BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Performance Of CHAMPUS Fiscal Intermediaries Needs Improvements

Several years ago the Department of Defense converted its contracts with fiscal intermediaries under the Civilian Health and Medical Program of the Uniformed Services from a cost-reimbursable to a fixed-price basis, in which a set fee is paid for each claim processed. While administrative savings have been achieved under these competitively bid, fixed-price contracts, performance has been less than satistactory.

Fiscal intermediaries have made incorrect and questionable payments and have generally not met contract standards for providing services to beneficiaries. Also, systems have not been established to adequately monitor and enforce these contracts.

This report evaluates the performances of selected fiscal intermediaries under fixed-price contracts and the administration of these contracts; it also contains recommendations for their improvement.

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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

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To the President of the Senate and the
Speaker of the House of Representatives

This report discusses the performance of fiscal intermediaries in processing claims and providing other services under the Department of Defense's Civilian Health and Medical Program of the Uniformed Services.

We are sending copies of this report to the Director, Office of Management and Budget; the Secretary of Defense; and other interested parties.

Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

PERFORMANCE OF CHAMPUS FISCAL INTERMEDIARIES NEEDS IMPROVEMENT

D I G E S T

Claims under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) are processed by fiscal intermediaries under competitively bid, fixed-price contracts with the Department of Defense (DOD). In fiscal year 1980, fiscal intermediaries processed approximately 3.8 million claims totaling $701.2 million in benefit payments, for which they received about $23.3 million in administrative payments. Benefit payments in fiscal year 1981 are expected to total about $809.4 million.

Starting in 1976, cost-reimbursable contracts, under which fiscal intermediaries were paid for whatever costs they incurred in processing claims, were phased out in favor of competitively bid contracts, under which the intermediaries are paid a fixed price per claim processed. In the first year the fixed-price contracts were used, the change in contracting resulted in administrative cost savings of about $7.6 million, and as of early 1980, the number of fiscal intermediaries was reduced from nearly 100 to 9.

However, since the conversion to fixed-price contracts, many beneficiaries and providers have complained about poor service by the fiscal intermediaries. Also, concern exists that under fixed-price contracts intermediaries may have an incentive to process claims quickly rather than administer benefits accurately, thereby minimizing their claim processing costs but increasing benefit costs of the program. For these reasons and because Members of Congress expressed concern about the performance of specific intermediaries, GAO reviewed

the performance under competitively bid, fixed-price contracts of five intermediaries that process over 80 percent of CHAMPUS claims.

The review showed that fiscal intermediaries were not fulfilling many of their contractual responsibilities. In addition, the Office for CHAMPUS, which administers the program, did not have adequate means to measure performance and enforce requirements.

Improvements were needed in

--the accuracy of administering benefits in order to comply more fully with CHAMPUS regulations, instructions, and policies;

--the systems established for controlling and containing costs;

--the services to beneficiaries and providers in processing claims, correspondence, and appeals; and

--the management of funds covering benefit and administrative costs.

Since the period covered by GAO's review, fiscal intermediaries and the Office for CHAMPUS have made some changes in their operations that may improve performance.

BENEFITS NEED TO BE ADMINISTERED MORE ACCURATELY

Analysis of a statistical sample of 1,335 claims disclosed errors in processing 571 claims (43 percent), involving incorrect payments, questionable payments, or other violations of CHAMPUS requirements.

Incorrect payments included payments for services not covered, payments when other insurance had already paid, and payment errors resulting from inaccurate application of deductibles and cost shares. Questionable payments--those made without adequate

information to determine that CHAMPUS had an obligation to pay--included failing to follow up when other insurance was indicated but details of the other insurance were not known, payment for treatment unrelated to the diagnosis, and payment for services without performing utilization or peer review at required intervals. Other errors, such as payment of claims without proper signatures, involved little likelihood that the payments were incorrect but violated CHAMPUS requirements.

GAO estimates, with a 90-percent confidence level, that for a 2-month period the five fiscal intermediaries made incorrect payments of from $4.1 million to $9.3 million and questionable payments of $7.1 million to $18.8 million. About 250,000 claims were paid by the five intermediaries during the 2-month period for which GAO's estimates were made. These represented about 11 percent of the total claims paid annually by CHAMPUS. (See pp. 9 to 11.)

SYSTEMS FOR CONTROLLING BENEFITS NEED IMPROVEMENT

Some fiscal intermediaries had not established effective systems to support claim processing functions. For example:

--Systems for utilization and peer review, which include review by a practitioner's peers to determine if services provided are necessary and conform to generally accepted standards, usually did not meet CHAMPUS requirements. For example, only one of the fiscal intermediaries GAO reviewed was performing peer review of psychiatric outpatient visits after the 8th, 24th, and 60th sessions as CHAMPUS requires. (See pp. 43 to 48.)

--Fiscal intermediaries have generally not adopted systems for detecting medically unnecessary services or hospital admissions

for diagnostic purposes, although such services are specifically excluded from coverage by the CHAMPUS regulation. Consequently, claims were paid for procedures that appeared medically unnecessary, claims were not reviewed for possible diagnostic admissions, and lengths of hospital stay were not reviewed. (See pp. 48 to 52.)

--Inpatient stays will generally result in both hospital and professional claims. If one type of claim requires rejection, the other type of claim for the same episode of care sometimes also requires rejection. The fiscal intermediaries generally had not developed adequate systems for coordinating review of such claims. For example, analysis of 74 rejected claims that had corresponding claims also requiring rejection showed that, in 19 cases (26 percent), the corresponding claims were not rejected, resulting in over $13,600 in improper payments. (See pp. 52 to 54.)

SERVICES TO BENEFICIARIES AND PROVIDERS NEED TO BE IMPROVED

Under the contracts GAO reviewed, fiscal intermediaries were not meeting CHAMPUS performance standards in such areas as prompt processing of claims, prompt handling of appeals of adverse decisions on claims, and prompt replies to inquiries and complaints. None of the intermediaries was close to achieving the standard of 21 days for processing routine claims. Performance ranged from 48 percent (130 of 272 claims sampled) to 2 percent (6 of 265 claims sampled) processed in 21 days. (See pp. 63 to 69.)

Only one fiscal intermediary had an average processing time that met the standards of 21 days for processing informal reviews (the first appeal level) and 30 days for reconsiderations (the second appeal level). For all five intermediaries, the range was 17

to 78 days for informal reviews and 13 to 80 days for reconsiderations. (See pp. 69 to 72.)

Reports submitted by fiscal intermediaries to be used by the Office for CHAMPUS to monitor performance were frequently not in the proper format or in sufficient detail to permit comparison of performance to standards. Some reports also contained inaccurate information. (See pp. 64, 71, and 76.)

FINANCIAL MANAGEMENT PRACTICES IN NEED OF IMPROVEMENT

Fiscal intermediaries had large outstanding balances of CHAMPUS funds in their bank accounts because of the method the Office for CHAMPUS used to advance funds and because intermediaries did not promptly return overpayments recovered from providers and beneficiaries. Consequently, the Government unnecessarily incurred interest costs because of Treasury borrowing necessitated by having these funds outstanding. GAO estimates that net balances held by three intermediaries alone could cost the Government about $1.1 million annually in interest expense.

Several fiscal intermediaries had large backlogs of adjustments to make resulting from the recovery of overpayments. One had amassed a backlog of $4.7 million in adjustments, and another $6.6 million. After GAO's review, the Office for CHAMPUS reviewed cash balances held by all the fiscal intermediaries and recovered over $19 million in excess funds. (See pp. 85 to 88.)

In certain situations, fiscal intermediaries need to adjust a previously processed claim. Generally, if the adjustment is required because of intermediary error, the intermediary is not entitled to additional compensation for processing the adjustment. Because two of

the intermediaries assigned improper computer codes to adjustment actions caused by their errors, they received excess payments for processing claims. One was receiving at least $11,100 a month in such excess payments. (See p. 91.)

In certain situations, claims can be split into two or more claims, and the fiscal intermediary receives reimbursement for processing each portion. Two of the intermediaries reviewed were splitting claims improperly, resulting in their receiving excessive reimbursement from the Office for CHAMPUS. (See pp. 91 and 92.)

Fiscal intermediaries are reimbursed a fixed rate for each claim processed on the basis of claims data on computer tapes periodically sent to the Office for CHAMPUS. Frequently, however, the Office incorrectly computed the number of claims on the tape, which has resulted in significant overpayments. For example, one intermediary received a net overpayment of about $25,000 for a 21-month period, and another received overpayments of about $89,000 for a 12-month period. (See p. 92.)

RECOMMENDATION TO THE CONGRESS

To prevent financial gain by beneficiaries as a result of double health insurance coverage, reduce CHAMPUS costs, and administer the program consistently for all categories of beneficiaries, the Congress should enact legislation requiring that no benefits be payable for dependents of active-duty members when the benefit claimed is payable under another insurance plan, obtained by employment or law, in which the beneficiary is covered.

RECOMMENDATIONS TO THE SECRETARY OF DEFENSE

GAO made 22 recommendations to the Secretary to improve specific aspects of CHAMPUS administration. (See pp. 40, 60, 84, and 93.)

DOD AND FISCAL INTERMEDIARY COMMENTS

DOD and the five fiscal intermediaries generally agreed with GAO's findings, and DOD agreed with all but three of the recommendations. (See pp. 41 and 61.) DOD and the intermediaries have already taken or planned a number of actions to improve conditions discussed in the report. (See apps. I to VI.)

Several fiscal intermediaries attributed the high incidence of claim errors and poor beneficiary services to the many changes made to CHAMPUS in recent years. Changes cited included the changeover to fixed-price contracting and the resulting increases in claims to be processed by a reduced number of intermediaries, multiple changes in program regulations, and changes in program direction from the Office for CHAMPUS.

Fiscal intermediaries stated that recent Office for CHAMPUS administrative actions have resulted in improved administrative and beneficiary services. According to DOD, it recognized the problems GAO found and took steps to reorganize and change key management personnel at the Office for CHAMPUS to improve overall program management. (See apps. I to IV.)

Contents

ABBREVIATIONS

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DOD	Department of Defense
FEHB	Federal Employees Health Benefits
FI	fiscal intermediary
GAO	General Accounting Office
OCHAMPUS	Office for the Civilian Health and Medical Program of the Uniformed Services
RFP	request for proposal

CHAPTER 1

INTRODUCTION

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) helps pay for medical care provided by civilian hospitals, physicians, and other civilian providers to dependents of active-duty members, retirees and their dependents, and the dependents of deceased members of the uniformed services. The uniformed services covered by CHAMPUS are the Army, Navy, Air Force, Marine Corps, Coast Guard, and Commissioned Corps of the Public Health Service and the National Oceanic and Atmospheric Administration.

Medical care claims for services provided to beneficiaries are processed and paid by private organizations, generally referred to as fiscal intermediaries (FIs), under contract with the Department of Defense (DOD). For fiscal year 1980, FIs processed about 3.8 million CHAMPUS claims, for which they were reimbursed about $23.3 million in administrative payments. Government payments for program benefits totaled $701.2 million. Fiscal year 1981 benefit costs are expected to total about $809.4 million.

In 1976 DOD began converting to competitive fixed-price contracts and reducing the number of FIs processing claims under the program. The contracts provide for a fixed price to be paid for each claim processed to completion. Previously, contracts were awarded on a cost-reimbursable basis, under which FIs were paid for all costs associated with processing CHAMPUS claims. At the time of cost-reimbursable contracting, nearly 100 FIs processed CHAMPUS claims. This number has now been reduced to nine. The conversion to competitive fixed-price contracting and the reduction in the number of FIs resulted in administrative cost savings of about $7.6 million in the first full year of the contracts.

However, since the conversion to fixed-price contracts, many beneficiaries and providers have complained about poor service provided by FIs in such areas as timeliness of claim processing and proper determination of benefit payments. Concern has also been expressed that under fixed-price contracts, FIs, instead of exercising adequate control over benefit payments, may be keeping administrative costs low to be more competitive but increasing benefit costs. Benefit payments represent about 96 percent of total program costs.

For these reasons and because Members of Congress have expressed concern regarding the performance of specific FIs that their constituents have complained about, we reviewed the performance of five FIs under the competitively bid, fixed-price contracts.

PROGRAM BENEFITS AND BENEFICIARIES

CHAMPUS originated in 1956 with the enactment of the Dependents' Medical Care Act (Public Law 84-569), and additional benefits and beneficiaries were included by the Military Medical Benefit Amendments of 1966 (Public Law 89-614). Under the basic portion of the program, CHAMPUS benefits are similar to those provided by comprehensive medical insurance plans, such as the high-option Government-wide Service Benefit Plan for Federal employees administered by Blue Cross and Blue Shield. The wide range of benefits under the basic portion of the program covers both inpatient and outpatient medical care. Included are such services as surgery, hospitalization, outpatient prescription drugs, clinical laboratory tests, and office visits. In addition to the basic program, a special program for the handicapped provides benefits to dependents of active-duty members for rehabilitative services and care for moderate or severe mental retardation or serious physical handicap.

CHAMPUS beneficiaries--unlike subscribers under most medical care programs--do not pay premiums, but pay only when medical services are obtained. The costs for services are shared by the Government and the beneficiary. Inpatient care costs dependents of active-duty members a total of $25, or $5 per day, whichever is greater; other beneficiaries pay 25 percent of total charges. For outpatient care, each beneficiary pays a deductible of $50 ($100 maximum deductible for each family) each fiscal year, after which dependents of active-duty members pay 20 percent and other beneficiaries pay 25 percent of remaining charges.

Cost sharing under the program for the handicapped is different; depending on their rank, active-duty members pay a specified monthly amount, ranging from $25 to $250, and the Government pays remaining charges up to $350 a month. Monthly charges exceeding these amounts are the responsibility of the active-duty member.

Each branch of the uniformed services is responsible for controlling and issuing eligibility identification cards to CHAMPUS beneficiaries. The categories of beneficiaries eligible for CHAMPUS are

--spouses of active-duty members and retirees;

--members receiving or entitled to receive retired, retainer, or equivalent pay based on duty in the uniformed services (retirees);

--children of active-duty members and retirees;

--children of deceased active-duty members and deceased retirees; and

--unremarried widows and widowers of deceased active-duty members and deceased retirees.

Active-duty members are not eligible for CHAMPUS. Retirees and other beneficiaries lose CHAMPUS eligibility upon reaching age 65 and becoming eligible for Part A of Medicare. Children lose eligibility upon passing their 21st birthday unless they are enrolled in an institution of higher learning or have a mental or physical incapacity that renders them incapable of self-support.

PROGRAM ADMINISTRATION

The program is administered by the Office for the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS), located at Fitzsimons Army Medical Center near Denver, Colorado. OCHAMPUS is a field activity under the policy guidance and operational direction of the Assistant Secretary of Defense (Health Affairs).

OCHAMPUS solicits FIs for processing and paying claims through requests for proposals (RFPs), which outline the services required and invite contractors to submit technical proposals describing how they will provide the services and at what cost. The technical proposal OCHAMPUS accepts with the completed RFP becomes the contract. The contracts are for 1 year with an option to extend for 2 additional years. Major responsibilities of FIs include:

--Processing all CHAMPUS claims accurately and timely in accordance with existing regulations, policies, and instructions.

--Processing all correspondence in a timely and effective manner.

--Providing for a formal appeals process.

--Informing CHAMPUS beneficiaries and providers of regulations, policies, and billing procedures.

--Providing program materials upon request.

--Providing management and administrative information by submitting accurate and timely reports.

--Receiving, disbursing, adjusting, and accounting for program funds.

FIs pay claims submitted by hospitals, physicians, and other health care providers for services provided to beneficiaries or reimburse beneficiaries directly if they submit claims. OCHAMPUS advances funds to FIs to pay benefits. Administrative expenses are paid to FIs at the fixed-rate price after they completely process the claims, including passing them through an edit process at OCHAMPUS.

OCHAMPUS monitors FI performance through reports they submit and reviews performed by an OCHAMPUS contract performance evaluation team. This team is responsible for evaluating FIs' operations to assure compliance with CHAMPUS regulations and for recommending management improvements. Visits to FIs are made about twice a year and last about 1 week each. Special visits are also made when FIs are having problems.

Conversion to fixed-price contracting

When CHAMPUS converted to fixed-price contracting, it combined under single contracts the processing of both physician and hospital claims. Except for a few instances, under the previous cost-reimbursement contracting method, one FI processed either hospital or physician claims and then for only one State or portion of a State. The large number of FIs precluded OCHAMPUS from taking full advantage

of economies of scale associated with processing large volumes of claims.

Also, the former cost-reimbursable contracts contained no incentives for FIs to process claims efficiently or economically. Instead, FIs were fully reimbursed for all costs incurred in claim processing. Our past reports 1/ showed that, under cost-reimbursable contracts, the costs per claim and efficiency of operations varied widely among FIs. For example, during April 1975 to March 1976 the cost per claim among FIs ranged from $3.50 to $38.40.

The first fixed-price, competitively bid contract was awarded in February 1976, and all contracts were converted to fixed price by April 1978. As of December 31, 1979, nine FIs had been awarded 25 contracts. In addition to the nine present CHAMPUS FIs, nine others have held fixed-price contracts since 1976 but have either dropped out of the program or been terminated for poor performance.

Current FIs

Shown below are the nine current FIs and the volume of claims they processed in calendar year 1979.

1/"Analysis of Variations in Claim Processing Costs of Fiscal Agents for the Civilian Health and Medical Program of the Uniformed Services" (HRD-77-93, June 8, 1977).

"Management of the Civilian Health and Medical Program of the Uniformed Services Needs Improvement" (MWD-76-48, Nov. 21, 1975).

FI (note a)	Claims processed (note b)	Percent of total program
Blue Shield of California	1,224,100	34.6
Mutual of Omaha Insurance Co.	787,100	22.4
Wisconsin Physicians Service	436,600	12.3
Blue Cross of Southwestern Virginia	436,500	12.3
Hawaii Medical Service Association	46,000	1.3
Blue Cross of Washington-Alaska	217,600	6.1
Pennsylvania Blue Shield	139,200	3.9
Blue Cross of Rhode Island	135,400	3.8
Blue Cross and Blue Shield of Tennessee	97,300	2.7

a/In addition, DOD employees in Heidleberg, Germany, process claims from Europe, Africa, and the Middle East which totaled 22,200 claims, or 0.6 percent of calendar year 1979 claims.

b/Includes both paid and rejected claims.

OBJECTIVES, SCOPE, AND METHODOLOGY

To determine their performance under fixed-price contracts, we reviewed the first five FIs listed above, which processed over 80 percent of the CHAMPUS claims in 1979. We selected the FIs for review on the basis of not only size, but also diversity of claim processing operations. To assess FI performance, we reviewed the (1) accuracy of administration of program benefits, (2) systems for control and protection of Government funds in claim processing, (3) services provided beneficiaries and providers, (4) efforts made in beneficiary and provider education, and (5) controls over receipt and disbursement of program funds.

We reviewed the applicable CHAMPUS laws and the CHAMPUS regulation, manuals, instructions, and interpretations that provide guidance for FIs. We also reviewed CHAMPUS contracts with FIs and the related technical proposals that become part of the contract and further describe FI responsibilities. Using information contained in the above documents as criteria, we reviewed FIs' performance in relation to their responsibilities.

In reviewing the accuracy of administration of CHAMPUS benefits and performing related tasks in measuring performance, we gathered information pertaining to selected contracts awarded the five FIs. To determine whether claim processing systems required by contracts had been implemented and whether these systems were adequate to meet CHAMPUS standards and other requirements, we selected contracts that had been in effect for some time (the Hawaii Medical Service Association contract had recently been negotiated but was basically an extension of a previous contract). These contracts were:

FI	Contract number	States covered by the contract
Blue Cross of Southwestern Virginia	MDA 906-77-D-0018	Virginia, District of Columbia
Blue Shield of California	MDA 906-78-D-0006	Arizona, California, Nevada, New Mexico
Hawaii Medical Service Association	MDA 906-79-D-0019	Hawaii
Mutual of Omaha Insurance Company	MDA 906-78-D-0007	Texas
Wisconsin Physicians Service	MDA 906-78-D-0008 MDA 906-78-D-0002	Arkansas, Illinois, Wisconsin

We interviewed FI personnel and reviewed policies, procedures, reports, financial records, and bank statements.

To measure the accuracy of benefit administration, we took a statistical sample from a universe of 250,000 claims paid by the five FIs reviewed and processed at OCHAMPUS in

January and February 1979. We extracted the sample using OCHAMPUS computer tapes and computer programs and designed it to estimate at a 90-percent confidence level with an expected precision rate of 3 percent when applied to the sample universe. We used a number of other nonstatistical samples in reviewing correspondence and appeals.

We also performed work at OCHAMPUS, which included reviewing the criteria developed for measuring FI performance, determining means used in monitoring performance, interviewing OCHAMPUS officials, and following up on findings of the OCHAMPUS contract performance evaluation team.

CHAPTER 2

BENEFITS NEED TO BE ADMINISTERED MORE ACCURATELY

OCHAMPUS fixed-price contracts require that claims be processed accurately and in accordance with regulations, policies, and instructions established by DOD and OCHAMPUS. Our examination of claims showed that FIs made many errors involving significant amounts of incorrect and questionable payments. Errors made in processing claims were caused by a combination of system problems, clerical mistakes, and FIs' failures to adopt OCHAMPUS requirements.

Because OCHAMPUS did not have complete data available on accuracy of claim processing under previous cost-reimbursement contracts, we were unable to compare performance with that under fixed-price contracts. However, OCHAMPUS recently drafted a new contract, which it plans to have in effect early in 1981, that provides new standards for claim processing accuracy and proposes a statistical sampling plan for determining error rates. We believe that these and other improvements, if properly administered and managed, can lead to higher standards of claim processing accuracy under fixed-price contracts.

Our review of a statistical sample of claims processed under selected contracts by five of the nine CHAMPUS FIs showed that 571 (43 percent) of the 1,335 claims sampled contained one or more errors involving incorrect payments, questionable payments, or other significant violations of OCHAMPUS processing requirements. Payment errors included overpayments and underpayments and errors involving deductibles. Projecting the incorrect and questionable payments to the total claims processed by the five selected FIs during a 2-month period under selected contracts, we found that payments totaling between $4.1 million and $9.3 million were incorrect and payments totaling between $7.1 million and $18.8 million were questionable. The universe of claims under the selected contracts to which the incorrect and questionable payments were projected represents about 11 percent of the total claims paid annually under CHAMPUS.

SUMMARY OF CLAIM PROCESSING ERRORS

We examined 1,335 claims processed by the five FIs. Of these claims, 571 contained 746 errors. Projecting to the universe of 250,000 claims processed during the 2-month period, we estimate, with a 90-percent confidence level and a precision rate of ±6.2 percent, that errors were made on 130,200 claims. The following table shows the number and general types of errors we found.

Type of error	Incorrect payments	Questionable payments	Other processing errors	Total errors
Benefits not properly coordinated with other insurance	30	122	26	178
Nonavailability statements and emergency certifications not obtained	25	5	0	30
Services not covered	60	113	7	180
Incorrect application of reasonable charges, deductibles, and cost shares	77	3	2	82
Eligibility not verified and acceptance of improper signatures	16	4	256	276
	208	247	291	746

We classified "incorrect payments" as those where claims or portions thereof were paid in violation of CHAMPUS requirements and the payments could be definitely determined to be in error. Incorrect payments included such errors as payments made when other insurance had already paid, payments without required nonavailability statements, payments for noncovered services, and payment errors resulting from inaccurate application of deductibles and cost shares.

We defined "questionable payments" as those in which the FI violated a CHAMPUS requirement and made payment without adequate information to determine if CHAMPUS had an obligation to pay. Questionable payments included such errors as failing to follow up when other insurance was indicated but details on the other insurance were not obtained, payment for treatment unrelated to the diagnosis, and payment for services without performing utilization or peer reviews at required intervals.

We defined as "other processing errors" those that violated CHAMPUS requirements but had little likelihood of affecting the correctness of the payment. Most claims with other processing errors involved payments where the signature of the patient or other responsible person was not obtained.

Although our sample sizes at each of the FIs were roughly equal, the number of sample claims containing errors ranged from 18 paid by Hawaii Medical Service Association to 154 claims paid by Blue Cross of Southwestern Virginia. The total volume of claims processed by Hawaii Medical Service Association is much less than that of the other four FIs reviewed, and Hawaii's claim processing system depended heavily on manual processing, whereas the other four FIs had highly automated systems.

The following table shows the number and categories of errors on claims paid by each FI reviewed.

FI	Number of claims sampled	Number of sample claims with errors	Percent of sample claims with errors	Number of incorrect payments	Number of questionable payments	Other processing errors	Total errors
Blue Cross of Southwestern Virginia	267	154	57.7	73	66	82	221
Blue Shield of California	272	151	55.5	54	87	60	201
Hawaii Medical Service Association	257	18	7.0	8	6	3	17
Mutual of Omaha Insurance Company	269	116	43.1	20	41	74	135
Wisconsin Physicians Service	270	132	48.9	53	47	72	172
	1,335	571	42.8	208	247	291	746

All of the errors were discussed with FI officials, who generally agreed with our determinations.

Detailed information on the types of errors we found are discussed in the following sections.

SIGNIFICANT COSTS BEING INCURRED UNNECESSARILY BECAUSE OF INADEQUATE COORDINATION OF BENEFITS

Coordinating CHAMPUS benefits with other insurance is a major problem. FIs made CHAMPUS payments on claims that had previously been reimbursed by other insurance or for which information showed other insurance was the primary payor. Also, other claims were paid when other insurance was indicated; however, the FI paid the claim without obtaining adequate assurances that CHAMPUS was the primary payor. In addition, claims involving possible third-party liability and workmen's compensation were not all identified by the FIs.

Sample results projected to the universe of claims show that the five FIs erroneously paid between $626,000 and $5.1 million during the 2-month period that other insurance had already paid or for which other insurance was supposed to be the primary payor. In addition, questionable payments of between $3.8 million and $9.0 million were made during this same 2-month period for which other insurance, third-party liability, or workmen's compensation was indicated but was not pursued by the FI.

The following table shows the number and types of coordination of benefits errors noted on sample claims.

Type of error	Incorrect payments	Questionable payments	Other processing errors	Total errors
CHAMPUS claims overpaid because other insurance payments overlooked or other insurance was primary	20	1	2	23
Failure to coordinate other insurance benefits by sending questionnaires as required (note a)	-	73	19	92
Computer files not updated to reject future claims when other insurance questionnaire not returned	6	-	-	6
Claim histories showed other insurance payments in the past but no efforts made to determine whether this insurance applied to the sample claim	-	9	1	10
Claims paid without referral to determine possible third-party liability	-	36	3	39
Miscellaneous	4	3	1	8
	30	122	26	178

a/Included in this category are claims from one FI that had not implemented the CHAMPUS requirements for sending questionnaires. (See p. 16.)

Inadequate efforts in coordinating other insurance benefits

CHAMPUS is almost always a secondary payor when a beneficiary has entitlement to other insurance through employment, law, membership in an organization, or student status. Insurance that is privately purchased is not considered as double coverage, and full CHAMPUS benefits are payable. Coordinating benefits with other insurance is extremely important in holding down CHAMPUS costs because many CHAMPUS beneficiaries are enrolled in other insurance and substantial sums of money are often involved. OCHAMPUS informs FIs that about 30 percent of all claims will involve coordination of benefits.

The errors identified in coordinating benefits with other insurance were caused in large part by the inadequate CHAMPUS claim forms. Three types of claim forms are used in the basic program: professional, hospital, and vendor drug. A new professional claim form adopted in July 1978 is a significant improvement over the previous professional form, but CHAMPUS also continues to accept the old form. The hospital, vendor drug, and old professional claim forms each contain two statements to be checked, neither of which provides for a positive response that other insurance exists which is payable. Both questions, directed only at retirees and dependents of retired and deceased members, are applicable only if other insurance is not payable (i.e., the beneficiary is either not enrolled in an insurance plan or enrolled but benefits are not payable under the other plan). If the beneficiary does have other insurance that is payable, the form does not provide for a positive statement to that effect. We recommended in July 1971 that OCHAMPUS revise the claim form to elicit a more informative response as to whether the beneficiary has other insurance. 1/ OCHAMPUS officials informed us at that time that a revised form was being prepared. However, as noted above, only one revised form has been adopted, and this was not done until 1978.

1/"Costs of Physicians and Psychiatric Care--Civilian Health and Medical Program of the Uniformed Services" (B-133142, July 9, 1971).

Other insurance payments overlooked or claims paid although other insurance was indicated as primary

FIs made payments on sample claims where other insurance had previously paid all or part of the claim or where CHAMPUS was not the primary payor.

Payments made by other insurance companies before the CHAMPUS claim was filed are shown normally either on the face of the CHAMPUS claim form or on documents submitted supporting the claim. When the other insurance has not yet made payment, beneficiaries sometimes provide information on this insurance either by inserting it on the claim form itself or by attaching documentation to the claim form. The FIs are responsible for examining claims and supporting documentation to determine whether other insurance is payable and, if so, whether other insurance has made payments for services shown on the claim.

Claims examiners often apparently overlooked other insurance payments in processing CHAMPUS claims. For example, on one claim, a hospital showed total charges of $3,017.75, an insurance payment of $2,242.31, and an amount due from CHAMPUS of $775.44. The FI ignored the insurance payment and paid $2,175.04 on allowed charges of $2,972.48, after deducting the patient's cost share of $797.44.

FIs also made payments on claims for which information provided showed that CHAMPUS was not the primary payor. For example, one FI paid seven sample claims for which other insurance was indicated as the primary payor. Voluntary refunds were later received on two of these claims. The same FI also incorrectly paid two additional claims filed on the new professional claim form although other payable insurance through employment was shown on the form.

