February 10, 2006

Health Care

TRICARE Overseas Controls Over Third Party Billing Agencies and Supplemental Health Insurance Plans (D-2006-051)

Department of Defense
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Acronyms

CDIS	Care Detail Information System
CMS	Centers for Medicare and Medicaid Services
DCIS	Defense Criminal Investigative Service
GAO	Government Accountability Office
RAO	Retired Activities Office
TMA	TRICARE Management Activity
TOP	TRICARE Overseas Program
WPS	Wisconsin Physician Services

INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
400 ARMY NAVY DRIVE
ARLINGTON, VIRGINIA 22202-4704

February 10, 2006

MEMORANDUM FOR ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

SUBJECT: Report on TRICARE Overseas Controls Over Third Party Billing Agencies and Supplemental Health Insurance Plans (Report No. D-2006-051)

We are providing this report for review and comment. We considered management comments on a draft of this report when preparing the final report.

DoD Directive 7650.3 requires that all recommendations be resolved promptly. The Assistant Secretary of Defense (Health Affairs) comments were fully responsive to Recommendations 1., 2., and 3.; however, comments to Recommendations 4. and 5. were not responsive. We request that the Assistant Secretary of Defense (Health Affairs) provide additional comments on Recommendations 4. and 5. by March 10, 2006.

If possible, please send management comments in electronic format (Adobe Acrobat file only) to AudYorktown@dodig.mil. Copies of the management comments must contain the actual signature of the authorizing official. We cannot accept the / Signed / symbol in place of the actual signature. If you arrange to send classified comments electronically, they must be sent over the SECRET Internet Protocol Router Network (SIPRNET).

Because information in this audit report may be exempt from public release under the Freedom of Information Act (FOIA), it is designated "For Official Use Only." The report is provided for the sole use of you and your staff. Requests for additional releases of the report should be referred to the FOIA/Privacy Act Office, Office of the Inspector General of the Department of Defense, 400 Army Navy Drive, Arlington, Virginia 22202-4704.

We appreciate the courtesies extended to the staff. Questions should be directed to Mr. Michael A. Joseph at (757) 872-4815, extension 223, or Mr. Scott J. Grady at (757) 872-4759. See Appendix B for the report distribution.

By direction of the Deputy Inspector General for Auditing:

Wanda A. Scott
Assistant Inspector General
Readiness and Logistics Support

Department of Defense Office of Inspector General

Report No. D-2006-051 **February 10, 2006**
(Project No. D2005-D000LF-0017.000)

TRICARE Overseas Controls Over Third Party Billing Agencies and Supplemental Health Insurance Plans

Executive Summary

Who Should Read This Report and Why? Policymakers and senior managers should read this report to gain an understanding of the potential for improper payments for health care provided to overseas DoD beneficiaries.

Background. This report is the first of two that discuss controls at the TRICARE Management Activity over payments made for healthcare services in overseas locations. Specifically, this report covers medical billing improprieties in the Philippines, apparent unlawful waivers of beneficiary cost shares, and sanctioning organizations who were abusing the TRICARE Overseas Program. The TRICARE Management Activity is a DoD field activity responsible for managing TRICARE, the DoD healthcare program for active duty and retired service members and their dependents. The TRICARE Overseas Program is the DoD-managed healthcare program outside the continental United States. The TRICARE Management Activity paid about $191 million in TRICARE Overseas Program claims during FY 2003.

According to the Health Insurance Portability and Accountability Act of 1996, punitive damages recovered in Federal healthcare convictions and judgments are deposited in the Federal Hospital Insurance Trust Fund to cover the costs of administering a Healthcare Fraud and Abuse Program. As of June 2005, only the Department of Health and Human Services, the Department of Justice, and the Federal Bureau of Investigation receive funding for the Healthcare Fraud and Abuse Program. DoD should have access to punitive damages awarded and recovered in TRICARE healthcare convictions and judgments. DoD should, at a minimum, have access to punitive damages awarded in TRICARE overseas healthcare fraud investigations where DoD has primary investigative responsibility. The funds can be used to help defray the cost of curtailing healthcare fraud and abuse in the TRICARE program.

Results. We performed this audit to evaluate controls over TRICARE payments made to overseas healthcare providers. Because of an ongoing Defense Criminal Investigative Service investigation and the dramatic increase in healthcare costs in the Philippines, we concentrated our efforts in the Philippines. Healthcare costs in the Philippines have risen from $2.87 million in FY 1998 to $64.19 million in FY 2003, even though the beneficiary population was relatively constant.*

* We did not include FY 2004 data in our report because providers are allowed 12 months for submitting claims, and as such, the FY 2004 Care Detail Information System data were not finalized at the time of our audit.

Wide-scale medical billing improprieties occurred in the Philippines by a company that functioned as a healthcare provider, a third party biller, and a supplemental insurer. Although the TRICARE Management Activity attempted to ensure that TRICARE payments for beneficiary healthcare were for the correct amount by tightening administrative controls, the TRICARE Management Activity can further strengthen controls by establishing additional guidelines and procedures for validating medical claims and establishing guidelines and procedures that will help ensure that beneficiaries pay statutorily mandated cost shares. In addition, the TRICARE Management Activity should exercise its administrative sanctioning authority to include excluding those found routinely abusing the TRICARE program. The TRICARE Management Activity should report the internal control weakness identified in this report in future annual statements of assurance and raise the risk level associated with the TRICARE Overseas Program assessable unit from low to high until the material weakness is corrected. Implementing the recommendations contained in this report could result in significant cost avoidance. Although we cannot quantify the amount, in July 2004, the Assistant Secretary of Defense (Health Affairs) estimated that healthcare fraud in the Philippines costs TRICARE more than $40 million annually. We will attempt to quantify the cost avoidance during our audit followup process**.** (See the Finding section of the report for the detailed recommendations.)

Management Comments and Audit Response. The Assistant Secretary of Defense (Health Affairs) generally concurred with the finding and the intent of the recommendations for additional controls and initiatives "to combat fraud." The Assistant Secretary disagreed that the internal control weakness identified in the report was material and therefore did not agree to report the weakness in future annual statements of assurance or to change the risk associated with the TRICARE Overseas Program assessable unit from low to high.

The Assistant Secretary's comments on the internal control weakness are not responsive. Although the TRICARE Management Activity has taken a number of steps to mitigate the likelihood of improper payments in the TRICARE Overseas Program, the risk of improper payments remains high and the weakness cited in the report is material. According to DoD Instruction 5010.40, "Management Control Program Procedures," August 28, 1996, a material weakness includes significantly weakened safeguards against fraud, waste, or mismanagement of funds. The Assistant Secretary recognized that improper payments continue and requested additional investigative support. While investigative support may be warranted, the TRICARE Management Activity cannot rely on the Office of Inspector General to resolve systemic management control problems in their TRICARE Overseas Program. Until it evaluates and certifies the effectiveness of the corrective action, management should report the material management control weakness. In addition, the TRICARE Management Activity should raise the risk level associated with the TRICARE Overseas Program assessable unit from low to high until improper payment issues are corrected. Accordingly, we request that the Assistant Secretary of Defense (Health Affairs) provide additional comments on the final report by March 10, 2006. See the Finding section of the report for a discussion of the management comments on the recommendations and the Management Comments section of the report for the complete text of the comments.

The Assistant Secretary of Defense (Health Affairs) stated that the absence of appropriate, necessary Defense Criminal Investigative Service personnel working to support TRICARE Management Activity efforts has significantly hampered the DoD ability to investigate fraud and abuse. Because it is responsible for the investigative resources, the Defense Criminal Investigative Service will respond directly to the Assistant Secretary.

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Background

This report is the first of two that discuss controls at the TRICARE Management Activity (TMA) over the payments made for healthcare services in overseas locations. The report covers controls related to overseas healthcare claims paid to third party billing agencies and payment of required beneficiary cost shares in the Philippines. This report also discusses additional administrative remedies that should help reduce the potential for improper healthcare claims and potential abuse of the TRICARE Overseas Program (TOP). TOP is the DoD-managed healthcare program outside the continental United States and includes four areas: TRICARE Europe, TRICARE Latin America and Canada, TRICARE Pacific, and TRICARE Puerto Rico and Virgin Islands. The second report in this series will cover price caps and other administrative controls. Because of an ongoing investigation, the names of companies or healthcare providers included in the review are not being revealed.

TRICARE Management Activity. TMA is a DoD field activity responsible for managing the TRICARE program. TRICARE is the DoD healthcare program for active duty and retired service members and their dependents. TMA establishes guidelines for paying healthcare providers, including locations overseas that participate in TOP. As part of TOP, TMA paid claims totaling about $191 million in FY 2003, of which about $64 million was paid for healthcare in the Philippines.

TRICARE Overseas Program. TOP blends many of the features of the DoD stateside TRICARE program while allowing for significant cultural differences unique to foreign countries and their healthcare practices. To process overseas claims for TRICARE beneficiaries, TMA awarded a contract to Humana Military Healthcare Services who subcontracted the responsibility of processing and monitoring claims to Wisconsin Physician Services (WPS). The responsibility for processing and monitoring claims included processing claims that third party billing agencies submitted.

Third Party Billing Agencies. According to General Accounting Office [now Government Accountability Office (GAO)] Report HEHS 99-127R, "Medicare: Identifying Third Party Billing Companies Submitting Claims," June 2, 1999, many providers are using third party billing agencies to assist in processing claims and provide advice regarding reimbursement matters, as well as overall business decision making. A third party billing agency prepares and submits claims on behalf of healthcare providers to TRICARE and private health insurers. Using third party billing agencies helps providers concentrate on the business of providing quality healthcare and ensure payment for services.

Claims History in the Philippines. Claims processed in the Philippines went from 7,558 in FY 1998 to 157,894 in FY 2003, an increase of approximately 1,990 percent. During that same time, the total dollar value of claims paid for TRICARE beneficiaries rose from $2.87 million to $64.19 million, an increase of approximately 2,135 percent while, according to the Defense Manpower Data

Center, the beneficiary population remained relatively constant at about 9,000. [1] For roughly the same time,[2] according to the National Statistics Office, Republic of the Philippines, the medical inflation rate for the Philippines increased approximately 80 percent. See Figure 1 below for an illustration of how claims increased in the Philippines while the number of beneficiaries remained relatively constant.

