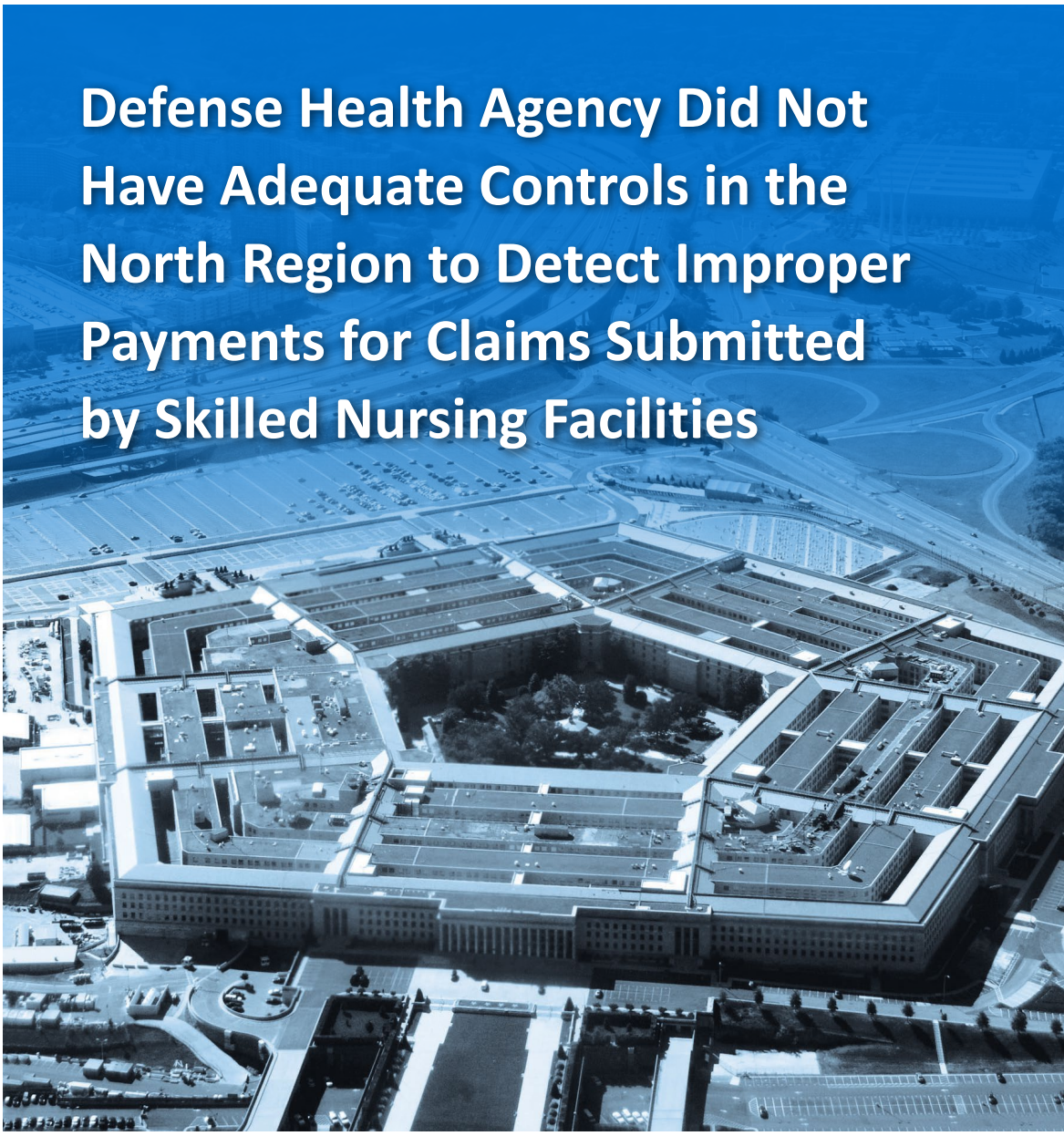
Report No. DODIG-2015-040

INSPECTOR GENERAL

U.S. Department of Defense

NOVEMBER 25, 2014

Defense Health Agency Did Not Have Adequate Controls in the North Region to Detect Improper Payments for Claims Submitted by Skilled Nursing Facilities



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Results in Brief

Defense Health Agency Did Not Have Adequate Controls in the North Region to Detect Improper Payments for Claims Submitted by Skilled Nursing Facilities

November 25, 2014

Objective

Our objective was to determine whether the Defense Health Agency had adequate controls to detect improper payments for TRICARE claims submitted by skilled nursing facilities (SNFs).

Finding

The Defense Health Agency did not have adequate controls to detect improper payments for TRICARE claims submitted by SNFs in the North region. Our review showed 67.4 percent of FY 2013 SNF claims in the TRICARE North region had insufficient documentation to support the claims submitted by the SNFs. Since these payments were made with insufficient or no documentation, they are considered improper payments.

These improper payments occurred because Defense Health Agency personnel:

- considered TRICARE claims processing to be low-risk and therefore did not perform comprehensive reviews of SNF-related claims, and
- implemented inadequate controls to determine whether the 3-day inpatient stay requirement was met before paying SNF claims.

As a result, the Defense Health Agency lacked assurance that SNF payments were accurate and appropriate. We estimate that

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Finding (cont'd)

in FY 2013, the Defense Health Agency did not detect 1,322 SNF improper payments, valued at $8.8 of $13.2 million paid by the TRICARE North region contractor. Specifically, we identified potential monetary benefits totaling $718,400 for the SNF claims in our audit sample where the SNFs did not provide sufficient documentation. See Appendix B for a summary of potential monetary benefits.