In another instance, an FI appropriately sought other insurance information but failed to properly follow up when the beneficiary reported other payable insurance. The beneficiary informed the FI that other insurance had paid the physician on all claims filed and that CHAMPUS had also paid the physician. The beneficiary stated that she had asked the physician to return the CHAMPUS funds to the FI or send it to her but the physician had refused, saying the FI would eventually find the error and request it. Despite this

information from the beneficiary, the FI made no attempt to recover funds from the physician. The FI's records show that this physician received over $2,500 from CHAMPUS for services to the beneficiary and other family members in 1978.

Questionnaires on other insurance often not sent

OCHAMPUS started using questionnaires to obtain information on other insurance because the two questions on claim forms did not require a beneficiary to make a positive response that other payable insurance existed. The instructions requiring FIs to send questionnaires to obtain other insurance information were issued in June 1977 and revised slightly in December 1977.

CHAMPUS instructions require that the questionnaire be sent to retirees and their spouses, but not to dependents of active-duty members or dependent children of retirees unless the claim form or other available records indicate other insurance. Claims of persons sent questionnaires are to continue to be paid for 60 days awaiting return of the questionnaires. However, if the questionnaires are not returned within 60 days, claims filed thereafter are to be denied. The questionnaires are to be filed upon receipt of the initial claim from the beneficiary.

One FI had not implemented the questionnaire instructions more than 2 years after the original implementation date but was still negotiating a contract change to cover the extra costs associated with administering the questionnaire. Had the CHAMPUS requirements been implemented, questionnaires would have been required on 35 of the sample claims. The claim history files showed that voluntary refunds totaling $3,078 of CHAMPUS payments were made on 5 of the 35 claims because of other insurance payments. Such voluntary refunds, however, constituted only 28.6 percent of the value of the 35 claims and, had other insurance been pursued, we believe more recoveries would have been made.

Other FIs were only sporadically sending questionnaires. None of the FIs sent the questionnaire with the first claim filed and annually thereafter as required by CHAMPUS instructions. Questionnaires, when they were sent, were sent only when retirees or their spouses checked the box indicating that the beneficiary had other insurance which was not payable.

Computer file not updated to reject claims for questionnaires not returned

One FI that had sent some questionnaires was not systematically updating the computer files to reflect information shown on the questionnaires or to reject future claims when the questionnaires were not returned.

The FI's system required that claims examiners flag the system with the information contained on the questionnaire or enter a flag indicating that the questionnaire had not been returned after the 60-day period. If the questionnaire indicated that other insurance was payable, this information was to be entered into the computer file so that future claims lacking information on the other insurance would be readily identifiable.

The FI sent questionnaires to 12 patients whose claims appeared in our sample. Our review of the claims showed that the computer file was appropriately flagged with the information received in four cases, but in two cases the questionnaire information was not entered in the computer file and in six cases the file was not flagged to indicate the questionnaire had not been returned after 60 days.

Payments made without investigating claims when other insurance has paid

FIs had either not developed systems or their systems were inadequate to investigate claims for which other insurance had previously made payments but for which other insurance coverage was not shown on current claims. Also, in several instances, other insurance made payments after the FI processed claims contained in our sample, but the FI made no effort to determine if this other insurance also covered the sample claims. Based on our observations of savings resulting from proper coordination of benefits, we believe the return on investigating insurance coverage when payments by other insurance have been made far outweigh the costs of such investigations.

To illustrate the problem, a review of claims histories for one FI's sampled claims showed that other insurance had paid for other claims of beneficiaries who submitted 33 of the sample claims. Information concerning the 33 claims indicated that:

--For 4 claims, other insurance was indicated as primary.

--For 19 claims, the individuals submitting the claims said that other insurance existed but was not payable.

--For 6 claims, no other insurance was said to exist.

--For 4 claims, no information on other insurance was submitted.

The FI did not investigate any of the 33 sample claims to determine if other insurance might be applicable to them, even though the beneficiaries submitting them had previously submitted claims for which other insurance was payable.

Another FI had a system of flagging the file for other insurance payments. However, if the beneficiary checked the box indicating no other insurance, even though other insurance had previously made payments, CHAMPUS was considered to be primary, and payment was made without any investigation.

CHAMPUS savings achievable by requiring active-duty dependents to report other insurance

Neither Public Law 84-569 nor Public Law 89-614 requires dependents of active-duty members to report other insurance. Public Law 89-614, however, does require retirees and the dependents of retirees and deceased members to report other insurance obtained through employment or by law. CHAMPUS regulations, published in January 1977, state that double coverage rules for dependents of active-duty members are left to the discretion of the Secretary of Defense. The regulation provides that CHAMPUS benefits, in the absence of another insurance payment already made, will be paid regardless of whether or not other insurance coverage is known to exist. If other insurance is later found to be primary, reimbursement is to be sought from the primary payor; or if payment by the primary payor has already been made, from the provider or beneficiary receiving the payment.

Little information is now obtained on whether dependents of active-duty members are covered by other insurance. The two questions on the CHAMPUS claim forms, other than the new professional form, apply only to retirees and the dependents

of retired and deceased members. Even when dependents of active-duty members check the box intended for retirees and the dependents of retired and deceased members that other nonpayable insurance exists, questionnaires on other insurance are not sent. Dependents of active-duty members are requested to fill out the other insurance information on the new professional claim form, but if not completed, claims were not being returned.

In addition, FIs did not always follow up when other insurance was indicated as the primary payor. For example, a spouse of an active-duty member submitted a claim with supporting documentation showing Blue Cross and Blue Shield coverage. The supporting documents also showed previous payments by this primary payor, but the FI did not attempt to collect from other insurance after making payment on this claim. Claim histories of other dependents of active-duty members also showed past payments by other insurance, but FIs made no attempts to determine if other insurance was payable on later claims.

At one FI, the OCHAMPUS contract performance evaluation team found, in March and October 1979, that procedures had not been implemented for coordination of benefits of active-duty dependents reporting other insurance on CHAMPUS claims.

Possible third-party liability and workmen's compensation claims not being identified

FIs are not identifying, as required by OCHAMPUS, all claims where liability may rest with a third party, automobile insurance, or workmen's compensation rather than CHAMPUS. We noted 39 errors in our sample of claims that either (1) met the criteria used by FIs in identifying such cases but were not pursued or (2) were not covered by the FIs' criteria. Further, FIs were not using consistent criteria in identifying claims for third-party liability or workmen's compensation.

The Federal Medical Care Recovery Act (42 U.S.C. 2651-2653) gives the Government the right to recover amounts expended for services provided a person who is injured or suffers a disease as a result of a third party's negligence. Also, the amounts paid by CHAMPUS for medical care arising from an automobile accident may be subject to recovery under the Federal Claims Collection Act (31 U.S.C. 951, et seq.).

OCHAMPUS also requires that benefits be coordinated in cases where the medical services are covered under any workmen's compensation law.

The CHAMPUS claim forms, other than the new professional claim form, do not include questions that would indicate the cause for the medical condition for which services are claimed. FIs can identify accidents, injuries, and related incidents by screening for International Classification of Diseases diagnostic codes, which indicate medical problems directly arising from accidents, poisonings, and violence.

Some of the errors identified on sample claims occurred because the FIs' criteria excluded certain types of claims and claims under certain dollar values from being screened for third-party liability. For example:

--Blue Cross of Southwestern Virginia excluded all outpatient and professional claims and inpatient hospital claims under $200.

--Blue Shield of California excluded all outpatient claims.

--Wisconsin Physicians Service excluded all outpatient claims and physician inpatient claims.

According to an official at Blue Shield of California, it was not screening outpatient claims because of instructions contained in an outdated CHAMPUS manual and because OCHAMPUS in its performance reviews has not faulted the FI for excluding outpatient claims. OCHAMPUS officials, however, informed us that FIs should be screening both inpatient and outpatient claims and said the Federal Medical Care Recovery Act applies to all types of claims.

Examples of claims where the diagnosis indicated a possible accident but no screening for third-party liability was performed included:

--An inpatient hospital claim with billed charges of $558.50 and a diagnosis of cerebral concussion.

--An inpatient hospital claim with billed charges of $683.70 and a diagnosis of nasal fracture with septal deviation.

--An outpatient professional claim with billed charges of $78 (filed on the new professional claim form with the box checked that the condition was related to an automobile accident) and a diagnosis of a fractured wrist.

--An outpatient hospital claim with billed charges of $108 and a diagnosis of cervical strain.

OCHAMPUS needs to issue more detailed criteria on identifying third-party liability, automobile insurance coverage, and workmen's compensation cases. Also, based on cost-benefit analysis, a minimum dollar value on claims should be established by OCHAMPUS where it is not economical to pursue collection on a case. Finally, the OCHAMPUS contract performance evaluation team needs to increase its surveillance over FIs' systems and procedures to assure that claims meeting CHAMPUS criteria are identified and forwarded in accordance with procedures to appropriate parties for possible recoupment of CHAMPUS funds.

Conclusions

Retirees and dependents of retired and deceased members are required to report other insurance obtained through employment, law, membership in an organization, or student status. We believe that CHAMPUS is incurring substantial additional costs because of lack of such a reporting requirement for dependents of active-duty members and that the Congress should amend the CHAMPUS legislation to impose such a requirement on these beneficiaries.

Dependents of active-duty members should not profit from entitlement to CHAMPUS. If active-duty members' dependents are entitled to insurance through employment, CHAMPUS should not also reimburse beneficiaries for medical services paid by such insurance. CHAMPUS should serve as a secondary payor to pay amounts not covered by other insurance or serve as an alternate should the dependents choose not to enroll in other insurance.

OCHAMPUS needs to replace its old claim forms. Present claim forms, except for the professional form, are inadequate for obtaining needed information on other insurance. Using questionnaires to supplement the claim forms has not worked well because of FIs' failure to use them as OCHAMPUS intended.

OCHAMPUS also must clarify its requirements on identifying third-party liability, automobile insurance coverage, and workmen's compensation cases because FIs are confused about cases to be identified and differing criteria are being applied.

CLAIMS PAID WITHOUT NONAVAILABILITY STATEMENTS INDICATING THAT SERVICES WERE NOT AVAILABLE IN UNIFORMED SERVICES HOSPITALS

CHAMPUS benefits for inpatient services, except in emergencies, are generally not authorized to beneficiaries who reside within a 40-mile radius of a uniformed services hospital that has the capability to provide the needed services. This requirement is consistent with the intent of CHAMPUS to serve as a supplement to the military's direct medical care system. When uniformed services hospitals are unable to provide the requested service, nonavailability statements are issued authorizing inpatient care under CHAMPUS.

Our review of sample claims showed that FIs paid 14 percent of inpatient claims requiring nonavailability statements without the statements. This practice not only increases CHAMPUS costs, but also defeats the intent of the statement requirement--to obtain maximum utilization of uniformed services hospitals. Also, some FIs had no procedures for determining whether claims without nonavailability statements had related inpatient claims for the same episodes of care for which statements were submitted. Although payment of the claims not accompanied by nonavailability statements was also technically in error, we did not count them as errors if nonavailability statements had been filed with related claims.

Also, claims examiners, apparently to avoid returning claims to providers, were making emergency designations in the absence of such designations by providers. CHAMPUS procedures require that claims without nonavailability statements appearing to be emergencies be returned to providers for the emergency designation.

In February 1976, the Congress enacted Public Law 94-212, which extended the requirement for nonavailability statements from only dependents of active-duty members to all classes of CHAMPUS beneficiaries and also extended the radius around uniformed services hospitals from 30 to 40 miles. We reported

in 1978 that the requirement saved CHAMPUS over $30 million in the 12-month period following its enactment. 1/ Uniformed services hospitals generally restrict issuance of nonavailability statements to cases where the hospitals cannot provide the services because of personnel or space restrictions.

Inadequate procedures established by some FIs to assure that nonavailability statements are obtained

Of 183 claims in our statistical sample requiring nonavailability statements, 25 (14 percent) were paid without the statements. Only one FI had programed in its computer system a method of flagging its file to indicate that a nonavailability statement had been received, thereby allowing all other claims for the same episode of inpatient care to be paid even though nonavailability statements were not submitted with each claim. FIs lacking similar methods of knowing whether nonavailability statements have been filed need to obtain such statements for each claim filed regarding the same episode of inpatient care.

Guidelines needed by claims examiners for establishing allowable emergencies

Nonavailability statements are not needed for inpatient care in valid emergencies. CHAMPUS procedures require FIs to return claims when the claim information indicates an emergency but the provider has not certified that fact on the claim. However, instead of being returned, claims were often paid without the emergency certification because claims examiners would make the emergency determination on the basis of information on the claim or supporting documents. However, OCHAMPUS has neither issued guidelines for FIs to use in identifying medical emergencies nor given FIs a list of symptoms or diagnoses that normally indicate emergency conditions. OCHAMPUS, by issuing these guidelines rather than requiring FIs to develop their own, will obtain more uniform program administration and reduce the number of claims required to be returned for emergency certification.

1/"Savings to CHAMPUS From Requirement to Use Uniformed Services Hospitals" (HRD-79-24, Dec. 29, 1978).

Conclusions

The requirement to ensure better utilization of uniformed service hospitals is being circumvented by inadequate FI procedures that allow CHAMPUS inpatient claims to be paid without required nonavailability statements. OCHAMPUS needs to review more closely FI systems and procedures to ensure that inpatient claims are not paid without the required statements. FIs should be encouraged to computerize this function more fully so that claims examiners know that a nonavailability statement has been submitted with one portion of an inpatient episode, rather than processing the claim by assuming that a nonavailability statement is filed with another claim.

PAYMENTS MADE FOR SERVICES THAT ARE NOT COVERED CHAMPUS BENEFITS

Our review of sample claims showed that FIs were not strictly enforcing the exclusions and limitations that apply to medical services under the program. While CHAMPUS covers many medical services, certain services are specifically excluded either by law or by CHAMPUS regulation. The services that are covered must be medically necessary and rendered in connection with or directly to a covered illness, injury, or definitive set of symptoms.

Our review of sample claims showed 180 errors involving benefit payments for excluded services or payments made without adequate determination that the benefits were covered. Based on our sample, we estimate that the five FIs paid in error between $430,000 and $1.1 million for excluded services during the 2-month period reviewed. Also, additional payments of between $2.7 and $13.8 million were questionable because FIs did not have adequate information to determine if the payments were for excluded services. Many of the errors resulted from FIs' failure to enforce CHAMPUS requirements on psychiatric care.

The CHAMPUS regulation, published in January 1977, provided the first complete compilation of program benefits, exclusions, and limitations. Additional guidance has since been issued in instructions and interpretations. CHAMPUS benefits include:

--Hospital and other institution services, including room and board, intensive care, operating rooms, drugs and medicines, X-rays, laboratory, blood, radiation therapy, physical therapy, oxygen, injections, chemotherapy, and psychological evaluation tests.

--Physician and other professional services provided on an inpatient and outpatient basis, including surgery, anesthesia, maternity care, laboratory, X-ray, consultation, and private nursing.

--Prescription drugs.

--Services for the handicapped, including diagnosis; inpatient, outpatient, and home treatment; institutional care; training and rehabilitation; and transportation (limited to dependents of active-duty members).

Excluded specifically by law are routine dental care; routine physical examinations and immunizations; and routine care of the newborn, well-baby care, and eye examinations. In addition, the regulation contains an extensive list of exclusions, including cosmetic surgery, acupuncture, custodial care, and services related to obesity and weight reduction.

Errors made in benefit determinations

The following table shows for our sample of claims the number of errors made by FIs regarding benefit determinations. All errors were in violation of requirements contained in the CHAMPUS regulation, instructions, or interpretations. The errors were discussed with FI officials, who agreed with our determination in all but a few cases.

Type of error	Incorrect payments	Questionable payments	Other processing errors	Total errors
Benefits exceeded allowed number of psychotherapy sessions without proper medical reviews	-	42	-	42
Psychotherapy sessions or benefits paid incorrectly	6	-	-	6
Services not a covered benefit	45	-	1	46
Treatment unrelated to the diagnosis	-	53	-	53
Name and/or strength of drug not shown on claim invoice	-	14	-	14
Miscellaneous	9	4	6	19
	60	113	7	180

Errors made involving psychiatric benefits

Many of the errors resulted from FIs' failure to enforce CHAMPUS limitations and exclusions on psychiatric benefits, which are intended to conform with good medical practice to help control psychiatric benefits. Payments for psychiatric benefits now account for about 16 percent of total CHAMPUS program costs. Although no ceiling exists on the total that can be paid out in a case, the CHAMPUS regulation does limit benefits within specific time periods and requires review of cases at specified intervals.

CHAMPUS requires that outpatient psychotherapy care be reviewed at the 8th and 24th sessions. Further reviews are suggested at eight-session intervals. Cases are required to be referred to peer review at the 60th session before additional benefits are payable. However, only one of the five FIs was regularly performing the psychiatric reviews at the 8th and 24th intervals. One FI reviewed cases only at the 24th session, and another only at the 60th session. An official of another FI attributed the lack of reviews to failure

of its computer to "kick out" psychiatric claims at the specified review levels. Several officials questioned the practicality and cited the high cost of making reviews as specified by OCHAMPUS. These officials hoped that OCHAMPUS would approve less frequent reviews. OCHAMPUS officials informed us that they are considering revising these requirements.

Violations of the following restrictions on psychiatric care were also found:

--Benefits are limited to 1 hour of inpatient or outpatient individual and/or group psychotherapy in any 24-hour period, except for crisis intervention where 2 hours are allowed.

--Inpatient benefits on a noncrisis intervention basis are limited to no more than five 1-hour therapy sessions (combination of individual and group therapy) in any 7-day period.

--Outpatient psychotherapy is generally limited to a maximum of two sessions per week. Before benefits can be extended for more frequent sessions, peer review is required.

Other types of benefit errors

Examples of services paid on claims in our sample that are not CHAMPUS benefits included:

--An extra charge was allowed for a cast removal by the same physician who applied the cast. The payment for application of the cast should have covered its removal.

--A physician was paid a nonallowable "standby charge" for a caesarean section.

--A newborn infant stayed in the hospital beyond the stay of the mother. The stay was treated as one admission instead of treating the infant's longer stay as a new admission as required.

--An abortion performed after October 1, 1978, was paid in violation of the 1979 DOD Appropriation Act.

--A child's preschool examination and physical was paid for.

An example of a claim paid, without question, where treatment was unrelated to the diagnosis was a hospital emergency room admission for dressing and cast services for a diagnosis of influenza.

Claims for drugs were being paid without the name and/or strength of the drug shown. Without this information, effective utilization review for drug abuse cannot be achieved, and payments may be made for nonprescription drugs.

Conclusions

Many payments were being made for services excluded under CHAMPUS. We attributed these improper payments to

--inadequate training of claims examiners,

--lack of effective quality assurance reviews,

--failure of FIs to comply with CHAMPUS requirements for review of cases at specified intervals,

--failure to establish adequate computerized prepayment screens, and

--failure of management to adequately emphasize detection of unauthorized services.

PAYMENT ERRORS RESULTING FROM INCORRECT APPLICATION OF REASONABLE CHARGES, DEDUCTIBLES, AND OTHER ADMINISTRATIVE MISTAKES

FIs made a number of errors involving reasonable charge determinations and application of deductibles and cost shares, primarily because of claims examiner errors in preparing the data for entry in the computer and incorrect entry of the data. When data were correctly entered in the computer, very few problems were noted in determining reasonable charges and applying deductibles and cost shares. Examination of sample claims also showed errors involving duplicate payments, payments made without documentation supporting that a service had been rendered, and payment of claims that exceeded claim filing deadlines.

The CHAMPUS obligation on a claim is computed after assuring that the claim is complete and that services billed are covered benefits. In computing the CHAMPUS payment, FIs apply reasonable charges, deductibles, and cost shares in determining the payment.

Applying reasonable charges in reimbursing professional services requires consideration of the provider's customary charge for a medical service and prevailing charges of other providers in a locality for this service. Reimbursement by the FI is made at the lowest of billed, customary, or prevailing fee. Hospitals, unlike professional providers, are paid billed charges, except in a few States where favorable rate agreements with FIs allow for payment at a specified percentage of billed charges.

In paying claims, FIs must also ensure that the claims are complete, the services have not been previously reimbursed, and the claims have been filed within deadlines.

Errors in Calculating Payments and Incorrectly Paying Claims

Type of error	Incorrect payments	Questionable payments	Other processing errors	Total errors
Reasonable charges computed erroneously	9	1	2	12
Deductible applied inconsistently	9	-	-	9
Cost share computed incorrectly	23	-	-	23
Duplicate payments	10	-	-	10
Claim form not signed by provider and no statement filed	12	-	-	12
Claim filed after deadline	5	-	-	5
Miscellaneous	9	2	-	11
	77	3	2	82

All five FIs visited used computerized systems for computing CHAMPUS payments. These automated systems made the reasonable charge determinations and applied deductibles and cost shares. Errors detected in these three areas were caused, not so much by system problems, but primarily by incorrect entry of information into the computer and by manual errors by claims examiners before computer entry.

Duplicate payments were also a problem, primarily because of a lack of adequate edits. For example, a claim received without a procedure code was assigned a code with a notation indicating that the code was assigned by a claims examiner. The same claim, but with a procedure code given, was received again; but because the procedure code did not have the examiner-assigned notation, it was treated as a new claim, and a duplicate payment was made. Another duplicate payment by the same FI involved payment for drugs. FI officials informed us that no computer edits to detect duplicate drug billings were operational.

One FI was also paying claims that contained neither a provider signature nor an attached itemized provider statement. Payment of these claims violates CHAMPUS regulations and presents the opportunity for program abuse.

In addition, claims were being paid although the deadlines had passed. To be eligible for payment, claims must be filed no later than the end of the calendar year immediately following the year in which the service was rendered. Exceptions to the claims filing deadline can be granted by the Director of OCHAMPUS in certain instances, but this approval was not sought.

CLAIMS PAID WITHOUT PROPER ELIGIBILITY INFORMATION

Our review of the sample claims showed that FIs paid claims from persons who may have been ineligible, accepted claims with improper signatures, and created multiple computer files for the same person. These errors resulted from FIs' lack of compliance with OCHAMPUS instructions, a lack of necessary computer edits, and numerous clerical errors.

The most frequent error involved FIs' acceptance of claims with improper signatures. These claims were normally signed by the patient's spouse; however, other signature problems included signatures by parents for children age 18

and over, signatures by children under age 18, and no signatures. However, since the period covered by our claims sample, FIs have begun to return claims with improper signatures. This practice should correct many of the eligibility-type errors we noted in our sample of claims.

Other such errors included:

--Claims being paid for services provided to children age 21 and over without documentation supporting student or incapacity status.

--Claims being paid with dates of care that were either before or after eligibility dates shown.

--Multiple claim history files being created for the same patient or sponsor, causing the withholding of excessive deductibles and incorrect payments.

FI responsibilities in verifying eligibility

FIs are responsible for verifying beneficiaries' eligibility from information shown on the claim form. FIs are required by OCHAMPUS to check for completeness of identifying data and compare dates of care to eligibility effective and expiration dates. They also are supposed to check birthdates to identify persons age 65 and over who may be ineligible for CHAMPUS because of Medicare eligibility and, in the case of children, to detect those ineligible because they have reached age 21 and are not enrolled as a student or do not have a physical or mental incapacity.

Most FIs use a combination of automated and manual checks in verifying eligibility. However, such verification is limited since each of the uniformed services is responsible for making eligibility determinations and issuing and recovering identification cards.

FIs, therefore, cannot normally detect inappropriate use of CHAMPUS benefits by persons with ostensibly valid identification cards who are not eligible because they have no association with the military or have lost eligibility for such reasons as divorce, early separation, or desertion. We

reported in November 1979 1/ that the lack of an eligibility verification system and weak control over identification cards resulted in about $780,000 being paid over a 26-month period for care received by dependents of former active-duty personnel after they were no longer eligible for benefits.

DOD is beginning to test a new eligibility enrollment system--the Defense Enrollment/Eligibility Reporting System, which will be a computerized bank of all eligible beneficiaries. The system, which will be tied into the military's direct care system and financial records systems, will provide immediate information on eligibility, and persons whose names are not in the system will not have their claims paid. The system is now being put into effect in parts of Virginia and North Carolina. The system is expected to be expanded incrementally, and DOD anticipates that it will take 5 years to install completely.

Types of errors with improper signatures and questionable eligibility data

The following table shows the number and type of claims paid with improper signatures and problems with eligibility information.

1/"Need for Better Control over Military ID Cards to Prevent Improper CHAMPUS Payments" (HRD-79-58, Nov. 16, 1979).

Type of error	Incorrect payments	Questionable payments	Other processing errors	Total errors
Claim not properly signed:				
Claim form signed by patient's spouse	-	1	218	219
Claim form signed by parent of child age 18 or over	-	-	28	28
Claim form signed by child under age 18	-	-	3	3
Claim not signed, copies of signature taped to claim, or unable to determine who signed	-	-	7	7
Claim of dependent child age 21 or over paid without support for continuing eligibility	9	-	-	9
Claim of patient age 65 or over paid--possible Medicare coverage	-	2	-	2
Claim paid with dates of care outside eligibility dates	6	1	-	7
Other eligibility errors	1	-	-	1
	16	4	256	276

Under CHAMPUS, dependent children age 18 and over are required to sign their own claim forms. The signature of the sponsor or sponsor's spouse is not acceptable. Parents must sign for children under age 18. The signature certifies that (1) the identification information is correct, (2) the medical care was provided, (3) double coverage information is accurate, and (4) medical information, under the Privacy Act, is releasable to the FI and OCHAMPUS.

Of the five FIs we reviewed, only Hawaii Medical Service Association regularly returned claims for signature by the patient during the period covered by our claims sample. However, at the insistence of OCHAMPUS, after the period covered by our claims review, the other four FIs began returning claims to obtain proper signatures.

Our review of sampled claims also showed that FIs paid claims of children age 21 and over without verifying their continued eligibility. OCHAMPUS requires that a certification form be mailed upon receipt of a claim to verify that the child is a college student or incapacitated.

Other problems with eligibility data

Another problem we noted was the creation of multiple claim history computer files for the same patient or sponsor. When this occurs, excess deductibles can be withheld and incorrect payments made. Multiple history files are created when claims for the same person contain slightly different identification information. Although several identification items on the claim may be the same, a difference, such as one different letter in the spelling of a first or last name or a different birthdate or eligibility date, can create a new computer file. These discrepancies are not detected in processing because there are too few computer edits.

We noted the following examples in computer claim histories when examining sample claims at Blue Shield of California:

--One service member was shown as having two wives. Although the wives' birthdates were the same, eligibility dates differed and spellings of the first name differed slightly. In this case, having two history files for the same person resulted in the withholding of excess deductibles of $70 in fiscal year 1978 and $40 in fiscal year 1979.

--One beneficiary was listed as both a wife and a son of the service member. Birth and eligibility dates in this case were identical.

--A 19-year-old female appeared as both a wife and a daughter of a service member. Birth and eligibility dates and other identification items were the same.

Eight cases of multiple history files were detected from sample claims at Blue Shield of California. Blue Shield informed us that this problem would be corrected in 1980. The same type of error was also found at other FIs.

Fifteen sample claims paid by the five FIs also showed patients with last names different from that of the service member and no supporting information that a legal relationship existed. OCHAMPUS has no requirement for verifying relationships when last names differ.

Conclusions

An adequate system to control eligibility will not be established until DOD completely installs an enrollment system. Meanwhile, however, FIs need to make improvements in eligibility information they maintain. Additional controls are needed to avoid creation of multiple files for the same beneficiary to prevent the incorrect withholding of deductibles. Also, to show that they are still eligible for CHAMPUS, documentation should be obtained from (1) sponsors to show that children over 21 are students or are disabled and (2) persons reaching age 65 to show that they are not eligible for Medicare.

It is particularly important that eligibility of children with last names different from that of sponsors be verified since the uniformed services do not normally issue identification cards to children under age 10. Eligibility of these children has not been established by the uniformed services, and FIs have no independent means of establishing eligibility. A means of control, such as requiring submission of adoption papers, is needed to assure a legal relationship before claims are paid.

The largest number of eligibility errors resulted from FIs' noncompliance with the CHAMPUS requirement for obtaining the signature of the patient. FIs were instead accepting signatures of the spouse. Since the period covered by the claims sample, we observed that the five FIs had begun complying with the requirement. However, because of the inconveniences involved to the patient, the large number of claims having to be returned, and the delay in processing, OCHAMPUS should, as discussed more fully in chapter 4, determine whether signatures of spouses can be accepted.

ACCEPTABLE LEVELS OF CLAIM PROCESSING ACCURACY NOT ESTABLISHED BY OCHAMPUS

The original fixed-price contracts contained requirements that FIs process claims accurately and in accordance with DOD and OCHAMPUS regulations, policies, and instructions. However, no standards for claim processing accuracy were established, and no method was devised for specifically measuring how accurately FIs were processing claims. A later version of the contract, which was not included in our review, contained essentially the same requirement, although it included a provision that FIs establish a quality assurance program to assure that clerical and other processing errors did not exceed 8 percent of the total claims processed. However, OCHAMPUS did not develop a method for measuring and verifying the error rate.

OCHAMPUS selects a sample of claims before performing site reviews of FIs, but this sampling is not statistically representative and, therefore, does not provide a basis for determining an overall error rate. OCHAMPUS requires FIs to correct errors detected on the examined claims involving overpayments or underpayments, and an OCHAMPUS official informed us that the claims examination results are used to detect larger system problems. The onsite review reports, however, show little evidence that the claims examination influenced the scope of findings of the onsite review.

For example, the claims examination corresponding to OCHAMPUS' October 1979 site visit at Blue Shield of California identified a number of claims processed without required nonavailability statements. The site-visit report, however, contained no indication that any attempt had been made to identify the reason for the deficiency. In fact, this report (and the one for the previous review) stated that nonavailability statement requirements were being effectively enforced through an automated system. Had OCHAMPUS followed through on the claims examination results, it would have discovered that the FI employs only a manual system for screening claims for required nonavailability statements.

The sample errors identified during OCHAMPUS' examination indicated the need for greater internal control than provided by manual processing. Our claims examination also found that multiple history files were being generated for

some beneficiaries. This problem was also recognized in the site-visit report as a preliminary finding, but no corrective action was specified. The report also made no mention of problems disclosed by the claims audit related to cost-share computations and payment for noncovered services.