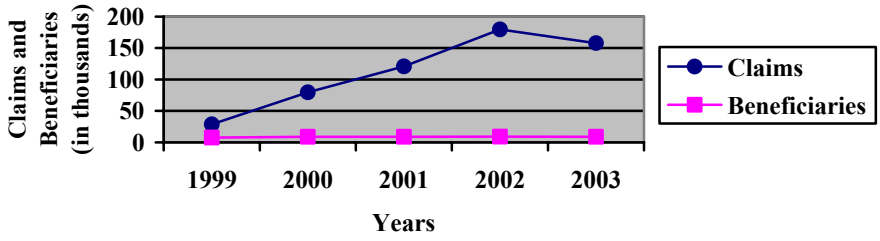

Figure 1. Number of Beneficiaries versus Claims Submitted in the Philippines

Although total claims dropped slightly from FY 2002 through FY 2003, the dollar amount of paid claims actually rose from $60.3 million in FY 2002 to $64.2 million in FY 2003. TRICARE beneficiaries in overseas locations have access to two primary benefit packages—TRICARE Overseas Prime, offered through TRICARE Global Remote Overseas for those locations that are not in close proximity to a military treatment facility, and TRICARE Overseas Standard. About 90 percent of claims originating in the Philippines were for retirees and dependents. Only active duty and their family members can participate in TRICARE Overseas Prime. Because retirees in overseas locations cannot participate in TRICARE Overseas Prime, TRICARE Overseas Standard is the predominant plan used in the Philippines. TRICARE Overseas Standard offers medical insurance to retirees, their family members, and survivors, with an individual deductible of $150, or $300 per family.

A beneficiary must pay the deductible each year before TRICARE will cover charges. After TRICARE begins to cover charges, the beneficiary must continue to pay a cost share fee based on the amount billed or an allowable charge. For inpatient and outpatient overseas services, beneficiaries must pay 25 percent of covered charges after the deductible is met. The beneficiary has an annual catastrophic cap (a maximum limit on beneficiary out-of-pocket expenses, which includes cost shares and deductibles) of $3,000.

[1] We did not include FY 2004 data in our report because providers are allowed 12 months for submitting claims, and as such, the FY 2004 Care Detail Information System data were not finalized at the time of our audit.

[2] The Philippines medical inflation rate before July 1998 was not available; we assumed the increase from October 1997 through July 1998 was approximately the same as the increase from July 1998 through March 1999.

Other Matters of Interest. According to the Health Insurance Portability and Accountability Act of 1996, punitive damages recovered in all Federal healthcare convictions and judgments are deposited in the Federal Hospital Insurance Trust Fund (Fund). The Fund is primarily financed from payroll taxes employees and employers pay, which, in turn, finance Medicare Part A to help pay for hospital, home healthcare, skilled nursing facilities, and hospice care for disabled and elderly individuals. To cover the cost of administering a Healthcare Fraud and Abuse Account Program, including audits and investigations, Congress also established a Healthcare Fraud and Abuse Control Account within the Fund.

The Health Insurance Portability and Accountability Act of 1996 requires that punitive damages recovered in all TRICARE healthcare convictions and judgments be deposited into the Fund; however, DoD does not have access to the Fund. The law allows only the Department of Health and Human Services, the Department of Justice, and the Federal Bureau of Investigation access to the Fund for use in audits and investigations designed to identify and prevent fraud and abuse. While the Department of Health and Human Services and the Federal Bureau of Investigation may play prominent roles in healthcare judgments and convictions obtained for cases occurring within the United States, they generally do not participate in TRICARE overseas audits and investigations but receive funding based on the outcome of those cases. Between October 1, 1999, and March 17, 2005, the Defense Criminal Investigative Service (DCIS) participated in overseas healthcare fraud investigations of TRICARE that resulted in $640,600 in punitive damages. DoD should pursue a legislative change to the Health Insurance Portability and Accountability Act of 1996 that would allow DoD access to the Fund—particularly punitive damages recovered in TRICARE overseas cases not involving Health and Human Services or the Federal Bureau of Investigation. Access to the Fund would support efforts to curtail healthcare fraud and abuse in the TRICARE program.

Objectives

Our overall audit objective was to evaluate controls over TRICARE payments made to overseas healthcare providers. We also reviewed the management control program as it related to the overall objective. Because of an ongoing DCIS investigation and a dramatic increase in healthcare costs in the Philippines, we concentrated our efforts in the Philippines. This report focuses on payment of healthcare claims to third party billing agencies and payment of required beneficiary cost shares. A second phase of the audit will address the need for additional administrative controls in the Philippines and other overseas locations. See Appendix A for a discussion of the scope, methodology, and prior coverage related to the objectives.

Management Control Program Review

DoD Directive 5010.38, "Management Control (MC) Program," August 26, 1996, and DoD Instruction 5010.40, "Management Control (MC) Program Procedures," August 28, 1996, require that DoD organizations implement a comprehensive

system of management controls that provides reasonable assurance programs are operating as intended and to evaluate the adequacy of the controls.

Scope of the Review of the Management Control Program. We reviewed the management control procedures related to TOP in the Philippines. We specifically reviewed the billing practices of overseas providers. We reviewed management's self-evaluation applicable to those controls.

Adequacy of Management Controls. We identified a material management control weakness for TMA as DoD Instruction 5010.40 defines. TMA controls did not adequately ensure that third party billing agencies were properly submitting TRICARE overseas claims. In addition, TMA should establish procedures for detecting unlawful waivers of cost shares and deductibles. Recommendations 1., 2., and 3., if implemented, should reduce the possibility of abusive practices by billing agencies in the Philippines as well as unlawful waivers of cost shares and deductibles. For details of the weakness, see the Finding section of the report. A copy of the report will be provided to the senior official responsible for management controls within TMA.

Adequacy of Management's Self-Evaluation. TMA officials identified the TRICARE Overseas Program—Access to Care in the Philippines as an assessable unit but identified the risk associated with TOP as low because TMA officials believed that sufficient controls were implemented. TMA officials reported that the material weakness identified in FY 2001 in the TRICARE Overseas Program—Access to Care in the Philippines was corrected. In FY 2004, the Assistant Secretary of Defense (Health Affairs) estimated fraud in the Philippines at $40 million annually. Therefore, TMA should reassess the risk to the TRICARE Overseas Program—Access to Care in the Philippines as high, as well as report a material weakness in any future Annual Report to Congress until the material weakness is corrected.

Validation of Overseas Third Party Billing Agency Claims and Identification of the Unlawful Waiver of Cost Shares

Wide-scale medical billing improprieties have occurred in the Philippines by a company functioning as a healthcare provider, a third party biller, and a supplemental insurer. During FY 2003, that company received about 80 percent of the TOP dollars in the Philippines. As a third party biller, the company billed and received payments from TRICARE directly without the provider certifying services were performed and accurately billed. Such a condition created an opportunity for the company to inflate charges. As a supplemental insurer, the company apparently waived required beneficiary co-payments and deductibles, passing the cost on to the Government through inflated medical claims. Although TMA initiated numerous administrative controls in the Philippines, additional controls are needed that will ensure providers are held accountable for claims submitted either by themselves or on their behalf and that supplemental health insurance plans do not illegally waive beneficiary co-payments and deductibles. Implementing the recommendations in this report could result in significant cost avoidance. Although we cannot quantify the amount, in July 2004 the Assistant Secretary of Defense (Health Affairs) estimated that healthcare fraud in the Philippines costs TRICARE more than $40 million annually. We will attempt to quantify the cost avoidance during our audit followup process.

TMA Initiatives

To ensure access to healthcare for beneficiaries, TMA guidance states that overseas claims will be paid as billed, generally without limits. TMA referred multiple hotlines to DCIS as early as October 2000, however, healthcare costs continued to rise in the Philippines. TMA met with DCIS and the U.S. Attorney's Office, Western District of Wisconsin, during 2001—at the invitation of DCIS and the U.S. Attorney's Office, Western District of Wisconsin—to develop administrative controls that would help deter improper TRICARE claims. Specifically, TMA modified payment procedures for pharmacy claims in FY 2002 to require National Drug Association Code (Red Book) pricing for the Philippines, Panama, and Costa Rica. TMA also contracted with a company, International SOS, to perform provider certification and verification before any payment of claims in the Philippines.

In 2003, TMA began denying claims submitted without an actual beneficiary signature and also began performing special reviews of beneficiaries in the Philippines with excessive claims. TMA initiated additional controls in 2004. Examples of those controls include limiting payment for professional services in the Philippines to the CHAMPUS Maximum Allowable Charge levels established for Puerto Rico and requiring coding on claims submitted by agencies in addition to the narrative explanation of services rendered. TMA also required pricing of hospital/physician-dispensed drugs in the Philippines at Red Book prices (in

addition to the previously established Red Book pricing on pharmacy claims) and began disallowing fees for doctor visits when billed with prescription refills. In addition, TMA instituted an inpatient per diem system in the Philippines for maximum allowable hospital charges.

After sharing our concerns about third party billing claims and the claims validation process, TMA modified their claims processing contract for overseas provider payments. The contract modification requires that Humana Military Healthcare Services notify Philippine healthcare providers that TRICARE will discontinue paying billing agencies directly. The contract modification also requires that the contractor send letters to Philippine beneficiaries advising them of their ability to choose any authorized physician as a provider, as well as the importance signatures play in the claims validation process. We also provided TMA with documentation showing that a third party billing agency (Company A) developed a scheme that apparently resulted in the routine waiver of deductibles and cost shares. Subsequently, TMA issued in June 2005 a news release on its Web site citing the congressional intent for establishing cost shares and the legal requirement for beneficiaries to pay cost shares.