Recommendations

We recommend that the Assistant Secretary of Defense (Health Affairs) conduct comprehensive medical reviews on a statistically valid number of SNF claims to ensure an adequate number of claims are reviewed. Additionally, the Assistant Secretary of Defense (Health Affairs) should review and pursue appropriate action on the claims in our sample where we did not receive documentation from the SNF, the SNF provided insufficient documentation, or we were unable to determine whether the SNF claims were appropriately paid. We also recommend that the Assistant Secretary of Defense (Health Affairs) revise system controls to ensure that a qualifying 3-day inpatient stay is met before payments are made for SNF claims. Further, the Assistant Secretary of Defense (Health Affairs) should identify and take action to collect improper payments made that did not meet the 3-day inpatient qualifying stay requirement.

Management Comments and Our Response

Comments from the Director, Business Support Directorate at the Defense Health Agency addressed all specifics of the recommendations, and no further comments are required. Please see the Recommendations Table on the back of this page.

Recommendations Table

Management	Recommendations Requiring Comment	No Additional Comments Required
Assistant Secretary of Defense (Health Affairs)		1, 2, 3, 4

INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
4800 MARK CENTER DRIVE
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November 25, 2014

MEMORANDUM FOR ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

SUBJECT: Defense Health Agency Did Not Have Adequate Controls in the North Region to Detect Improper Payments for Claims Submitted by Skilled Nursing Facilities (Report No. DODIG-2015-040)

We are providing this report for your information and use. We estimate that in FY 2013, the Defense Health Agency did not detect 1,322 skilled nursing facility improper payments, valued at $8.8 of $13.2 million paid by the TRICARE North region contractor. We considered management comments on a draft of this report when preparing the final report. Comments from the Defense Health Agency conformed to the requirements of DoD Directive 7650.3; therefore, we do not require additional comments.

We appreciate the courtesies extended to the staff. Please direct questions to me at (703) 604-9187.

Michael J. Roark
Assistant Inspector General
Contract Management and Payments

Contents

Introduction

Objective

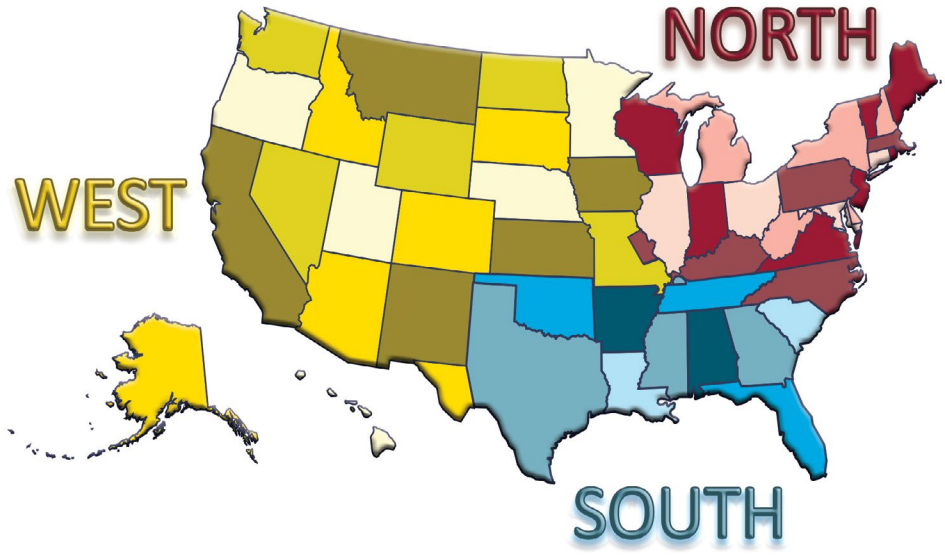
Our objective was to determine whether adequate controls exist to detect improper payments for TRICARE claims submitted by skilled nursing facilities (SNFs). See Appendix A for a discussion of the scope and methodology and prior coverage.

Background

Defense Health Agency and the TRICARE Program

The Defense Health Agency (DHA), an agency under the control, authority, and direction of the Assistant Secretary of Defense (Health Affairs) (ASD[HA]), manages the TRICARE program. To ensure DoD beneficiaries receive health care, TRICARE combines the resources of military hospitals and clinics with civilian health care.[1] The National Defense Authorization Act for FY 2013 authorized $15.8 billion for the Defense Health Program's private sector care. The TRICARE program provides healthcare services to DoD beneficiaries in the North, South, West, and Overseas health service regions, which are administered by managed care support contractors. Figure 1 shows the TRICARE regions in the United States. Our audit scope focused on payments for care provided by SNFs in the North region in FY 2013, which totaled $13.2 million.

Figure 1. TRICARE Regions in the United States



[1] DHA's website: http://www.tricare.mil/About.aspx.

TRICARE Management Activity[2] contracting officials awarded the North region managed care support contract HT9402-10-C-0002 on May 13, 2010, to Health Net Federal Services, Inc. (North region contractor). This contract had an estimated value of about $17.2 billion if all 5 option years were exercised. The North region contractor subcontracted with PGBA (North region claims processor) to process claims.

TRICARE Coverage Requirements for Skilled Nursing Facilities

The TRICARE Reimbursement Manual[3] defines a SNF as an institution primarily engaged in providing: (A) skilled nursing care and related services for residents who require medical or nursing care, or (B) services for the rehabilitation of injured, disabled, or sick individuals. TRICARE-covered SNF services are similar to those provided under the Medicare[4] program; however, TRICARE continues to pay for SNF care beyond Medicare's 100-day coverage limit.