Similar omissions were noted in recent OCHAMPUS reviews at other FIs. The claims examination corresponding to OCHAMPUS' June 1979 onsite review at the Hawaii Medical Service Association found a number of cases where the annual deductible requirement had been improperly applied. The site-visit report, however, dealt only superficially with the FI's system for enforcing the deductible requirement and included no investigation of why the errors were occurring.

Also, a recent OCHAMPUS review of claims from Blue Cross of Southwestern Virginia disclosed that multiple history files were being created for certain beneficiaries. The FI was required to correct only the specific files reviewed. The site-visit report contained no evidence that any effort was made to identify and correct the system deficiency that permitted the problem to occur.

The effectiveness of the claims examination is hampered because the review is performed totally at OCHAMPUS headquarters, and OCHAMPUS staff therefore do not have access to all of the information maintained by the FI. We noted a number of cases in which questions raised on claims could not be resolved because needed information, if it existed, would have been filed at the FI.

OCHAMPUS expects to adopt a new contract in 1981, which will contain the following two standards for regular and adjustment claims:

--The value of the payment errors shall not exceed 4 percent of billed charges for each of the following types of claims:

1. Basic program inpatient.

2. Basic program outpatient.

3. Program for the handicapped.

4. Drugs.

--The line-item error rate shall not exceed 10 percent for all types of claims.

OCHAMPUS intends to use statistical sampling to measure the payment and line-item error rates.

While development of standards for claim processing accuracy and methodology for measuring accuracy are significant improvements, we believe the standards OCHAMPUS plans to adopt are too liberal. For example, although under the Medicare program contracts with FIs do not have a claim processing standard, the average payment error rate is only about 2-1/2 percent. Medicare costs for fiscal year 1980 are estimated over $30 billion as compared to less than $800 million for CHAMPUS. Also, although the Office of Personnel Management does not include such standards in its contracts with carriers for the Federal Employees Health Benefits (FEHB) program, some carriers have developed their own internal standards. For example, a carrier for one of the two Government-wide plans, which has about 14 percent of the FEHB program enrollees, regards more than a 1-percent error rate on amounts paid as unacceptable. Since billed charges, which is the basis for the OCHAMPUS error rate, are normally more than amounts paid, the carrier's error rate comparable to OCHAMPUS would be less than 1 percent.

The carrier for the other Government-wide plan, which has about 54 percent of the FEHB enrollees, has a standard for all types of claim processing errors, including payment errors, of 3 percent. Further, there are differences in methods of payment between CHAMPUS and other carriers which indicate that CHAMPUS should have a more stringent payment standard than others. To illustrate, for hospital bills, which make up a major portion of program costs, Medicare pays on the basis of costs. Blue Cross, a major carrier for the FEHB program, has agreements with many hospitals to reimburse them based on a given percentage of charges. CHAMPUS, however, normally reimburses hospitals on the basis of billed charges. Consequently, the same error rate when applied to a specific hospital bill would result in a greater payment error under CHAMPUS than under other programs. Accordingly, we believe a standard for payment errors of about 2 percent of billed charges would be more appropriate and that this standard should be evaluated periodically and possibly made even lower as FIs become more proficient in processing CHAMPUS claims.

Often it cannot be determined definitely whether a payment is in error, such as when other insurance is indicated and when treatment is unrelated to the diagnosis. In these cases, payments must be considered questionable. Also, other errors are made which may not be significant. For example, at Blue Shield of California, we counted 201 errors involving 1,594 line items, or a line-item error rate of 12.6 percent. However, we found another 132 errors but did not count them since they either did not affect the payment or were not considered significant enough to be counted. Including these errors in the count would have brought the line-item error rate up to about 21 percent.

Conclusions

Although benefit costs constitute approximately 96 percent of total program costs, OCHAMPUS has no valid method for measuring whether FIs are processing benefit payments at an acceptable level of accuracy. The original fixed-fee contracts with FIs did not contain standards for claim processing accuracy, and while more current contracts contain a standard, OCHAMPUS has not established methods for measuring how well FIs are meeting the standard. The claims examination performed by OCHAMPUS is not used in determining a level of claim processing accuracy, and the claims examination results are not fully integrated with the systems review in site visits. An OCHAMPUS draft of a new contract proposes new standards for accuracy of claim processing and a method for measuring accuracy. However, we believe the standards proposed are too liberal in view of the standards used in other programs and because of the CHAMPUS practice of reimbursing hospitals for billed charges.

As indicated in our foregoing conclusions, the Congress in one instance, and DOD in several others, need to take specific actions to correct the numerous problems we identified concerning the processing of CHAMPUS claims.

RECOMMENDATION TO THE CONGRESS

To (1) prevent financial gain by beneficiaries as a result of double health insurance coverage, (2) reduce CHAMPUS program costs, and (3) administer the program consistently for all categories of beneficiaries, we recommend that the Congress enact legislation requiring that no benefits be payable for dependents of active-duty members when

the benefit claimed is payable under another insurance plan, obtained by employment or law, in which the beneficiary is covered.

RECOMMENDATIONS TO THE SECRETARY OF DEFENSE

We recommend that the Secretary:

--Establish standards for accuracy of claim processing and benefit administration, and that the standard for payment errors be about 2 percent of billed charges, rather than 4 percent as proposed by OCHAMPUS. This standard should be evaluated periodically and adjusted downward as fiscal intermediaries become more proficient in processing CHAMPUS claims.

--Fully integrate the claims examination function with system reviews in performing OCHAMPUS visits to FIs' sites in order to achieve optimum benefits from this function.

--Require FIs to adopt OCHAMPUS contract requirements within specified time limits and follow up on these requirements to assure they have been implemented and are being administered uniformly.

--Improve specific program areas of claim processing and benefit administration by:

1. Discontinuing the use of old claim forms and adopting new forms that contain clear instructions on supplying information on other insurance in which beneficiaries are enrolled.

2. Requiring FIs to adopt procedures that result in investigating claims where other insurance has made payments in the past.

3. Issuing clarifying instructions to FIs on cases requiring further development because of possible third-party liability, automobile insurance, or workmen's compensation.

4. Requiring that FIs submit for OCHAMPUS approval their procedures and system description for assuring that nonavailability statements are obtained as required.

5. Issuing guidelines requiring confirmation of eligibility of dependents without identification cards when their last names are different from that of service members.

DOD AND FISCAL INTERMEDIARY COMMENTS AND OUR EVALUATION

In commenting on our draft report (see apps. I to VI), DOD and the five FIs reviewed generally agreed with our findings concerning paid claims. DOD also agreed with most of our recommendations, and both it and the FIs have taken action to correct many of the problems discussed.

However, DOD disagreed with our recommendation to the Congress. DOD stated that regulations already require coordination of benefits for all beneficiaries and that, although active-duty dependent claims indicating other insurance, unlike other claims, are paid without first requiring complete coordination of benefits, no benefit dollars are lost since any overpayments are required to be recouped. DOD stated that its policy of paying active-duty dependents' claims without first requiring that benefits be coordinated with other insurance is in force because CHAMPUS is to provide active-duty dependents a substitute for the direct care system where necessary. Therefore, initial payments by CHAMPUS are intended to reduce the financial hardship that could occur if payment were delayed while CHAMPUS and other insurance benefits are coordinated.

We believe CHAMPUS has, for a long time, incurred unnecessary costs because of the lack of a clear mandate to apply other insurance benefits of active-duty dependents before paying CHAMPUS benefits. Since it is becoming more common for both spouses in households to be employed, we believe the problem is increasing.

We recognize that an administrative requirement exists for dependents of active members to report other insurance. Until January 1977, the requirement for active-duty dependents to report other insurance did not exist. When DOD made the change in policy, it was never widely publicized to the beneficiary population, and no effective means of obtaining other insurance information was developed. Rather, FIs were instructed not to seek other insurance information from active-duty members' dependents unless the claimants specifically indicated that other insurance might be payable. Since then,

DOD has done little to assure that CHAMPUS is not paying for services to active-duty members' dependents which should be paid by other insurance.

DOD's apparent lack of commitment to require dependents of active-duty members to report other insurance was also evident at the FI level. As discussed on pages 17 and 18, one FI was found not to have any procedures for coordinating benefits of active-duty dependents reporting other insurance, while other FIs did not always follow up to recoup moneys when other insurance made payments after CHAMPUS had paid the claims.

We believe that the Congress, by enacting the legislative requirements we recommend, can indicate its concern for controlling CHAMPUS costs and assure that all CHAMPUS beneficiaries are treated consistently and fairly insofar as coordination of benefits is concerned. We also believe that, without such a legislative requirement, FIs' handling of coordination of benefits for dependents of active-duty members will remain as we found it--inconsistent and sporadic.

Concerning our recommendation that guidelines be issued requiring confirmation of eligibility of dependents without identification cards when their last names are different from that of service members, DOD stated that determining eligibility for CHAMPUS benefits is the responsibility of the uniformed services. It added that the Director, OCHAMPUS, may request a review of eligibility should a question arise as to entitlement to CHAMPUS benefits.

We agree that the uniformed services are responsible for making the initial eligibility determination, but believe that OCHAMPUS and its FIs are responsible for assuring that adequate controls are implemented to avoid abuse of CHAMPUS. In the absence of an enrollment system, the opportunities for abuse are increased. This is particularly true in instances involving persons with last names different from sponsors'. In cases of children under age 10 with last names different from that of the sponsor, the uniformed services, under present procedures, have not made eligibility determinations. We believe adopting a procedure to provide some positive proof of eligibility for persons without identification cards when last names are different from that of sponsors would help prevent abuse of CHAMPUS and would not greatly inconvenience beneficiaries. This procedure would be necessary only until DOD's newly developed enrollment system is completely implemented.

CHAPTER 3

SYSTEMS FOR CONTROLLING BENEFIT COSTS NEED TO BE IMPROVED

To accurately administer program benefits and to protect and control program funds, FIs need to establish more effective systems to support claim processing functions. Some FIs had not established adequate systems for

--utilization and peer review in accordance with contracts or OCHAMPUS requirements,

--evaluating medical necessity of services, and

--identifying claims requiring rejection.

FIs' systems for determining the reasonableness of provider charges were established generally in accordance with CHAMPUS requirements.

UTILIZATION AND PEER REVIEW SYSTEMS NOT IMPLEMENTED AS REQUIRED

The systems and procedures established by some FIs for utilization and peer review were usually not meeting contractual or OCHAMPUS requirements. Specifically,

--excessive delays had occurred in establishing post-payment review systems,

--needed prepayment screens had not been established,

--written procedures and guidelines for performing utilization and peer reviews were sometimes lacking,

--documentation was lacking on cases referred for utilization and peer reviews, and

--utilization reviews of psychiatric claims were not made at required intervals, and some reviews made appeared to be of questionable value.

Utilization review involves monitoring or controlling health care benefits to (1) identify possible cases of fraud or abuse by beneficiaries or providers and (2) ensure high quality and medically necessary care at a reasonable price. FIs are expected to have two types of utilization review. The first involves a prepayment check of claims against predetermined screens and a manual review of claims that exceed the screen limits to detect misutilization. The second type is postpayment utilization review, usually by medically trained personnel, to identify cases of program misutilization and to identify necessary corrective action.

Questionable claims not resolved during utilization review and certain other claims proceed to peer review. In this process, peers of providers usually determine if services conform to generally accepted standards. FIs we reviewed used either in-house professional staff or had arrangements with local medical societies or individual practitioners to perform peer review.

Each FI is authorized to develop its own methods and procedures for meeting CHAMPUS utilization and peer review requirements.

Delays in establishing postpayment utilization review systems

Excessive delays have occurred in establishing postpayment utilization review systems. The systems described in the contract technical proposals of three FIs we reviewed had not become fully operational almost 2 years after their contracts were awarded. Another FI's system had just become operational, 23 months after award of the contract. Only Hawaii Medical Service Association had promptly established its system.

The postpayment utilization review system described in Blue Shield of California's technical proposal for its contract covering the Southwestern States was not fully operational in December 1979, about 23 months after the effective date of the contract. Only a few reports from the system described in the technical proposal were being generated, and these were still in a testing stage. A Blue Shield official informed us that, because 1 year's claim data history was needed before the system could become operational, no

contractual obligation existed until May 1979. The FI's technical proposal did not indicate that the system was still being developed; instead, it stated that the system had been developed building upon many years of claim processing experience by Blue Shield in all lines of business.

Since its system described in the technical proposal was not operational, Blue Shield of California performed its postpayment utilization reviews by analyzing two computer-generated reports--one covering quarterly earnings of CHAMPUS providers and the other comparing providers' delivery and billing patterns. Two full-time employees were finally hired to handle the task in June 1979. As of September 1979, no funds had been recovered as a result of postpayment utilization review. The system had identified only a few providers whose claims were to be screened on a postpayment basis.

The OCHAMPUS contract performance evaluation team had reported in September 1978 that no postpayment utilization review system was in effect and requested a status report on total system implementation. The Blue Shield response stated that full implementation was scheduled for August 1979. This timetable, however, was not achieved.

Mutual of Omaha was designing and implementing its formal postpayment utilization review. In the meantime, postpayment utilization review was primarily a manual function. The OCHAMPUS contract performance evaluation team reported in September 1978 and again in October 1979 that Mutual of Omaha had not implemented the system described in its technical proposal.

The automated postpayment utilization review system described by Wisconsin Physicians Service in its technical proposal, which became part of a contract effective February 13, 1978, was also not operational. Reasons given by Wisconsin Physicians Service officials for the delays included higher priorities given to other recommendations by OCHAMPUS, special one-time demands on the computer system, computer downtime, and personnel shortages.

Blue Cross of Southwestern Virginia's technical proposal for its contract effective August 1, 1977, provided for an automated system to accumulate data and identify, analyze, and document deviant practices of providers. However, in late

May 1979, almost 2 years after the effective date of the contract, the OCHAMPUS contract performance evaluation team found the system was not operational. Later, Blue Cross reported to OCHAMPUS that the system had been implemented, and the first reports were run in July 1979. At the time of our review, it was still too early to tell if the system was effective. Only one case had been developed and sent to peer review in the first half of 1979, with no disposition rendered on the case by early October 1979.

Prepayment utilization review needs to be improved

Several of the FIs reviewed need to improve systems and procedures for prepayment utilization review. With more effective prepayment screens, the errors involving payments for excluded services (discussed in ch. 2) would be minimized. Although they were not required under the contracts we reviewed, we evaluated FIs' systems for prepayment review. It is anticipated that the contracts to be awarded beginning in early 1981 will require that the claim processing system have automated prepayment edits for CHAMPUS benefits and exclusions. Currently, OCHAMPUS has not developed specific requirements for such a system, but rather identified desirable characteristics for it.

Blue Shield of California had implementd only one of the desirable characteristics identified by OCHAMPUS for a prepayment utilization review system. Among system characteristics not in effect were automated screens to identify claims of individuals who exceeded normal utilization patterns and to determine consistency between diagnosis and treatment procedures. Also, Blue Shield had no screens to identify irrational use or abuse of drugs. Two of our sample claims from Blue Shield of California were paid without question although possible drug abuse was indicated. Blue Shield had 48 medical policy edits operational and was testing 79 others.

Wisconsin Physicians Service had not implemented all of the automated prepayment utilization reviews described in its contract technical proposal. In some cases, however, automated screens described in the technical proposal were being satisfied by manual review. Wisconsin Physicians Service officials informed us that OCHAMPUS, as a result of a contract performance evaluation review in November 1979, requested compliance with the automated prepayment screens described in the technical proposal.

Prepayment screening guidelines provided to Hawaii Medical Service Association claims examiners did not cover many areas of the CHAMPUS benefit structure. This discrepancy was also reported by the OCHAMPUS contract performance evaluation group after a June 1979 review. Prepayment screening by this FI is almost totally manual. The system depends on the alertness of claims examiners during the regular claim processing.

Documentation lacking to fully evaluate utilization and peer review efforts

Several FIs we reviewed did not have documentation available that would allow us to fully evaluate the effectiveness of systems for utilization and peer review. OCHAMPUS requires such documentation, including such information as the nature of the illness or injury, any complications, the provider's name, the reviewer's findings, and any additional review of the claims.

The following example illustrates the problems encountered in evaluating the effectiveness of utilization and peer review. From a record showing cases referred to peer review, we selected 21 of 83 cases referred to Wisconsin Physicians Service medical advisers in 1978. The FI's staff could locate only seven of the case files, and these did not indicate the scope or nature of the advisers' review. Wisconsin Physicians Service revised its records in 1979 to include more information, but again a review of a number of cases did not show the level of review effort.

Psychiatric reviews not made at required intervals

An effective system for evaluating psychiatric services provided beneficiaries is particularly important under CHAMPUS because of the liberal program benefits and the history of abuses of these benefits under the program. Benefit payments for individual beneficiaries can amount to many thousands of dollars because there is no limit on the total amount that can be paid for a patient.

As discussed in chapter 2, only one of the five FIs we reviewed was regularly performing utilization or peer review of psychiatric outpatient visits at the required 8th, 24th, and 60th outpatient session intervals. Mutual of Omaha reviewed cases when 24 outpatient sessions were reached; automatic approval without review was granted until then.

Blue Shield of California was reviewing cases at only the 60th session; it decided that the volume of claims was too great to perform the reviews at the 8th and 24th sessions. The systems of Blue Cross of Southwestern Virginia and Wisconsin Physicians Service were set up to review claims at the 8th, 24th, and 60th sessions, but these reviews were not always being made.

OCHAMPUS has contracted with the American Psychiatric Association and American Psychological Association for peer review of mental health services. OCHAMPUS intends to phase in these reviews gradually. The portion implemented, as of the end of 1979, involves peer review by the American Psychiatric Association of claims for continuous inpatient hospital psychiatric care of 180 or more days. Eventually these reviews will extend to outpatient mental health services. The project coordinator at one FI stated that the quality of the reviews made so far was excellent. The only problem this person identified was the need for more reviewers in some States and more reviewers specializing in child and adolescent cases.

Conclusions

Utilization and peer review systems adopted by some FIs did not meet contract or OCHAMPUS requirements. Excessive delays have been experienced in establishing postpayment utilization review, and needed prepayment utilization review screens have not been implemented. In addition, reviews of psychiatric cases at intervals specified by OCHAMPUS were rarely made. The effectiveness of utilization and peer review was difficult to assess because guidelines on conducting such reviews were not always prepared and cases reviewed were not documented as required. The OCHAMPUS contract performance evaluation team disclosed many of these deficiencies in its site visits, but FIs have been slow to make improvements. OCHAMPUS needs to establish timetables for implementing required systems and procedures to assess penalties when they are not met.

LITTLE EFFORT MADE TO DETERMINE MEDICAL NECESSITY

OCHAMPUS has not given FIs adequate guidance on how to detect medically unnecessary services included under the CHAMPUS regulation. FIs have also done little on their own to develop criteria or screening for these noncovered services. As a result, the medical necessity requirement has been largely ignored in processing claims for payment.

The CHAMPUS regulation specifically excludes from coverage:

--Services and supplies that are not medically necessary for the diagnosis and/or treatment of a covered illness or injury.

--X-ray, laboratory, and pathological services and machine diagnostic tests that are not related to a specific illness or injury or a definitive set of symptoms.

--Services and supplies connected with an inpatient admission primarily intended to perform diagnostic tests, examinations, and procedures that could have been and routinely are performed on an outpatient basis. (The cost of the diagnostic procedures, if determined to be medically necessary, are covered to the extent of outpatient cost-sharing limitations.)

Because of increased administrative costs involved, FIs have little incentive to develop and administer medical necessity guidelines and to practice cost containment measures; and the FIs we reviewed placed little emphasis on enforcing medical necessity restrictions. Comprehensive criteria for applying the restrictions had not been developed, and claims examiners did little to attempt to identify medically unnecessary services. Computer screens for determining medical necessity were limited.

Several practices followed at one or more FIs precluded effective review of claims for medical necessity and cost containment, including:

--Acceptance of hospital claims without itemized hospital statements, thereby precluding review for medical necessity.

--Lack of review of hospital itemized billings when they were provided.

--Payment of claims amounting to $50 or less without diagnosis or with an improper diagnosis.

--Lack of screening of hospital lengths of stay for possible excessive stays.

--Using admittedly diluted medical necessity guidelines from commercial and government programs.

--Not verifying hospital room rates.

To determine if payment for medically unnecessary services was being made under CHAMPUS, we applied cost containment guidelines developed under the Service Benefit Plan of the FEHB program for determining medical necessity.

Our review of the sample claims selected in connection with the review of claim processing accuracy showed claims paid although services did not appear medically necessary, treatment did not appear related to the diagnosis, and hospital admissions appeared to be for diagnostic reasons.

Following are examples of claims paid by FIs that should have been questioned if medical necessity criteria had been strictly applied:

--A hospital claim for an emergency admission with a diagnosis of a superficial laceration of the left knee contained questionable charges for chest X-rays.

--A hospital claim for a 3-day stay contained the diagnosis of recurrent abdominal pain and acute cholecystitis suspected. This appeared to be a diagnostic admission since no surgery was performed and charges were primarily for X-rays and laboratory tests.

--A drug claim containing allergy medicines had a diagnosis of hypertension and thyroid condition.

--A physician's bill with a diagnosis of early Parkinson's disease, diabetes, and hypothyroidism did not contain the services normally related to these diagnoses but appeared more related to a physical examination (a noncovered service). Charges of $128 included those for an electrocardiogram, chest X-rays, pulmonary function test, sedimentation rate, and blood test.

--A claim for $273.75 was paid without a diagnosis being given by the provider. The claims examiner assigned a code that indicated an unspecified diagnosis.

A detailed examination of sample claims from one FI showed 29 claims that were not questioned although (1) no diagnosis was given, (2) the diagnosis given did not relate to the services on the claim, or (3) the claims examiner assigned an inappropriate diagnosis in claim processing. This FI had a policy of paying claims of $50 or less without returning claims that do not contain a diagnosis. However, claims lacking a diagnosis with charges over $50 were also paid.

Several FIs did no screening for diagnostic admissions, even though one FI had stated in its contract technical proposal that all claims for hospital stays of 3 days or less would be suspended for examination as possible diagnostic admissions.

Confusion appeared to exist over the need for itemized hospital statements. Although the CHAMPUS regulation states that itemized statements are required, one FI had received oral authority and another FI written authority from an OCHAMPUS operating division waiving the requirement. Of the five FIs reviewed, three did not require hospital itemized charges, one required them only when specific categories of ancillary charges exceeded established dollar amounts, and one required them in all cases except where hospitals did not itemize statements but billed on a per-diem basis.

According to an OCHAMPUS official responsible for policy, the OCHAMPUS operating division should not have waived the requirement, and FIs should be allowed to use discretion in requiring itemized statements. The official said, however, that as a minimum, itemized statements should be required when X-ray, laboratory, and other ancillary charges appear high in relation to the diagnosis.

Only two of the five FIs applied guidelines for reviewing the reasonableness of hospital lengths of stay. One FI stated in its contract technical proposal that all inpatient claims would be reviewed for lengths of stay, but this was not being done.

One FI was paying hospital room rates billed without any verification that these rates were the same as those charged the public. In its contract technical proposal, the FI had stated that hospital room rates would be obtained annually and that a rate not on file would be suspended. FI officials stated that requests for room rates had recently been sent

but the response from hospitals had been poor. In a special test run by the FI of an automated hospital room rate screen, 428 of 1,539 hospital claims had been rejected because no room rate was on file. However, another 216 claims were reduced a total of $62,000 by reference rates that were on file.

In addition, FIs have no means of verifying charges of residential treatment centers for children and adolescents. Although OCHAMPUS enters into participation agreements with these facilities which require that rates charged CHAMPUS be no higher than the most favorable rate charged any other patients, a specific rate is not agreed upon and FIs are not notified of the public rate. As a result, FIs accept claims from residential treatment centers without knowing whether these are amounts charged the public.

Officials of several FIs told us that returning claims for diagnosis or other information needed to review medical necessity creates ill will and discourages provider participation. Also, we were told the administrative costs involved may exceed any savings realized. Several FIs questioned whether OCHAMPUS wanted claims to be reviewed strictly for medical necessity. One FI official cited the waiving of the hospital itemized statement requirement as an indication of the intent not to strictly enforce medical necessity.

Conclusions

Although CHAMPUS specifically limits payment for only medically necessary services, OCHAMPUS and the FIs have done little to implement means of identifying unnecessary services. FIs followed practices that precluded effective review of claims for medical necessity. OCHAMPUS should require screening for medical necessity and practicing effective cost containment techniques. Guidelines for identifying unnecessary medical services should be provided to FIs, and FIs' efforts in reviewing for medical necessity should be monitored.

CLAIMS REQUIRING REJECTION NOT ALWAYS IDENTIFIED

Claims are required to be rejected for various reasons, such as when

--the claims contain services that duplicate those previously paid,

--the services provided are not covered CHAMPUS benefits,

--the claims are filed without a required nonavailability statement,

--a problem exists with eligibility information, or

--the claims are filed after the deadline.

In September 1979, the nine current FIs rejected 26,287 claims, or about 10.6 percent of the more than 248,000 claims processed that month. FIs have not, however, developed systems that adequately identify all claims that should be rejected.

To test the adequacy of the FIs' claim rejection systems, we randomly selected claims for one portion of an inpatient stay that were rejected. We determined whether the systems properly identified and rejected other claims for the same inpatient episode. For example, if the rejected claim in the sample was for a hospital visit, physician and other related claims were examined to determine if they also were properly rejected.

We reviewed 255 claims rejected by the five FIs. Claims corresponding to 74 sampled claims required rejection. The FIs properly rejected claims in 55 of the 74 cases, but in 19 cases (or 26 percent) the corresponding claims were paid, resulting in improper payment of $13,658.

The following table shows the results of our sample.

FI	Claims in sample: Total	With corresponding claims requiring rejection	With corresponding claims requiring rejection but not rejected	Amount overpaid on corresponding claims
Blue Shield of California	50	6	5	$ 3,369
Blue Cross of Southwestern Virginia	50	9	3	1,126
Mutual of Omaha	52	20	5	3,684
Wisconsin Physicians Service	53	11	4	2,241
Hawaii Medical Service Association	50	28	2	3,238
	255	74	19	$13,658

Following are examples of corresponding claims that should have been rejected:

--A physician's claim for reversal of a vasectomy was properly rejected as an excluded service. The corresponding hospital claim of $934 for this service was paid.

--A physician's claim was rejected because the patient was eligible for Medicare, but the hospital claim of $675 for the same inpatient stay was paid.

--A hospital claim was properly rejected because it was not accompanied by a required nonavailability statement. The corresponding surgeon, assistant surgeon, and anesthesiologist were paid $657, $187, and $168, respectively, although they also lacked nonavailability statements.

--Both the hospital and physician claims were rejected for a plastic surgery procedure that is not a covered benefit. However, the anesthesia and laboratory claims of $147 were paid.

Our sample of 50 claims at one FI also included 5 that were improperly rejected. These claims should have been paid but were rejected because of claims examiners' errors.

Conclusions

FIs' systems for identifying claims requiring rejection are not totally effective. Tests of claims showed a serious problem--claims that should be rejected are not being identified and are being processed through to payment. Our limited tests indicate that costs are being incurred unnecessarily because of these inadequacies in the FIs' systems. OCHAMPUS needs to increase its monitoring in this area and assure that these systems function more effectively.

REASONABLE CHARGE SYSTEMS FUNCTIONING FAIRLY EFFECTIVELY

FIs we reviewed had generally followed OCHAMPUS directives in establishing reasonable charge systems. In addition, tests made of selected reasonable charge levels established under these systems showed the amounts to be accurately computed. While the low level at which reasonable charges

are established is a common complaint about the program, the problem is not caused by FIs' failure to follow prescribed procedures in establishing reasonable charges or their computation of reasonable charges.

OCHAMPUS is allowing providers to be reimbursed for billed charges when CHAMPUS payments are combined with other insurance payments rather than limiting the combined amount to reasonable charges. We recommended in 1971 that the combined other insurance and CHAMPUS payment be limited to reasonable charges, 1/ but OCHAMPUS has not adopted this recommendation. Our review showed that the five FIs paid out substantial additional amounts during a 2-month period because the combined amounts were not limited to reasonable charges.

Reasonable charge systems established in accordance with OCHAMPUS guidelines

The reasonable charge concept is used to determine the level of payment for physicians, medical groups, independent laboratories, and other professional providers. The reasonable charge is the lowest of the billed, customary, or prevailing charge. The reasonable charge concept used under CHAMPUS for paying physicians and other professional providers contrasts with the method of paying hospitals at billed charges.

Payment on the basis of reasonable charges is a common method of reimbursing professional providers and is used under federally assisted medical programs (such as Medicare) as well as private medical insurance. The level of reasonable charges is important to the Government, beneficiaries, and providers since it directly affects total program costs, beneficiaries' satisfaction with the program, and providers' willingness to participate. Participation means providers agree to accept the reasonable charge determined amounts as payment in full for services. When providers do not participate, beneficiaries are responsible for differences between billed amounts and reasonable charges in addition to legal cost-sharing amounts. A 1978 analysis showed the CHAMPUS participation rate on outpatient claims had dropped to 51 percent compared to 57 percent during the 12 months ended

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1/See note, page 14.

December 1975. A common complaint received by FIs is that the reasonable charge levels are too low.

Our review of reasonable charge systems of four of the five FIs showed that the methodology required by OCHAMPUS directives had been followed in establishing reasonable charge levels. Our tests of selected customary and prevailing fees showed them to be computed correctly. One FI had not established its own reasonable charges but had accepted the customary and prevailing charges provided by the Medicare paying agent.

An analysis of professional and other nonhospital claims in our statistical sample of claims of the five FIs showed that the amount billed exceeded the amount allowed by the following average percentages:

FI	Average percentage by which amount billed exceeded amount allowed (note a)
Blue Shield of California	27.1
Blue Cross of Southwestern Virginia	19.3
Mutual of Omaha	25.4
Wisconsin Physicians Service	24.3
Hawaii Medical Service Association	30.8

a/The claims in our sample were processed before conversion to the 80th percentile of customary charges. (See below.)

