Agency
  Inspector General, National Security Agency

Non-Defense Federal Organizations and Individuals

Office of Management and Budget
General Accounting Office
National Security and International Affairs Division
Technical Information Center
Health, Education, and Human Services

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 National Security, Committee on Appropriations
House Committee on Government Reform and Oversight
House Subcommittee on National Security, International Affairs, and Criminal Justice, Committee on Government Reform and Oversight
House Committee on National Security

Audit Team Members

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