The TRICARE Reimbursement Manual states that SNFs follow Medicare's SNF prospective payment system methodology and assessment schedule. According to the TRICARE Reimbursement Manual, SNF personnel assess patients on days 5, 14, 30, 60, and 90 of the SNF stay. After day 90, DHA requires SNF personnel to assess patients every 30 days. SNF personnel perform assessments using the Minimum Data Set (MDS), a set of clinical and functional status measures that are the basis for classifying patients into a payment category/ medical rate, known as a resource utilization group. The MDS includes the clinical characteristics, functional status, and expected resource needs of the patient. For example, a patient at a SNF may receive some combination of oxygen therapy, intravenous medications, speech-language pathology therapy, occupational therapy, or physical therapy.

The TRICARE Reimbursement Manual states that for a SNF admission to be covered by TRICARE, the beneficiary must:

- have a 3-day qualifying hospital stay,
- enter the SNF within 30 days of discharge from the 3-day qualifying hospital stay,
- receive care from a Medicare-certified and TRICARE-approved SNF, and
- be assessed using the MDS assessment form.

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[2] DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30 2013, disestablished the TRICARE Management Activity, and transferred appropriate TRICARE Management Activity functions to the DHA, including managing the TRICARE program, on October 1, 2013.

[3] TRICARE Reimbursement Manual 6010.58-M, February 1, 2008, Chapter 8, Section 2, "Skilled Nursing Facility (SNF) Prospective Payment System (PPS)."

[4] Medicare is the Federal health insurance program for persons age 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease, according to Medicare.gov.

According to the Centers for Medicare and Medicaid Services (CMS),[5] SNFs are expected to document in the medical record the care a beneficiary needs and receives, as well as how the beneficiary responds to the care. CMS states that it is good practice to require SNFs to document the number of therapy minutes provided to a beneficiary. In addition, the medical record should support and be consistent with the MDS. The TRICARE Reimbursement Manual states that SNFs are not required to provide MDS assessment data to the TRICARE managed care support contractors. However, the TRICARE contractor, at its discretion, may at any time request from SNFs the MDS assessment data and documentation for claim adjudication or audit and tracking purposes.

Inappropriate Medicare Payments to Skilled Nursing Facilities

Prior audit reports from the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) identified problems with Medicare claims submitted by SNFs, including inaccurate claims, medically unnecessary care, and fraudulent claims. For example, in November 2012,[6] the HHS OIG found that:

- 25 percent of all SNF claims were billed in error in 2009—Medicare inappropriately paid $1.5 billion for these claims;
- 20 percent of claims were billed by SNFs at a higher medical rate than was appropriate (upcoded claims); and
- 47 percent of claims submitted by SNFs misreported information in the medical documentation.

HHS OIG recommended, and CMS agreed, to take actions, including increasing and expanding reviews of SNF claims and following up with the SNFs that billed in error.

We performed this audit to determine whether DoD experienced similar problems with SNFs for the TRICARE program. Specifically, we reviewed SNF claims and supporting medical documentation to determine whether the TRICARE North region contractor made appropriate payments.

Improper Payments

Federal guidance[7] defines an improper payment as "any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements." The guidance

[5] CMS is an agency within the Department of Health and Human Services that oversees Medicare.

[6] HHS OIG Report No. OEI-02-09-00200, "Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than a Billion Dollars in 2009," November 2012.

[7] Office of Management and Budget Memorandum 11-16, "Issuance of Revised Parts I and II to Appendix C of OMB Circular A-123," April 14, 2011.

also states that a payment must also be considered an improper payment when an agency's review is unable to determine whether a payment was proper as a result of insufficient or lack of documentation. Additionally, Federal regulation[8] states that "documentation of medical records must be legible and prepared as soon as possible after the care is rendered." Another Federal regulation[9] states that erroneous payments are expenditures of Government funds that are not authorized by law, to include payment for care provided to an ineligible person or payment for care which is not an authorized benefit.

Review of Internal Controls

DoD Instruction 5010.40, "Managers' Internal Control Program Procedures," May 30, 2013, requires DoD organizations to implement a comprehensive system of internal controls that provides reasonable assurance that programs are operating as intended and to evaluate the effectiveness of the controls. We identified an internal control weakness with DHA's controls to detect improper payments for SNF care provided to TRICARE beneficiaries in the North region. Specifically, DHA personnel considered TRICARE claims processing to be low-risk and therefore did not perform comprehensive reviews of SNF-related claims, and implemented inadequate controls to determine whether the 3-day inpatient stay requirement was met before paying SNF claims. We will provide a copy of the report to the senior official responsible for internal controls in the Office of the ASD(HA).

[8] Title 32, Code of Federal Regulations, Section 199.7, "Claims submission, review, and payment" (2014)."

[9] Title 32, Code of Federal Regulations, Section 199.11, "Overpayments recovery" (2014).

Finding

Controls Need Improvement in the North Region to Ensure Proper Payments of Skilled Nursing Facility Claims

DHA did not have adequate controls to detect improper payments for TRICARE claims submitted by SNFs in the North region. Our review of SNF claims in the North region showed that 67.4 percent of SNF claims had insufficient documentation to support the claims submitted by the SNFs. These improper payments occurred because DHA personnel:

- considered TRICARE claims processing to be low-risk and therefore did not perform comprehensive reviews of SNF-related claims; and
- implemented inadequate controls to determine whether SNF claims met the 3-day inpatient stay requirement before paying SNF claims.

As a result, DHA lacked assurance that SNF payments were accurate and appropriate. We estimate that in FY 2013, DHA did not detect 1,322 SNF improper payments, valued at $8.8 of $13.2 million paid by the TRICARE North region contractor. Specifically, we identified potential monetary benefits totaling $718,400 for the SNF claims in our audit sample where the SNFs did not provide sufficient documentation. See Appendix B for a summary of potential monetary benefits.