In October 1978, the Congress, to grant some relief to beneficiaries from the low level of reasonable charges, passed Public Law 95-457, which increased the prevailing charge from the 75th to the 80th percentile of customary charges. This increase resulted in FIs paying slightly more of billed charges on some claims. However, because (1) physicians continued to increase their charges, (2) the customary charge was established as the physician's median charge, and (3) customary prevailing fees were computed based on charges that are 6 to 18 months old at the beginning of the period in which they are applied, reasonable charges will continue to lag considerably behind billed charges under the present methodology for computing reasonable charges. An OCHAMPUS official believed that physicians often increase their level

of charges over what they expect to receive currently in order to build a base for later computation of higher customary and prevailing charges.

Late updating of reasonable charges caused by delays in receipt of Medicare charge data

Reasonable charges are to be updated by July 1 of each year using charge data from the previous calendar year. Medicare charge data as well as CHAMPUS charges are to be used in this update. Charge data can also be used from other programs paying on the basis of reasonable charges, such as the FI's private insurance business or the FEHB program.

FIs relying on Medicare charge data have been unable to update reasonable charges by the required July 1 date because Medicare data are received late from Medicare paying agents and because it takes time to correct and convert the data for use on CHAMPUS FI systems.

Blue Cross of Southwestern Virginia completed the required July 1, 1979, update for the District of Columbia on September 11, 1979. The charge data from the Medicare paying agent were not received until July 24.

Wisconsin Physicians Service completed the required July 1978 and July 1979 updates in September of those years. An official of the FI cited slow response by Medicare paying agents and problems with the fee data provided as reasons for the delayed update.

Blue Shield of California, under its CHAMPUS contract for California, Arizona, New Mexico, and Nevada, has been able to meet the July 1 deadline only for California. The other three States were updated by August 15, although not always based on Medicare data from each State. A Blue Shield official said that, to meet the July 1 update, Medicare providers' lists must be received by April 30 and charge data by May 15 because of the many edit conversions needed to get the data in usable form.

Two FIs reviewed met the July 1 date for updating charges, but as discussed below, these FIs did not use the required Medicare data in establishing reasonable charges.

Reasonable charges determined without Medicare charge data

OCHAMPUS has granted Mutual of Omaha and Hawaii Medical Service Association exceptions from the requirement to use Medicare data in computing reasonable charges without granting similar exceptions to the other FIs reviewed. OCHAMPUS granted these exclusions without determining their effect on the level of reasonable charges.

Mutual of Omaha employs the methodology required by CHAMPUS in establishing reasonable charges but uses only CHAMPUS in computing reasonable charges. Hawaii Medical Service Association includes the private business charges of all providers for whose services it has made payment in its computations.

Including Medicare data in establishing customary and prevailing charges is a costly, time-consuming process. If Medicare data are important in building valid customary and prevailing charges, OCHAMPUS should not grant exemptions from the requirement. If Medicare data are not important and valid data bases can be established from CHAMPUS data alone or other sources, OCHAMPUS should consider eliminating the requirement to use Medicare data. OCHAMPUS should not make concessions to some FIs and not others.

OCHAMPUS study of reasonable charges

OCHAMPUS has recently made a study of alternative ways of establishing reasonable charges in order to lessen the hardship on beneficiaries. An alternative recommended in the study would increase amounts allowed. While such an increase would lessen the hardship on beneficiaries and increase program satisfaction, the increased costs to the Government must also be carefully considered. OCHAMPUS, in contrast to Medicare, already pays at the 80th percentile and does not limit increases in prevailing charges by an economic index.

CHAMPUS payments when combined with other insurance not limited to reasonable charges

Even though CHAMPUS has adopted the reasonable charge concept, it does not limit the CHAMPUS payment when combined with other insurance payments to reasonable charges. The result is that physicians and other professional providers

receive billed charges when CHAMPUS payments are combined with other insurance payments. Under what is known as the "last-pay concept," CHAMPUS will pay charges not paid for by other insurance up to the amount it would have paid had there been no other insurance. In a July 1971 report, we recommended that CHAMPUS payments to physicians, when combined with other insurance payments, be limited to the reasonable charges for the services rendered. OCHAMPUS has still not adopted this recommendation. OCHAMPUS officials told us that they were reluctant to adopt our recommendation because it is health insurance industry practice to not limit payment, when combined with other insurance, to reasonable charges.

Projection of our statistical sample of claims during a 2-month period shows that the five FIs paid between $103,100 and $317,400 in additional costs because CHAMPUS payments to professional providers, when combined with other insurance, were not limited to reasonable charges. For example, on one of the sample claims, a physician billed $506 for services provided a beneficiary. Other insurance paid $363.20 for the services, and CHAMPUS paid the remaining $142.80. Reasonable charges as determined by the FI for these services were $371.00. If CHAMPUS had limited payment, when combined with the other insurance payment, to the reasonable charges, it would have paid only $7.80, or $135.00 less than it paid.

The FEHB program's Service Benefit Plan, after which the Congress intended CHAMPUS to be patterned, also pays on the basis of reasonable charges, and it does limit its payment, when combined with other insurance, to reasonable charges.

Conclusions

FIs' systems for applying reasonable charges were found to be established in accordance with CHAMPUS directives. FIs had followed the correct methodology in establishing customary and prevailing charges, and our tests of the reasonable charge level computations showed them to be accurate. Application of reasonable charges, however, was resulting in significant reductions of billed charges because of (1) the way reasonable charges are established and (2) late updatings of reasonable charges. When physicians do not participate in the program, beneficiaries must pay the difference between billed and reasonable charges. CHAMPUS previously paid prevailing charges at the 75th percentile of customary charges, but the Congress recently passed legislation to increase prevailing charges to the 80th percentile. Preliminary indications show

that this has not greatly increased the level of payment. OCHAMPUS has been studying alternate methods of computing reasonable charges in an effort to lessen payments by beneficiaries.

FIs could not meet the CHAMPUS deadline for updating reasonable charges because of the late receipt of required Medicare charge data and the time required to convert these data for CHAMPUS. OCHAMPUS granted exemptions from using the Medicare data to two FIs reviewed without determining the effect these exceptions had on the level of reasonable charges.

OCHAMPUS also had not adopted a recommendation we made in 1971 that would result in program savings. This recommendation would limit the amount of CHAMPUS payments, when combined with other insurance payments, to the reasonable charges.

RECOMMENDATIONS TO THE SECRETARY OF DEFENSE

As indicated in our conclusions concerning individual aspects of FIs' claim processing systems, OCHAMPUS does not have the necessary assurance that program funds are expended only for covered services that are medically necessary, of high quality, and free from fraud and abuse. To provide such assurances, we recommend that the Secretary:

--Require OCHAMPUS to closely monitor FIs' implementation of utilization and peer review systems and to assess penalties when systems required either by the contract or by OCHAMPUS regulations are not implemented within specified time periods.

--Require OCHAMPUS to give FIs guidelines for reviewing claims for medical necessity and monitor the implementation of these guidelines.

--Require OCHAMPUS to develop methods for testing whether FI systems are appropriately identifying claims requiring rejection and to more closely review FI systems for rejecting claims.

--Obtain more uniform administration of reasonable charges by requiring all FIs to use similar charge data in establishing reasonable charges.

--Adopt our 1971 recommendation to limit CHAMPUS payments, when combined with other insurance, to reasonable charges.

DOD AND FISCAL INTERMEDIARY COMMENTS AND OUR EVALUATION

DOD and the five FIs agreed with our recommendations (see apps. I to VI), and actions have already been taken in some areas. DOD disagreed, however, with the recommendation that we made in 1971, and repeated in this report, that CHAMPUS payments, when combined with other insurance, be limited to reasonable charges. DOD contended that, rather than reduce program costs as we stated, implementing the recommendation would increase program costs because beneficiaries would cancel other insurance coverage since they often would have no financial advantage over beneficiaries without such coverage. DOD also said that limiting the combination of other insurance and CHAMPUS payments to reasonable charges would increase beneficiary discontent and increase administrative costs.

The type of insurance coverage addressed by our recommendation is that which the persons receive free or at a fraction of total cost because of their employment or under laws other than CHAMPUS legislation. We do not believe, as DOD contends, that employees will cancel this type of insurance. The employee benefits from other insurance by not having to pay normal deductibles and cost shares. The portions of the billed charges that would not be covered, if our recommendation were adopted, would be only those amounts over reasonable charges. Our recommendation is also in line with the CHAMPUS policy of limiting amounts payable to reasonable charges.

We also do not agree that administrative costs would be increased. FIs are already required to determine reasonable charges in computing the amount payable on claims. This is to assure, as DOD points out, that CHAMPUS does not pay more than what would have been reimbursed in the absence of other insurance. The DOD response to our recommendation, by stating that every line item would require review, implies that the recommendation would also cover hospital billings, which frequently have many pages of itemized charges. However, our recommendation is limited to application of reasonable charges to physician and other professional service billings, and not to hospital billings, where rather than paying reasonable charges, CHAMPUS pays billed charges. Physician billings are limited to a maximum of 32 line items, although they normally involve many fewer than that.

CHAPTER 4

SERVICES TO BENEFICIARIES AND PROVIDERS NEED TO BE IMPROVED

FIs' responsibilities include providing beneficiaries and health care providers with prompt claim processing and handling of appeals of adverse decisions on claims, and prompt and responsive replies to inquiries and complaints. OCHAMPUS is responsible for monitoring FI performance to assure that acceptable service is provided. Although OCHAMPUS has established performance standards for FIs in the above areas, standards were generally not being met. However, by the end of our review, peformance in some areas was improving.

In addition, many claims were being returned to beneficiaries and/or providers for additional information without all required information being requested. This practice resulted in claims being returned more than once. Also, in some cases, claims were returned for invalid reasons. Timeliness of return of claims for additional information was also a problem at some FIs. In addition to not meeting time standards for replying to inquiries, FIs were frequently not sending required interim responses when final responses were expected to take a long time to prepare.

Also, some FIs' replies to inquiries were unresponsive or unclear. Two of the five were not providing adequate telephone service to respond to inquiries. One FI did not have enough telephone lines and personnel to handle the volume of calls, and the other was not promptly responding to calls that required written responses.

Periodic reports of FIs to OCHAMPUS were inadequate because they did not provide information in the detail or format necessary to compare performance to standards. Many inaccuracies were also found in some reports.

Under the contracts we reviewed, OCHAMPUS' only means of enforcing standards is terminating the contract, which may be undesirable because services could be disrupted during the changeover to new FIs and because the FI's performance in other areas may be generally acceptable. In more recent contracts, OCHAMPUS used liquidated damages provisions to penalize FIs for failure to meet standards. Although the effectiveness of these new contracts in assuring acceptable performance

remains to be seen, we noted that, under three of OCHAMPUS' new contracts with the FIs we reviewed, performance standards for timeliness of claim processing were generally being met.

SLOW PROCESSING OF CLAIMS

Failure to meet CHAMPUS standards

The contracts between OCHAMPUS and the FIs reviewed require that complete claims be processed within 20 calendar days after the FIs receive them. Complete or routine claims are those which require no additional information or for which additional information can be quickly obtained. The CHAMPUS Operations Manual (a guide to FIs) states that 97.5 percent of routine claims must be processed within 21 days and the other 2.5 percent within 30 days. Although the requirements of the contracts and the Operations Manual are somewhat inconsistent, our review of routine claims in our statistical sample of claims processed by OCHAMPUS in January and February 1979 showed that neither requirement was being met, as shown below.

FI	Number of claims	Total average days processing time	Percent of claims processed		
			0-21 days	22-30 days	Over 30 days
Blue Shield of California	a/272	27	48	29	23
Blue Cross of Southwestern Virginia	265	33	2	51	47
Wisconsin Physicians Service	259	40	12	22	66
Hawaii Medical Service Association	213	31	21	39	40
Mutual of Omaha	202	32	6	45	49

a/This FI does not specifically identify nonroutine claims. The inclusion of any nonroutine claims in the sample may increase the processing time in relation to the standards of other FIs.

Although the table shows the FIs were not meeting the criteria for timely claim processing, some improvement has been made since the period of our claims sample. For example, during September 1979, Blue Cross of Southwestern Virginia's average processing time was 23 days (routine and nonroutine claims), compared to 33 days for our sample (routine claims only). For Hawaii Medical Service Association, our review of a sample of claims received in July 1979 showed that over 60 percent were processed in 21 days or less, compared to 21 percent for our sample. For Wisconsin Physicians Service, our review of a sample of 62 claims processed in November 1979 showed that 24 percent were processed within 21 days, compared to 12 percent for our original sample.

OCHAMPUS does not enforce standards

To determine if FIs are meeting the 21-day processing standard for routine claims, OCHAMPUS requires them to submit Monthly Claims Cycle Time Reports, which show processing times for both routine claims and claims requiring development, broken into various time categories, such as 1 to 10 days and 11 to 21 days. However, two FIs we reviewed did not differentiate between routine and development claims but reported the time to process all claims. This increases the average per claim processing time to be compared to the 21-day standard. Also, one FI did not start reporting claim processing times until September 1979.

Another factor hampering OCHAMPUS comparison of performance to standards under specific contracts is that the FIs report claims processed in total for all contracts and by individual States, whereas the contracts are normally for a combination of States. OCHAMPUS does not compile the data for States covered by individual contracts to determine if the standard for given contracts is being met. Even if an FI's performance could be easily compared to contractually required standards, contracts awarded before September 1978 did not provide for penalties to be assessed against the FI for failure to meet the standards. OCHAMPUS' only recourse would have been to terminate the contract for unacceptable performance, which could cause a long disruption of service during the changeover to a new FI.

Recent performance requirements

To resolve these deficiencies, OCHAMPUS has revised the contracts it has awarded since our review began. These recent

contracts provided for liquidated damages for failure to meet, on a quarterly basis, one or more workload-related standards. Two percent of the fixed-price per claim is to be denied the contractor for each standard not met. The liquidated damages are not assessed for the first quarter of an FI's first contract. The standard regarding claim processing time (which applies to all claims, both routine and development) is that the contractor's inventory of claims in process, on the average, shall not exceed a workload of 15 workdays at the end of each quarter. If the FI's claims inventory requires 16 or more workdays to process, the FI will have failed to meet this standard.

As of November 1979, six of the new contracts were in effect, including four contracts with three FIs in our review. Claim volume under these contracts is relatively small, but the standards were generally being met, as the data for July through September 1979 show.

FI	Contract area	Claims processed	Claims pending end of period	Workdays of claims on hand
Blue Shield of California	5 New England States	35,669	7,488	13.2
Blue Shield of California	Michigan	13,769	2,284	10.4
Hawaii Medical Service Association	Hawaii/ Pacific	10,753	2,665	15.6

Delayed processing due to return of claims

Claims returned to beneficiaries and providers to obtain additional information before they are processed are not included in the above analysis of FI performance against the 21-day processing time standard. However, one of the most prevalent complaints by beneficiaries and providers about FIs is that claims are returned excessively.

Claim activity data for September 1979 for the five FIs we reviewed show the extent to which claims were returned.

	Claims received	Claims returned	Percent returned
Blue Shield of California	77,997	38,251	49
Mutual of Omaha	54,286	21,310	39
Wisconsin Physicians Service	27,426	9,125	33
Blue Cross of Southwestern Virginia	27,404	8,175	30
Hawaii Medical Service Association	2,573	801	31
Total	189,686	77,662	41
All nine CHAMPUS intermediaries	232,037	92,709	40

CHAMPUS requires that (1) all items of needed information be identified at one time rather than returning claims several times for missing information and (2) complete claims be mailed within 2 workdays after it is determined further information is needed. To speed up claim processing, OCHAMPUS encourages FIs to determine if missing information can be retrieved by other means, such as researching the FIs' files.

At four of the five FIs we reviewed, we selected samples of about 50 claims being returned to determine if these requirements were being met. Performance of the FIs varied considerably.

Our review of 50 claims at Blue Cross of Southwestern Virginia showed that all were returned for valid reasons and all needed information was identified, although six were returned for the second time for information not previously requested. This was a significant improvement in that a May 1979 OCHAMPUS audit report had noted that a sample of 35 claims being returned included 14 for which all needed information was not being requested. As a result of the OCHAMPUS report, Blue Cross revised its screening procedures so that more experienced claims examiners screened entire claims for completeness to avoid returning them for only partial information.

Our review of 54 claims being returned by Wisconsin Physicians Service showed 7 for which all required information had not been identified and requested on the first inquiry and 6 for which the requested information, such as social

security number, could apparently have been obtained by telephone. Just before our review of returned claims, Wisconsin Physicians Service revised its claim processing system to provide greater assurance that claims are not returned until all needed information has been identified, and our review indicated improvement. Wisconsin Physicians Service officials agreed that the telephone should be used to obtain needed information whenever feasible but noted the following problems:

--Beneficiaries frequently do not provide telephone numbers on claims.

--Beneficiaries sometimes have difficulty understanding what is needed when phone inquiries are made.

--Telephone use is not cost effective because of the large area the FI serves.

Our review of 50 claims about to be returned at Blue Shield of California showed that, for 2 of them, the reasons for return were not valid because the requested information was already with the claim but had apparently been overlooked by the examiner. For 18 claims, all required information had not been identified. Thirteen claims (26 percent) were being returned for the second time, compared to a 19-percent rate of second returns noted in an OCHAMPUS October 1979 audit report.

Timeliness of processing returned claims at Blue Shield of California was a major problem. Our review of another sample of 20 returned claims awaiting mailing showed that the average elapsed time from the date of receipt of the claim to the day of our review was 43 days, with a range of 19 to 89 days. Elapsed time from determination that additional information was required until we reviewed the claims ranged from 4 to 64 days, compared to the CHAMPUS requirement for mailing within 2 workdays from such determination.

At the conclusion of our review, Blue Shield of California officials stated that new procedures had been implemented to help correct this problem. For example, claims lacking a proper signature (a frequent reason for return of claims) are now identified early in the processing system, separated from other claims, and sent directly to claims examiners for complete screening. Emphasis is placed on identifying all additional information required. Only limited use is made of the telephone to obtain required information.

Our review of 50 claims being returned by Mutual of Omaha disclosed that 40 items of additional information needed on 32 claims were not requested. Three of the claims were being returned for the second time. Only three of the claims were being returned for invalid reasons, such as returns for information already on the claim but overlooked by claims examiners. Two additional claims that were being returned for valid reasons also included unnecessary requests.

Another problem with returned claims at Mutual is that the computer-printed letters requesting additional information can be confusing. For example, in Mutual's request for clarification of the dates of eligibility, the return letter requested

--the patient identification card number, including any alphabetical prefix and/or suffix;

--a photocopy of both sides of the identification card;

--the expiration date listed on the card;

--verification of the patient's eligibility date; and

--verification of the expiration date on the card.

The request for a copy of both sides of the card would have sufficed.

As noted above, a major reason for return of claims is for the proper signature. OCHAMPUS requires the claim to be signed by the patient if 18 years or older. For patients under 18, the sponsor (active-duty member or retiree) or other responsible family member may sign. One prevalent case of improper signature is the sponsor or other family member signing for a patient over 18 years of age. For example, our sample of 50 returned claims at Blue Cross of Southwestern Virginia showed 53 reasons for returns and 25 (47 percent) for improper signatures. At Wisconsin Physicians Service, 16 of 68 reasons identified for return (23 percent) were because of improper signatures. At one FI, which had not been returning claims for the required signature, the return rate jumped from 20 to 33 percent of all claims received following compliance with this requirement.

OCHAMPUS officials believe it is necessary for the patient to sign a claim to authorize the release of the medical

information it contains to the FI because of the requirements of the Privacy Act (5 U.S.C. 552a). However, because of the extensive number of claims that have to be returned because of this requirement, we believe OCHAMPUS should explore with DOD's General Counsel the extent to which the constraints of the Privacy Act are applicable here, and if such constraints are applicable, the possibility of obtaining an exemption to the requirement for the purpose of submitting CHAMPUS claims for payment.

Delayed processing due to utilization and peer reviews

Utilization and peer reviews of claims may also extensively delay claim processing. Data compiled by Blue Shield of California showed that, of 1,781 prepayment utilization and peer review cases pending as of September 21, 1979, 72 percent had been pending longer than 60 days. Reasons a Blue Shield official gave for the extensive delays were the failure of physicians to appear at scheduled peer review meetings, the infrequency of meetings, and slow turnaround times for cases mailed from San Diego (where Blue Shield's CHAMPUS operations are located) to Blue Shield physicians in Los Angeles and San Francisco.

SLOW PROCESSING OF BENEFICIARY APPEALS

CHAMPUS regulations give beneficiaries the right to appeal adverse decisions by FIs regarding payment of claims. The first two appeal levels--informal review and reconsideration--are performed by the FIs. The beneficiary may request an informal review within 180 days of notice of the adverse action. The request must be in writing and should identify the disputed matter and state why the beneficiary believes the decision should be changed. The request should also be accompanied by a copy of the FIs' notice of the decision and any new evidence. If the informal review is also adverse, the beneficiary may submit a request for reconsideration within 60 days after notice of the informal review decision. Reconsideration is to be performed by FI personnel not involved in the initial determination or the informal review. If the disputed amount is $50 or less, the reconsideration decision is final. If the amount is more than $50, the beneficiary may request further review by OCHAMPUS. CHAMPUS standards require the FI to notify the beneficiary of a decision within 21 days of receiving a request for a reconsideration. To determine whether these standards were

being met, we reviewed a small sample of appealed cases completed by the five FIs during April to June 1979. The following table illustrates the timeliness with which FIs were processing beneficiary appeals for informal reviews and reconsideration.

	Informal reviews			Reconsiderations		
	Number of cases	Number (and percent) meeting 21-day standard	Average days processing time	Number of cases	Number (and percent) meeting 30-day standard	Average days processing time
Blue Shield of California	20	9(45)	36	20	1(5)	80
Mutual of Omaha	14	0(0)	43	11	9(82)	19
Blue Cross of Southwestern Virginia	66	6(9)	78	12	3(25)	49
Wisconsin Physicians Service	40	27(68)	20	20	14(70)	31
Hawaii Medical Service Association	28	25(89)	17	12	12(100)	13

Blue Shield of California attributed its long processing times for appeals to delays from claims research and medical review groups, staff vacancies, increased workload from new CHAMPUS contracts, and its policy of having informal reviews handled by personnel other than those making the initial decision (not required by OCHAMPUS for informal reviews). Blue Shield did not appear to monitor appeals processing times or to give special preference to overdue cases.

Although not meeting the standard for all cases, Wisconsin Physicians Service performance was relatively good. Our review of an additional sample of cases processed after June 1, 1979, showed an average processing time of 18 days.

Blue Cross of Southwestern Virginia attributed its slow processing of appeals to a backlog in claim microfilming and failure to route appeals cases directly to the medical review section for resolution.

In addition to slow processing of informal reviews, Mutual of Omaha failed to properly classify cases as appeals. OCHAMPUS instructions direct FIs to make a liberal interpretation when determining what constitutes a request for an appeal review. For example, a letter from a beneficiary questioning the disallowance of a claim should be regarded as an appeal. Mutual, however, required the letter to specifically request an informal review or reconsideration for it to be considered an appeal.

Of 89 Mutual of Omaha claim-related inquiries, 18 (20 percent) should have been considered appeals under the liberal definition specified by OCHAMPUS. Since many cases that should have been classified as appeals were not, beneficiaries were not obtaining the full review of their grievances provided for by CHAMPUS regulations because Mutual did not advise them of further appeals rights, which is required for responses to appeals. After completion of our fieldwork, Mutual reported that internal procedures for identifying appeals were being revised to comply with OCHAMPUS instructions.

Hawaii Medical Service Association accords priority processing to appeals and handles them in accordance with OCHAMPUS requirements. We found no problems with its appeals procedures.

OCHAMPUS failure to enforce standards

To monitor FI performance regarding appeals, OCHAMPUS requires submission of a Quarterly Report on Appeals Activity. Since the only data these reports require relating to timeliness of appeals processing are the number of cases pending over 30 days, the reports are inadequate for OCHAMPUS to monitor compliance with performance standards. Also, in several instances, FIs submitted inaccurate reports to CHAMPUS.

Although CHAMPUS defines the completion date as the date a written final response is mailed notifying the claimant of the review results, reconsideration cases were recorded as completed when the draft responses were completed rather than when the responses were mailed. The quarterly reports for the first and second quarters of 1979 had an average of 46 reconsiderations. For a sampling of those cases, the average difference between the recorded completion date and the date on the final response letter was 65 days.

Wisconsin Physicians Service, in preparing its quarterly reports on appeals activity, reported processing times that reflected only the time the cases were with the utilization review unit; they did not include the additional time required to obtain claim copies and produce response letters. Also, the reports included data on nonappeal cases, which should have been regarded as inquiries.

Mutual of Omaha had no established procedure for monitoring the number and age of pending appeal cases; therefore, it did not report on pending appeals over 30 days old as required.

Recent contracts being used by OCHAMPUS provide for assessing liquidated damages for failure to meet the standards of an average processing time of 15 workdays for informal reviews and 25 workdays for reconsiderations. OCHAMPUS intends to use the Quarterly Report on Appeals Activity and onsite visits to monitor compliance with these standards. Because of the limitation of the quarterly report and the errors noted in recording of processing times, OCHAMPUS currently has no way of knowing--short of the onsite reviews of FIs' activities--whether FIs are meeting the standard for appeals processing.

SLOW AND INADEQUATE RESPONSES TO BENEFICIARY AND PROVIDER INQUIRIES AND COMPLAINTS

An important aspect of adequate service to beneficiaries and providers is making timely responses to written inquiries, which are usually to request assistance or to complain about some part of CHAMPUS. Since written correspondence involves direct contact between the FI and beneficiaries and providers, it is important not only for public relations but also for identifying and correcting processing errors.

The performance of the FIs in relation to OCHAMPUS standards for response time for the three types of inquiries and complaints, based on our limited sample of such cases, was as follows:

FI and type of inquiry	OCHAMPUS standard (workdays)	Number of cases reviewed	Number (and percent) meeting standard	Average processing time (workdays)
Blue Shield of California:				
Congressional/ OCHAMPUS	5	22	5 (23)	12
Claim-related	10	81	6 (7)	24
General	90% in 15	8	4 (50)	20
Blue Cross of Southwestern Virginia:				
Congressional/ OCHAMPUS	5	18	2 (11)	26
Claim-related	10	58	20 (34)	20
General	90% in 15	12	7 (58)	14
Wisconsin Physicians Service:				
Congressional/ OCHAMPUS	5	41	19 (46)	6
Claim-related	10	74	47 (64)	14
General	90% in 15	22	13 (59)	24
Hawaii Medical Service Association:				
Congressional/ OCHAMPUS	5	6	5 (83)	3
Claim-related	10	26	17 (65)	10
General	90% in 15	18	14 (78)	10
Mutual of Omaha:				
Congressional/ OCHAMPUS	5	20	2 (10)	10
Claim-related	10	89	6 (7)	16
General	90% in 15	10	6 (60)	15

In addition to the above sample of cases, which shows that time standards for correspondence are often not met, FIs' monthly reports to OCHAMPUS on correspondence cycle time for September 1979 showed that, except for Hawaii Medical Service Association, standards were not being met.

FI (note a)	Total pieces of corrrespondence processed	Percent processed within 15 days
Blue Shield of California	10,594	51
Blue Cross of Southwestern Virginia	3,153	29
Wisconsin Physicians Service	3,091	8
Hawaii Medical Service Association	208	93

a/Mutual of Omaha has not prepared the above report.

The failure of some FIs to meet standards for processing inquiries and complaints appears to be caused by a shortage of personnel to handle the inquiry and complaint workload. For example, at Blue Cross of Southwestern Virginia, the correspondence backlog of 1,269 pieces on hand on July 1, 1979, increased to 2,090 pieces by July 31 and to 2,455 pieces by September 30. Based on the workload for July, each of the nine correspondence clerks processed an average of about 8 pieces of correspondence a day, whereas to maintain the same backlog, about 13 pieces per day would have to have been processed.

Wisconsin Physicians Service's performance has improved from 56 percent of all cases processed within 10 days in January 1979, to 83 percent for September 1979. The improvement is attributed to increased staffing and new procedures.

A second reason for some FIs' failure to meet the processing standards is that they are not consistently applied by OCHAMPUS. For example, at Blue Shield of California, the priority correspondence section tries to meet a 21-calendar day response standard rather than the OCHAMPUS 5-workday standard. The section supervisor said the 21-day standard was used because OCHAMPUS frequently requested that priority inquiries (congressional/OCHAMPUS) be processed within 21 days. Of the 22 pieces of priority correspondence we sampled, 5 had such a request from OCHAMPUS. At Mutual of Omaha, 5 of the 14 OCHAMPUS inquiries in our sample requested that a reply be made within 21 days.

Failure to send interim responses and implement controls over inquiries

In addition to the above standards, whenever extensive delays in responding are expected, interim responses to inquiries providing a tentative response date are to be sent within 7 workdays of receipt of the inquiry. OCHAMPUS also requires that individual control be maintained over each inquiry, so that it may be located and its status readily identified from receipt through final disposition, including prompt association with prior inquiries.

The FIs we reviewed generally did not meet these requirements. At Hawaii Medical Service Association, no interim responses were sent for any of the claim-related inquiries in our sample. In addition, its system for processing inquiries does not provide for control upon receipt. Written inquiries are not logged in until a response is ready for mailing. Therefore, individual inquiries cannot be identified or tracked while they are being processed.

At Blue Shield of California, only 7 interim responses were sent on a total of 137 written responses sampled for compliance with this requirement. Also, manual procedures discourage any attempt to determine the status of an inquiry. A Blue Shield official stated that the volume of inquiries processed--over 10,000 in September 1979--makes locating inquiries in process impracticable. Long-range plans include automating part of the correspondence system to provide better control over inquiries.