Payments to Third Party Billing Agencies

TMA should establish strict guidelines and procedures for validating medical claims from overseas third party billing agencies. Specifically, TMA should direct that the claims processing contractor, Humana Military Healthcare Services:

- Require that providers submit a statement of services rendered for each third party billing agency claim processed,
- Require that providers sign the Health Insurance Claim form submitted by the third party billing agency, and
- Discontinue directly paying third party billing agencies.

Healthcare Market in the Philippines. Several third party billing agencies in the Philippines bill TRICARE on behalf of healthcare providers, however, Company A dominated the market in the Philippines. Company A also expanded its operations to Panama, Costa Rica, and Thailand. In FY 2003, Company A billed for 80 percent of the healthcare claims paid in the Philippines. See Figure 2 for an illustration of Company A claims versus the remaining TRICARE claims in the Philippines.

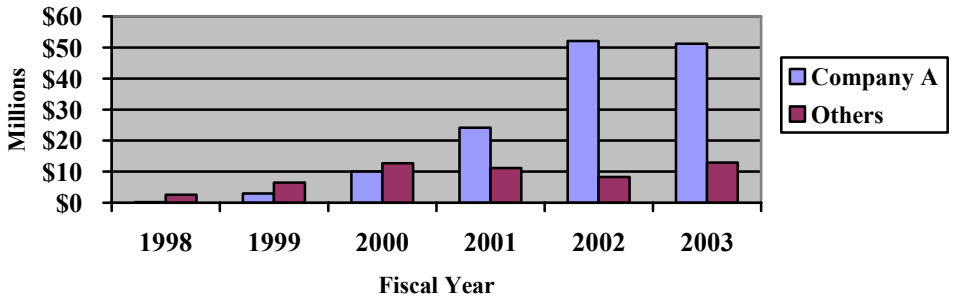

Figure 2. Amount Paid to Company A and Others for Philippine Claims From FY 1998 through FY 2003

In addition to being a third party billing agency, Company A was also a healthcare provider. The company owns hospitals and clinics in the Philippines and has partnered with numerous physicians and related medical professionals.

Company A employed military retirees as independent Retired Activities Office (RAO) representatives.[3] The independent RAO representatives Company A hired attempted to recruit fellow retirees who would use the Company A network of providers. The supplemental health insurance plan offered by a division of Company A enticed beneficiaries further to use its network of providers and facilities. The supplemental health insurance was available only to TRICARE beneficiaries and covered beneficiary cost shares. In effect, Company A (in their supplemental insurer capacity) apparently waived beneficiary deductibles and cost shares. The supplemental health insurance plan and its legal ramifications are discussed later in this report.

Third Party Billing Agency's Claim Processing Procedure. In their capacity as third party billing agency, Company A bills TRICARE without sending supporting provider statements. Company A then receives payments directly from TRICARE. In its standard agreement with medical providers in its network, Company A compensated providers directly for healthcare services rendered to beneficiaries. Company A in turn prepared and submitted the Centers for Medicare and Medicaid Services (CMS) Health Insurance Claim Form 1500 (CMS Form 1500) to the TMA claims processing contractor, WPS.

The intent of CMS Form 1500 was to provide a detailed listing of procedures providers perform as well as diagnosis codes and associated rates. Company A did not submit provider statements of services supporting the claim, nor did TMA require such support. Requiring that third party billing agencies attach provider statements of services to claim forms would help WPS validate the accuracy of claims submitted by third party billing agencies. Further, in the agreements between Company A and providers, each provider agreed to allow that Company A receive and endorse for deposit into the bank account of Company A

[3] RAOs serve as a link between local retirees and the military communities, as well as Government agencies providing assistance to retirees. RAOs are staffed with retiree volunteers who assist other retirees and retiree families to ensure that they receive the benefits to which they are entitled. Independent RAOs operate in locations geographically isolated from commands.

any TRICARE benefit checks made in the provider's name. Such flexibility creates an opportunity not only for Company A but other third party billing agencies to potentially inflate charges without alerting providers or healthcare institutions. Sending payments directly to the providers, rather than third party billing agencies, should assist TMA in holding providers accountable for claims submitted, regardless of whether those claims are self-submitted or submitted through a third party billing agency.

Inflated Claims and Claims for Services Not Rendered. To identify potentially inflated claims, we compared original provider statements of service DCIS obtained in the Philippines against corresponding claims Company A submitted in their third party billing agency capacity. Specifically, we reviewed 322 Philippine TRICARE medical claims the U.S. Attorney's Office, Western District of Wisconsin selected in support of an ongoing DCIS investigation of Company A. Company A filed those claims from 2000 through 2004 on behalf of seven hospitals. We reviewed each line item of service provided for bed charges and other items for costs exceeding about 1,000 Philippine pesos that directly matched an item on the Company A claim. The claim amounts Company A submitted to WPS should have been the same as the original hospital bill amounts, after conversion of pesos to U.S. dollars. However, for line items where quantities of services and supplies matched on the provider statements and the Company A claims, Company A inflated the original hospital line item amounts from $.4 million to $1.3 million, resulting in about $.9 million (about 232 percent) in excess charges. Table 1 shows the inflation of matched dollar line items from hospital statements of account and claims that Company A submitted.

Table 1. Hospital Billed Amount Compared with Company A Claimed Amount (Bed Charges and Matched Items Exceeding 1,000 Philippine Pesos)

Hospital	Claims Reviewed	Hospital Billed Amount	Company A Claimed Amount	Difference	Percentage Difference
A	54	$ 50,317	$ 170,342	$120,024	239
B	28	19,179	54,136	34,956	182
C	23	3,104	8,671	5,567	179
D	56	147,002	464,174	317,172	216
E	26	55,035	182,425	127,390	231
F	117	129,371	459,474	330,104	255
G	18	1,307	4,682	3,375	258
Total	**322**	**$405,315**	**$1,343,903**	**$938,588**	**232**

Of the 322 claims reviewed, we identified 282 claims (88 percent) with matched items inflated on Company A claims. The remaining 40 claims were also inflated because the total claims were significantly higher than the total hospital bill. However, we could not definitively match any individual items that exceeded 1,000 Philippine pesos on the hospital bill to the Company A bill. Using a static exchange rate, our review demonstrated that Company A generally increased the billed amount by about 233 percent. However, Company A actually increased provider fees often by several thousand percent. Table 2 provides examples of inflated items identified from our review of 322 claims Company A submitted.

Table 2. Examples of Inflated Line Items by Company A

Hospital	Supply or Service	Date	Hospital	Company A	Difference	Percentage Difference
A	Room Fee	Aug. 2000	$ 38.00	$ 126.67	$ 88.67	233
A	Zantac	Apr. 2001	34.08	113.64	79.56	233
A	Doctor Fee	Jan. 2002	40.00	273.00	233.00	583
B	Timentin	Aug. 2003	249.79	832.64	582.85	233
B	Lipid Profile	Jan. 2004	48.00	160.00	112.00	233
C	Doctor Fee	Aug. 2003	10.00	331.10	321.10	3,211
C	Doctor Fee	Sept. 2003	40.00	1,110.25	1,070.25	2,676
D	Duplex Scan	Nov. 2001	62.80	209.33	146.53	233
D	Losec	Jan. 2002	47.44	158.13	110.69	233
D	Stent Tsunami	Nov. 2003	3,243.00	10,810.00	7,567.00	233
D	Blood Culture	Jan. 2004	102.24	340.80	238.56	233
E	Doctor Fee	Jan. 2003	4,800.00	16,000.00	11,200	233
E	Amoclav	Mar. 2003	60.10	200.34	140.24	233
E	Eprex	Apr. 2003	76.13	253.77	177.64	233
F	Therapy	May 2002	23.00	76.67	53.67	233
F	Room Fee	Dec. 2002	731.00	2,436.67	1,705.67	233
F	Doctor Fee	Jan. 2004	434.00	1,602.00	1,168.00	269
G	Doctor Fee	May 2002	112.00	1,681.19	1,569.19	1,401
G	Operating Room	Sept. 2003	21.20	70.67	49.47	233

Alleged Billing for Services Not Rendered. The methodology used to review the 322 claims Company A submitted would not have identified services billed but not rendered. However, based on a review of Defense Hotline complaints and beneficiary survey results TMA provided, Company A appears to have submitted claims for services not rendered. Survey results received from beneficiaries in the Philippines repeatedly state that Company A submitted TRICARE claims for services not rendered, often during times when either the physician listed as providing the service or the beneficiary listed as receiving the service was reported as out of the country. In addition, TMA identified potentially false claims by Company A for doctor visits that never occurred when prescription refills were given.

Validating Billing Agency Claims. To reduce the likelihood of paying for improper claims, TMA should require that billing agencies submit provider statements of services rendered and that providers performing the services sign claims third party billing agencies submit to WPS for payment. Additionally, as provided for in the contract modifications for overseas claims, TMA should also discontinue the practice of sending payments to third party billing agencies. Instead, TMA should send payments to the practice address of the provider when claims are submitted by third party billing agencies.

Provider Statements and Claim Forms. Requiring that provider statements accompany claims third party billing agencies filed, and requiring that providers who performed the services sign the claims, should place responsibility on the provider for the accuracy of claims and help ensure that inflated claims are not submitted. For the 322 claims reviewed, Company A (in their third party billing agency capacity) did not submit provider statements of services along with the claim (CMS Form 1500) sent to WPS for payment. As a result, WPS had no statements of service from the provider of the medical services against which to compare the claim Company A submitted. Further, even though the CMS Form 1500 requires that the provider sign the form attesting to the accuracy of the claim for services the provider (or employees under their immediate supervision) furnished, that generally did not occur.

Our review of the 322 hospital claims Company A submitted showed that 20 claim forms had no signature, 19 forms could not be identified to either a provider or Company A representative, 277 forms were signed by Company A representatives (not the hospital or institution providing the services), and 6 forms were signed by the provider rendering services. Of the 277 forms Company A representatives signed, 32 forms were signed by one of the members of the Board of Directors for Company A, while the remaining 245 forms received from 7 separate hospitals were signed by a Company A provider. Therefore, of the 322 hospital claims reviewed, at least 277 (86 percent) were not signed by the provider of services.