Controls Did Not Adequately Detect Improper Payments for Care

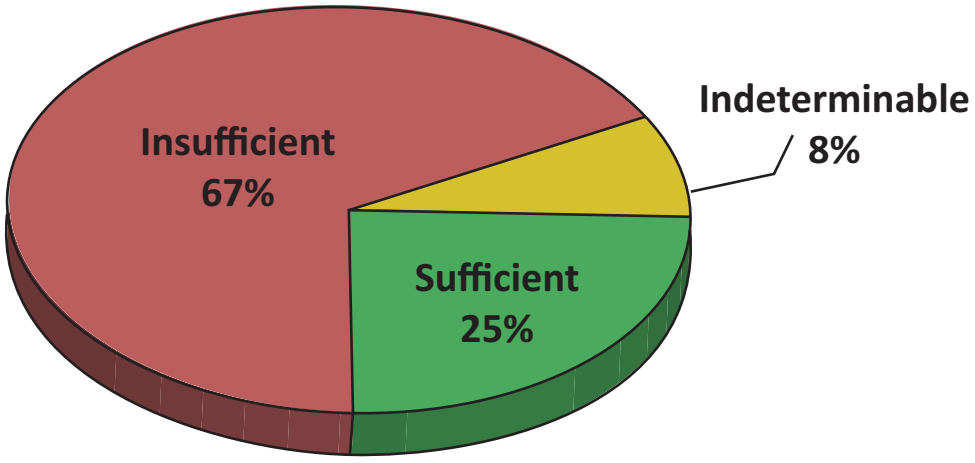
Although DHA had controls for processing North region SNF claims, DHA did not have adequate controls to detect improper payments. SNFs submit claims manually or electronically, and claims are processed through various system edit checks before payment. Generally, healthcare providers (including SNFs) are not required to submit patients' medical records as supporting documentation when submitting claims. However, a DHA contractor may request a medical record from a SNF to verify the services were provided and were medically necessary.

We reviewed a sample of 144 SNF claims, with a paid value of $1.0 million.[10] Beginning in late February 2014, the North region claims processor requested medical records from SNFs for the claims in our sample. The North region claims processor submitted additional request letters to those SNFs that had not provided medical records. Over the following 11 weeks, the North region claims processor provided the SNF medical records to us for our review.

Based on our review, 67.4 percent of claims processed by the North region contractor for SNF care provided in FY 2013 lacked appropriate documentation to support the claims submitted by the SNFs. Specifically, we estimate, as shown in Figure 2, that SNFs provided:

- sufficient documentation to support the medical rate paid by the SNF for 491 claims, valued at $3.3 million;
- insufficient documentation for 1,322 claims, with a paid value of $8.8 million; and
- documentation with indeterminable sufficiency for 150 claims, with a paid value of $1.1 million.

Figure 2. SNF Claims Review Estimates by Documentation Category



[10] See Appendix C for our summary of the projection methodology.

We concluded that documentation for claims was insufficient when the SNF (1) did not provide any documentation,[11] (2) did not provide MDS documentation, (3) provided incomplete MDS documentation to include missing MDS sections or documentation for only partial claims time frames, (4) did not provide documentation to support the planned duration and frequency or actual patient time in therapy, or (5) provided documentation with conflicting information. SNF personnel perform assessments using MDSs as a method of recording clinical and functional status measures, as well as determining a payment rate, known as a resource utilization group. The following are examples of SNF claims from our sample that had insufficient documentation.

- The North region claims processor paid $20,815.96 for 30 days of SNF care for lung cancer. This claim was insufficient because the SNF did not provide any supporting MDS documentation. Without MDS documentation to show what services were provided by the SNF (e.g., therapy, monitoring activities of daily living, specialty treatments and procedures), we were unable to determine whether the North region claims processor paid the appropriate medical rate. It is likely that DHA would have concluded the same results if they had reviewed the documentation to support the claim.
- The North region claims processor paid $9,012.12 for 18 days of SNF care for recovery from knee replacement surgery. Although the SNF provided some documentation, we considered it insufficient because essential sections of the MDS were missing, including activities of daily living and assessment administration. Activities of daily living and assessment administration are used to determine the medical rate.
- The North region claims processor paid $12,897.60 for 29 days of SNF care for spinal problems. We considered the claim insufficient because the SNF did not provide therapy documentation to support the therapy minutes recorded on the MDS documentation. The number of therapy minutes affects the medical rate. For example, an increase in therapy minutes may increase the medical rate. Without the supporting documentation to verify the number of minutes, we were unable to determine whether the North region claims processor paid the correct medical rate. It is likely that DHA would have concluded the same results if they had reviewed the documentation to support the claim.

We concluded that claims documentation was indeterminable when the SNF provided an unreadable MDS or supporting documentation. For example, DHA paid $3,340.50 for 10 days of SNF care for an individual recovering from a broken leg. However, the SNF provided a poorly scanned MDS document that we were unable to read.

[11] We did not receive any documentation for 5 of the 144 SNF claims in our sample. We considered these 5 claims as insufficient documentation.

Defense Health Agency Needs To Perform Comprehensive Reviews on Skilled Nursing Facility Claims

According to the Chief, Improper Payments Evaluation and Transition Branch, DHA program managers considered TRICARE claims processing to be low-risk for improper payments; therefore, DHA did not perform comprehensive reviews[12] of SNF-related claims. For FY 2012, DHA assessed all claims-processing activities for the North, South, and West TRICARE regions as low-risk—including the processing of SNF claims.