Wisconsin Physicians Service uses a computer system to accumulate descriptive data on inquiries processed and produces weekly activity reports on elapsed time, unit production, and type of inquiries processed; however, individual inquiries cannot be located in the system without manual search. Plans were underway to develop and evaluate a pilot system to track inquiries, but we were told the absence of such a system had not impaired the FIs' performance.

At Blue Cross of Southwestern Virginia, interim responses were not being sent. A system has been established to generate and control claim-related correspondence, but it is not automated as the FI said it would be in its technical proposal for its contract with OCHAMPUS. According to Blue Cross of Southwestern Virginia officials, the cost of a computerized control system for correspondence could be prohibitive, and

a number of planned changes and improved procedures to the manual system would provide adequate correspondence control.

Mutual of Omaha was not always sending interim responses as required. Also, at the time of our review, this FI did not have a control system over inquiries. Inquiries were being date stamped and sorted by State, but no procedure existed to readily locate inquiries in process. At the conclusion of our review, Mutual of Omaha had started to implement revised correspondence control procedures, including (1) preparing a daily inventory of all correspondence received by type, such as appeals and congressional, and (2) daily monitoring the age and number of pieces of correspondence pending.

OCHAMPUS' failure to enforce standards

Correspondence Cycle Time Reports to be submitted by FIs to OCHAMPUS provide for data on inquiries to be broken down between claim-related and non-claim-related. However, not all FIs break down the numbers into these two categories, and processing time is shown in calendar days rather than workdays as specified in the OCHAMPUS standard. In addition, the reported information is not categorized by individual OCHAMPUS contract. Accordingly, OCHAMPUS does not have an adequate means of comparing performance to its standards.

OCHAMPUS' new contracts provide for liquidated damages to be assessed if the contractor does not process at least 90 percent of all written inquiries to final disposition within 15 workdays. A quarterly inventory of written inquiries of more than 10 percent of all inquiries received and pending more than 15 workdays will be considered a failure to meet the standard.

Under two of the new contracts with Blue Shield of California, OCHAMPUS determined from monthly correspondence cycle reports that only 40 and 57 percent of correspondence had been processed within 30 calendar days and, therefore, the standards had not been met. OCHAMPUS planned to assess liquidated damages of about $3,900.

Complaints and responsiveness of replies

We examined samples of correspondence at each of the five FIs to determine the type and validity of complaints

and inquiries, and the responsiveness of the FIs' replies. Although many of the complaints were valid, others indicated widespread misunderstanding by beneficiaries and providers about CHAMPUS, particularly in the areas of limits of coverage, application of deductibles and reasonable charges, and claim submittal procedures.

At Blue Shield of California, numerous complaints correctly identified processing errors, such as withholding excess amounts for deductibles, applying the wrong reasonable fee limit, and applying outpatient cost shares to inpatient claims. Our review of Blue Shield's responsiveness showed that replies frequently did not fully answer the inquiry. OCHAMPUS' audit team had also found, in March 1979, that the quality of correspondence was generally inadequate. Blue Shield officials attribute the problem to its correspondents' carelessness and to OCHAMPUS standards, which emphasize timely completion rather than quality. OCHAMPUS requirements for a quality assurance program for correspondence had not been met.

At Blue Cross of Southern Virginia, we found both valid complaints, such as lengthy claims processing time, and misunderstanding by beneficiaries and providers. Many responses were unclearly worded, incomplete, inaccurate, or not fully responsive. In some cases, form letters used were not responsive to the inquiry. We believe these problems were caused, in part, by the lack of a formal management review process to monitor the quality of outgoing correspondence. At the end of our review, a system was being adopted under which outgoing correspondence will be reviewed by a supervisor twice weekly to assure that all questions are answered clearly and appropriately and that necessary followup actions, such as adjustments to payments, are made. Blue Cross officials believe that OCHAMPUS emphasizes timeliness rather than quality of responses and the fixed-price contracts do not permit top quality service; however, the above review procedure was improving the quality of written replies.

At Wisconsin Physicians Service, nearly half of the complaints dealing with amounts allowed, cost sharing, and deductibles were valid. The other complaints indicated a lack of knowledge about CHAMPUS by beneficiaries and providers. The quality of responses was generally satisfactory. None of the responses contained incorrect or unclear information.

At Hawaii Medical Service Association and Mutual of Omaha, responses to inquiries were clearly worded, accurate, and complete, and they contained a name and/or telephone number for followup contact if needed.

Planned contract revision

In 1981, OCHAMPUS plans to adopt (1) revised contracts with FIs that have new performance standards and (2) both negative and positive incentives for FIs to meet or exceed certain standards. The planned standards include:

--For claim processing, 75 percent of all claims (routine and nonroutine) are to be processed within 21 days of receipt.

--For routine written inquiries, 85 percent of final responses are to be provided within 15 calendar days and 100 pecent within 30 days of receipt; for priority inquiries (from OCHAMPUS, the Congress, and DOD), 85 percent are to be responded to within 10 days and 100 percent within 15 days.

--For appeals, 85 percent of informal reviews are to be completed within 15 days and interim responses sent within 15 days of receipt for informal reviews not processed to completion by that time; for reconsiderations, an acknowledgement notice is to be sent within 3 workdays of receipt and 90 percent are to be processed to completion within 60 calendar days.

Based on our review of sampled claims, none of the FIs reviewed were performing near the planned standard for timeliness in processing claims. For inquiries and appeals, the performance data compiled were not directly comparable to the planned standards, but it appears the FIs would have been close to meeting them, except for response times for informal reviews.

OCHAMPUS plans to rely on periodic reports from FIs to determine compliance with the standards for inquiries and appeals. As noted previously, reports from some FIs have been inaccurate and inadequate to compare performance with standards. OCHAMPUS will need to verify the accuracy of these reports and require the data to be provided in a manner that permits comparison of performance to standards.

OCHAMPUS plans to determine compliance with timeliness in processing claims by calculating cycle time from data on payment record tapes submitted by FIs.

Telephone service

At Blue Shield of California, the CHAMPUS telephone unit consisted of 13 phone lines normally monitored by 10 employees, although an average of 7 employees handled the calls during June and July 1979. The average volume of 293 calls received daily during this period amounted to 37 to 51 calls handled each day per person. One outgoing WATS line is available to handle callbacks, but incoming WATS lines are unavailable because of the cost and because the FI believes free telephone service to the caller would encourage excessive phone calls.

Blue Shield's technical proposal for its contracts with OCHAMPUS stated that telephone inquiries which cannot be resolved at the time of receipt are assigned a control number to permit monitoring of processing time. Also, a telephone inquiry record is prepared on all inquiries requiring research. Such research results in a delayed response to about 40 percent of phone inquiries. OCHAMPUS instructions also provide for FIs to prepare a record identifying and dating each telephone call requiring development.

However, control numbers were not assigned to telephone inquiries, and very few return calls in response to inquiries were being made (14 in a 3-day period). Instead, most responses to telephone inquiries were made by mail. Further, only one employee was writing such responses, and our review of 15 cases showed an average response time of 44 calendar days, well above the 15-workday standard stipulated in the technical proposal.

Blue Cross of Southwestern Virginia lacks enough telephone clerks to handle telephone inquiries, resulting in long waits and many complaints. Also toll-free lines are available only for Virginia and District of Columbia callers. Callers from other States served by Blue Cross must pay for their calls. Officials told us that in September 1979 they adopted a rotary response telephone system, which will enable the telephone company to conduct a study of CHAMPUS calls to determine the number of lines and people needed to adequately handle incoming calls.

The following excerpt is representative of complaints about telephone service extracted from 93 pieces of randomly selected correspondence:

> "I have made calls consistently, including calls in the middle of the night, the result always is a busy signal. I checked the number I call, 1-800-542-5829, with the telephone operator. She assured me the number is correct. When I asked her why I get a busy signal after hours, she said they probably have their phone set up to provide the busy signal. Can it be that this phone is set up to record a busy signal 24 hours a day?"

At Wisconsin Physicians Service the current telephone capacity for CHAMPUS is adequate. Nine telephone receptionists handle CHAMPUS inquiries using seven telephone lines, including three toll-free lines for providers. Toll-free telephone lines for beneficiaries were discontinued in August 1978, with the approval of OCHAMPUS, because of beneficiary misuse.

Mutual of Omaha's telephone service was adequate. Mutual receives about 225 to 250 telephone calls concerning CHAMPUS each day over six CHAMPUS telephone lines and two corporate lines. Personnel handling telephone inquiries have on-line access to the computer to obtain claim information, and Mutual estimates that 93 percent of the telephone inquiries are closed out on the first call, with the average call lasting about 4 minutes.

Education of providers and beneficiaries

Regarding beneficiary and provider relations, the uniformed services are primarily responsible for educating beneficiaries about CHAMPUS. FIs are expected to maintain liaison with uniformed service facilities in their region and respond to inquiries about CHAMPUS benefits and eligibility. The FIs have, however, the primary responsibility for informing providers of CHAMPUS coverage, regulations, and procedures and issuing timely notification of changes in program requirements and procedures through provider information releases. FIs are also expected to implement educational programs for providers to promote accurate claims submission, improve understanding of the CHAMPUS program, and encourage

providers to participate (that is, to accept the CHAMPUS reasonable charge payments as full payment for services provided).

At Blue Shield of California, the use of CHAMPUS fact sheets and the FI's own publications about CHAMPUS appeared to be adequately meeting program needs. Ample inventories of CHAMPUS fact sheets were available, and the FI's publications were generally accurate and clearly worded although the required OCHAMPUS approval for release of 4 of 11 of the Blue Shield proposed publications had not been obtained.

At the time of our review, Blue Shield, under the Southwest States contract, had subcontracts with Blue Cross/Blue Shield plans in Nevada, Arizona, and New Mexico to help provide beneficiary and provider assistance and education by responding to walk-in, telephone, and written inquiries and holding workshops. To coordinate these subcontractors' activities and to function as a liaison with congressional representatives and CHAMPUS advisers at uniformed services facilities, Blue Shield hired a full-time CHAMPUS field representative in August 1979. A Blue Shield official said that CHAMPUS advisers at military facilities, because of their short tenure in the position, generally lacked adequate program knowledge and can be helped considerably by the field representative. For beneficiary and provider education in California, Blue Shield uses its professional and public relations departments in San Francisco and San Diego and its own field representatives.

Blue Cross of Southwestern Virginia has prepared and distributed a number of informational brochures on CHAMPUS without obtaining advance OCHAMPUS approval. Blue Cross' field representative program is to include advisory services on how to submit and expedite CHAMPUS claims, assist providers experiencing problems with any aspect of CHAMPUS, coordinate workshops for providers, and act as liaison between civilian providers and uniformed services facilities. Blue Cross has three full-time field representatives for North and South Carolina, Indiana, and Kentucky. Blue Cross' coordinator of the beneficiary and provider relations section acts as field representative for Virginia and the District of Columbia, which account for about 40 percent of Blue Cross' CHAMPUS workload. Although a Blue Cross official said the field representatives were carrying out their functions satisfactorily, we noted one representative making only limited contact with beneficiaries and providers, averaging less

than two calls per day during July 1979. At the end of our review, Blue Cross had prepared new performance standards, requiring at least seven calls per day, and officials said quality checks would be made through random calls to persons visited. Blue Cross also planned to hire two additional field representatives to cover the Northern Virginia-D.C. and Tidewater Virginia areas.

Wisconsin Physicians Service distributes OCHAMPUS materials on the program as needed, but has experienced delays in obtaining requested materials from OCHAMPUS. The FI has also developed some material to help the correspondence section assist beneficiaries and providers, including an instruction sheet on preparing the new CHAMPUS claim forms for physician services, an explanation on the requirement for patient signature, a claim inquiry form, and a newsletter.

Nine field representatives cover the 10 States served by Wisconsin Physicians Services under CHAMPUS, including five representatives for Wisconsin, who also handle Medicare and the FI's private business. The other four representatives handle only CHAMPUS matters. The FI also has contracted to use five representatives from the Illinois State Medical Society to provide additional service in Illinois because of the large number of providers in the State. A Wisconsin Physicians Service report to OCHAMPUS cited over 2,400 contacts for the 5-month period ended July 31, 1979, including 57 workshops and seminars for 40 beneficiary and provider groups.

Hawaii Medical Service Association has published none of its own material concerning CHAMPUS, but it does have available CHAMPUS publications which are used in answering walk-in and written inquiries. This FI considers the OCHAMPUS material satisfactory and reports no problems in obtaining supplies. Provider education efforts consist mainly of a visit to all new providers by a member of the professional relations staff, who gives the provider information on all of the FI's programs, including CHAMPUS. Later contacts, sometimes through group meetings or seminars, are made only if problems arise.

Mutual of Omaha maintains a supply of most OCHAMPUS publications, but uses them mostly in responding to general inquiries about the program. Mutual believes that they are too general to be used in responding to more specific

inquiries. The FI develops supplemental materials as needed, such as to explain revisions of program policy, and submits them to OCHAMPUS for approval.

Mutual uses 16 field representatives employed by its Medicare division to serve also as CHAMPUS representatives. Their duties include acting as liaison to uniformed service facilities, making field contacts with beneficiaries and providers, and presenting seminars to interested parties. Since the representatives report to the Medicare rather than CHAMPUS division, data were not readily available to assess the number of contacts or the effectiveness of the program. Mutual, however, has made a commitment in recent CHAMPUS contracts to make 125 provider contacts for each 100,000 claims processed per year.

CONCLUSIONS

In our opinion, the performance of FIs, as it relates to providing services to beneficiaries, is important to the beneficiaries' satisfaction with the CHAMPUS program. Beneficiaries' perceptions concerning the lack of adequate services have traditionally been a major source of complaints about the program. The performances of the FIs we reviewed varied considerably in this area. However, the FIs generally did not meet OCHAMPUS timeliness standards for processing claims and appeals and for responding to inquiries and complaints. In addition, several other aspects of beneficiary services required to be provided by the FIs need to be improved.

FIs' periodic reports did not give OCHAMPUS sufficient detail to permit comparison of performance to standards, and the reports were sometimes inaccurate. Under the contracts we reviewed, OCHAMPUS has no means of enforcing standards other than terminating the contracts. Although recent contracts include liquidated damage provisions to penalize FIs for failure to meet standards, the effectiveness of these contracts in assuring acceptable performance has yet to be determined. However, FIs' continued submission of inaccurate reports will make OCHAMPUS assessments of damages difficult.

Our analysis of the complaints and inquiries from beneficiaries indicates that many of them do not understand the program provisions and that additional beneficiary education efforts are needed. Some FIs believe the uniformed services

are ineffective in educating beneficiaries about CHAMPUS because of the short tenure of personnel serving as health benefits advisers.

RECOMMENDATIONS TO THE SECRETARY OF DEFENSE

We recommend that the Secretary improve the performance of CHAMPUS FIs in providing services to beneficiaries by:

--Requiring FIs to prepare periodic reports in the detail and format necessary for OCHAMPUS to compare performance to standards and requiring OCHAMPUS to verify the accuracy of the reports during periodic visits to FIs.

--Revising contracts to (1) increase penalties for failure to meet performance standards and/or (2) provide positive incentives for meeting standards, if the penalties assessed under the liquidated damage provisions of current contracts do not result in acceptable performance.

--Exploring the possibility of permitting FIs to accept sponsors' signatures in lieu of patients' signatures on claims, thereby significantly reducing the number of claims returned to beneficiaries.

--Revising contracts to provide for penalities and/or incentives relating to performance in such areas as implementation of systems to determine the location and status of inquiries, responsiveness to inquiries, and provision of adequate telephone service.

--Revising contracts to increase FIs' role in educating beneficiaries in regard to CHAMPUS program provisions and claim submission requirements.

DOD AND FISCAL INTERMEDIARY COMMENTS AND OUR EVALUATION

DOD and the five FIs generally agreed with our findings, and DOD has already taken or planned actions to implement our recommendations and to improve conditions discussed in this chapter. (See apps. I to VI.)

CHAPTER 5

FINANCIAL MANAGEMENT PRACTICES NEED TO BE IMPROVED

Improvements are needed in OCHAMPUS' and FIs' financial management practices concerning both benefit and administrative funds. FIs maintained much larger cash balances in bank accounts than required to meet obligations for benefit payments, resulting in unnecessary interest cost to the Government. Slow processing of refunds and other adjustments contributed to the excessive balances, and improved procedures are needed to identify and recover erroneous benefit payments.

In addition, FIs were receiving excessive administrative reimbursement for processing claims because of incorrect coding of claims and incorrect OCHAMPUS claim counts. Further, controls by FIs over benefit and refund checks were sometimes inadequate.

EXCESSIVE FUND BALANCES HELD BY FISCAL INTERMEDIARIES

OCHAMPUS procedures for advancing funds and a lack of OCHAMPUS emphasis on the timely return of funds recovered by FIs resulted in their holding excess fund balances. Our analysis of financial records of three FIs showed combined average daily bank account balances in excess of $11 million. Because of Treasury borrowing requirements to fund these outstanding balances, we estimate that the Government annually incurred unnecessary interest costs of about $1.1 million. Another FI held Treasury checks outstanding, in September 1979, totaling over $9.7 million. The Government did not incur interest costs in this case as the Treasury checks do not become obligations until cashed.

One cause of the excess fund balances is OCHAMPUS' failure to comply with the Treasury Department's requirements for advancing benefit payment funds to FIs. Treasury's Fiscal Requirements Manual stipulates that, when an agency expects to have a continuing relationship with a recipient organization for at least 1 year, involving annual advances aggregating at least $120,000, the agency shall use the letter-of-credit method. Each of the CHAMPUS FIs regularly receive advances to cover benefit payments that annually total

well over $120,000. Hawaii Medical Service Association (the smallest contractor) received more than $8.25 million in advanced funds during fiscal year 1979. The largest contractor, Blue Shield of California, received more than $211.45 million.

Instead of the letter-of-credit method, OCHAMPUS advances FIs funds either in the form of a direct Treasury check or through an electronic transfer of funds. Under the second method, OCHAMPUS first deposits a Treasury check in a Denver bank, which transfers the funds directly to the FI's bank. Fund advances generally coincide closely with the FI's mailing of benefit payment checks. Funds stay in the FI's account until the benefit checks are cashed, are processed, and ultimately clear the FI's bank. This process can take several weeks or even longer, depending on how promptly the benefit checks are cashed by the recipient. In the meantime, additional advances are received since FIs normally request advances weekly or biweekly. In addition, some checks are never cashed and eventually require cancellation.

To illustrate the delays in clearing checks at one FI within about a 3-month period, 329 checks had aged 180 days without clearing the FI's bank account. Consequently, the Treasury funds to cover those checks had remained idle for this period. Had the letter-of-credit procedure been used, the drawdown of Federal funds could have been avoided since it provides for only drawing enough Treasury funds to cover checks currently being presented for payment.

A second factor contributing to large balances of idle funds was that FIs did not promptly return recovered erroneous payments or overpayments and voided benefit payment checks that were not cashed. Such funds are required by 31 U.S.C. 495 to be returned to the Treasury without delay, and in all cases within 30 days of receipt.

Blue Cross of Southwestern Virginia had a backlog of $4.7 million in credits due CHAMPUS that had not been processed at the time of our review. At the existing processing rate, it would have taken 23 months to clear this backlog. In addition, the backlog was increasing. The FI was capable of processing about $200,000 in CHAMPUS benefit payments each month; however, more than $500,000 was added in each of the 2 months tested.

At Blue Shield of California, unprocessed credits totaled nearly $6.6 million. During the first 10 months of 1979, the FI processed credits of $13.5 million, or about $1.3 million each month. At that rate it would have taken nearly 5 months to clear the backlog.

In addition to the unprocessed adjustments, excess fund balances were caused by an overadvance of funds by OCHAMPUS during 1978. The funds were not returned to OCHAMPUS because of a disagreement about the amount owed. Blue Shield took the position that it owed CHAMPUS $767,300, while OCHAMPUS maintained that more than $3.2 million in excess funds were advanced. Despite the large amount of money involved, at the time of our review (nearly 18 months after the overadvance occurred), OCHAMPUS had still not resolved the issue.

Wisconsin Physicians Service was working to liquidate a large backlog of unprocessed fund recoveries. The FI had taken steps, however, to lessen the effects on CHAMPUS of the backlog. In July 1979, the FI returned $4 million to CHAMPUS although the adjustments for these funds had not been processed. As adjustments were processed, they were applied against the $4 million. Before return of the $4 million, bank balances were large relative to disbursements.

At Hawaii Medical Service Association, records showed only three fund recoveries. At the time of our review, two had still not been processed, nearly 3 months after receipt.

Only one FI, Mutual of Omaha, was current in processing recovered funds. At the time of our review, recovered funds were being returned as offsets against future fund advances, within about 1 week of receipt.

Several of the FIs attributed their large inventories of unprocessed program credits in part to recent workload increases. One had recently assumed several new CHAMPUS contracts that resulted in a larger number of claims being processed. Another felt that a recent change in OCHAMPUS policy regarding the verification of other insurance coverage was causing increased refunds to CHAMPUS. The key problem, however, seemed to be inadequate staffing. OCHAMPUS, on the other hand, has not established clear standards for the timely processing of recovered funds. In the absence of such standards, FIs have difficulty determining staffing required to meet program needs.

OCHAMPUS is aware of the need for improved cash management. One OCHAMPUS official estimated that better cash-management procedures in CHAMPUS could result in $3 million to $5 million in annual interest savings to the Government.

After recent action to reduce excess fund balances resulting from refunds held by FIs, OCHAMPUS obtained over $19 million. Also, OCHAMPUS, in a recently prepared draft of a new contract for FIs, proposed an improved cash-management system that would require FIs to maintain an average daily CHAMPUS bank account balance of not more than 10 percent of the benefit funds paid out during the previous month. While this is a significant improvement over past practices, it is not as effective or economical as the letter-of-credit method. An OCHAMPUS official informed us that the letter-of-credit method had been discussed but no decision on its adoption had been made.

INADEQUATE PROCEDURES FOR IDENTIFYING AND RECOVERING ERRONEOUS BENEFIT PAYMENTS

The FIs we reviewed had generally not developed internal systems for routinely identifying and recovering erroneous benefit payments. Substantial fund recoveries are being made, but few come about because overpayments were detected by FIs. In most cases, refunds are made voluntarily by providers or beneficiaries, or funds are recovered after a provider, beneficiary, or another insurance company independently notified the FI that an overpayment has been made. Each of the five FIs we visited relied heavily on such voluntary notification.

In addition, FIs often do not take timely or uniform action to recover overpayments once they are discovered. Recoupment efforts generally consist of several written refund requests, followed by an attempt to offset the amount due against future claims. The actual procedures for and timing of recovery action varied significantly among FIs visited, however.

For example, two FIs attempted to recover any overpayment that exceeded $10; another generally required that overpayments exceed $50 before taking recovery action. The $50 criterion is in compliance with OCHAMPUS guidelines, but at least one FI felt that it was cost effective to pursue smaller overpayments.

The amount of time allowed beneficiaries and providers to respond to initial and followup refund requests also varied considerably. Two FIs allow beneficiaries and providers 30 days to respond to the initial letter. One, however, allowed 21 days to reply to the followup request, while the other allowed only 15 days. Another FI gave beneficiaries only 15 days to respond to either the initial or followup letter, while providers were given 40 days.

Once the allowed response time has passed, FIs were slow to move on the next step in the recovery process. For example, Hawaii Medical Service Association, in one instance, allowed more than a year to elapse between the initial refund request and the followup letter. Two other cases involved 11-month delays, and another an 8-month delay.

At Blue Shield of California, 17 cases we reviewed took an average of 204 days between when overpayment was indentified and the refund request issued. The average delay between the initial request and the followup request was 80 days. In two cases at Mutual of Omaha, 30 days elapsed between identification of overpayment and issuance of a refund request. Followup was to be made 30 days after the request letters but was not made until 44 and 72 days later.

While the problems were caused partly by either inadequate staffing or internal control at the FIs' sites, guidance from OCHAMPUS has also been lacking. OCHAMPUS has not established adequate performance standards to assure timely action by FIs to recover overpayment. OCHAMPUS must provide such guidance to achieve uniformly effective recoupment programs from all FIs.

IMPROVED PHYSICAL CONTROLS NEEDED TO SAFEGUARD BENEFIT AND REFUND CHECKS

FIs often have many unmailed benefit checks and refund checks from beneficiaries and providers on the premises. Adequate internal controls should be established to safeguard these funds.

At three of the five FIs visited, however, controls were inadequate. For example, on one occasion at Blue Cross of Southwestern Virginia, we observed signed benefit checks lying in an unattended room off a heavily traveled corridor. In addition, the FI had not provided for any special security

or handling of refund checks received, even though they are negotiable. The FI conceded that the problems existed and said solutions were being developed, but no immediate corrective action was indicated.

Weak controls over refund checks were also found at Hawaii Medical Service Association and Wisconsin Physicians Service. At Hawaii Medical Service Association, the diversion of funds would be difficult to detect. Recoupment cases are handled by the same claims examiner who originally processed the overpayment. Refunds received went initially to a mail clerk and then were forwarded to the appropriate claims examiner for processing. A record was not made of the refund receipt at either point. Similar problems existed at Wisconsin Physicians Service, as there was no separation of duties involving receiving refund checks, recording refunds, and forwarding refunds to the accounting department for deposit. Also, no reconciliation was made between the amount of refunds received and actual deposits recorded. This FI acknowledged the system weaknesses and agreed to correct them.

The FIs are responsible for the fiscal integrity of systems used to disburse and collect Federal funds. However, OCHAMPUS, which is responsible for providing administrative guidance and oversight, needs to assure that each FI exercises acceptable internal control over Government funds.

EXCESSIVE ADMINISTRATIVE REIMBURSEMENT FOR NUMBER OF CLAIMS PROCESSED

The FIs periodically submit to OCHAMPUS computer payment tapes containing specific data on all claims processed to completion. Completed claims are those that have been either paid, denied, or applied toward meeting the beneficiaries' annual deductible requirements. The payment tapes also contain corrections made to claim records submitted on earlier tapes. The payment tapes are accompanied by the FIs' invoice showing the number of reimbursable claims on the tape and the administrative payment due.

When the payment tape is processed by OCHAMPUS, a series of computerized edits is applied to assure that the data are accurate and reported in accordance with program instructions. OCHAMPUS does not reimburse FIs for processing claims that the computer edits identify as containing serious errors until the FIs correct the errors. Acceptable claims are reimbursed at the fixed rate agreed to in the FIs' contract.

The FIs' administrative costs were not being accurately reimbursed. Some FIs were receiving excessive reimbursement, either because the coding of certain claim adjustment actions on the payment tape was improper or because one claim was split into two or more claims under nonallowed circumstances. Incorrect administrative payments also resulted from a difference in claim counts between FIs and OCHAMPUS apparently caused by a problem with OCHAMPUS computer processing.

Administrative reimbursements improperly paid for adjustments caused by FI errors

In certain situations, FIs need to adjust previously processed claims. Depending on the circumstances, the contractor may or may not be entitled to additional administrative reimbursement for the adjustments. Generally, if the adjustments result from errors the FIs made when the claim was originally processed, no additional compensation is allowed.

Our limited review at two FI locations showed that both FIs had received excessive administrative reimbursement by improperly coding such adjustments on the payment tapes to indicate that they were not caused by the FI's error. One FI was making no attempt to identify responsibility for the processing error and simply assigned a code that resulted in administrative reimbursement for the adjustment. A test of adjustment actions indicated that this FI was receiving administrative overpayment of at least $11,100 monthly.

We did not attempt to quantify the amount of possible overpayment to the second FI; however, our examination of 23 claim adjustments showed that 9 (39 percent) had been improperly coded as administratively reimbursable.

Improper claim splitting

CHAMPUS claims are normally processed to completion intact. In seven specific situations, however, OCHAMPUS allows FIs to split a single claim into two or more before processing. Each split portion of the claim receives a separate claim number and warrants separate administrative cost reimbursement at the fixed rate. Three of the five FIs reviewed were found to be splitting claims only in allowed situations. The other two FIs, however, were improperly splitting claims for other than the allowed reasons and were thereby collecting additional administrative reimbursement.

One FI was continuing to improperly split claims even after OCHAMPUS had detected the practice.

The two FIs' systems did not readily provide for identifying all claims split during a period. Therefore, we were unable to fully assess the amount of administrative cost overpayments that were occurring. A large percentage of the claim splits reviewed at each of the two FIs, however, were found to be improper.

Differences in administrative claim count between FIs and OCHAMPUS

Claim counts of FIs for administrative cost reimbursement were frequently different from OCHAMPUS counts. When OCHAMPUS processes the FI payment tape, the claims are counted, and FIs are paid the fixed administrative reimbursement rate for each acceptable claim on the tape, based on the OCHAMPUS-determined claim count. That claim count, however, is seldom the same as the count invoiced by the FIs after allowing for claims failing to pass the OCHAMPUS edit. However, the OCHAMPUS count was normally greater than that invoiced by FIs. An OCHAMPUS official estimated that differences occurred on 90 to 95 percent of all payments.

The pattern and extent of claim count differences varied among FIs. For example, three FIs were overpaid by just 55, 92, and 213 claims. However, for the two other FIs, we identified 4,825 overpaid claims (about $25,000) for a 21-month period at one and 17,282 overpaid claims (about $89,000) for a 12-month period at the other.

According to an OCHAMPUS official, the problem with claim counts started when OCHAMPUS converted to fixed-price contracting, but the problem was corrected in February 1979. Discussions with several FIs indicate that, although the situation improved greatly after February 1979, it has not been totally corrected. One FI reported that the discrepancies were still occurring to some extent as recently as March 1980.

CONCLUSIONS

Improved management of funds to cover benefit and administrative payments and more effective procedures and controls in administering these funds can reduce program costs. The method of advancing funds to FIs to cover benefit payments

needs to be changed in order to minimize FIs' bank account balances. Effective cash management procedures could result in savings of several million dollars annually in interest costs. OCHAMPUS also needs to monitor FI operations more closely to prevent the accumulation of (1) large backlogs of credit adjustments and (2) funds in bank accounts for these adjustments. FIs also need to improve systems for detecting and recovering erroneous benefit payments and improve internal controls over funds. Improvements are also needed in administrative payments to FIs.