The Company A representative (in the capacity as the third party billing agency) signed claim forms at each of the seven hospitals reviewed. Certification from an employee of the third party billing agency, rather than the provider of services or supplies, defeats the purpose of the physician or supplier signature block on the CMS Form 1500. With neither an accompanying statement of service from the provider nor a provider's signature on the claim, WPS did not have validation from the provider that the specific services were performed and that the amounts charged were accurate.

Payments to Third Party Billing Agencies. GAO Report OSI-00-5R, "Improper Billing of Medicare by BMS," March 30, 2000, cites section 1395u(b)(6)(1998), title 42, United States Code [10 U.S.C. 1395u(b)(6)(1998)], which states that Medicare payments must be made to the beneficiary or, under assignment, to the medical provider who rendered the service. The report also states that third party billing has been a congressional concern because third party billing has historically been a source of incorrect and inflated claims for services. WPS routinely sends payments and a corresponding Explanation of Benefits statement directly to Company A and other third party billing agencies without

validation from the healthcare provider. Sending the payment and an Explanation of Benefits statement directly to providers should help ensure that providers are aware of claims submitted on their behalf and should also reduce the likelihood of improper claims submitted by third party billing agencies. Moreover, such a control should allow TMA to hold providers accountable for claims submitted on their behalf by third party billing agencies.

Waiver of Beneficiary Cost Shares

Company A required that beneficiaries in the Philippines using its network of providers join the company's supplemental health insurance plan, according to a Department of Justice interview with a Company A representative. The supplemental health insurance plan was available to only TRICARE-eligible beneficiaries and covered beneficiary cost shares, including the 25-percent cost share on claims and annual deductibles of $150 per individual or $300 per family, with a maximum membership fee of $100 per year. Until October 31, 2004, the annual enrollment fee was frequently waived according to a Company A hospital administrator. Records from the Philippine Securities and Exchange Commission show that both Company A and their supplemental health insurance company generally have the same members on the Board of Directors. Further, based on a Company A document, the supplemental health insurance company is a division of Company A. Thus, the "triple-hatted" role of Company A as billing agent, provider, and supplemental insurer apparently allowed that company to waive required beneficiary deductibles and cost shares while suffering no financial loss—because the inflated claims (233 percent discussed previously) more than covered annual deductibles and cost shares for the beneficiaries.

Cost to Risk Analysis. Company A (in their capacity as supplemental insurer) apparently waived enrollment fees for beneficiaries to participate in its supplemental health insurance plan, and when the company did charge, the enrollment fees were minimal and not commensurate with the actuarial risk. In May 1991, the Department of Health and Human Services issued a special fraud alert to the Federal healthcare industry. The alert advised that when supplemental health insurance premiums paid by beneficiaries are insignificant and not based upon actuarial risks, the premiums ". . . are a sham used to disguise the routine waiver of co-payments and deductibles." The fraud alert further stated that routinely waiving co-payments and deductibles is illegal.

The annual fee schedule for the Company A supplemental health insurance ranged from a minimum of $20 to a maximum of $100. Assuming conservatively that each of the approximate 9,000 beneficiaries in the Philippines paid the maximum $100 enrollment fee (as of November 1, 2004), the supplemental insurance company could have suffered severe losses when comparing the low enrollment fee to actual beneficiary expenses that the plan would have covered. Out-of-pocket expenses consist of cost shares (co-payments and co-insurance) and deductibles the beneficiary would have paid if no such supplemental plan existed. See Table 3 for a comparison of income based on collection of maximum premiums versus actual out-of-pocket expenses.

Table 3. FY 2000 through FY 2003 Supplemental Insurance Premiums and Costs

Year	Income	Out-of-Pocket Expenses	Estimated Loss
FY 2000	$900,000	$2,513,587	$1,613,587
FY 2001	$900,000	$3,255,618	$2,355,618
FY 2002	$900,000	$4,997,806	$4,097,806
FY 2003	$900,000	$5,876,594	$4,976,594

While not conclusive evidence that Company A incurred a loss for the supplemental health insurance plan offered to TRICARE beneficiaries, the data are an indicator supporting that premiums were not commensurate with the risk. Additionally, supplemental health insurance plans normally have deductibles and limit what companies will pay for an item or service. In contrast, the supplemental plan Company A offers TRICARE beneficiaries apparently waives cost shares and deductibles and has no such coverage limitations. The practice of offering discounts and waiving cost shares to beneficiaries covered through Federal health plans is another indicator of potential unlawful waiver of cost shares the Department of Health and Human Services Fraud Alert outlined.

Potentially Unlawful Supplemental Health Insurance Plans. The statutorily mandated requirement that beneficiaries pay a portion of their medical costs, outlined in 10 U.S.C. 1086, is intended as a "self-policing" method for ensuring that medical services are necessary and reasonably priced. We worked with DCIS investigators to review documents relative to the Company A supplemental plan. TMA was aware of that supplemental plan as early as September 2002, expressed concerns about its legality, and referred the matter to DCIS. We provided TMA with data showing that the Company A supplemental health insurance plan was improper and was used to disguise the apparently routine waiver of required beneficiary cost shares. We also provided TMA with a copy of the May 1991 Special Alert where the Department of Health and Human Services warned against similar schemes. As a result, the Director of the Program Integrity Office at TMA issued the following news release on June 13, 2005, on their Web site. The news release cites the congressional intent for establishing cost shares and the legal requirement for beneficiaries to pay cost shares:

> Uniformed Services beneficiaries who use TRICARE Standard and Extra are responsible, under law, to pay annual deductibles and cost-shares associated with their care. The law prohibits healthcare providers from waiving TRICARE beneficiary deductibles or cost-shares and requires providers to make reasonable efforts to collect these amounts. Healthcare providers who offer to waive deductibles and cost-shares or who advertise that they will do so may be investigated for program abuse and suspended or excluded as authorized providers. . . TRICARE prohibits any scheme designed to waive a patient's deductible or cost-share. One type of scheme comes in the form of a supplemental insurance program which covers

> copayments or deductibles only for items or services provided by the entity offering the insurance. These programs can be identified when the 'insurance premium' paid by the beneficiary is insignificant and the premiums so low that they are not based upon actuarial risks, but instead are a sham used to disguise the routine waiver of copayments and deductibles. Such a scam can result in excessive utilization of items and services. . . When Congress established beneficiary deductibles and cost-shares, their intent was to make the beneficiary a financial partner with the government. The cost-share encourages responsible beneficiary health care decisions when faced with choices, and acts to avoid waste of taxpayer dollars. Beneficiaries who have a financial risk associated with their health care decisions are more likely to choose cost-effective treatment for their medical conditions.

The TMA news release warns beneficiaries of circumstances outlined in the Department of Health and Human Services Fraud Alert, which states that the routine waiver of cost shares by providers is unlawful because the results are false claims, violations of the anti-kickback statute, and excessive use of medical services and supplies for which the Government pays. The release warns that failure to collect cost shares or deductibles for reasons unrelated to indigency as well as insurance premiums not based upon actuarial risks, may be a sham used to disguise the routine waiver of cost shares. The anti-kickback statute, 42 U.S.C. 1320a-7b, makes it a criminal offense for those who knowingly and willfully offer, pay, solicit, or receive remuneration that induces the referral of business and for which a Federal healthcare program might pay. In addition, 42 U.S.C. 1320a-7a provides civil monetary penalties and discusses the link between waiver of cost shares and remuneration, stating that because Medicare beneficiaries are obligated to pay cost shares, a waiver of that obligation constitutes remuneration to the beneficiary.

Identifying Unlawful Waiver of Cost Shares. TMA should establish procedures for identifying and eliminating supplemental plans that unlawfully waive required beneficiary cost shares. While we recognize that TMA cannot prevent beneficiaries from joining supplemental plans, the arrangement between Company A and the required supplemental insurer is contrary to the guidance on supplemental plans and may be an illegal waiver of required beneficiary cost shares. TRICARE Operations Manual 6010.51-M, August 1, 2002, Chapter 14, Program Integrity, states that 32 C.F.R. Section 199.4 (2004) sets forth the financial liability of the TRICARE beneficiary for cost shares. The manual also states that the regulatory requirement is derived from the statutory requirements of 10 U.S.C. 1079 and 1086. The manual requires that the claims processing contractor establish procedures for detecting providers who waive cost shares and provides possible methods for detecting cost share waivers. Through their supplemental health insurance plan, Company A apparently waived statutorily mandated beneficiary cost shares. Waiver of cost shares is evidenced not only by the insignificant supplemental health insurance premiums but also through the Company A Web site and newsletters as well as responses from a 2004 beneficiary survey.

Administrative Sanctions

As it identifies those abusing or committing healthcare fraud against the TRICARE program, TMA needs to pursue administrative remedies provided for in 32 C.F.R. Section 199. Administrative remedies exist through 32 C.F.R. Section 199.9 under CHAMPUS in situations involving fraud, abuse, or conflict of interest.

The term abuse generally describes incidents and practices that may directly or indirectly cause financial loss to the Government under CHAMPUS or CHAMPUS beneficiaries. According to 32 C.F.R. 199.2, abuse includes any practice inconsistent with accepted sound fiscal, business, or professional practice and results in unnecessary costs. Abuse includes deception or misrepresentation by a provider, or any person or entity acting on behalf of a provider, in relation to a CHAMPUS claim. Abuse situations covered in 32 C.F.R. Section 199.9 include, but are not limited to:

- Improper billing practices that include charging rates in excess of those routinely charged to the general public, commercial health insurance carriers, or other Federal health benefit entitlement programs for the same or similar services;
- Billing in excess of customary or reasonable charges;
- A pattern of waiver of beneficiary (patient) cost shares or deductibles;
- Unauthorized use of the term CHAMPUS in private business to imply an official connection with the Government; and
- Refusal to furnish or allow the Government or Government contractors' access to records related to CHAMPUS claims.