DHA assessed all claims-processing activities for the North, South, and West TRICARE regions as low-risk—including the processing of SNF claims.

DHA required its external independent contractor (EIC) to conduct statistical claims audits of each of the TRICARE Purchased Care Contractors[13] every quarter. The EIC reviewed a statistical sample of all TRICARE claims, including SNF claims. According to the Chief, Improper Payments Evaluation and Transition Branch, the results of the statistical claims audits were the basis for the low-risk assessment. In the samples, the EIC reviewed only 21 SNF claims during FY 2013 and found two payment errors totaling $6,318.95 where the EIC was unable to verify the North region contractor's allowed amount for SNF care. However, the EIC did not compare the patient's medical record to the SNF claim for the 21 claims the EIC reviewed. The EIC relied only on information the TRICARE Purchased Care Contractors provided as part of the claims documentation.

In addition to the EIC reviews, DHA's North region contractor conducted quarterly reviews to meet the requirements of the TRICARE Operations Manual. These reviews compared the medical records with the claims to identify any inaccuracies. However, according to contractor personnel, in the past 3 years, the North region contractor's samples did not include any SNF claims. DHA personnel were unaware of the problems with SNFs. Thus, neither had performed comprehensive reviews of SNF-related claims. DHA cannot fully assess the SNF claim without reviews of the medical records and supporting documentation.

[12] For the purposes of this report, comprehensive reviews typically involve manual examinations of each SNF claim, including documentation from the provider, such as paper files, MDS documentation, therapy minutes, and clinical notes. Such reviews aim to determine whether the service was billed properly and was covered, reasonable, and necessary.

[13] TRICARE Purchased Care contractors include the managed care support contractors, the TRICARE Dual Eligible Fiscal Intermediary Contract contractor, the TRICARE Overseas Program contractor, the TRICARE Pharmacy contractor, and the TRICARE Active Duty Dental Program contractor.

The ASD(HA) should conduct comprehensive medical reviews on a statistically valid number of SNF claims to ensure an adequate number of claims are reviewed. Reviews should compare patients' medical records to the SNF claims to determine whether all required documentation exists and is adequate. Also, the ASD(HA) should review and pursue appropriate action on the SNF claims in our sample where we did not receive documentation from the SNFs, the SNF provided insufficient documentation, or we were unable to determine whether the SNF claims were appropriately paid.

Prepayment Controls Need Improvement to Ensure That Beneficiaries Meet Preadmission Requirements

Although the North region claims-processing system had prepayment edit checks and controls built in to detect and flag certain elements for review before the contractor made payments, controls could not adequately determine whether the required 3-day qualifying stay was met. TRICARE policy requires a 3-day qualifying hospital stay before the claims processor can pay a SNF claim. The controls built into the claims-processing system required the SNF to enter the dates of the 3-day qualifying inpatient stay. However, we discovered that the claims-processing system did not calculate whether the dates of the qualifying stay provided by the SNF met a minimum of 3 days. Instead, the claims-processing system verified only whether data were populated in the date fields. For example, one claim we reviewed showed the SNF provider entered dates for a 1-day hospital stay on the claim form, as shown in Figure 3, but the contractor still paid the claim.

We discovered that the claims-processing system did not calculate whether the dates of the qualifying stay provided by the SNF met a minimum of 3 days.

Figure 3. Inadequate Control for 3-Day Qualifying Hospital Stay

Figure 3 Legend

35 Code	Occurence Span From	Through
70	041013	041113

Source: Claim document in our claims review

We submitted 1 test SNF claim with a qualifying stay of only 1 day to determine whether the control worked effectively. The claims-processing system did not stop the claim from being processed further.

According to personnel from the North region claims processor, the system controls in the claims-processing system had not been updated since 2003. Contractor personnel agreed the system controls needed to be updated to look for a 3-day span of dates. On April 15, 2014, according to a DHA program analyst, the North claims processor acknowledged the prepayment edit-check problem and agreed to implement a manual review process until the North region claims-processing contractor corrects the prepayment edit check. The ASD(HA) should revise system controls to ensure a qualifying 3-day inpatient stay is documented before paying SNF claims. The ASD(HA) should also identify and take action to collect improper payments made that did not meet the 3-day inpatient qualifying stay requirement.

Defense Health Agency Made Improper Payments for Skilled Nursing Facility Claims

DHA lacked assurance that SNF payments were accurate and appropriate. We estimate that in FY 2013, DHA did not detect 1,322 SNF improper payments, valued at $8.8 of $13.2 million paid by the TRICARE North region contractor—these payments were made with insufficient or no documentation. DHA will continue to be at an increased risk of making improper payments for North region SNF care if DHA does not implement additional controls. Specifically, DHA should expand its review of SNF claims, and as part of its expanded review, compare each patient's medical record to the SNF claim to ensure all required documentation exists and is adequate. Additionally, improving DHA controls will help ensure that TRICARE beneficiaries meet preadmission requirements before payment for SNF claims.

Management Comments on the Finding and Our Response

The Director, DHA Business Support Directorate, responding for the ASD(HA), commented that it was not clear if we used the same methodology the HHS OIG used in a study we cited in our findings. He stated that we may have inaccurately identified the $8.8 million as an improper payment if we did not use the same methodology.

The Director also stated DHA has a robust internal review and audit process through the quarterly claims audits and TRICARE Quality Monitoring Contractor audit mechanisms, which DHA uses to review proper payments and quality of care. He stated that because there is a low volume of SNF claims in the managed care regions, SNF claims were not previously identified for audit. He stated that based on the findings of this report, DHA will use its internal audit capabilities to conduct comprehensive medical reviews of SNF claims.