RECOMMENDATIONS TO THE SECRETARY OF DEFENSE

We recommend that the Secretary improve the financial management of CHAMPUS funds by:

--Adopting the letter-of-credit method for providing funds.

--Adopting procedures that assure that FIs routinely and promptly return excess benefit funds to OCHAMPUS.

--Establishing minimum time requirements for processing audit adjustments and monitoring the processing of these adjustments more closely.

--Developing specific procedures for FIs to follow in identifying and collecting erroneous payments.

--Developing guidelines for internal controls over the safeguarding of checks and separation of duties in handling and processing checks.

--Issuing clarifying instruction on types of claims entitled to administrative reimbursement.

--Determining the types of claims each fiscal intermediary splits and examining a sampling of split claims to verify that reasons for the splits comply with program regulations.

--Recovering overpayments and rectifying underpayments from the incorrect counting of claims by OCHAMPUS.

DOD AND FISCAL INTERMEDIARY COMMENTS AND OUR EVALUATION

DOD and the five FIs generally agreed with our recommendations, and DOD has either already taken or planned action to implement them. (See apps. I to VI.)

APPENDIX I

HEALTH AFFAIRS

ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D.C. 20301

4 December 1980

Mr. Gregory J. Ahart
Director, Human Resources Division
United States General Accounting Office
Washington, DC 20548

Dear Mr. Ahart:

This is in response to your letter of October 15 forwarding the Draft GAO Report "Performance of CHAMPUS Fiscal Intermediaries Needs Improvement" (OSD Case 5549).

We have carefully reviewed the report and offer the following general comments. A more detailed response to each of your specific recommendations in the draft report is enclosed.

We agree that at the time of the GAO review the CHAMPUS Program had many problems. DoD had recognized these problems and had taken steps to reorganize and to change key management personnel at OCHAMPUS to improve the overall management of the program.

The GAO review was conducted during the spring and summer of 1979. The claims sample analyzed by GAO was for claims processed in January and February of 1979. Since then many major improvements have occurred in the CHAMPUS Program and the claims processing system. OCHAMPUS has improved and simplified its instructions to the fiscal intermediaries, our monitoring of fiscal intermediary performance has improved significantly and the performance of the fiscal intermediaries has improved dramatically.

For the month of September 1980, 84.5% of all claims processed by all fiscal intermediaries were processed within 21 days and 91.6% were processed within 30 days. In the area of correspondence 61.7% of all inquiries were processed within 10 days, and 77.3% were processed within 15 days. This is a significant improvement over the September 1979 figures GAO reviewed, when 54.6% of all claims were processed within 21 days and 72.4% within 30 days, while only 46.4% of all correspondence was completed in 10 days and 61.2% was completed within 15 days. To assure this performance continues to improve, we have developed a new very comprehensive Request for Proposal (RFP) for procurement of fiscal intermediary services. This RFP includes much clearer statements of work, precise instructions and guidelines, and clear objective performance standards. We have included incentives which take into account both positive and negative contractor performance.

APPENDIX I

The area of double coverage and coordination of benefits has long been a problem for the CHAMPUS Program. We have spent a significant amount of time in addressing this problem and in developing more comprehensive guidelines and procedures to fiscal intermediaries to improve performance in this area. This area has been specifically addressed in the new RFP, and an entire comprehensive instruction has been developed and will be issued in December 1980.

We realize that additional efforts are needed in assuring that the Nonavailability Statements are secured when required. We have addressed this in the new RFP, and we are developing additional instructions for the fiscal intermediaries. We believe additional changes are warranted in this area. Where CHAMPUS is second pay to other insurance coverage, in many instances it would be more cost effective not to require a Nonavailability Statement. If other insurance is the primary payer the government would only be required to pay about 20% of the cost of treatment. However, if we require a Nonavailability Statement, or require that the care be performed in a direct care facility, the government would be paying for 100% of the cost of care. We are analyzing this problem and expect to reach a conclusion regarding it in the near future.

Overall, we believe that significant improvement has occurred in the management of the CHAMPUS Program and in the performance of the fiscal intermediaries since the GAO review. Further improvements are being made, and all of the problems identified by GAO as well as problems identified by OCHAMPUS are being addressed and rectified. We expect to continue improvement in the administration of the Program.

We appreciate having the opportunity to review and provide our comments on the draft report.

Sincerely,

John H. Moxley III, M. D.

Enclosure

GAO note: Numbers in brackets refer to pages in the final report.

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OSD(HA) RESPONSE TO DRAFT GAO REPORT
"PERFORMANCE OF CHAMPUS FISCAL INTERMEDIARIES NEEDS IMPROVEMENT"

[vi]

The GAO recommendations to the Congress on page VIII of the draft report are [39] repeated again on page 51 of the draft report.

[39]

GAO Recommendation Page 51 Draft Report:

GAO recommends that Congress enact legislation that requires: dependents of active duty members to report other insurance provided by law or through employment.

OSD(HA) Response:

We nonconcur with this recommendation. There is presently no statutory prohibition against Coordination of Benefits (COB) for active duty dependents, and our instructions provide for COB for all beneficiary classes. Initial payment is made by CHAMPUS for active duty dependents regardless of the existence of other insurance, but this does not affect the required application of COB by the FI. Moreover, the problem with the 1863-series claim forms is rapidly being eliminated as the 500- and 600-series claim forms replace them.

GAO Recommendation:

Congress enact legislation that requires DoD to administer COB consistently for all beneficiaries.

OSD(HA) Response:

This recommendation is apparently aimed at the policy of making initial payments for active duty dependents regardless of the existence of other insurance. We do not agree with the recommendation. This practice is based on the fact that CHAMPUS is to provide active duty dependents a substitute for the direct care system where necessary. Therefore, initial payments by CHAMPUS are intended to reduce the financial hardship on active duty members which could occur if payment were delayed while CHAMPUS and other insurance benefits are coordinated. At the

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same time, this policy will not result in the loss of any benefit dollars since COB is still required and any overpayments are required to be recouped.

[40]

GAO Recommendations to the Secretary of Defense Page 52 of the Draft Report.

GAO Recommendation:

Establish standards for accuracy of claims processing and benefit administration, and that the standard for payment errors be about 2 percent of billed charges, rather than 4 percent as proposed by OCHAMPUS. This standard should be evaluated periodically and adjusted downward as fiscal intermediaries become more proficient in processing CHAMPUS claims.

OSD(HA) Response:

The 4 percent standard established by OCHAMPUS in the new RFP is probably too high. OCHAMPUS has been reducing the error rate standards continuously and 4 percent is only an interim permissable rate. We expect that revisions of the Model RFP, planned as soon as possible after some experience has been obtained under new contracts, will contain the 2 percent error rate standard. It did not seem advisable to go from a "no rate" standard to 2 percent in one action. Any rate set will be continuously evaluated to ascertain whether a lower rate is possible.

GAO Recommendation:

Fully integrate the claims examination function with system reviews in performing OCHAMPUS visits to FIs' sites in order to achieve optimum benefits from the examination of claims.

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OSD(HA) Response:

The new RFP requires quarterly claims audits which will facilitate integration of claims examination with Contractor Performance Evaluations (CPEs).

GAO Recommendation:

Require FIs to adopt OCHAMPUS contracts requirements within specified time limits and follow-up on these requirements to assure they have been implemented and are being administered uniformly.

OSD(HA) Response:

This recommendation has been incorporated into the Model RFP through the identification of Minimum Standards of Performance for each major FI task. These Standards (found on pages 11-18 of the Model RFP) incorporate both timeliness and accuracy levels of FI performance which are measurable. The Contract Operations Branch is responsible for conducting ongoing assessments and monitoring of FI performance. The Contract Performance Evaluation Branch conduct periodic on-site validation reviews of FI performance.

GAO Recommendation:

Improve specific areas of claims processing by:

Discontinuing the use of old claim forms and adopting new claim forms that contain clear instructions on supplying information on other insurance in which beneficiaries are enrolled.

OSD(HA) Response:

New and revised claim forms are being implemented.

1. CHAMPUS/CHAMPVA Claim Form 500 is being revised by OCHAMPUS for use by the beneficiary to file any CHAMPUS claim, e.g., institutional, individual provider, drug, Program for the Handicapped, etc. The form requires completion of only

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eligibility information and the attachment of the provider's itemized bill. A separate implementation instruction with a sample of the Form will be issued during January 1981. Implementation is planned for April 1, 1981.

2. CHAMPUS Form 500 (initial version) will remain in use, but its use will not be recommended after the new form becomes generally available by July 1, 1981.

3. CHAMPUS Form 501 is the newly revised version of the AMA Uniform Claim Form. While FI's will process the form if completed by a beneficiary, Form 501 is recommended for use only by physicians and all other individual providers of care (psychologists, dentists, pharmacists, marriage counselors, suppliers, etc.) to file their CHAMPUS claims. First printings of the form were distributed about October 1, 1980, and quantities of the form can be expected to be available in a few local areas by January 1, 1981. Other areas will begin distribution between January and July of 1981. Printing and distribution of the form will be handled through local agreements established by third-party payers (including CHAMPUS FIs). This form (and the revised Form 500) will replace the initial version of Form 500 and DA Forms 1863-2, 1863-3, and 1863-4 for non-institutional provider services.

4. CHAMPUS Form 601 will be a new version of the UB-16 uniform institutional provider billing form. The certifications on the back of the claim form have been changed to meet requirements of Federal law, but no changes have been made to the front of the form. This form will be for use by those hospitals and other institutional providers employing the UB-16. The form is privately produced and purchased by the provider. CHAMPUS will not cost-share in the printing, purchase, or distribution of the form. CHAMPUS providers should obtain the form through its current suppliers. It is anticipated that the first printings of the

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revised form will not be in distribution earlier than January 1, 1982. The form (and the revised Form 500) will replace DA Forms 1863-1 and 1863-3 for institutional provider services. Separate implementation instructions will be issued.

5. CHAMPUS Form 600 may be a new institutional claim form for use by those institutional providers that do not utilize Form 601. Currently, the utility of this proposed form is being reviewed in light of the UB-16 five-state test results which demonstrate that a substantial number of small hospitals are preparing the UB-16 on typewriters. Since the form is being prepared manually, and Medicare and Medicaid implementation of the revised UB-16 will now coincide with CHAMPUS implementation, this form may be deleted as unnecessary, and special effort given to provide specialized treatment facilities who are CHAMPUS providers with the implementation instructions for use of CHAMPUS Form 601, when it becomes available.

If it is decided to proceed with CHAMPUS Form 600, first printings of the form are not expected prior to October 1, 1981, with quantities in distribution to the Uniformed Services depots and CHAMPUS FI's by January 1, 1982. The form, if adopted, (and Form 601 and revised Form 500) will replace DA Forms 1863-1 and 1863-3 for institutional provider services.

6. DA Form 1863-1 will remain in use, but its use will not be recommended after CHAMPUS Form 601 (and perhaps Form 600) become generally available.

7. DA Form 1863-3 and DA Form 1863-4 will remain in use, but their use will not be recommended after CHAMPUS Forms 501, 500 (Revised), and 601 (and perhaps 600) become generally available.

An example of the type of information requested regarding other insurance on the above forms, item 9 of the 501 says, "Enter any other health/hospital insurance which covers the patient whose eligibility is a result of group affiliation, such as place of employment, etc. Health insurance that is a specific supplement to CHAMPUS (such as those offered by various service and retired associations that reimburse items such as deductibles, and cost-shares, etc.) should not be listed."

CHAMPUS is redesigning all its claims forms. Through publication of clearer instructions on supplying information on other insurance desired results will be achieved.

GAO Recommendation:

2. Requiring FIs to adopt procedures that result in investigating claims where other insurance has made payments in the past;

OSD(HA) Response:

The new RFP requires automated COB flags and the new instructions require FIs to fully investigate past claims, etc., as part of the COB actions. We have also simplified the development procedures which should better ensure consistent application.

[40]

GAO Recommendations on Page 52a of the Draft Report.

GAO Recommendations:

3. Issue clarifying instructions to FIs on cases requiring further development because of possible third party liability, automobile insurance, and workman's compensation;

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OSD(HA) Response:

A revision to Chapter IX, DoD 6010.8-R, covering third party liability is now being coordinated with the appropriate Uniformed Services claims offices. Following formal amendment of the Regulation, appropriate implementing instruction will be issued.

Also clarifying instructions on the development of claims involving double coverage, e.g., other health insurance, automobile insurance and workman's compensation have been drafted and should be issued to the FIs in November 1980.

GAO Recommendation:

4. Requiring that FIs submit for OCHAMPUS approval their procedures and system descriptions for assuring that Nonavailability Statements are obtained as required;

CHAMPUS Response:

We have determined that a major factor contributing to the failure to check for Nonavailability Statements required has been the reliance on manual processing. The Model RFP requires automated procedures to identify all cases requiring processing for Nonavailability Statements using zip codes for areas within 40 miles of an appropriate military medical facility. The cases when identified will still be processed manually.

Where an obvious medical emergency has occurred, but the claim does not contain the required physician's certification, FIs may now waive the requirement for a Nonavailability Statement. Authority and implementing guidelines were issued in July 1980.

We are also pursuing other possibilities for simplifying the FIs processing in the area and reducing the need for returning claims for additional Nonavailability

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Statements. Such as not requiring the Nonavailability Statement when CHAMPUS is second pay to other insurance, and the government would only be liable for up to 20% of the cost of providing the care, as opposed to 75% or more if the care were provided in a direct care facility.

GAO Recommendation:

5. issuing guidelines requiring confirmation of eligibility of dependents without identification cards when their last names are different than that of service members.

OSD(HA) Response:

Determination of a person's eligibility as a CHAMPUS beneficiary is the responsibility of the Uniformed Service of which the active duty member, retiree, or deceased member or deceased retiree is, or was, a member.

The Director, OCHAMPUS, may request the appropriate Uniformed Service to review the eligibility determination should a question arise as to entitlement to CHAMPUS benefits.

If identification card information is missing from the claim form, the FIs are instructed not to process the claim and to develop that claim for the needed information. The one exception to this is on the new CHAMPUS Form 501, where the SSN of the sponsor will be considered sufficient identification.

If the eligibility determination cannot be obtained through the sponsor, the OCHAMPUS Form 88R procedures shall be initiated for verification using OCHAMPUS Form 88R, "Determination of Eligibility/Civilian Health and Medical Program of the Uniformed Services." If the OCHAMPUS form 88R confirms that the beneficiary is not eligible for CHAMPUS benefits, the FI shall flag the current claims history file.

The fact that the dependent's name differs from the sponsor, does not necessarily mean eligibility verification procedures are needed.

[60]

GAO Recommendations to the Secretary of Defense on Page 80 of the Draft Report.

GAO Recommendation:

Require OCHAMPUS to closely monitor implementation by FIs of the systems for utilization and peer review and to assess penalties when systems required either by the contract or by OCHAMPUS regulations are not implemented within specified time periods.

OSD(HA) Response:

OCHAMPUS is working on the utilization peer review problems in three steps.

First: On January 31, 1980, OCHAMPUS issued instructions to the fiscal intermediary for the establishment of a uniform system for the professional review of all inpatient and outpatient psychiatric claims and all outpatient psychological claims. All fiscal intermediaries will have fully implemented this system by December 31, 1980.

Among other things, the system requires the fiscal intermediaries to comply with the regulatory requirements for screening psychiatric and psychologic claims. The instructions include psychiatric and psychologic criteria for determining the necessity and appropriateness of the care. Professional reviewers will review treatment reports that are prepared by the providers in accordance with predetermined review points and professional criteria.

This system has required each fiscal intermediary to establish prepayment and post-payment control organizations and systems for psychiatric and psychologic claims that can be adapted to the review of other medical claims.

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Second: OCHAMPUS has contracted for a survey, documentation and assessment of all CHAMPUS related utilization review and professional review activities. This survey, which included the fiscal intermediaries, will be completed and reported on in December 1980. This will be followed by a contract to determine the cost-benefits of alternative systems of review and CHAMPUS policy will be based upon these and other findings.

Finally: With respect to post-payment and pre-payment control systems, OCHAMPUS is actively considering adopting the policies and procedures established by Health Care Financing Administration of the Department of Health and Human Services for Medicare. In March 1980, HCFA through Transmittal No. 794, established minimum and uniform identification, control and reporting systems for their carriers.

These systems will identify practice, service and payment norms, determine deviations from such norms and facilitate investigation of the deviations. Although the system has not been validated, it is intended to identify probable fraud, inappropriate care, misutilization and unusual payments.

OCHAMPUS, after coordination with HCFA, expects to make the HCFA reporting system a CHAMPUS requirement. As the change orders to accomplish this are completed, implementation schedules and monitoring mechanisms will be established and enforced with appropriate standards as other CHAMPUS contract requirements have been, through the new procedures and standards in the new RFP.

GAO Recommendation:

Require OCHAMPUS to provide FIs with guidelines for reviewing claims for medical necessity and monitor the implementation of these guidelines.

OSD(HA) Response:

See the last two paragraphs of the previous response. We believe these measures will fulfill the requirements of the recommendation.

GAO Recommendation:

Require OCHAMPUS to develop methods for testing whether FI systems are appropriately identifying claims requiring rejection and require OCHAMPUS to more closely review FI systems for rejecting claims.

OSD(HA) Response:

OCHAMPUS has an ongoing end of line claims sampling, quality control system. This sample claims review will identify whether FI systems are appropriately identifying claims requiring rejection. OCHAMPUS is now planning to expand this effort, not only to identify reject claims but to identify other claims processing system problems.

[60]

GAO Recommendations to the Secretary of Defense on Page 81 of the Draft Report.

GAO Recommendation:

Obtain more uniform administration of reasonable charges by requiring all FIs to use similar charge data in establishing reasonable charges.

OSD(HA) Response:

This has been accomplished. On April 15, 1980, instructions were issued to all FIs (OCI 7000.1) eliminating the requirement to use Medicare charge data in the development of profiles. The instruction requires that CHAMPUS charge data be used. The instruction was effective with the July 1 profile update.

GAO Recommendation:

Adopt our 1971 recommendation to limit the CHAMPUS payment when combined with other insurance to reasonable charges.

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OSD(HA) Response:

We do not agree with this recommendation. Contrary to GAO's contention, we believe the recommendation would not only result in Program savings but would actually increase Program expenditures in the long run. If the allowable charge is used as the basis of payment, in many instances a beneficiary with other health insurance will be reimbursed the same amount as a beneficiary with no other insurance. Thus, the financial responsibility of the two would be identical. In addition to the obvious beneficiary discontent this will create, beneficiaries will soon realize they gain nothing by having other insurance and will cancel it. Since CHAMPUS payments are generally substantially reduced as a result of other insurance, any cancellation of other insurance will increase CHAMPUS payments significantly.

In addition to the benefit dollars which can be saved by not adopting the GAO recommendation, sizeable administrative savings can also be made. Use of billed charges rather than allowable charges as the basis of payment is considerably easier for FIs to administer, and thus reduces administrative costs as well as claims processing times since the procedures can be easily automated. While a procedure using allowable charges could be automated, it would also involve a large amount of manual review as well as subsequent adjustments. For example, to equitably administer a procedure using allowable charges as a basis, it would be necessary to manually review the coverage of each and every item so that items which are allowed by the OBI but not by CHAMPUS, are not included in the computation. Otherwise, such services would not be reimbursed even though covered by the OBI. Such items that are missed would require subsequent adjustments with the attached administrative cost, delay in complete processing, and beneficiary irritation. Lastly, it should be remembered that even if the billed charge rather than the allowable charge is used

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as the basis of payment, CHAMPUS instructions explicitly require that CHAMPUS payments never exceed what would have been reimbursed in the absence of other insurance. Moreover, the instructions prohibit payment which would result in the beneficiary being reimbursed more than the billed amount.

[84]

GAO Recommendations to the Secretary of Defense on Page 117 and 118 of the Draft Report.

GAO Recommendation:

Require FIs to prepare periodic reports to OCHAMPUS in the detail and format necessary for OCHAMPUS to compare performance to standards, and requiring OCHAMPUS to verify the accuracy of the reports during periodic visits to FIs.

OSD(HA) Response:

Improved reports are required by the new Model RFP. These and the RFP's new more detailed and measurable Standards of Performance will permit greater improved contractor performance evaluation and verification of accuracy of reports during periodic visits to the FIs.

GAO Recommendation:

Revise contracts to (1) increase penalties for failure to meet performance standards and/or (2) provide positive incentives for meeting the standards, if the penalties assessed under the liquidated damages provisions of current contracts do not result in acceptable levels of performance.

OSD(HA) Response:

Several of the current contracts will be rewritten with a new scope of work which will include a revised liquidated damages provision. These sole source contracts are a necessary measure to provide sufficient time to effect the 1980 long range

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procurement plan on a competitive basis. OCHAMPUS has given careful consideration to the significant scope changes mandated by the 1980 request for proposals and has selected seventeen items which, when implemented, will not give an incumbent contractor an unfair competitive advantage. The positive incentive package will not be incorporated into these contracts.

GAO Recommendation:

Explore the possibility of permitting FIs to accept sponsors' signatures in lieu of patients' signatures on claims, thereby significantly reducing the number of claims returned to beneficiaries.

OSD(HA) Response:

On June 20, 1980, OCHAMPUS issues CHAMPUS Instruction (CI) 6010.12 which informs fiscal intermediaries (FIs) of the requirement for development of a CHAMPUS/CHAMPVA claim form for a beneficiary's signature.

According to CI 6010.12, the signature of the beneficiary is normally required on every claim form, whether the claim is submitted by the beneficiary or by the provider. However, if a claim for services provided a beneficiary 18 years of age or over is signed by a sponsor, parent, or spouse, it shall be returned for the signature of the beneficiary only if the claim requires return for some other reason (e.g., development of missing information). A claim received without any signature must still be returned for the signature of the beneficiary.

The relaxation of signature requirements does not relax the confidentiality requirements imposed by the Privacy Act. Checks, CHAMPUS Explanation of Benefits, responses to inquiries, etc. shall continue to be addressed to the beneficiary.

A signed request from a sponsor or parent for an Informal Review of a denied claim for a beneficiary 18 years of age or over is acceptable documentation for

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initiating the review. The Informal Review decision and further appeal rights (if any) must be addressed to the beneficiary.

GAO Recommendation:

Revise contracts to provide for penalties and/or incentives in regard to performance in such areas as implementation of systems to determine the location and status of inquiries, responsiveness to inquiries, and provision of adequate telephone service.

OAS(HA) Response:

Those items will be incorporated into future contracts. Emphasis will be placed on achieving timely delivery to the point that location of correspondence will no longer be of significant consideration. This new standard requires a final response to 85% of all routine correspondence within fifteen days or an interim written response for those not processed to completion. It has been determined that the cost would be excessive to develop a location/status system and it is anticipated that timely responses will preclude extensive additional inquiry by the beneficiary population. Finally, all existing contracts will be modified to provide extensive toll-free telephone service which should reduce the volume of written correspondence and thereby further enhance the capability to meet the performance standards.

GAO Recommendation:

Revise contracts to increase the FIs role in educating beneficiaries in regard to CHAMPUS program provisions and claim submission requirements.

OSD(HA) Response:

The new contracts will significantly expand the education of the provider and HBA population. This, in turn, will serve the beneficiary population in addition to the beneficiary education program currently in effect.

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[93]

GAO Recommendations to the Secretary of Defense, Page 130 of the Draft Report.

GAO Recommendation:

Improve the financial management of CHAMPUS funds by:

adopting the letter-of-credit method for providing funds to FIs to cover benefit payments.

OSD(HA) Response:

As discussed with the auditors during the audit, it is the intention of OCHAMPUS to adopt the letter-of-credit procedures for financing beneficiary/provider payments. Due to the funding of OCHAMPUS by an annual appropriation, unique procedures are required for use of a letter-of-credit. Substantial effort has been expended by OCHAMPUS and DoD Accounting Policy personnel, in coordination with the Department of Treasury, to develop the procedures. Final preparations are now in process and letter-of-credit financing will be implemented in the very near future.

GAO Recommendation:

Adopting procedures that assure that FIs routinely and promptly return excess benefit funds to OCHAMPUS.

OSD(HA) Response:

Action has been taken to assure that FIs promptly process excess benefit funds to OCHAMPUS. The Contractor Performance Evaluations (CPE) now include a review of the FI's bank account, including unprocessed refunds. A professional auditor on the team determines if funds are on hand in excess of outstanding checks, to assure that FIs are promptly processing refunds. The CPE report identifies the amount of excess funds and requires corrective action by the FI.

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GAO Recommendation:

Establishing minimum time requirements for processing audit adjustments and monitoring the processing of these adjustments more closely.

OSD(HA) Response:

Revised contract performance standards specifically include adjustment transaction in the requirement for a 21-day processing time.

[93]

GAO Recommendations to the Secretary of Defense, Page 131 of the Draft Report.

GAO Recommendation:

Developing specific procedures for FIs to follow in identifying and collecting erroneous payments.

OSD(HA) Response:

The new RFP requires quality control procedures to be implemented by FIs, using accepted industry standards for sample size. In addition, CPE teams perform a claims audit of sample claim selection. Further, payment tapes submitted by FIs are processed through the OCHAMPUS edit system, which contain edits for miscalculations of payment, non-covered procedure codes and other obvious errors. All of these actions are designed to insure the accuracy of claims payments. In all identified erroneous payments, corrective action is taken on each claim so identified.

GAO Recommendation:

Developing guidelines for internal controls over the safeguarding of checks and separation of duties in handling and processing checks.

OSD(HA) Response:

During the past year, CPE's have included an in-depth review of FI internal financial operations as related to CHAMPUS payments using normally accepted

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accounting principles. Controls of blank checks, separation of duties and operating practices are part of the review, and the CPE report requires corrective action on any deficiencies. In the development of a new FI operations manual, guidelines for proper financial operations are being included.

GAO Recommendation:

Issuing clarifying instructions on types of claims entitled to administrative reimbursement, that the correct coding is being assigned.

OSD(HA) Response:

In our opinion, there is no need for clarifying instructions; the problem is one of assuring that the FIs follow current instructions. It must be recognized, however, that a physical review of claim adjustments is required to determine the reason for the adjustment. Only by review of the documentation supporting the adjustment can one determine if the adjustment was caused by an FI error. OCHAMPUS has taken action to insure that FIs are using correct codes. Again, this area has been added to CPEs. In addition, a monthly report has been developed which will identify the numbers of adjustments by transaction codes. Although this will not identify improperly coded adjustments, it will provide information on the percentage of adjustments made because of FI error. FIs with a low percentage or even no adjustments in this category become suspect and will become subject to a special review.

GAO Recommendation:

Determining the types of claims each fiscal intermediary splits and examine a sampling of split claims to verify that reasons for the splits are in accordance with program regulations.

OSD(HA) Response:

Claims splitting is included in CPEs to insure that FIs are following contract provisions. The reviews have found instances of improper claims splitting, and

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have recommended corrective actions as well as recoupment of erroneous administrative payments.

Recoupment actions were initiated by the Contracting Officer against several FIs and lump sum reimbursements have been obtained. Recoupment actions will be continued as necessary.

GAO Recommendation:

Recovering overpayments as well as rectifying any underpayments from the incorrect counting of claims by OCHAMPUS.

OSD(HA) Response:

As discussed with GAO auditors, the problems of erroneous claim count in the OCHAMPUS ADP system was corrected in February 1979. Since that time, the OCHAMPUS system counts claims in accordance with contract provisions. Discrepancies reported since that date have all been found to be in FI systems, not the OCHAMPUS system. In addition, OCHAMPUS has begun the reconciliation process to correct the over-/under-payments that occurred prior to February 1979. It is anticipated that this reconciliation process will be completed in FY 1981.

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Blue Cross
of Southwestern Virginia

CHAMPUS

Post Office Box 13828
Roanoke, Virginia 24034
(703) 774-4482

Civilian Health and
Medical Program of the
Uniformed Services

November 14, 1980

Mr. Gregory J. Ahart
Director
United States General
Accounting Office
Human Resources Division
Washington, D.C. 20548

Dear Mr. Ahart:

Thank you for the opportunity to review the draft report entitled, Performance of CHAMPUS Fiscal Intermediaries Needs Improvement.

Blue Cross of Southwestern Virginia, as a CHAMPUS Fiscal Intermediary, is interested in improving their administration of the CHAMPUS Program and has taken numerous steps to implement many of the recommendations reflected in the above mentioned draft report.

The requested comments have been structured and referenced in a compatible format with the draft report.

If there are any questions or additional information is required, please consider this an offer to cooperate.

Sincerely,

James R. Smith
Coordinator
Beneficiary/Provider Relations

JRS:psc

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DIGEST

Blue Cross of Southwestern Virginia as a CHAMPUS Fiscal Intermediary processed over 350,000 CHAMPUS claims in 1978. The average cost nationally for processing a CHAMPUS claim in 1978 was less than $6.00 per claim according to the G.A.O. Report entitled, Performance of CHAMPUS Intermediaries Needs Improvement.

The fixed price competitively bid contracts are a relatively new method of reimbursement afforded fiscal intermediaries. Blue Cross of Southwestern Virginia, at the time of this study, held three fixed price competitively bid contracts and processed approximately 12 percent of the CHAMPUS claims nationally.

According to the G.A.O. Report, fiscal intermediaries provided poor service and maximized claim processing at the expense of program benefit dollars. The fact that the report further indicated that fiscal intermediaries provided poor service was, in part, caused by uncontrollable circumstances during the period under study. The obligation that fiscal intermediaries minimize claim processing at the expense of program benefit dollars suggests an intent that was not present. The forces of change that were acting in 1978 and into 1979 created the situation indicated in the G.A.O. Draft Report.