Because Company A may have perpetuated each of those abuse situations, TMA should exercise appropriate administrative remedies available in 32 C.F.R. Section 199.9. In addition to inflated billing and the apparent waiver of beneficiary cost shares, Company A may have also inferred an official connection with the Government through use of Government symbols on their Web site and on independent RAO newsletters that Company A employees prepared. As outlined in Secretary of Navy Instruction 5420.169H, "Department of the Navy Retired Activities Program," dated April 23, 1996, RAOs serve as a link between retirees and Government agencies such as TRICARE that provide assistance to retirees. Company A employees serving as independent RAOs in the Philippines inappropriately referred to Company A in RAO newsletters as the TRICARE provider in the Philippines, thereby possibly presenting an official connection between Company A and the Government. Further, according to investigators from DCIS and the U.S. Attorney's Office, Western District of Wisconsin, Company A had agreements with providers to withhold information from the U.S. Government and not provide the Government with requested documentation.

TMA should coordinate with the U.S. Attorney's Office and their legal staff to exercise appropriate administrative sanctions against Company A and Company A affiliates, to include exclusion from participating in the TRICARE program. Our review of records received from the Philippine Securities and Exchange Commission and other Company A documents showed that Company A has agreements with, or shares the same members on their boards of directors with, at least 13 hospitals, clinics, or providers. Also, the Company A Web site as of January 19, 2005, lists 118 hospitals, clinics, and providers in the Philippines; 10 in Costa Rica; and 7 in Thailand. As a result, TMA should exercise appropriate administrative sanctioning authority against Company A and any other companies who routinely abuse the TRICARE program. Following coordination with DCIS and the U.S. Attorney's Office, Western District of Wisconsin, we forwarded to TMA records supporting Company A abuse of the TRICARE Program and affiliations with other companies.

Assessing the Management Control Program

TMA should report the material weakness identified in this report in future annual statements required under the Federal Managers' Financial Integrity Act of 1982. Specifically, TMA controls did not adequately ensure that third party billing agencies were properly submitting TRICARE overseas claims. In addition, TMA should establish procedures that can detect improper waivers of cost shares and deductibles. Further, TMA should reassess the risk associated with the TRICARE Overseas Program—Access to Care in the Philippines as high because as stated in a July 23, 2004, memorandum, the Assistant Secretary of Defense (Health Affairs) estimates the cost of healthcare fraud in the Philippines to exceed $40 million annually. TMA should continue to assess the risk for the TRICARE Overseas Program—Access to Care in the Philippines as high until management successfully implements additional controls that will further reduce the risk of fraud.

Conclusion

TMA should strengthen controls that reduce the possibility for abusive practices of the TRICARE program in the Philippines by establishing guidelines and procedures for validating medical claims. Although TMA initiated control procedures not previously applied to overseas claims, more can and should be accomplished. TMA needs to implement controls that will ensure providers are accountable for claims submitted and ensure that supplemental health insurance plans do not illegally waive beneficiary cost shares and deductibles. Specifically, TMA should require that billing agencies submit provider statements of service along with billing agency claims, ensure that providers sign all billing agency claims, and stop the practice of sending payments directly to third party billing agencies. Additionally, TMA should be proactive in exercising its administrative sanctioning authority, to include excluding those who might routinely abuse the TRICARE program. Implementing the recommendations in this report should result in significant cost avoidance. Although we cannot quantify the amount, the Assistant Secretary of Defense (Health Affairs) estimated healthcare fraud in the

Philippines costs TRICARE more than $40 million annually in July 2004. We will attempt to quantify the cost avoidance during our audit followup process.

Recommendations, Management Comments, and Audit Response

Revised Recommendation. We revised draft Recommendation 2. to clarify the intent of the recommendation. The Assistant Secretary of Health Affairs response supports the revised recommendation. Therefore, as discussed below, no additional comments are required on the revised recommendation.

1. We recommend that the Director, TRICARE Management Activity direct through modification of its operations manual and contract that the claims processing contractor for the TRICARE Overseas Program:

a. Require that third party billing agencies submit provider statements of services rendered.

b. Require that the provider who performs the services certify the claims forms rather than accepting signatures of third party billing agency representatives.

c. Discontinue sending claims payments to the address of third party billing agencies. For claims that third party billing agencies submit, payments should be sent only to the provider.

Management Comments. The Assistant Secretary of Defense (Health Affairs) concurred, stating that the recommendations were implemented. Specifically, the Assistant Secretary stated that TMA now requires provider signatures on claim forms and sends payments to provider addresses only. To satisfy Recommendation 1.a., TMA changed the TRICARE Policy Manual to require that the claims processing contractor obtain attestations from the top 10 percent of providers in the Philippines. In changing the process, TMA now requires that the claims processing contractor receive attestations for claims before payment.

Audit Response. The Assistant Secretary of Defense (Health Affairs) comments are responsive. We agree with the Assistant Secretary's alternative proposal for Recommendation 1.a. By requiring that the claims processing contractor receive attestations from providers before payments are made, TMA satisfied the intent of the recommendation to prevent improper payments. No additional comments are required.

2. We recommend that the Director, TRICARE Management Activity establish TRICARE Overseas Program procedures that can not identify supplemental health insurance plans that unlawfully waive cost shares.

Management Comments. The Assistant Secretary of Defense (Health Affairs) concurred. Specifically, the Assistant Secretary stated that TMA will establish a program that can identify supplemental health insurance plans that may result in illegal inflation of fees or waiver of cost-shares and deductibles.

Audit Response. The Assistant Secretary of Defense (Health Affairs) comments are fully responsive. No additional comments are required.

3. We recommend that the Director, TRICARE Management Activity exercise its administrative sanctioning authority, to include excluding those found routinely abusing the TRICARE program.

Management Comments. The Assistant Secretary of Defense (Health Affairs) concurred, stating that TMA initiated action to exclude Company A. The Assistant Secretary also stated that TMA will review other situations DoD Office of Inspector General (OIG) identified for administrative action.

Audit Response. The Assistant Secretary of Defense (Health Affairs) comments are responsive. However, we caution TMA from relying on criminal proceedings or recommendations from DoD OIG to initiate administrative sanctions. Aggressive pursuit and implementation of timely administrative controls and sanctions are needed. TMA used data provided by the DoD OIG to propose excluding Company A from the TRICARE program in November 2005. TMA had access to the data for years and could have used their administrative sanctioning authority. Following receipt of allegations of abuse from TMA and beginning in December 2000, DCIS repeatedly advised that TMA take immediate actions that would prevent fraud without regard to the impact on the investigation. Moreover, TMA was aware as early as September 2002 of the supplemental plan Company A offered that apparently waived required beneficiary cost shares. On that factor alone, TMA could have taken action against Company A for violating the anti-kickback statute. Further, there were numerous beneficiary allegations that Company A billed for services not rendered, or not medically necessary, and grossly inflated TRICARE claims.

As discussed in this report, 32 C.F.R. Section 199 provides sanctioning authority to TMA for instances that include abuse. The term abuse describes incidents and practices that may directly or indirectly cause financial loss to the Government. TMA should not rely solely on investigative support when initiating sanctioning. Identification and prevention of fraud, waste, and abuse in the TRICARE program is a TMA responsibility, the outcome of which cannot be controlled through criminal or civil proceedings or DoD OIG recommendations.

4. We recommend that the Director, TRICARE Management Activity report the material weakness identified in this report in future annual statements required under the Federal Managers' Financial Integrity Act of 1982 until the material weakness is corrected.

Management Comments. The Assistant Secretary of Defense (Health Affairs) did not concur, stating that a material weakness did not exist. Specifically, the Assistant Secretary cites the definition for a material weakness as DoD Instruction 5010.40 defines. The definition states:

> E2.1.18. Material Weakness. Specific instances of noncompliance with 31 U.S.C. 3512 (reference (b)) of such sufficient importance to warrant reporting of the control deficiency to the next higher level of management. Such weaknesses significantly impair or may impair the

> fulfillment of a DoD Component's mission or operational objective; to deprive the public of needed services; violate statutory or regulatory requirements; significantly weaken safeguards against fraud, waste, or mismanagement of funds, property, or other assets; or result in a conflict of interest . . ..

The Assistant Secretary also asserts that fraud was identified and that TMA developed evidence for taking action against Company A. The Assistant Secretary also referred to other administrative actions discussed in this report that serve as a deterrent to future wide-scale fraud.

Audit Response. The Assistant Secretary of Defense (Health Affairs) comments are not responsive. While TMA actions reduced possible fraud in the Philippines, until it obtains evidence that the material weakness is corrected, TMA should report the weakness as material in its annual statement the Federal Manager's Financial Integrity Act of 1982 requires. DoD Instruction 5010.40 supports the determination that the management control weakness cited was material. Specifically, the lack of controls weakens safeguards against fraud, waste, or mismanagement of funds, property, or other assets.

Considering that TMA continues to request assistance from DCIS investigators and believes that alleged fraud is rapidly spreading to countries in Latin America, TMA should report the weakness cited in the report as material. DoD Instruction 5010.40 provides 12 factors for management to consider for determining whether the absence of or noncompliance with a control is a material weakness and includes:

- actual or potential loss of resources;
- magnitude of funds, property, or other resources involved;
- frequency of actual loss and/or potential loss;
- current or probable media interest (adverse publicity); and
- current or probable congressional interest (adverse publicity).

TMA estimated that fraudulent healthcare payments in the Philippines totaled about $40 million out of payments totaling $64.2 million in FY 2003. TMAs' comment to the report that fraudulent practices continue to occur and are rapidly spreading to Latin American countries supports the basis for reporting a material control weakness on the widespread problem of fraudulent claims. The spread of abuse would likely peak media and congressional interest as well as increase the frequency of loss to the TOP.