Our Response

Federal guidance states that a payment must be considered improper when an agency's review cannot determine whether a payment was proper, as a result of insufficient documentation. We identified $718,400 of claims in our audit sample for which the SNFs did not provide sufficient documentation. Therefore, we estimate that for the FY 2013 SNF claims population, the Defense Health Agency did not detect 1,322 improper SNF payments, valued at $8.8 million, from a total claims population of $13.2 million paid by the TRICARE North region contractor. See Appendix C for our summary of the projection methodology.

Recommendations, Management Comments and Our Response

Recommendation 1

We recommend that the Assistant Secretary of Defense (Health Affairs) conduct comprehensive medical reviews on a statistically valid number of skilled nursing facility claims to ensure an adequate number of claims are reviewed. Reviews should compare the patients' medical records to the skilled nursing facility claims to determine whether all required documentation exists and is adequate.

Assistant Secretary of Defense (Health Affairs) Comments

The Director, DHA Business Support Directorate, responding for the ASD(HA), did not explicitly agree or disagree with the recommendation; however, he stated that DHA is committed to taking action to increase reviews of SNF claims. He also stated DHA plans to use its internal audit capabilities to conduct comprehensive reviews of these claims to ensure that SNF claims are documented, billed, and paid appropriately.

Our Response

Comments from the Director addressed all specifics of the recommendation, and no further comments are required.

Recommendation 2

We recommend that the Assistant Secretary of Defense (Health Affairs) review and pursue appropriate action on the claims in our sample for which we received insufficient or no documentation from the skilled nursing facilities or whose eligibility we were unable to determine.

Assistant Secretary of Defense (Health Affairs) Comments

The Director, DHA Business Support Directorate, responding for the ASD(HA), did not explicitly agree or disagree with the recommendation; however, he stated that DHA took appropriate action and initiated recoupment on April 3, 2014, against SNF providers who had not provided sufficient medical record documentation to support the associated claim. The Director stated DHA recouped $131,764 by June 2014.

Our Response

Comments from the Director addressed all specifics of the recommendation, and no further comments are required.

Recommendation 3

We recommend that the Assistant Secretary of Defense (Health Affairs) revise system controls to ensure that a qualifying 3-day inpatient stay is documented before payments are made for skilled nursing facility claims.

Assistant Secretary of Defense (Health Affairs) Comments

The Director, DHA Business Support Directorate, responding for the ASD(HA), did not explicitly agree or disagree with the recommendation; however, he stated that the contractor immediately took action by implementing a manual review process. He stated that the contractor modified the work instructions and claims-processing personnel were instructed to manually review dates for accuracy and search claims history for the 3-day qualifying stay. The Director stated when the claims-processing staff did not find a qualifying stay, the staff denied the claim. The Director also stated that recoupments were initiated for 29 claims, valued at $194,938, from April 1, 2011, (the start of the contract) through May 9, 2014, when the contractor implemented a system change automating the validation of the qualifying 3-day inpatient stay.

Our Response

Comments from the Director addressed all specifics of the recommendation, and no further comments are required.

Recommendation 4

We recommend that the Assistant Secretary of Defense (Health Affairs) identify and take action to collect improper payments made that did not meet the 3-day inpatient qualifying stay requirement.

Assistant Secretary of Defense (Health Affairs) Comments

The Director, DHA Business Support Directorate, responding for the ASD(HA), did not explicitly agree or disagree with the recommendation, however, he stated that before our report, recoupments were initiated for 29 claims, valued at $194,938, from the start of the contract, April 1, 2011, through May 9, 2014, when the contractor implemented a system change automating the validation of the qualifying 3-day inpatient stay.

Our Response

Comments from the Director addressed all specifics of the recommendation, and no further comments are required.

Appendix A

Scope and Methodology

We conducted this performance audit from January 2014 through September 2014 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusion based on our audit objectives.

Review of Documentation and Interviews

To accomplish our audit objectives, we interviewed officials from DHA; the TRICARE North region contractor, Health Net Federal Services, Inc. and its claims-processing subcontractor, PGBA. We determined whether DHA and the North region contractor performed reviews of payments made on SNF claims and the results of any claims reviews.

We visited the North region claims processor to obtain information on the claims-payment process and system controls. We observed general and SNF-specific claims-processing procedures. We created and submitted test claims into the claims processor's payment system to evaluate the effectiveness of the system controls, including the prepayment edit check to ensure that a 3-day qualifying hospital stay was documented.

We obtained SNF claims data from the Military Health System Data Repository (MDR) for FY 2013. The DoD OIG Quantitative Methods Division used the data to create a statistical variable sample of 144 SNF claims from the universe of 1,963 SNF claims for the North region in FY 2013. The DHA claims processor requested SNFs to send the complete medical record for the 144 SNF claims. We analyzed the documentation in the medical records and the MDS data to determine whether the documentation supported the information on the claim submitted by the SNF. We compared the medical rate (resource utilization group) billed on the claim with that on the MDS. We also compared therapy minutes entered on the MDS with the minutes in therapy notes or grids. We concluded that claims documentation was insufficient when the SNF (1) did not provide any documentation, (2) did not provide MDS documentation, (3) provided incomplete MDS documentation to include missing MDS sections or documentation for only partial claims timeframes, (4) did not provide documentation to support the

planned duration and frequency or actual patient time in therapy, or (5) provided documentation with conflicting information. We concluded that claims documentation was indeterminable when the SNF provided an unreadable MDS or supporting documentation.

We reviewed SNF claims for the North region contractor because it was the TRICARE contractor with the highest number of SNF payments in FY 2013, as shown in the Table below.