The administration of the CHAMPUS Program changed significantly with the implementation of fixed price contracts in conjunction with new CHAMPUS regulations and guidelines. The changes that occurred were felt not only by the beneficiary/provider communities but also by the fiscal intermediaries servicing the CHAMPUS Program in 1978. The number of fiscal intermediaries servicing the CHAMPUS Program were reduced from 100 processing CHAMPUS claims in 1976 to the current 9 now processing CHAMPUS claims. The reduction in Fiscal

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Intermediaries alone accounted for a significant amount of confusion in the beneficiary/provider communities. The reduction in Fiscal Intermediaries required beneficiary/provider communities to adjust to new coding structures, automated system requirements, and program interpretations implemented by the remaining nine Fiscal Intermediaries.

The growth of Blue Cross of Southwestern Virginia as a Fiscal Intermediary serves as an excellent model to describe the numerous changes affecting beneficiary/provider communities in and around 1978. Blue Cross of Southwestern Virginia competitively bid for the Virginia/District of Columbia Contract and was selected a successful bidder to begin processing CHAMPUS claims in August 1977. By April 1978, due to the above mentioned consolidations of several contracts, Blue Cross of Southwestern Virginia was again selected as a successful bidder for the contract involving North and South Carolina. In September 1978, Blue Cross once again was selected a successful bidder for the CHAMPUS contract processing claims for the States of Indiana and Kentucky. In each successful round of bidding, associated changes in the beneficiary/provider communities were felt. The change in Fiscal Intermediaries involves changes in the beneficiary/provider community such as:

1. Conversion of automated claim history file data.
2. Coding structure modalities.
3. Program benefit interpretations.
4. Administrative procedures.
5. Relationships built up between prior Fiscal Intermediaries and the beneficiary or provider.

In 1977 the rate of reimbursement changed from the 90th percentile to the 75th percentile, based on Medicare pricing data excluding the economic index data. The reduced payments to the beneficiary and the provider community were expressed in many different fashions. Reasonable charge

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complaints and complaints in general were expressed by both communities. The reduction in the level of payment to beneficiary/providers would have accounted for a large amount of the concern expressed during the 1978 period of time.

The CHAMPUS Regulation, as it is now administered, was recorded in the Federal Register in 1977. The Regulation was much more explicit and contained much more detail than the prior Regulation. Many beneficiaries found that services that were covered in 1976 were not covered in 1977. This significant change in the CHAMPUS Program did count for a large amount of dissatisfaction by the publics served by the Program.

The family folder approach to administering the CHAMPUS Program was changed to an automated claims processing system designed to handle larger volumes of claims. The contact with Fiscal Intermediaries experienced by the beneficiaries prior to 1977 changed a great deal in 1978. The personal attention was replaced with a more impersonal automated claims system.

The changes experienced in converting from the cost reimbursable contract to the fixed price competitively bid contract was only one of the changes experienced by the beneficiary/provider community in 1978. Many of the findings expressed in the G.A.O. Report entitled, Performance of CHAMPUS Fiscal Intermediaries Needs Improvement, can be attributed to:

1. The reduction in CHAMPUS Intermediaries from one hundred (100) in 1976 to the nine (9) Fiscal Intermediaries currently processing CHAMPUS claims.
2. The change in the level of payment from the 90th percentile to the 75th percentile; therefore, a reduction in the amount of money paid per covered service.
3. The Regulation changed in 1977; and therefore, items which were covered in 1976 were not covered in 1977.

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4. The family folder approach to administering the CHAMPUS Program changed to an automated claims processing system, which required each claim to stand on its own.

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Chapter I. Scope and Methodology of Review

The General Accounting Office selected claims which were processed through the OCHAMPUS payment cycle in January or February 1979. Those claims were processed by Blue Cross of Southwestern Virginia in November and December 1978. The claim sample study selected by the General Accounting Office was claims that were processed in the peak seasonal cycle. The calendar year-end is the date in which Fiscal Intermediaries normally receive their highest volume of claim receipts. This is also a period of time in which Fiscal Intermediaries experience peak vacation periods. This history of Blue Cross of Southwestern Virginia as explained in the Digest section of this response indicates the numerous contracts that were implemented in the 1978 period of time. The changes necessary to accommodate volume increases were compounded by the backlog of claims and correspondence received from the previous fiscal intermediaries. Systems which were capable of handling claim volumes prior to contract expansion were not adequate to handle the increased volumes at the period of time in which the claim sample study was conducted. Numerous changes affecting the Fiscal Intermediaries, beneficiary, and provider community such as the reduction of fiscal intermediaries, the change in level of payment from the 90th to the 75th percentile, the Regulation change in 1977, and the replacement of the family folder approach by an automated system all contributed to the results of the study conducted in 1978.

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Chapter I. Recommendations to the Secretary of Defense

The on-site audit conducted by the General Accounting Office was conducted from May to September 1979. The resulting findings of the on-site audit made comparison difficult to the claim samples and the problems experienced with the 1978 population. Scope and methodology of G.A.O. Review was impacted by the following seasonal and historical situations.

1. The claim sample was selected from a peak receipt processing period, November and December 1978.
2. Fiscal Intermediaries experienced high vacation absenteeism in the November/ December period of time.
3. The Program history, including the regulation change, change in level of reimbursement, reduction of Fiscal Intermediaries, automated system from a family folder system impacted the 1978 claims sample.
4. With the reduction of Fiscal Intermediaries came problems associated with inherited backlogs of claims and correspondence.
5. The claims sample was selected from 1978 processed claims while the on-site audit reviewed systems and situations experienced in the 1979 period of time.

The G.A.O. Report and its findings fairly reflect the problems experienced by Fiscal Intermediaries in the 1978 and 1979 period of time. The situations as experienced in 1978 and 1979 have now received the benefit of additional experience and program maturity as administered and directed by the Office of CHAMPUS.

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Chapter II. Benefits Need to be Administered More Accurately

The G.A.O. Report entitled, Performance of CHAMPUS Fiscal Intermediaries Needs Improvement, reflected total errors sampled to contain approximately forty-two (42) percent of the claims processed in error. All Fiscal Intermediaries reviewed had errors that exceeded forty (40) percent of claims processed. The only exception was Hawaii Medical Service Association which had an error rate of seven (7) percent. Hawaii Medical Service was the only consolidation of contracts or implementation of an automated system in the 1978 period of time. The report indicated that Fiscal Intermediaries had little incentive to process claims accurately in that Fiscal Intermediaries had maximized claims processing at the expense of program benefit dollars. The above mentioned claim sample suggests that the source of the error rate discovered by the G.A.O. Audit was caused by the consolidation of 100 CHAMPUS contracts to 9 Fiscal Intermediaries servicing the Program in 1978.

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Chapter II. Recommendations to the Secretary of Defense

The General Accounting Office has made four recommendations in Chapter II to the Secretary of Defense. The first recommendation was concerning the error rate on claim processing. The General Accounting Office suggested a two percent error rate which is an ambitious goal that Fiscal Intermediaries will strive to meet in the future. The four percent error rate suggested by OCHAMPUS, as proposed in its new regional contract, will be the standard of performance over the next three-year period. The four percent standard offers positive incentives to the Fiscal Intermediaries for increases in their level of performance. By supplying a range of positive incentives in this area, the Fiscal Intermediaries have the advantage of receiving monetary rewards for decreasing the error rate.

The second recommendation involves integrating the Claims Examination function for OCHAMPUS visits with the regular performance audits. It has been the recent experience of Blue Cross of Southwestern Virginia to receive a much more indepth audit from the Office of CHAMPUS. Blue Cross of Southwestern Virginia looks forward to continuing the improvement of its performance through enhanced working relationships with the Office of CHAMPUS.

The third recommendation deals with specified time limits to achieve standards requested by OCHAMPUS. The new fixed price competitively bid contracts released by the Office of CHAMPUS allow for a three-month implementation period of the standards. These requirements have bench marks to measure achievement and progress of individual Fiscal Intermediaries.

The fourth recommendation to the Secretary of Defense reflected five items:

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1. Discontinuing the old claim form.

   Response: The old claim form was considered to be obsolete as of October 1, 1980.

2. The other recommendation concerned requiring Fiscal Intermediaries to adopt procedures that result in investigating claims where other insurance had paid in the past.

   Response: While Fiscal Intermediaries nationally are pursuing coordination of benefits more stringently, this recommendation requires more study.

3. Clarifying instructions to Fiscal Intermediaries for cases requiring further development for possible third party liability.

   Response: Third party liability cases are now pursued per the CHAMPUS instruction.

4. Requiring Fiscal Intermediaries to submit to OCHAMPUS for approval of their procedures and systems descriptions in reference to non-availability statements.

   Response: Fiscal Intermediaries are now provided with zip code information in relation to non-availability statements. Those areas which require a non-availability statement are kicked out for non-emergency inpatient care from the automated claim system.

5. Issuing guidelines requiring confirmation of eligibility of dependents without I.D. cards.

   Response: Blue Cross of Southwestern Virginia is participating in the central eligibility system being developed by the Office of CHAMPUS which will facilitate the investigation and identification of those dependents whose last names differ from that of the service member.

All five items have been addressed and are operational or will be operational in the near future.

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The Office of CHAMPUS has made great advances in the recent months to clarify and enhance the performance of the CHAMPUS Fiscal Intermediaries. The new fixed price competitively bid contracts now subject to bid contain stricter standards and more indepth verification procedures. Through the continued communication between the Office of CHAMPUS and the Fiscal Intermediaries, the service and Program integrity experienced with the CHAMPUS Program should continue to improve.

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Chapter III. System for Controlling Benefit Cost Needs Improvement

The Office of CHAMPUS along with the Fiscal Intermediaries have taken numerous steps to enhance program integrity. Blue Cross of Southwestern Virginia has met with a UR/QC consulting firm (Interqual) for the purpose of enhancing the Utilization and Peer Review procedures. The Office of CHAMPUS has implemented the A.P.A. concept, which is in place and functioning properly.

The Reasonable Charge calculation methodology has changed since the on-site audit. The present reasonable charge calculation allows for a timely update of allowed charges. At least three services (occurrences) for the procedure at any charge are required as the minimum experience base to permit a Customary Charge to be established for a provider. The Customary charges will be used in the calculation of a prevailing charge screen only. At least four customary charges, weighed by frequency, are required before a prevailing charge can be established for a given procedure.

The "Plan's" formal training programs have had an opportunity to take effect on the overall administration of the CHAMPUS Program. The combined charges which took place in 1977 and 1978 have been addressed.

Many of the recommendations and concerns expressed in Chapter III of the Draft Report have been adopted and are functional. The following comments provide an explanation of the 1978 through 1979 review and a current update of the recommendation expressed in the Draft Report.

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Chapter III. Recommendations to the Secretary of Defense

The draft report indicated several areas of concern related to:

1. Monitoring Fiscal Intermediaries for proper system utilization and peer review.

   Response: A system of pre and post utilization review has been implemented by Blue Cross of Southwestern Virginia and is currently functioning satisfactorily.

   Blue Cross of Southwestern Virginia has continued to implement and enhance the utilization procedures reflected in the Virginia/District of Columbia proposal. As recently as November 7, 1980, a representative of the Plan appeared in the U.S. Federal Court to pursue a case developed from these procedures. [60] (Page 80, Draft Report)

2. Develop guidelines for reviewing claims for medical necessity and OCHAMPUS to monitor the implementation of these guidelines.

   Response: OCHAMPUS has established guidelines for reviewing claims of medical necessity and has increased the length of the on-site review so they are better able to monitor the implementation of these guidelines. Blue Cross of Southwestern Virginia reviews psychiatric outpatient claims at the eighth, twenty-fourth, and sixtieth visit. No statistics are available on how many claims may have failed this procedure for the audit review. These review procedures have been strengthened by the American Psychological Association's guidelines now operational.

   Each OCHAMPUS claim is suppose to stand on its own. Outpatient claims do not require non-availability statements unless the service was in relation to a non-emergency inpatient stay within a 40-mile radius of a military hospital. It should be noted that Blue Cross of Southwestern Virginia had the lowest rate and the lowest dollar amount in error. [53] (Page 69, Draft Report)

3. Require OCHAMPUS to develop methods for testing whether Fiscal Intermediaries' systems are appropriately identifying claims that require rejection and require OCHAMPUS to more closely review Fiscal Intermediaries' systems for rejecting claims.

   Response: OCHAMPUS audits have been extended and the scope is more indepth than it was prior to this G.A.O. review.

   Blue Cross of Southwestern Virginia had a 19.3 percent difference allowed on billed charges. This allowed charge compares very favorably to the billed amount. [56] (Page 73, Draft Report)

4. Obtain more uniform administration of reasonable charge calculation by requiring Fiscal Intermediaries to use similar data and establishing reasonable charge.

   Response: The administration of the reasonable charge area has been revamped allowing the Fiscal Intermediaries to establish reasonable charge data from CHAMPUS paid claims, documentation, and information.

   The contract area under study is the Virginia/District of Columbia area which has five economic zones which greatly affect an average of billed to allowed charges. The problems associated with the timely receipts of Part "B" Medicare data has been resolved with the implementation of the new method of calculating reasonable data. [58] (Page 75, Draft Report)

5. Adopted 1971 report recommendation to limit CHAMPUS payments we combine with other insurance to reasonable charge.

   Response: The 1971 Report is unavailable for review at the time the response is scheduled for completion.

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Chapter IV. Services to Beneficiaries and Providers Needs to be Improved

Chapter IV of the Draft Report deals with the performance of claims processing and the delivery of service to the beneficiaries and providers of the CHAMPUS Program.

Blue Cross of Southwestern Virginia has exceeded the claims and correspondence cycle time standards for the past six months. The Office of CHAMPUS has assisted the Fiscal Intermediaries in exceeding the performance standards by aggressively pursuing needed program changes. The change in the signature regulation alone accounted for a significant improvement in the Program image. New claim forms have been designed and scheduled for implementation.

Many of the review comments and recommendations have been addressed in the last year. The following are comments and responses to the recommendations and observations generated by the General Accounting Office review.

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Chapter IV. Recommendations to the Secretary of Defense

1. Require Fiscal Intermediary to prepare periodic reports to OCHAMPUS in detail format necessary for OCHAMPUS to compare performance to standards and require OCHAMPUS to verify accuracy of reports during periodic visits.

   Response: Blue Cross of Southwestern Virginia prepares a workload report which indicates percent processed within certain time periods for correspondence, claims, appeals, and other requested information. Blue Cross of Southwestern Virginia is in compliance with all aspects of the claim cycle time standards, correspondence cycle time standards, and the reporting requirements. Blue Cross of Southwestern Virginia had a claims cycle time of 33 days for the claim sample in 1978. At the time the on-site audit occurred in 1979, the cycle time had improved to 23-day average processing. For the last five months, the cycle time has improved to a high of 92.7 percent in 21 days in August. The average cycle time for August was 13.3 days.

   [64]
   (Page 84 - Draft Report)

   The return claim rate has been declining in recent months. The audit reflected a 30 percent return rate at the end of the on-site review, which was the lowest return rate reflected in the Draft Report. Blue Cross of Southwestern Virginia will continue to encourage program changes, such as the recent change in the signature requirements, which will provide easier access to the program for the public we serve. [66] (Page 87, Draft Report)

2. Revising contracts to increase penalties for failure to meet performance standards and provide positive incentives for meeting standards and liquidated damage provisions of current contracts does not result in an acceptable level of performance.

   Response: The new Mid Atlantic Contract contains this type of positive/ negative incentives to encourage Fiscal Intermediaries to increase service to the

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beneficiaries. Blue Cross of Southwestern Virginia is looking forward to the competitive bidding process and is in compliance with those standards.

The identification of appeals and maintenance of appropriate cycle times has been addressed by the Plan. The correspondence cycle times for August of 1980 was 99 percent in 15 days. [73-74] (Page 99-100, Draft Report) The improvement in cycle time for reconsiderations and appeals can be attributed to a more experienced staff both in the correspondence area and also in the screening/sorting areas. [70] [73] (Page 95 and 99 - Draft Report).

3. Exploring the possibility of permitting Fiscal Intermediaries to accept sponsor signature in lieu of patient signature on claims, thereby significantly reducing the number of claims returned to beneficiaries.

   Response: OCHAMPUS has taken the initiative to change this Regulation, thereby allowing the Fiscal Intermediaries to accept the sponsor's signature in lieu of the patient's signature on claims submitted to the Fiscal Intermediary for reimbursement.

   Blue Cross of Southwestern Virginia is a leader in the implementation and promotion of an active Telephone Development Process. Blue Cross proposed to the Office of CHAMPUS a telephone development procedure which was adopted in the new fixed price contracts. [66] (Page 88 - Draft Report)

   The error which resulted in most of the claims requiring additional information (returns) was the signature requirement. [68] (Page 91 - Draft Report)

4. Revising contracts to provide for penalties and/or incentives in regard to such areas as implementation of systems, determine location, and status of inquiries, responsiveness to inquiries, provision of adequate telephone service.

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Response: Blue Cross of Southwestern Virginia has totally revamped its telephone system to a rotary system thereby allowing a higher utilization of personnel and telephone equipment. The telephone service now experienced by the beneficiary/provider community has been greatly enhanced. There are four beneficiary incoming lines, two provider incoming lines, and a congressional line. This provides adequate service to all CHAMPUS publics. (Page 111 - Draft Report)

The Plan has a manual system for locating correspondence which is effective in meeting the contractual obligations. [73] (Page 102 - Draft Report) The on-site audit verified that the location of claims was possible. [76] (Page 105 - Draft Report) The correspondence area has greatly improved since the on-site audit and the C.P.E. audit has verified the Plan's commitment to quality service. [77] (Page 107 - Draft Report)

5. Revising contracts to increase the Fiscal Intermediaries' role in educating the beneficiaries in regard to the CHAMPUS Program's provisions and claim submission requirements.

Response: Blue Cross of Southwestern Virginia has been a leader in Beneficiary education. Our Plan seeks out opportunities to discuss this Program with the beneficiary population in an effort to create a better understanding of the Program's limitations and benefits. Blue Cross of Southwestern Virginia has participated in the largest beneficiary workshop known to have occurred in the nation. This workshop provided participation for 750 beneficiaries at Fort Lee, Virginia, on May 12, 1979. This workshop was conducted again in 1980 and 560 people attended. Blue Cross of Southwestern Virginia takes advantage of participating in recruiter workshops thereby creating the understanding of the Program at an entrance level into the military community.

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Blue Cross of Southwestern Virginia has designed CHAMPUS brochures for the Office of CHAMPUS under a supplemental contract in North and South Carolina. Copies of these suggested brochures were submitted to OCHAMPUS with the proposal contract. [81] (Page 113 - Draft Report)

Blue Cross of Southwestern Virginia is a recognized leader in Field Representatives. The standards both for quantity and quality are being maintained by the Field Representatives staff. [82] (Page 114 - Draft Report)

Chapter V. Financial Management Practices in Need of Improvement

Chapter V deals with the financial practices employed at the time of the on-site audit.

The Office of CHAMPUS has taken numerous steps in the last year to assist Fiscal Intermediaries in developing and maintaining adequate financial procedures. The OCHAMPUS audit team now has a financial expert as a regular member of the on-site audit team.

The Letter of Credit method for providing funds to Fiscal Intermediaries to cover benefit payments will resolve many of the problems in the on-site review. Blue Cross of Southwestern Virginia will participate in the Letter of Credit method and will assist OCHAMPUS in making this arrangement functional.

Many of the recommendations reflected in the G.A.O. review are scheduled for implementation or already functional. The following are comments directed to the recommendation and observations of the on-site review.

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Chapter V. Recommendations to the Secretary of Defense

1. Adopting the Letter of Credit method for providing funds to Fiscal Intermediaries to cover benefit payment.

   Response: Blue Cross of Southwestern Virginia will be involved with the experiment in conducting the business by Letter of Credit method. We look forward to participating in this activity and will assist in any way possible in the successful implementation of a Letter of Credit program.

2. Adopting procedures that assure Fiscal Intermediaries routinely and promptly return excess benefit funds to OCHAMPUS.

   Response: Procedures have been established to assure that Fiscal Intermediaries routinely return excess benefit funds to OCHAMPUS. Blue Cross of Southwestern Virginia views this as an important problem and has taken steps to facilitate the return of government monies. Monthly the Financial Department will monitor the credits for a promot return of government funds. [86] (Page 121 - Draft Report)

3. Establishing minimum time requirements for processing audited adjustments and monitoring the processing of these adjustments more closely.

   Response: The Mid Atlantic Contract requires cycle time reporting for the processing of adjustments as well as regular claims. Additional controls will be utilized for more closely monitoring adjustment processing.

4. Develop specific procedures for Fiscal Intermediaries to follow in identifying and collecting erroneous payment.

   Response: OCHAMPUS continues to clarify the Requirements dealing with erroneous payments. This Fiscal Intermediary will implement and participate with whatever guidelines OCHAMPUS selects to develop. Blue Cross of Southwestern Virginia has developed guidelines for internal control

over the safeguarding of checks and the separation of duties in handling and processing of checks. Blue Cross of Southwestern Virginia is currently in compliance with the separation of duties in handling and processing of checks. These functions are performed by two separate and distinct departments in the Plan.

5. Issuing and clarifying instructions on types of claims entitled to administrative reimbursement, that the correct coding is being assigned.

   Response: Proper controls have been established to insure that all checks are properly secured from the moment the check is receipted until the checks are disbursed. [89] (Page 125 - Draft Report)

6. Determining types of claims each Intermediary splits and examining a sample split claim to verify reasons for the split are in accordance with Program regulations.

   Response: Blue Cross of Southwestern Virginia is in compliance with the splitting of claims so that government monies are utilized properly. OCHAMPUS audits the splitting of claims to ensure the proper administrative reimbursement.

7. Recovering over payments as well as rectifying any under payments from the incorrect counting of claims.

   Response: The claims processing system utilized by Blue Cross of Southwestern Virginia automatically calculates the number of claims processed to completion thereby taking any subjective calculation out of the process.

BLUE SHIELD
of California

Blue Shield Plaza, Two North Point, San Francisco, California 94133

November 14, 1980

Mr. David Baine
c/o Mike Zimmerman
United States General Accounting
Office
Room 6741
441 G Street, Northwest
Washington DC 20548

Dear Mr. Baine:

This is in regard to G. Ahart's October 15 letter to me which transmitted a copy of the draft report, "Performance of CHAMPUS Fiscal Intermediaries Needs Improvement" for review and comment.

Due to the time frame allowed for preparing our response, we have not addressed all of the issues nor have we provided the detail that we normally would when responding to such a document. The report was received by Blue Shield on October 20, 1980; thereby allowing us 19 work days in which to review the report and prepare a response. We will continue to review the report and provide you with any additional comments we feel are substantive.

It should be noted that most of the performance deficiencies cited in the report were recognized by Blue Shield CHAMPUS management and corrective action had been initiated. Recent performance figures show that progress is being achieved and that our performance is nearing the OCHAMPUS performance standards. Blue Shield will continue to concentrate its efforts in all areas to ensure compliance with contractual obligations and achievement of OCHAMPUS performance standards.

We sincerely appreciate the opportunity to comment on the findings contained in the report. Should you have any questions regarding our response, please do not hesitate to contact me.

Sincerely,

MARGARET M. GREEN
Vice President
Government Operations

MMG:sgl

APPENDIX III

Chapter 1 Introduction

No Comments

Chapter 2 Benefits Need to be Administered More Accurately

o Coordination of Benefits (COB)

Two major factors which contribute to the problems regarding coordination of CHAMPUS benefits with other insurance are:

- o inadequate education of beneficiaries/sponsors by the uniformed services regarding double coverage regulations.
- o inadequate information on the claim form to properly identify when the patient has other insurance coverage.

The old CHAMPUS claim forms 1863-1, 2 and 4 have caused problems with other insurance identification because of the inadequate language in the other insurance field on the claim form. This problem should be rectified by the use of the new claim forms and better education of CHAMPUS beneficiaries and providers regarding other insurance coverage.

Blue Shield of California does recognize the problems inherent with COB and has upgraded its computer system to automatically handle identification of other insurance; additional system upgrades to the existing system are also being considered.

In early 1979, Blue Shield of California implemented into the CHAMPUS ADP system an automated COB capability. The ADP system presently processes claims based on "COB YES" taking precedence over "COB NO" on both the claim and the eligibility file. If the combination of codes on the claim and eligibility file are conflicting or incomplete, a questionnaire is manually sent to determine the missing information while the claim is processed for payment.

Requirements for automating the questionnaire research process and eligibility file updating process are being analyzed. Implementation of automated procedures will provide more consistency in applying OCHAMPUS COB regulations by minimizing the amount of clerical intervention required in processing COB research documents.

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As part of this proposed upgrade, the system will automatically print a questionnaire when all required COB data is not available from the claim and/or eligibility file. In all cases, the information on the eligibility file will not be used if the data is more than twelve months old.

The report states that an FI's computer files are not always updated to reject claims when the questionnaire is not returned.

Currently, Blue Shield of California, upon receipt of a COB questionnaire, manually prepares an eligibility maintenance transaction to flag the beneficiary's file.

If the questionnaire is not returned within sixty (60) days, the eligibility file is updated manually to indicate rejection of subsequent claims.

The proposed COB upgrades previously referenced above will automatically update the eligibility file after sixty (60) days to indicate rejection of subsequent claims if the questionnaire has not been returned. Upon receipt of a completed questionnaire, the responses will be entered directly from the questionnaire, eliminating the need for manual preparation of an eligibility file maintenance transaction.

In addition, a Beneficiary History Profile will be generated when other insurance is determined to be the primary payor; this will allow a claims processor to check previously paid claims to determine if recoupment action should be taken.

Blue Shield of California has current procedures in effect for active duty dependent claims which allow for the proper coordination of CHAMPUS benefits with other insurance companies.

A recent letter from OCHAMPUS indicates that they will be issuing comprehensive instructions relative to double coverage procedures which will be applicable to active duty dependents, retirees and dependents of retired and deceased sponsors.

With the receipt of these procedures, FIs should be able to resolve some of the problems associated with unclear and confusing instructions previously issued on this subject.

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- TPL and Worker's Compensation Claims

  The guidelines in the CHAMPUS Program Manual, dated December 16, 1974, and the instructions contained in the draft COM Part II (page 11.007 - 11.008) imply that inpatient claims with diagnosis code of 800-999 are the only types of claims to be screened for potential third party liability. In addition, due to the lack of adequate information on the claim form, identification of claims for treatment of a medical condition as a result of the negligence of a third party is very difficult.

  Blue Shield of California's claims processing system has an audit which causes a research document to be produced if the diagnosis code on an inpatient claim falls within a specified ICDA-8 range. This research document is used to review the claim for potential third party liability or Worker's Compensation follow-up.

  OCHAMPUS clarification on specific procedures to be followed by FIs in identifying TPL or Worker's Compensation cases would resolve problems in this area.

- Nonavailability Statements (NAS)

  The GAO report states that FIs do not have adequate procedures for assuring that NAS' are obtained when required.

  On claims lacking a physician certification of emergency, Blue Shield of California did have a letter from C. Booker, dated March 14, 1977 which authorized us to determine an emergency situation existed based on the diagnosis and type of care provided. Subsequent to our Contractor Performance Evaluation (CPE) in late 1979, we reinstituted the return of claims for this information based on the CPE team's findings and recommendations.

  Blue Shield of California is currently testing the implementation of a computerized zip code file which will identify the location of approved military hospital facilities and their proximity to the site where services were actually performed. The ADP system will determine if a Nonavailability Statement is required. Once sufficient claims history has been captured under the new system, claims for the same episode of care can be processed without an attendant Nonavailability Statement if a previous claim did contain a statement.

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The new CHAMPUS professional claim form 500 does not have a box for the physician to certify that the services provided were for an emergency. Therefore, to ensure consistency in making an emergency determination, more specific guidelines will need to be issued to FIs by OCHAMPUS.

- Noncovered CHAMPUS Benefits

On numerous occasions, Blue Shield of California discussed with OCHAMPUS the possibility of obtaining a waiver to omit review of psychiatric/psychological sessions at the 8th and 24th sessions since this requirement had not proved to be an effective means of controlling medically unnecessary services. In addition, the high volume and frequent suspensions of claims at 8 session intervals was administratively impractical. Approval was never granted by OCHAMPUS.

In October, 1980, Blue Shield of California implemented the new American Psychological/Psychiatric Association peer review guidelines for adjudicating psychiatric/psychological claims.

Computer audits have been established which will allow a combination of automated and manual review techniques to aid in proper adjudication of psychiatric and psychological services.

Blue Shield of California's CHAMPUS program has two full-time end-of-line auditors who review a sample of claims paid during each quarter to detect examiner or system related errors. The auditors provide feedback to management and the supervisory staff for corrective action. The primary errors detected through this process are incorporated into training classes conducted for new and old employees. In addition, the lead examiners in each of the claims processing areas review a random sample of claims processed daily.

Blue Shield of California's ADP system employs prepayment audits which automatically disposition (i.e., pay, deny or suspend) specific claims or procedures. As new CHAMPUS guidelines on benefit limitations, noncovered services, etc. are received, an audit is established, whenever feasible, to automatically handle the disposition of the procedure/claim which allows for consistency in payment.

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- Payment Errors Resulting From Incorrect Application of Reasonable Charges, Deductibles and Other Administative Mistakes

  As indicated previously, Blue Shield of California has an internal audit program to ensure that examiner errors are detected and that feedback on these errors is disseminated to the appropriate personnel for corrective action.

  The Blue Shield of California's ADP system has extensive duplicate checking capabilities built into its system to avoid paying duplicate services. Blue Shield of California will continue to monitor its manual procedures and take corrective action where necessary to ensure that duplicate payments are not made.

  A 15-day administrative tolerance was allowed for processing claims submitted after the time filing limit when claims bore no postmark or the postmark was illegible. This administrative tolerance was authorized by the Policy Branch at OCHAMPUS.

- Claims Paid Without Proper Eligibility Information

  Due to the lack of a central eligibility file, the verification of eligibility is limited to what appears on the claim form or on the FI's eligibility file. Until OCHAMPUS implements an eligibility verification system, problems such as the ones cited in this report will continue to occur.