TMA should also consider reporting that the TOP is susceptible to significant erroneous payments in the DoD Annual Performance and Accountability Report to the President and Congress in accordance with Public Law 107-300, Improper Payments Information Act of 2002. According to that Act, for program and activities where the risk of erroneous payments is significant, agencies must estimate the annual amount of erroneous payments as well as include those

estimates in their Annual Performance and Accountability Report to the President and Congress. In addition to including the information in the annual report, agencies must provide a progress report on any action that resulted in reductions of erroneous payments. The Act also defines significant erroneous payments (including payments for incorrect amounts and for services not received) as those payments exceeding both $10 million annually and 2.5 percent of program payments. TMA should continue to estimate the amount of erroneous payments and consider reporting that information as appropriate under Public Law 107-300. We request that management provide additional comments on Recommendation 4. by March 10, 2006.

5. We recommend that the Director, TRICARE Management Activity assess the risk associated with the TRICARE Overseas Program—Access to Care in the Philippines as high until additional controls that minimize the risk of fraud are implemented.

Management Comments. The Assistant Secretary of Defense (Health Affairs) did not concur, stating that the risk associated with the TOP assessable unit was correctly assessed at low. The Assistant Secretary also stated that the assessment of low was based on the TMA assertion that it met the Established Entity-Wide Objective to effectively manage the taxpayers' finite dollars through the minimalization of fraud. The Assistant Secretary stated that effective practices are in place that identify fraud resulting in notification of DCIS of possible criminal activity. The Assistant Secretary further stated that the absence of appropriate, necessary DCIS personnel significantly hampered the DoD ability to investigate the fraud and abuse TMA believes occurred.

Audit Response. The Assistant Secretary of Defense (Health Affairs) comments are not responsive. TMA should elevate from low to high the risk level associated with the TOP assessable unit until additional controls that minimize the risk are implemented and tested. According to DoD Instruction 5010.40, risk levels represent "the probable or potential adverse effects from inadequate management controls that may result in the loss of Government resources or cause an agency to fail to accomplish significant mission objectives through fraud, error, or mismanagement." In addition, the Office of Management and Budget Circular No. A-123 (Revised), "Management's Responsibility for Internal Control," states, "Management should identify internal and external risks that may prevent the organization from meeting its objective." According to the GAO publication, "Standards for Internal Control in the Federal Government," November 1999, internal controls (management controls) help Government program managers achieve desired results through effective stewardship of public resources. Further, in analyzing the possible effect of a risk, an organization should generally include estimating the risk's significance, assessing the likelihood of its occurrence and deciding how to manage the risk and what actions should be taken.

Although TMA implemented a number of controls over healthcare payments in the Philippines, additional management controls are needed that will ensure TMA effectively manages the TOP and minimizes fraud. The TMA assessment of the program's risk as low is inconsistent with their request for additional investigative support for specific instances of alleged fraud and their statement that alleged

fraudulent practices are rapidly spreading to countries in Latin America. While successful prosecutions are a deterrent, management needs to close systemic loopholes in management controls that allow improper payments to take place. As stated previously, TMA has ultimate responsibility for managing TOP. Identifying potential fraudulent actions after they occur and referring such actions for OIG investigation does not fulfill TMA responsibility for program management and does not lessen program risk to fraud, waste, and abuse. We request that management provide additional comments on Recommendation 5. by March 10, 2006.

Appendix A. Scope and Methodology

We reviewed public laws, the Code of Federal Regulations, as well as DoD and TMA regulations relating to how third party billing agencies submit claims in TOP. We visited the Program Integrity Office for TMA in Aurora, Colorado, the office responsible for preventing and identifying fraudulent and abusive healthcare activities against TRICARE. We visited WPS in Madison, Wisconsin. WPS is responsible for processing all overseas TRICARE claims. We also visited the Department of Veterans Affairs, Health Administration Center, in Denver, Colorado. That organization is responsible for preventing and identifying fraudulent and abusive healthcare activities against the Department of Veterans Affairs and determining the controls in place for third party billing agencies. Additionally, we visited the TRICARE South region in San Antonio, Texas, because it is responsible for the overseas claims processing contract.

As an investigative assist to DCIS, we assessed accuracy of the claims Company A submitted by comparing the original provider statements of service with corresponding Company A claims. Specifically, we reviewed 322 claims (selected by the U.S. Attorney's Office, Western District of Wisconsin) Company A filed on behalf of 7 separate hospitals from 2000 through 2004. We performed a detailed analysis of each line item of service provided for all bed charges as well as other line items with a cost exceeding about 1,000 Philippine pesos and that could be directly matched to a line item on the Company A claim form.

In addition to our analysis for DCIS, we identified information that TMA could have used to manage TOP. We queried TMA Care Detail Information System (CDIS) data to determine if supplemental health insurance premiums were commensurate with the actuarial risk and obtain background information. We did not include FY 2004 data in our report because providers are allowed 12 months for submitting claims, and as such, FY 2004 CDIS data were not yet finalized.

We used the CDIS database to determine if the premiums Company A could have charged beneficiaries to join its supplemental plan were commensurate with the benefits the company would have had to pay. Specifically, we extracted from the CDIS database for FY 2000 through FY 2003 the out-of-pocket expenses for all claims paid to Company A and compared that amount to the maximum income Company A would have received had each beneficiary joined its supplemental health insurance plan and paid the maximum enrollment (premium) fee of $100 a year. To determine the beneficiary out-of-pocket expenses, we queried CDIS to find the actual amount of cost shares and deductibles for claims Company A submitted.

We performed this audit from October 2004 through October 2005 in accordance with generally accepted government auditing standards.

Use of Computer-Processed Data. We used CDIS claims data to determine background information as well as the amount of cost shares and deductibles TRICARE beneficiaries in the Philippines should have incurred. To determine the adequacy of computer-processed data, we compared claims submitted by

Company A to the information WPS entered into CDIS. For the 322 claims reviewed as part of our assist work provided to the U.S. Attorney's Office, Western District of Wisconsin, 255 matched (79 percent) the information in CDIS. Most of the differences between CDIS and the claims the company submitted could be explained and generally were not inaccuracies. Therefore, the information is still usable for our intended purposes. According to DoD Inspector General (IG) Report No. D-2002-072, "Information Assurance Controls for the Source Data Collection System Used for Purchased Care Data," March 26, 2002, the source data collection system, which is where the CDIS claims are stored, is vulnerable to loss of data and providing unreliable financial data. In the report, TMA concurs with all recommendations and states that necessary actions were either completed or in progress.

Use of Technical Assistance. We consulted the DoD OIG Qualitative Methods Division to assist with determining the rate of inflation for medical services in the Philippines from 1998 through 2003. The Qualitative Methods Division adjusted data on TRICARE payments for medical inflation and exchange rates.

GAO High-Risk Areas. GAO has identified several high-risk areas in DoD. This report provides coverage of the high risk areas: "DoD Financial Management" and "DoD Support Infrastructure Management."

Prior Coverage

During the last 5 years, GAO and DoD IG issued two reports that discuss improper third party billing practices and reliability of computer-processed data. Unrestricted GAO reports can be accessed over the Internet at http://www.gao.gov. Unrestricted DoD IG reports can be accessed at http://www.dodig.mil/audit/reports.

GAO

GAO Testimony Report No. T-OSI-00-15, "Healthcare Fraud: Schemes to Defraud Medicare, Medicaid, and Private Healthcare Insurers," July 25, 2000

DoD IG

DoD IG Report No. D-2002-072, "Information Assurance Controls for the Source Data Collection System Used for Purchased Care Data," March 26, 2002

Appendix B. Report Distribution

Office of the Secretary of Defense

Under Secretary of Defense (Comptroller)/Chief Financial Officer
    Deputy Chief Financial Officer
    Deputy Comptroller (Program/Budget)
Director, Program Analysis and Evaluation
Assistant Secretary of Defense (Health Affairs)
General Counsel

Department of the Army

Auditor General, Department of the Army

Department of the Navy

Naval Inspector General
Auditor General, Department of the Navy

Department of the Air Force

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

Other Defense Organizations

Director, Defense Manpower Data Center

Non-Defense Federal Organization

Office of Management and Budget
Office of the United States Attorney, Madison, Wisconsin

Congressional Committees and Subcommittees, Chairman and Ranking Minority Member

Senate Committee on Appropriations
Senate Subcommittee on Defense, Committee on Appropriations
Senate Committee on Armed Services
Senate Committee on Homeland Security and Governmental Affairs
House Committee on Appropriations

Congressional Committees and Subcommittees, Chairman and Ranking Minority Member (cont'd)

House Subcommittee on Defense, Committee on Appropriations
House Committee on Armed Services
House Committee on Government Reform
House Subcommittee on Government Efficiency and Financial Management, Committee on Government Reform
House Subcommittee on National Security, Emerging Threats, and International Relations, Committee on Government Reform
House Subcommittee on Technology, Information Policy, Intergovernmental Relations, and the Census, Committee on Government Reform

Assistant Secretary of Defense (Health Affairs) Comments

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

NOV 29 2005

MEMORANDUM FOR DEPARTMENT OF DEFENSE INSPECTOR GENERAL
DEPUTY INSPECTOR GENERAL FOR AUDITING
DIRECTOR, READINESS AND LOGISTICS SUPPPORT DIRECTORATE

SUBJECT: Draft Report on TRICARE Overseas Controls Over Third Party Billing Agencies and Supplemental Insurance Plans (Project No. D2005LF-0017.000)

Thank you for the opportunity to review and provide comments on the draft report "TRICARE Overseas Controls Over Third Party Billing Agencies and Supplemental Insurance Plans," dated October 20, 2005. Our comments are attached.

We concur with the recommendations for additional controls and initiatives to combat fraud, and have already implemented several new programs. While your outlined approach to helping combat fraud in the Philippines is lauded, I believe a major opportunity in this effort was lost by your decision to not provide Defense Criminal Investigative Service (DCIS) personnel for placement in the Philippines to assist the Department with on-the-ground fraud identification efforts. The late assistance provided in supporting an investigative team visit to the Philippines was helpful and appreciated, but full time investigative support would have been invaluable in this fight.