Table. Amount Paid for SNF Care in FY 2013

DHA Contract	Amount Paid
North Region Contract	$13,190,693.60
South Region Contract	$7,887,867.47
West Region Contract	$7,030,834.95
TRICARE Overseas Program Contract	$17,718.15
TRICARE Dual Eligible Fiscal Intermediary Contract	$275,382,584.18
Total	**$303,509,698.35**

Source: MDR, as of January 8, 2014

Although the TRICARE Dual Eligible Fiscal Intermediary Contract accounted for approximately 91 percent of the SNF payments in FY 2013, we did not select these claims because the Medicare program was the primary payer and TRICARE the secondary payer for these claims.

We reviewed public law and the Code of Federal Regulations, as well as DHA and CMS documents. We identified procedures and requirements established for the payment of care provided to TRICARE beneficiaries in SNFs and for the submission of healthcare claims by SNFs. Specifically, we reviewed Public Law 109-364, the 2007 National Defense Authorization Act, Section 731, "Standardization of Claims Processing Under TRICARE Program and Medicare Program," October 17, 2006; Title 32, Code of Federal Regulations, Section 199.4, "Basic Program Benefits"; Title 42, Code of Federal Regulations, Sections 409.17 and 409.23, "Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services"; TRICARE Reimbursement Manual 6010.58-M, February 1, 2008, Chapter 8, Section 2, "Skilled Nursing Facility (SNF) Prospective Payment System (PPS)"; as well as various sections of the TRICARE Operations Manual 6010.56-M, February 1, 2008. We reviewed the CMS "Long Term Care Facility Resident Assessment Instrument User's Manual," revised in October 2012 and again in May 2013. We also reviewed the North region contract with Health Net Federal Services, Inc., HT9402-10-C-0002, effective May 30, 2010.

Use of Computer-Processed Data

We used computer-processed data obtained from the MDR to determine the amount paid for SNF care provided in the North region, to determine whether claims for SNF care were accurately captured in the MDR, and to develop a statistical sample of claims to determine whether the North region contractor adequately processed claims submitted by SNFs. Specifically, we obtained the universe of all claims data from the MDR for FY 2013 for SNF care provided in the TRICARE North region.

We tested the reliability of the MDR data by comparing the data to documentation obtained from PGBA for our statistical sample of 144 claims submitted by SNFs. We obtained the claims documentation from Health Net Federal Services, Inc., the TRICARE North region claims processor.[14] Specifically, we compared the following as shown in the MDR and the North region contractor's payment system records:

- the billed, allowed, and paid amounts;
- the SNF admission date;
- the begin and end dates of the claim timeframe;
- the number of days in the claim timeframe;
- the internal control number;
- the Health Insurance Prospective Payment System code;
- the patient's age; and
- the sponsor's Social Security number.

Based on our testing, we determined that the North region SNF data were sufficiently reliable for the purposes of this report.

Use of Technical Assistance

We obtained support from the DoD OIG Quantitative Methods Division in developing the statistical sample of SNF claims for review. See Appendix C for our summary of the projection methodology.

[14] Claims documentation included copies of health care claim forms (Form UB-04) submitted by SNFs, explanations of benefits, and data residing in the North region claims processor system.

Prior Coverage

During the last 5 years, the HHS OIG issued numerous reports discussing SNF payments and the quality of care at these facilities. HHS OIG reports can be accessed at: http://oig.hhs.gov/reports-and-publications/index.asp.

HHS OIG

Report No. OEI-06-11-00370, "Adverse Events In Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries," February 2014

Report No. OEI-02-09-00201, "Skilled Nursing Facilities Often Fail To Meet Care Planning And Discharge Planning Requirements," February 2013

Report No. OEI-02-09-00200, "Inappropriate Payments To Skilled Nursing Facilities Cost Medicare More Than A Billion Dollars In 2009," November 2012

Report No. OEI-02-09-00204, Early Alert Memorandum Report: "Changes In Skilled Nursing Facilities Billing in Fiscal Year 2011," July 8, 2011

Report No. OEI-02-09-00202, "Questionable Billings By Skilled Nursing Facilities," December 2010

Appendix B

Summary of Potential Monetary Benefits

Recommendation	Type of Benefit	Amount of Benefit	Account
1	Internal Controls. This post payment control will compare SNF claims to the patient's medical record to verify that the SNF claim was billed properly, covered, reasonable, and necessary.	Undeterminable. Amount is subject to results of DHA or its contractor's review of SNF claims in future years.	97X0130
2	Internal Controls. This post payment control will identify improper payments for SNF claims in our audit sample.	Funds put to better use of $718,400 for FY 2013 SNF claims in the North region.	97X0130
3	Internal Controls. This prepayment control will help prevent DHA from paying SNF claims that did not have a 3-day qualifying inpatient stay.	Undeterminable. Amount is subject to future years of SNF claims that were not paid because the patient did not have a 3-day qualifying inpatient stay.	97X0130
4	Internal Controls. This post payment control will identify improper payments for SNF claims that did not meet the 3-day qualifying inpatient stay.	Undeterminable. Amount is subject to results of DHA or its contractor's review of SNF claims from prior years.	97X0130

Appendix C

Summary of Projection Methodology for North Region Skilled Nursing Facility Claims

With the assistance of the DoD OIG Quantitative Methods Division, we used a statistical sample to project whether adequate controls existed to detect improper payments for TRICARE claims submitted by SNFs.

Quantitative Plan

The population consisted of 1,963 SNF claims processed by the TRICARE North region contractor during FY 2013. The measures were the book value paid for claims in each of three categories, as discussed in the Sample Plan section below, and the number of claims paid in each category. We used a simple random sample of 144 claims as the basis for our estimates. We used a 95 percent confidence level for the statistical estimate.