  It should be noted, however, Blue Shield of California attempts to resolve eligibility discrepancies by requesting additional information and/or clarification from the sponsor and/or dependent and correcting history as needed. This is accomplished through the use of a computer generated listing which identifies the histories which appear to be duplicated. This procedure was suspended during 1979 due to other priorities, but it was resumed in 1980.

  Blue Shield of California claims examiners have the capability, based on their research into the eligibility file, of flagging a beneficiary for follow-up research/correction of the eligibility information if it appears that duplication exists on the eligibility file. In addition, any correspondence which identifies problems with eligibility data is researched and appropriate corrections are made to the sponsor/beneficiary history through the use of maintenance transactions to the eligibility file.

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Compliance with the CHAMPUS requirement that claims be returned for the proper signature had a major impact on Blue Shield performance by increasing the return rate during the period of this review from 20% to 33%. This particular requirement had a negative effect on many beneficiaries and is considered by them as a form of harassment to those we are supposed to serve.

In June, 1980, OCHAMPUS issued CHAMPUS Instruction 6010.12 which revised the guideline requiring a beneficiary 18 years of age and over to sign the claim form. The signature of the beneficiary 18 years of age or older or any responsible party (e.g., spouse, mother or sponsor) is now acceptable. The signature of the patient (if 18 years of age or older) is requested only when the claim requires development for other missing information. As a result of this revised requirement, the total errors shown on the chart on page 15 of the GAO report would show a reduction from 746 to 499 errors; other processing errors would likewise be reduced from 291 to 44.

The guideline requiring the FI to verify eligibility for dependent children over 21 years old was rescinded effective June, 1980. Verification of eligibility is now the responsibility of the Uniformed Service of which the sponsor is a member (reference CHAMPUS Instruction 6010.11).

o Acceptable Levels of Claims Processing Accuracy Not Established by OCHAMPUS

One of Blue Shield of California's primary goals as a CHAMPUS FI is to ensure the quality and accuracy of claims processing and payment.

For example, any deficient findings contained in the OCHAMPUS Contractor Performance Evaluation Reports are carefully analyzed and corrective action, as necessary and appropriate, is taken to resolve the deficiencies.

To compare CHAMPUS FI's error rates with Medicare Carriers is somewhat misleading because of the differences in program administration and the complexity of CHAMPUS program requirements. For example, COB is not done by Medicare; diagnosis is generally not required on x-ray and lab claims under Medicare; Medicare Carriers employ a query system to verify eligibility and deductible data and Medicare also does not have differences in cost-sharing requirements like CHAMPUS does. Errors related to these few examples account for a high percentage of errors made by CHAMPUS FIs.

Although, we are not justifying a higher payment error standard than Medicare or FEHB, the differences in program requirements and lack of central eligibility system should be taken into consideration when developing payment error standards under CHAMPUS.

Chapter 3 Systems for Controlling Benefit Costs Need Improvments

- Delays in Establishing Postpayment Utilization Review Systems

Effective June, 1979, Blue Shield of California implemented the Retrospective Analysis of Medical Services (RAMS) postpayment utilization review system; all reports are now being produced and utilized. Prior to June, 1979, Blue Shield of California ran its previous postpayment system, the Peer Group Norm . This system was not turned off until June, 1979 when the RAMS system was implemented.

The fixed price Southwest contract was awarded to Blue Shield of California effective, January 1, 1978. Since our technical proposal indicated that one year's claim data history was needed before the postpayment system became operational, the system was scheduled to generate the first quarterly reports in May, 1979 following the accumulation of the required data; as stated above it was operational in June. Blue Shield of California implemented the RAMS system 18 months following contract award; two months later than originally scheduled.

In the past, Blue Shield of California did not have written desk level procedures as it utilized senior employees employed by Blue Shield for ten or more years who were familiar with UR guidelines. However, written desk level procedures and guidelines have been developed and a copy of these procedures/guidelines were provided to OCHAMPUS in July, 1980.

- Prepayment Utilization Review Needs to be Improved

Currently, Blue Shield of California has 56 medical policy prepayment audits in operation; other audits are in a test mode to determine the accuracy and potential impact of the audit. For example, medical policy length of stay audits have been coded and are now being tested for immediate implementation. As new CHAMPUS guidelines are issued, audits are established, whenever feasible, so that the system can automatically disposition the claim.

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Hospital accommodation rate pricing has been implemented into the CHAMPUS system, effective October 1, 1980.

Because of the differences in coding vendor and beneficiary drug claims (i.e., drug code versus prescription number), computer audits are not feasible at this time. A recent CHAMPUS Instruction (CI) 6010.13 provided FIs with specific parameters to apply in detecting irrational or abuse of drugs. The CI is currently being analyzed and when it is implemented, it will meet the CHAMPUS requirements.

- Documentation Lacking to Fully Evaluate Utilization and Peer Review Effort

We have had some form of documentation on a case or claim basis for those cases referred for Medical Review in San Francisco. We have increased the amount of documentation (effective October, 1980) on all cases to include the reason a claim was reduced/denied and the advisor's signature or ID number. A standard form has been developed for use on postpayment cases.

- Psychiatric Reviews Not Made At Required Intervals

As stated earlier, the APA peer review system for the review of psychiatric/psychological claims was implemented October 1, 1980.

- Little Effort Made to Determine Medical Necessity

Blue Shield of California will review its claims examining procedures and OCHAMPUS guidelines to develop medical necessity guidelines; computer audits will be established whenever practical and feasible.

- Claims Requiring Rejection Are Not Always Being Identified

Blue Shield of California will review its system capabilities and claims processing procedures to ensure compliance with the requirements relating to rejection of claims involving the same episode of inpatient care.

Audits will be established whenever feasible to allow the ADP system to automatically disposition all related claims.

APPENDIX III

- Reasonable Charge Systems Functioning Fairly Effective

  Profile updates for out-of-state providers did not occur until August 15, 1979 for FSY 80 due to the late receipt of Medicare charge data. The FSY 81 profiles for all providers in Blue Shield of California's jurisdiction were updated on July 1, 1980. Also, the new profile methodology as directed by OCHAMPUS was used.

  Should the late receipt of Medicare charge data occur in the future, timely notification will be provided to OCHAMPUS.

- Increase of Prevailing Charge to the 80th Percentile of Customary Charges

  The administrative/system modifications costs for the retroactive processing of claims by Blue Shield of California from the 75th to 80th percentile was $229,273 not $513,225.

Chapter 4 Services to Beneficiaries and Providers Need to be Improved

- Slow Processing of Claims

  As the report indicates, Blue Shield of California's processing time is misleading since our performance figures include claims developed for missing information, peer review, fraud and prior authorization. If we were to exclude these claims, the percentage of claims processed within 21 days would be significantly higher.

  Subsequent to the GAO review, additional staff was hired in the major processing areas of the department such as batching, microfilming, and direct data entry to improve the overall performance of the program. Significant strides in reducing inventories and improving processing times were made as a result of these efforts.

APPENDIX III

As an example, the following statistics for the period July through September, 1980, reflect a significant improvement in the percent of claims processed within 21 days, cycle time and days work on hand:

	July	August	September
Southwest contract	76%	84%	83%
All contracts	76%	84%	84%
Cycle time:			
-- routine/ nonroutine claims	18.2	15.5	15
-- routine claims	14.6	11.4	9.4
Days work on hand	8.5	6.6	9.8

The new CHAMPUS RFPs no longer require FIs to differentiate between routine and nonroutine claims on the Monthly Claims Cycle Time Report. OCHAMPUS has requested Blue Shield of California to implement this new report into its operation; therefore, no further action has been taken to supply OCHAMPUS with the routine/nonroutine claims processing breakdown.

- Delayed Processing Due to Return of Claims

As of January 2, 1980, procedures for the return of claims were rewritten and strengthened to reduce processing times and preclude multiple returns of the same claim. Quality control procedures have also been implemented to ensure that these revised procedures are enforced. For example, to reduce returning a claim more than once, claims to be returned are audited by fully trained examiners to ensure that all missing information is requested.

The creation of an Automated Development System (ADS) is now in progress. Implementation of the ADS will require that an examiner key an entire claim, noting each of those items of information requiring development.

APPENDIX III

The September data applicable to Blue Shield of California, shown on page 87 of the GAO report, reflects significantly higher percentage of returned claims due to the strict enforcement of the signature requirement mandated by OCHAMPUS; the return of claims for proper signature was implemented August 1, 1979. In June, 1980, subsequent to OCHAMPUS rescinding the signature requirement, Blue Shield of California's percent of returned claims declined from an average of 28 to 30 percent to approximately 18 percent.

As previously mentioned, Blue Shield of California has made significant improvements in the timely processing of claims since the writing of this report.

- Delayed Processing Due to Utilization and Peer Review

Blue Shield of California has taken corrective action to reduce the delays resulting from claims requiring medical/peer review.

- Slow Processing of Beneficiary Appeals

Effective February 1, 1980, Blue Shield of California implemented a procedure to identify and flag overdue appeals. The additional staff which was added to the correspondence section has resulted in improved processing times. Blue Shield of California will continue to concentrate its efforts in this area to ensure its compliance with OCHAMPUS performance standards for reviews and reconsiderations.

Blue Shield has taken corrective action to resolve the problems associated with the processing delays cited in the report.

Blue Shield of California management will ensure that processing statistics reported to OCHAMPUS on appeals are accurate. Quality control procedures have been implemented to ensure that completion dates on reconsiderations are recorded to reflect the date of mailing. A full time auditor is assigned to the correspondence section to review samples of correspondence including appeals to ensure the accuracy, quality and timeliness of the correspondence being sent out.

- Slow and Inadequate Responses to Beneficiary and Provider Inquiries and Complaints

  Additional staff was hired to reduce the correspondence inventory and improve the processing time for routine and priority correspondence.

  Blue Shield of California is continuing to concentrate its efforts in this area to improve the quality and timely processing of routine and priority correspondence.

- Failure to Send Interim Responses and Implement Controls Over Inquiries

  Procedures for sending out interim responses on all delayed correspondence were implemented on January 1, 1980.

  An expansion of the CHAMPUS ADP system is in the planning stage. This expansion will provide for location/status and aging of inquiries, as well as automatically generating interim responses on inquiries not completed within the specified time periods.

- Improvements Needed in Claims Control

  Blue Shield of California's ability to access pended claims in a timely manner is more than adequate. The computer reports which are generated twice a week provide the specific location of a claim; a claim is retrievable within 48 hours of a request. [See GAO note.]

- Complaints and Responsiveness of Replies

  Formal documented supplemental training programs are being conducted as needed. A new correspondence quality control program utilized by our Medicare Program has been implemented to measure the quality, responsiveness and tone of the CHAMPUS correspondence. In conjunction with this program, additional procedures have been implemented to monitor types of correspondence as well as errors which generate correspondence and provide feedback to the claims department on a regular basis.

- Telephone Services

  Toll free WATS lines have been installed for beneficiaries in the New England states.

GAO note: This section was deleted from draft report.

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A proposal for the implementation of toll free WATS lines for all states in Blue Shield of California jurisdiction is being submitted to OCHAMPUS for approval.

Blue Shield of California has reviewed the procedures relating to telephone inquiries and will take corrective action as warranted. It should be noted that the reason call backs are not made is that, in many cases, the initial telephone inquiry requires futher research and action on our part (e.g., preparation of an adjustment) and thus are better handled by a written response. Blue Shield of California will monitor this area to ensure that responses to telephone inquiries are made in a timely manner.

- Education of Providers and Beneficiaries

Prior approval from OCHAMPUS is being requested on all bulletins, HBA publications and CHAMPUS/CHAMPVA updates.

Chapter 5 Financial Management Practices in Need of Improvment

- Excessive Fund Balances Held by Fiscal Intermediaries

In March, 1980, Blue Shield of California forwarded OCHAMPUS a $6.5 million refund check. Since that time, we have processed credits against that advance and will provide a final reconciliation for the $6.5 million to OCHAMPUS by December 31, 1980.

In regard to the disagreement on the amount of overadvance, Blue Shield of California and OCHAMPUS settled on approximately $910,000 in February, 1980; the item is now closed.

- Inadequate Procedures for Identification and Recovery of Erroneous Benefit Payments

The present time span between determination of a repayment case and the issuance of a refund request is 45 days. All follow-up requests are sent within 30-40 days of initial request.

APPENDIX III

- Administrative Reimbursements Improperly Paid for Adjustments Caused by FI Errors

  System and clerical processing procedures have been established and implemented which enable the Blue Shield of California CHAMPUS program to identify and report adjustments caused by FI error.

16896/34-47

APPENDIX IV

HMSA CHAMPUS

HAWAII MEDICAL SERVICE ASSOCIATION contractor for CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES

P.O. BOX 860, HONOLULU, HAWAII 96808 TELEPHONE: (808)-944-2281

October 28, 1980

Mr. Gregory J. Ahart
Director
United States General Accounting Office
Washington, D. C. 20548

Re: Draft Report "Performance of CHAMPUS Fiscal Intermediaries Needs Improvement"

Dear Mr. Ahart:

Thank you for the opportunity to review and comment on the draft of the report cited above.

While we have no significant disagreement with the facts presented in the report, we would like to correct the second sentence of the fourth paragraph on page 76 to read:

[58]
"Hawaii Medical Service Association includes the private business charges of all providers, for whose services it has made payment, in its computations." [See GAO note.]

Of course, many of the issues and suggestions the report discusses have subsequently been addressed by OCHAMPUS and the problems corrected by the fiscal intermediaries.

Finally, I would like to convey to you my appreciation of the consideration and active interest shown by your audit staff during their review last year. The team not only made a real effort to be as least disruptive as possible, but made several good suggestions to us which we implemented immediately.

Again, thank you for this opportunity to respond to the draft report and please let me know if you have any further questions about our CHAMPUS operation.

Sincerely,

ROBERT P. HIAM
Vice President
Government Programs

cc: Mr. Anthony C. Graziano, OCHAMPUS
Mr. J. Graham Kolb, OCHAMPUS

GAO note: Changed as suggested in draft report.

APPENDIX V

Mutual of Omaha Insurance Company ■ Home Office: Dodge at 33rd Street, Omaha, Nebraska 68131 ■ V. J. Skutt, Chairman of the Board ■ I. D. Minton, President

Mutual of Omaha
People you can count on...

November 13, 1980

Gregory J. Ahart, Director
Human Resources Division
United States General Accounting Office
Washington, D.C. 20548

Re: Proposed Report
-CHAMPUS Fiscal Intermediary
Performance

Dear Mr. Ahart;

This will acknowledge receipt of this Report, which has been rather quickly reviewed in the interests of making response within the time frame available.

Mutual of Omaha's response is attached, directed to the specific problem areas involving Mutual's operations. We believe the response shows a positive improvement of operation in all current performance as compared to performance in the problem areas at the time of Review . . . . now meeting performance requirements in most areas, progressing in that direction in the few remaining.

A Review of this type probably couldn't have taken place at a more inopportune time, closely following great changes in Procurement methods, multiple changes in Fiscal Intermediaries areas of responsibility, multiple changes in the CHAMPUS Program Regulations, the Direction of OCHAMPUS, etc., etc.

While the CHAMPUS Program may be comparatively small in relation to other government programs, it is not correspondingly simpler . . . . it has retained a status of greater complexity. As such, an immediate turn-about could/cannot be expected in it's general administration, as evidenced by the deterioration following the attempts at massive change toward this end in 1977-78.

As noted in some areas of the response, there have been recent administrative changes initiated by the current Direction in OCHAMPUS in a reasonably orderly manner that have had a very positive effect on improvement in general administration and Beneficiary service, with probably more to come.

APPENDIX V

We believe this has been brought about in part due to the markedly increased communication and working relationship during the past year between OCHAMPUS Direction and Fiscal Intermediaries, with an approach toward working together to solve Program problems.

We do not believe there is any deliberate shirking of contractual responsibilities on the part of any current CHAMPUS Fiscal Intermediary. The routine claim processing times shown in the exhibit on Page 84 of the Report (32.6 average days processing time for the five Intermediaries reviewed) would seem to contradict the assumption on Page i of the Digest concerning FI processing of claims quickly rather than administering benefits accurately under fixed-price contracts.

Rather the deteriorated situation with apparent lack of fulfillment of responsibility, it is felt, developed thru changing and successive top priority Fiscal Intermediary tasks required without sufficient implementation time or follow up, resulting in some high priority tasks not being accomplished or receiving minimal attention.

We believe the overall CHAMPUS Program is proceeding on a course toward eventual levels of proper service and proper benefits administration within the constrictions imposed by fixed fee contract operation after a rather chaotic period of transition.

Sincerely,

F. J. Williams
Second Vice President, Director
CHAMPUS Division

MUTUAL OF OMAHA RESPONSE TO GAO REVIEW

CLAIM PROCESSING ERRORS [11]

Table on Page 15 of report shows Mutual with 135 total errors on 116 out of 269 claims processed, for a 43.1% claim error ratio.

The 135 errors are categorized as . . . .

ELIGIBILITY	71
DOUBLE COVERAGE	52
NON-AVAIL. STMTS.	4
AUTHORIZED BENEFITS	7
PAYMENTS	1

Eligibility

This Category of error is detailed as . . . .

Improper Signature - Claim Signed by Patients Spouse	51
Improper Signature - Signed by parent of Child Age 18 or over	14
Dependent Child Over 21 and no Support for Continued Dependency	2
Patient Over 65 Years Old - Possible Medicare Coverage	2
Care Outside Eligibility Dates Shown on Claim Form	1
Claim Form Not Signed	1
Total	71

Improper Signature . . . . Due to the multitude of reasons for returned claims and the multitude of complaints for same, which adversely affected the CHAMPUS Beneficiary and Provider population, Mutual had made an Administrative decision to accept claims, on a limited basis, presented with a signature other than the patient when it was obvious that the claim was otherwise valid and proper intent was evident. In general, Mutual accepted the Sponsor's signature in lieu of the spouse or dependent signature.

Your Review initiated questions regarding this procedure, and Mutual subsequently enforced signature requirements in mid-1979, which promptly increased the return rate from an average of 22% to 28% of claims received, a 17% increase in returned claim volume.

APPENDIX V

The complaints increased even more so, placing the signature requirements in a position of focus to the extent that a subsequent OCHAMPUS Directive liberalized the requirements in recognition of their unwarranted restrictions.

Perhaps Mutual was considered to be not fulfilling a contractual responsibility in this regard, however the current requirements would indicate it's administrative decision was not necessarily an injudicious action.

By today's standards, 65 of the 71 Eligibility errors would be erased.

Dependent Child Over 21 . . . . Mutual has two "errors" in this category which would also not exist by today's standards, as the Form 348 usage and the responsibility for this determination has been removed from FI activity.

Double Coverage Errors . . . .

Mutual has been charged with 52 processing errors in this category. Twenty-one are of the "possible" variety. The remaining 31 cases involve a variety of situations, mostly those of a nature attributable to inadequacies of the CHAMPUS Claim Form as noted beginning on Page 18 of the Report.

At this point, perhaps it should also be noted that there is a current project under way involving a uniform Claim Form for use in all Government Programs which provides even less other insurance information than on current CHAMPUS claim forms.

The Fiscal Intermediary referred to on Page 21 of the Report is Mutual of Omaha . . . . and involves a slight misconception in preparation of the Report. Negotiations were not only for the extra costs of a coordination of benefits program, but for the approval of the procedures necessary to accomplish the Program.

OCHAMPUS and Mutual have reached an agreement on procedures and costs, and implementation of a complete coordination of benefits program is taking place at this time. This eliminates future concern for Mutual's operation in this area.

Non-availability Statements . . . .

Mutual has been charged with four errors in this category. Approximately six months ago, a completely automated system was installed in Mutual's operation, with zip code tables and claim history cross-referencing capability. This has eliminated the human element in determining requirements and broadened the application/non-application of need for non-availability statement to all related claims.

This action gives virtually 100% effectiveness in controlling processing errors of this type.

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Authorized Benefits . . . .

Mutual has been charged with seven errors in this category. These were various types ranging from not reviewing a claim at a specified time interval, thru inadvertent payment or nonpayment of an item in a claim. These are manual processes in adjudication, and some will occur. However, Mutual's Quality Control program of postpayment review of every tenth claim (a re-audit) implemented more than a year ago is geared toward an on-going educational and administrative assist in maintaining as low a ratio of human error as possible.

Payments . . .

Mutual has been charged with one error in this category, which involves reasonable charges, cost sharing, and application of deductible.

Claim payments are almost 100% a computerized function, and as such achieve a high degree of accuracy. Further positive action in this area not being indicated, Mutual will continue it's on-going efforts toward maintaining accurate payment computations.

CONCLUSIONS - CLAIM PROCESSING ERRORS

Considering the foregoing points, should a comparable GAO review be made now or in the immediate future, Mutual's current operation would show complete elimination of 67 eligibility and 4 non-availability statement errors . . . . and elimination of the bulk of the 52 double coverage errors. Any remaining claim processing errors that occurred would be in the acceptable range for adequate processing standards.

POST-PAYMENT UTILIZATION REVIEW SYSTEM

[45]

Page 56 of the Report refers to Mutual of Omaha not implementing the postpayment utilization review system described in its technical proposal.

There were delays in implementation occasioned by problems in the originally contemplated system that remained unsolved, requiring re-development of the system. The latter was subject to then current higher priorities mandated by Directives, which prolonged delay.

The reporting system, generating four separate reports quarterly, was implemented in March 1980.

PSYCHIATRIC OUTPATIENT VISIT REVIEW AT 8TH SESSION

[47]

Page 60-61 of the Report refers to Mutual of Omaha not reviewing these claims at 8th session intervals as prescribed in Regulation 6010.8-R.

At this time Mutual is subjecting all Psychiatric/Psychological out-patient treatment cases to a second level "Review" at the 8th visit interval as required . . . . also at 24th, 40th, and 60th visit intervals.

ASSOCIATED CLAIMS REQUIRING REJECTION NOT ALWAYS IDENTIFIED

[53]
Table on Page 69 of the Report shows Mutual of Omaha did not reject 5 claims associated with claims rejected.

The previously described actions in the areas of non-availability statements and double coverage referred to in the Section on Claim Processing Errors are eliminating the greater portion of the volume of discrepancies in this situation. Further steps toward correlating disallow claims are under consideration with positive development of procedures anticipated soon.

CLAIM PROCESSING TIME STANDARDS

[63]
Table on Page 84 of the Report shows Mutual of Omaha's average time for processing routine claims in January and February, 1979 as 32 days, with only 6% processed in 21 days.

At this time, Mutual of Omaha can refer to a record of routine claim processing for the past six months as follows . . . .

Month	% Processed 21 Days
April 1980	98%
May 1980	99.27%
June 1980	99.27%
July 1980	99.48%
Aug. 1980	99.4%
Sept. 1980	99.7%

Believe this record relieves any concern for this area at this time.

DELAYED PROCESSING DUE TO RETURN OF CLAIMS

[66]
Page 87 of the Report shows Mutual of Omaha's claims returned as 39% of claims received in September, 1979. Page 90 outlines some problems with returns. [68]

As referred to in the Section on claims processing errors; Improper Signature and Dependents over 21 areas; these two reasons for returning claims have been liberalized by OCHAMPUS considerably. For example, for the month of September, 1980 . . . . Mutual's return rate was 16.8% to claims processed, 19.4% to claims received.

Mutual was also aware of some problems with returns, and over a year ago initiated a program of review of all claims in a second return status at end of processing. These claims are reviewed for validity

APPENDIX V

of return and completeness of the information requested with the individual responsible, as a part of on-going training. A further spot check of claims being returned is performed by Supervision on a daily basis.

Additionally, an experimental program for telephone development of needed information has been in place for three months, on a limited basis. This has proven to be of such value that a full scale implementation is anticipated upon procurement and training of additional personnel and additional WATS line installation.

These steps will not only further reduce the return claim rate, but further assure quality of those still requiring a return.

BENEFICIARY APPEALS/INQUIRY PROCESSING

This whole area basically involves processing of correspondence received, from Mutual of Omaha's standpoint, as approximately 93% of Mutual's telephone inquiries have been handled while on the phone through use of on-line computer terminals by those receiving calls.

It is recognized that problems have existed over the past several years . . . . generated in part by the numerous changes in processing brought about by application of the Regulation 6010.8-R, changes in Fiscal Intermediaries, changes in some program benefits, etc., ... which create a proliferation of inquiries for various reasons at different times . . . . making on-going resource (manpower) requirements extremely difficult to assess or maintain.

[70]

Mutual of Omaha did broaden the interpretation of what constituted an appeal late in 1979 upon resolution of a consideration by OCHAMPUS, as referred to on Page 96 of the Report. Example: Quarterly report ending 12-31-79 showed 23 informal reviews received as opposed to 178 received for the quarter ending 6-30-80.

[74]

Page 100 of the Report notes that Mutual of Omaha had not prepared the monthly correspondence cycle time report . . . . Page 103 notes that the Correspondence Control System was under implementation at conclusion of the Review. This item was under the contract change-order process which had delayed the implementation.

Since the Review generating this GAO Report, Mutual has had correspondence processing under almost continuous scrutiny, with the implementation mentioned above and additional revisions taking place at this time. A result has been a significant steady improvement from the 7% claim-related correspondence processed in 10 days as shown on Page 99 of the Report to 50% on the September 1980 Report. [73]

The current revisions are directed toward meeting all processing standards within the next two months.

APPENDIX VI

Champus Champva
CIVILIAN HEALTH AND MEDICAL PROGRAMS OF THE UNIFORMED SERVICES
CIVILIAN HEALTH AND MEDICAL PROGRAMS OF THE VETERANS ADMINISTRATION

P.O. BOX 7927 MADISON, WISCONSIN 53707

November 14, 1980

Mr. Gregory J. Abart, Director
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Abart:

Mr. Koenig has asked our staff to provide you with the comments you invited when you provided us with your draft report entitled, "Performance of CHAMPUS Fiscal Intermediaries Needs Improvement".

We appreciate the opportunity to review the report and hope that our comments will provide some additional useful insights and perspective into the administration of the CHAMPUS Program.

I'm sure that every respondent has pointed out that when your staff conducted the audit in early 1979 most of the claims reviewed were from the last quarter of 1978, a period during which Wisconsin Physicians Service was still completing the transition tasks from some jurisdictions which had been acquired from 2 to 9 months earlier. These transition tasks included obtaining and organizing information from prior contractors, conversion of massive data files of past claims history, provider identification, and fee profiles for thousands of physicians and suppliers. Your auditors were reviewing the results of administrative procedures in a complex program that were still in a state of transition. Carriers who were involved in the Medicare and Medicaid programs in 1966 can attest to similar startup problems in those programs.

The Contractor Performance Evaluation program of OCHAMPUS has been instrumental, in our opinion, in rapidly identifying and correcting the administrative deficiences which your staff identified in their audit.

We would like to comment in very general terms on the four basic administration areas in which your auditors cited need for improvement.

Administered by WPS WISCONSIN PHYSICIANS SERVICE

APPENDIX VI

--Benefits Need to Be Administered More Accurately.

OCHAMPUS has a well organized system for issuing and interpreting program policies and has established standards for clerical and payment errors. Fiscal Intermediaries are required to have effective training programs and quality assurance procedures. In the Contractor Performance Evaluations, knowledgable OCHAMPUS personnel audit Fiscal Intermediary compliance with program policy and issue reports with detailed findings and directions for correction. In more recent procurements there are provisions for financial penalities for failures in compliance. In our opinion, these control measures have reduced payment error rates to levels which compare favorably with other third party payment programs.

--System for Controlling Benefits Need Improvement

Requirements for utilization and peer review and detection of medically unnecessary or categorically noncovered services are clearly defined, compliance is monitored through both the Fiscal Intermediary quality assurance processes and through OCHAMPUS' Performance Evaluation program. Communication of information about benefits and exclusions to providers and to beneficiaries has become much more effective. Post-payment pattern of care analysis, to the extent practical in a program where beneficiaries are so widely dispersed, has identified questionable and fraudulent situations and corrective action has been taken. Therefore in our opinion many of the improvements recommended by your audit have been made.

--Services to Beneficiaries and Providers Need to Be Improved.

Fiscal Intermediaries as a group, and Wisconsin Physicians Service specifically, have for months been meeting the OCHAMPUS standards for timeliness of claims processing. During the past nine months WPS has consistently processed more than 90% of routine claims in less than 21 days.

Similarly, claims inventory levels at WPS have been well below the standard of 15 days work on hand; the percentage of claims being returned has been sharply reduced through the utilization of phone development; and responses to all categories of correspondence regularly exceed contractual standards.

WPS has developed a program of beneficiary and provider field services which includes individual counselling and group seminars for beneficiary and provider groups, closely coordinated with Health Benefit Advisors and OCHAMPUS staff.

These field contacts and workshops have significantly increased understanding and acceptance of the program and of proper claims submission. We feel that the deficiencies identified in the audit have been corrected. We are enclosing some letters from the military, retiree, and provider communities in our jurisdictions which illustrate positive reaction to this field activity.

--Financial Management Practices In Need of Improvement.

The outstanding bank balances due to unresolved adjustments, recovered overpayments, and stale dated checks have been reduced to reasonable levels. OCHAMPUS has issued a draft instruction on use of a Letter of Credit procedure which should further facilitate cash management.

Summary

We have not attempted to make specific comments on the audit findings because they essentially reflect many of the conditions which existed in the operating environment in 1978. Those operating deficiences had already been recognized, and correction measures were being taken by OCHAMPUS and the fiscal intermediaries. In the intervening months since the audit these efforts of OCHAMPUS and the contractors have in our opinion substantially improved all aspects of program administration.

We attempted to work constructively with your audit staff in the best interests of the program and appreciate the opportunity to submit these general comments.

Sincerely,

I.A. Zyduck

I.A. Zyduck
Assistant Director
Government Programs

IAZ:kl

cc: R.E. Koenig
President

Theodore D. Wood
Director, OCHAMPUS

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