We do not concur with the recommendation to report the material weakness identified in this report in future annual statement required under the Federal Managers' Financial Integrity Act of 1982 until the material weakness is corrected, or the recommendation to assess the risk associated with the TRICARE Overseas Program-Access to Care in the Philippines as high until additional controls that minimize the risk of fraud are implemented. Based on the definition of a Material Weakness, found in DoD Instruction 5010.40, we do not believe a material weakness exists, and our position is that the low risk assessment remains appropriate.

The Department continues to review and implement efforts to curb fraud in the TRICARE program, and we look forward to our continued partnership with the DoD IG in these efforts.

My points of contact are Mr. Ron Richards (functional) at (703) 681-1133 and Mr. Gunther Zimmerman (audit liaison) at (703) 681-3492, ext. 4065.

William Winkenwerder, Jr., MD

Attachments:
As stated

The absence of appropriate, necessary DCIS personnel working to support our efforts, despite my repeated requests for such assistance, significantly hampered DoD's ability to investigate the fraud and abuse we believe occurred, and to prosecute those who were responsible. This was most unfortunate.

Sincerely,

DoD IG DRAFT REPORT – DATED OCTOBER 20, 2005
(D2005-D000LF-0017.000)
Agency Comments on Draft Report "TRICARE Overseas Controls Over Third Party Billing Agencies and Supplemental Insurance Plans"

DEPARTMENT OF DEFENSE COMMENTS

TECHNICAL CHANGES: No technical changes noted.

OVERALL COMMENTS:

In an effort to help combat the rapid growth of fraud in the Philippines, the Department requested in a July 23, 2004 memorandum to the Department of Defense Inspector General assistance in assigning additional Defense Criminal Investigative Services (DCIS) staff or personnel to work fraud issues in the Philippines. On August 11, 2004 the Deputy Inspector General for Investigations indicated that the DoD IG was unable to provide additional staff to assist in fraud identification in the Philippines due to inadequate staffing and maximum use of current personnel in support of the war efforts in the overseas theater.

The TRICARE Management Activity (TMA) works in conjunction with DCIS and the managed care contractors to develop and coordinate vital investigative efforts to assure delivery of cost effective and top quality healthcare to TRICARE beneficiaries. Despite this unified approach to combating abusive billing practices, fraud in the Philippines was initially estimated to cost TRICARE $40 million annually.

The TMA initiatives to combat healthcare fraud in the Philippines include implementing allowable charge caps, mailing letters of education to all suspect billing agencies, implementing stronger provider certification procedures, initiating special audits/reviews of claims, and coordinating with the DCIS, the Veterans Administration, and the Office of Personnel Management. Additional fraud controls are under development that will help combat fraud but many obstacles remain, including onsite investigations. Additional DoD IG and DCIS support is an important factor to fully exploit the planned initiatives to reduce or eliminate fraud in the Philippines. Currently, DoD IG support for investigating the Philippines cases consists of only one part-time DCIS special agent. Even with the multiple management initiatives and controls that TRICARE has put in place, these efforts are inadequate without additional DCIS investigative support to evaluate the allegations of fraudulent practices in the Philippines - practices that are rapidly spreading to Latin American countries. DoD IG's assistance with providing additional investigators on-the-ground would substantially increase the effectiveness of our fight against fraud.

When TMA initiated a referral on "Company A" to DCIS in 2000, numerous controls were instituted to minimize the impact of the fraud pending completion of the criminal investigation. Since the end of Fiscal Year 2002, TMA has continuously implemented, on an ongoing basis, a number of loss prevention efforts in the Philippines (see Attachment 3). These added loss prevention efforts have included numerous administrative actions, to include cost caps for

outpatient and inpatient care and prescription drugs, and enhanced review and validation of services prior to payment of questionable claims. A complete fiscal year is required to measure the full effect of an initiative. For example a measure initiated in April 2004 would only have a partial impact on 2004 claims, but a full impact on FY2005.

Fiscal Year 2004 data is now available with the appropriate 13 month lag (12 month claims filing deadline plus 1 month processing time), and there is an indication progress has been made. Expenditures in FY03 according to the DoD IG report totaled $64.19 million for services in the Philippines, while expenditures for FY04 paid claims total $36.99 million. The FY04 total may increase as there may be some additional lag in the data; however, with the full 13 months, the number should be substantially accurate. The data shows that the downward trend in the amount paid from FY03-04 exceeds 42% and the amount paid now is less than paid in FY2001. The downward trend substantiates that the ongoing continuous efforts of TRICARE have effectively contained the egregious billings and had a dramatic impact on controlling the fraud. TMA will continue to monitor the expenditures and collaborate with the DoD IG and DCIS to identify and investigate suspected instances of fraud. Those efforts, combined with the multiple initiatives noted in Attachment 3 for FY04 and the initiatives begun in FY05, should assure that the downward trend continues.

Lastly, the Department submitted a legislative proposal for Department of Defense consideration for the Fiscal Year 2007 legislative cycle that, if approved, will authorize TMA to receive a portion of a health care judgment fund that will support further investigative fraud efforts. This legislative proposal will require the acceptance of the Departments of Justice and Health and Human Services in order to be implemented.

DoD IG DRAFT REPORT – DATED OCTOBER 20, 2005
(D2005-D000LF-0017.000)
Agency Comments on Draft Report "TRICARE Overseas Controls Over Third Party Billing Agencies and Supplemental Insurance Plans"

DEPARTMENT OF DEFENSE COMMENTS

Recommendation 1: We recommend that the Director, TRICARE Management Activity direct through modification of its operations manual and contract that the claims processing contractor for the TRICARE Overseas Program:

a. Require that third party billing agencies submit provider statements of services rendered.

b. Require that the provider who performs the services certify the claims forms rather than accepting signatures of third party billing agency representatives.

c. Discontinue sending claims payments to the address of third party billing agencies. For claims that third party billing agencies submit, payment should be sent only to the provider.

DoD Response:

a. Concur. This recommendation has been implemented. TMA issued a change to the TRICARE Policy Manual on April 20, 2005 requiring the overseas claims processing contractor to return all claims received from the top ten percent of Philippine providers.[1] The returned claims requires an "Attestation" (Attachment 1) the provider must sign and return certifying that the services being claimed were actually rendered to the identified patient on the date specified on the claim and that the billed charges are the charges normally billed to the general public. The claims processor estimates that this action alone, will impact 80% of claims received for services in the Philippines. This change also eliminated the ability of Philippine providers to file claims electronically and directed the contractor to address all benefit checks to the providers' practice addresses vice that of billing or business offices.

TMA advised providers of these changes in individual letters (Attachment 2). These letters also informed providers that their original signatures must be on claims stating they agree to accept the TRICARE determined allowable amounts and that they must collect deductible and cost-shares, among other things.

[1] Excerpt from TRICARE Policy Manual, Chapter 12. "For the Philippines and other nations as may later be determined by the Government, the contractor shall quarterly determine the top 10% of institutional and individual professional providers. The contractor shall return a copy of all claims received from these providers to the provider's practice address requesting the providers signature on the attestation at Figure 12-12.2-15. Only the original signature of the provider is acceptable. For institutional providers, the signature shall be that of the institution's chief executive. Claims shall be pended for 35 calendar days following the mailing of the attestation and a copy of the claim. If no response is received within 35 calendar days, the contractor shall deny the claim."

Final Report Reference

We believe these actions not only fulfill this recommendation but go beyond the recommendation by revalidating the providers' signatures on claims and by essentially eliminating any value associated with the use of billing agencies.

[1] Excerpt from TRICARE Policy Manual, Chapter 12. "For the Philippines and other nations as may later be determined by the Government, the contractor shall quarterly determine the top 10% of institutional and individual professional providers. The contractor shall return a copy of all claims received from these providers to the provider's practice address requesting the provider's signature on the attestation at Figure 12-12.2-15. Only the original signature of the provider is acceptable. For institutional providers, the signature shall be that of the institution's chief executive. Claims shall be pended for 35 calendar days following the mailing of the attestation and a copy of the claim. If no response is received within 35 calendar days, the contractor shall deny the claim."

b. Concur. This recommendation has been implemented. Please see our previous response and Attachment 2 that demonstrate that TMA has accepted and is implementing this recommendation.

c. Concur. This recommendation has been implemented. Please see our response to 1.a. above, and Change 22 to the TRICARE Policy Manual, dated April 22, 2005, which states, in part, "Benefit payment checks and EOBs to Philippine providers, and other nations' providers as determined by the Government, shall be mailed to the place of service identified on the claim. No provider payments may be sent to any other address." We believe that this change implements the recommendation as the "place of service" represents the provider's practice address.

Recommendation 2: We recommend that the Director, TRICARE Management Activity establish TRICARE Overseas Program procedures that can not only identify unlawful supplemental health insurance plans but also detect those who routinely waive costs-shares.

DoD Response:

Concur with comment. Supplemental health insurance plans are licensed to practice in accordance with the laws of the foreign countries within which they operate. TRICARE will establish a program to search web sites for supplemental insurance plans offering coverage in the Philippines that may not be actuarially sound and determine if these insurers have relationships with providers, which may result in the illegal inflation of fees or waiver of cost-shares and deductibles.

Recommendation 3. We recommend that the Director, TRICARE Management Activity exercise its administrative sanctioning authority, to include excluding those found routinely abusing the TRICARE program.

DoD Response.

Concur with comment. The agency assumes the recommendation is for those cases for which the agency has evidence. Based on the information the IG was able to obtain from the

DCIS, the agency has initiated action to exclude "Company A" as a TRICARE provider. Once the proposed action against "Company A" is resolved, TMA will review other situations identified by the IG for administrative action. We look forward to a continuing relationship with the DoD IG and DCIS that will provide TMA with the criminal investigators needed to promptly investigate and eradicate fraud and abuse throughout the program, and uncover evidence that provides adequate justification administrative proceedings.

Recommendation 4. We recommend that the Director, TRICARE Management Activity report the material weakness identified in this report in future annual statement required under the Federal Managers' Financial Integrity Act of 1982 until the material weakness is corrected.

DoD Response.

Non-concur. Based on the definition of a material weakness[2] found in DoD Instruction 5010.40 we do not find that a material weakness exists. We do find that there has been fraud, but that the combined efforts of TMA, DoD IG, and DCIS have identified the fraud, and also developed the criminal evidence necessary to allow for the decertification of the principle culprit. Further, we find that the administrative actions DoD has implemented, in addition to those articulated above, (Attachment 3) have created deterrents to future wide-scale fraud. As a result of these efforts, there is no weakness that significantly impairs the fulfillment of TMA's mission or operational objective; deprives the public of needed services; violated statutory or regulatory requirements; significantly weakened safeguards against fraud, waste, or mismanagement of funds, property, or other assets; or resulted in a conflict of interest. We are cognizant of the fact that fraud exists throughout the healthcare system and we will remain vigilant in identifying fraud or potentially fraudulent practices and implementing steps to combat fraud.

[2] *DODI 5010.40, Aug. 28, 9.*
"E2.1.18. Material Weakness. Specific instances of noncompliance with 31 U.S.C. 3512 (reference (b)) of such sufficient importance to warrant reporting of the control deficiency to the next higher level of management. Such weaknesses significantly impair or may impair the fulfillment of a DoD Component's mission or operational objective; deprive the public of needed services; violate statutory or regulatory requirements; significantly weaken safeguards against fraud, waste, or mismanagement of funds, property, or other assets; or result in a conflict of interest. (See enclosure 3 for further information.) MC weaknesses should be identified using one of the 15 functional reporting categories. (See enclosure 4.)"

Recommendation 5. We recommend that the Director, TRICARE Management Activity assess the risk associated with the TRICARE Overseas Program-Access to Care in the Philippines as high until additional controls that minimize the risk of fraud are implemented.

DoD Response.

Non-concur. The Agency's position is that the low risk assessment remains appropriate. The risk assessment is based on the Established Entity-wide Objective to effectively manage the taxpayers' finite dollars through the minimalization of fraud. This agency wide objective is

duplicated at the TMA Activity Level and codified in 32 C.F.R. 199. TMA has demonstrated that effective practices are in place to identify fraud including, but not limited to, on-site investigative teams, fraud detection claims review procedures, issuance of explanations of benefits and fraud reporting by beneficiaries and providers. These identification activities result in the notification of DCIS of possible criminal activity, the flagging of records for manual review following the development of medical records, et cetera. This identification results in the data available for the Risk Analysis and the development of mechanisms (see attachment 3) to detect and control fraud initiated in the Philippines.

Final Report Reference

DoD IG DRAFT REPORT – DATED OCTOBER 20, 2005
(D2005-D2000LF-0017.000)
Agency Comments on Draft Report "TRICARE Overseas Controls Over Third Party Billing Agencies and Supplemental Insurance Plans"

DEPARTMENT OF DEFENSE COMMENTS

Management Control Weakness

Management Control Weakness: The DoD IG asserts on page 19 of the Draft Report that TMA should report the material weakness identified in this report in the Annual Statement Required under the Financial Managers' Financial Integrity Act of 1982. Specifically, TMA controls did not adequately ensure that third party billing agencies were properly submitting TRICARE overseas claims. In addition, TMA should establish procedures for detecting improper waivers of cost shares and deductibles. Further, TMA should reassess the risk associated with the TRICARE Overseas Program-Access to Care in the Philippines as high because the ASD(HA) conservatively estimated healthcare fraud in the Philippines cots TRICARE over $40 million annually. TMA should continue to assess the risk for the TRICARE Overseas Program-Access to Care in the Philippines as high until management has successfully implemented controls which will minimize the risk of fraud.

DoD Response: TMA strongly disagrees with the DoD IG assertion that TMA has not implemented controls that minimize the risk of fraud in the Philippines. Significant administrative control measures have been put into place to restrict the ability of fraudulent providers or individuals from defrauding the Department of Defense. Caps have been placed on "reimbursement rates" for health care provided in the Philippines since the Department pays claims based on "billed charges."

ATTACHMENT 1

TRICARE Policy Manual, Chapter 12, Section 12.2, Figures
FIGURE 12-12.2-16 ATTESTATION
ATTESTATION

I _____ certify that I personally provided the services listed on the attached TRICARE claim I signed and dated

_____ to _____,
(date claim form signed) (beneficiary's name)

a TRICARE Beneficiary. I further certify that the amount billed for these services is the amount I routinely charge the general public, Governmental, and other health plans and health insurers for these services.

I understand that TRICARE beneficiaries are required, by law, to pay their cost-share and deductible and that I will collect the required cost-share and deductible from the beneficiary listed on the claim or another individual or entity on behalf of the beneficiary. I further understand that by accepting the TRICARE payment, I am accepting the TRICARE determined allowable charge plus the beneficiary's cost-share and deductible as payment in full and that I will not bill or collect any amounts in excess of the TRICARE allowable charge. This does not prohibit me from billing for any non-covered services.

_____
Provider's Signature Date

ATTACHMENT 2

DEPARTMENT OF DEFENSE
TRICARE AREA OFFICE - Pacific

Bldg 6060, Camp Lester, Okinawa, Japan

Dear

I want to thank you for treating TRICARE beneficiaries. Ensuring high quality health care for our beneficiaries is of paramount importance. I appreciate your willingness to deliver professional services to our beneficiaries.

I wish to take this opportunity to update you on current requirements applicable to our TRICARE Standard beneficiaries in the Philippines. These requirements differ somewhat from those that apply to TRICARE Prime beneficiaries covered by the TRICARE Global Remote Overseas (TGRO) contract with International SOS. Procedures for TGRO beneficiaries are unchanged and their claims should continue to be submitted via International SOS.

TRICARE requires the beneficiary's original signature on the claim form. In signing the form, the beneficiary certifies the accuracy of the patient information; certifies that the medical care being claimed was actually rendered; authorizes the release of medical information necessary to process the claim; and certifies the accuracy of any other health insurance information.

TRICARE also require your original signature on the claim. Your signature certifies that the specific medical care listed on the claim form was provided to the beneficiary named on the claim form, on the date or dates indicated, and by the provider signing the claim. Your signature also certifies that you have agreed to be a participating provider, which means that TRICARE will reimburse you directly (instead of paying the beneficiary) because you agree to accept the allowable amount plus the beneficiary's cost-share and deductible as payment in full. As a TRICARE provider, you must collect the beneficiary's cost-share and deductible unless they have reached their catastrophic cap.

TRICARE only authorizes payments to providers who bill TRICARE the same amount routinely charged the general public, commercial health insurance carriers, or other health benefit entitlement programs for the same or similar services. TRICARE will send all future benefit payments to your practice address to ensure that you are personally aware of the amount being charged TRICARE and of the amount of TRICARE's reimbursement. We will no longer send TRICARE payments to your billing address.

Finally, it has become necessary to validate that you actually submitted the claim because of our very serious concern with improper and/or false claims. I regret that the inappropriate practices of a few providers and their agents require this action, but it is necessary in order for us

to fulfill our fiduciary responsibility. TRICARE will be returning a sample of claims and a form asking providers to confirm that you actually provided the services to the patient identified on the claims on the dates and at the location specified. We will further request that you certify that the amount billed TRICARE is the amount you charge the general public and other health plans/insurers. This certification form will be mailed to you after receipt of a claim and may not be included with the initial submission since someone fraudulently submitting claims in your name could include a fraudulent attestation without your knowledge.

I have also heard that some providers believe it is necessary to belong to or contract with an organization in order to receive TRICARE reimbursement for care provided to Standard beneficiaries. This is not accurate. Licensed providers may become certified TRICARE providers by requesting certification from International SOS, a company that contracts with the U.S. Government to validate provider's credentials and practice location. International SOS may be contacted by email at: pi_cert_unit@internationalsos.com, or mail to:

TRICARE Certification Project
Attn: Raymond Mallari, MD
Suite 1205/6 One Magnificant Mile Building
San Miguel Avenue, Ortigas Center
1600 Pasig City, Metro Manila, Philippines

This certification is at no cost to you and you are under no obligation as a result of obtaining TRICARE certification. Once certified, you have the option of submitting your claims directly to our claims processing contractor, Wisconsin Physicians Services (WPS) at Post Office Box 7985, Madison, WI 53707-7985. Generally, providers who submit their claim directly to WPS experience improved cash flow by the elimination of a middleman.

If you have questions reference this letter, please contact my TRICARE Pacific Regional Customer Service Center at Voice TOLL FREE: 1-888-777-8343, Option 4 or COMM: (81) 6117-43-2036 or DSN 643-2036, and FAX COMM: (81) 6117-43-2037 or DSN 643-2037. Also, email us at "TPAO.CSC@oki10.med.navy.mil"

Once again, I want to thank you for providing healthcare to our beneficiaries and look forward to your continuing relationship with TRICARE. You may obtain additional information about TRICARE through our web site at www.tricare.osd.mil.

Sincerely,

Ed Chan, MBA, MPH
Director, TRICARE Area Office - Pacific

ATTACHMENT 3

Philippines

TMA Administrative Actions/Controls

09/01/02	Required NDA coding/ (Red Book) (Blue Book) pricing on pharmacy claims for the Philippines, Costa Rica, and Panama plus $3.00 dispensing fee per prescription.
10/01/02	Contractor (International SOS) on the ground "bricks & Mortar" assessments of providers including certification before WPS would process claims.
03/15/03	Discontinued "Signature on File" authorizations for providers required actual sponsor/bene signatures on claims.
10/01/03	WPS began performing special Utilization Reviews.
02/01/04	Implemented CMAC pricing (Puerto Rico level) on professional claims.
04/01/04	Required Current Procedural Terminology coding on claims in addition to narrative.
05/01/04	Required clinic/physician dispensed drugs to be priced at Blue Book prices.
08/13/04	Citibank Philippines began providing courier service on foreign draft deliveries to combat theft.
06/15/04	Drs' office visits not allowed when billed with prescriptions.
10/01/04	Hospital "Per Diem" reimbursement system.