Sample Plan

We used simple random sample design covering all 1,963 SNF claims and drew a sample of 144 claims. We drew the simple random sample without replacement using SAS programming tools. We found that SNFs provided (1) sufficient documentation for only 36 of the 144 sample claims, valued at $241,948; (2) insufficient documentation for 97 of 144 claims, valued at $718,400; and (3) indeterminable documentation because some of the documentation was illegible for 11 of 144 claims, valued at $78,361.

Statistical Projections and Interpretation

The planned analysis included making projections of the number and the dollar value paid for each category. The results generalize to FY 2013 North region SNF care and do not apply to other TRICARE regions. We projected the results of the sample using the simple random sample design at the 95 percent confidence level.

Claims with Sufficient Documentation

Based on the sample results we projected at the 95 percent confidence level that the MDR paid value of claims having sufficient documentation was between $2.2 million and $4.4 million, with the point estimate of $3.3 million.[15]

[15] The MDR paid value estimates exhibit what is called sampling bias. Statistical samples represent the population from which they are drawn and the sample statistics are approximations of the population values. The value estimates were calculated using formulae found in Sampling Techniques, Third Edition, New York: Wiley, 1977, by William G. Cochran, pages 22 and 26-27. The confidence bounds will, in these calculations, include the true population value 95 percent of the time. For this sample, the lower bound to upper bound range of the estimated paid value of record, $12.6 million to $15.7 million, included the total MDR paid value of record, $13.2 million. This particular sample had a higher average paid value than the population paid value, but is statistically representative.

Based on the sample results we projected at the 95 percent confidence level that the number of claims with sufficient documentation was between 357 and 646, with the point estimate of 491.[16] The corresponding percent range was between 18.2 percent and 32.9 percent with the point estimate being 25.0 percent.

Claims with Insufficient Documentation

Based on the sample results we projected at the 95 percent confidence level that the MDR paid value of claims having insufficient documentation was between $7.2 million and $10.5 million, with the point estimate of $8.8 million.[17]

Based on the sample results we projected at the 95 percent confidence level that the number of claims with insufficient documentation was between 1,159 and 1,471, with the point estimate of 1,322. The corresponding percent range was between 59.1 percent and 74.9 percent with the point estimate being 67.4 percent.

Claims with Indeterminable Documentation

Based on the sample results we projected at the 95 percent confidence level that the MDR paid value of claims having indeterminable documentation was between $0.4 million and $1.8 million, with the point estimate of $1.1 million.

Based on the sample results we projected at the 95 percent confidence level that the number of claims with indeterminable documentation was between 76 and 260, with the point estimate of 150. The corresponding percent range was between 3.9 percent and 13.3 percent with the point estimate being 7.6 percent.

[16] The attribute estimates for all three categories were calculated as exact binomial upper and lower bounds using the beta inverse distribution.

[17] In calculating the value of claims with insufficient documentation, we used the statistical estimates for claims with sufficient documentation ($3.3 million) and with indeterminable documentation ($1.1 million) and calculated the difference ($8.8 million) as the point estimate for claims with insufficient documentation.

Management Comments

Office of the Assistant Secretary of Defense (Health Affairs)

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DEFENSE
HEALTH AGENCY

OCT 31 2014

MEMORANDUM FOR DEPARTMENT OF DEFENSE INSPECTOR GENERAL, DEPUTY INSPECTOR GENERAL FOR CONTRACT MANAGEMENT AND PAYMENTS

SUBJECT: Department of Defense Inspector General Draft Report, "Defense Health Agency Did Not Have Adequate Controls in the North Region to Detect Improper Payments for Claims Submitted by Skilled Nursing Facilities"

Thank you for the opportunity to review and comment on the Department of Defense Draft Report, Project No. D2014-D000CJ-0098.000, "Defense Health Agency (DHA) Did Not Have Adequate Controls in the North Region to Detect Improper Payments for Claims Submitted by Skilled Nursing Facilities," dated September 29, 2014.

My specific comments to the recommendations are attached for your consideration to incorporate in the final report. Overall, I concur with the Draft Report's findings and conclusions. The DHA continues to strive for appropriateness of payments, and welcomes the findings as an area for improvement. There are a few points that require clarification.

The report contains an estimate of $8.8 million in improper payments for skilled nursing facility (SNF) claims in fiscal year 2013 and references a similar study conducted by the Health and Human Services (HHS) Office of Inspector General (OIG), where 25 percent of SNF claims were billed in error with an estimated overpayment of $1.5 billion. The calculation of inappropriate payments in the HHS OIG report was identified by noting the difference between the medical rate billed and the medical rate supported in the documentation of each record. It is not clear that this same methodology was used to calculate improper payments in this review. Consequently, the $8.8 million identified as improper payment may be inaccurate.

The report finds weakness with DHA's internal controls to detect improper payments for SNF care. The report attributes this to a statement that, "DHA personnel considered TRICARE claims processing to be low-risk and therefore did not perform comprehensive reviews of SNF-related claims." The DHA has a robust internal review and audit process through the quarterly claims audits and TRICARE Quality Monitoring Contractor audits mechanisms which are used on a quarterly and annual basis to review proper payments and quality of care. Due to the relatively low volume of skilled nursing claims within the managed care regions, SNF claims were not previously identified for audit under the TRICARE Third Generation of Contracts. Using the knowledge gained from these report findings, the DHA will leverage current internal audit capabilities to conduct comprehensive medical reviews on skilled nursing facility claims across the DHA in order to ensure skilled nursing facility claims are documented, billed and paid appropriately.

Office of the Assistant Secretary of Defense (Health Affairs) (cont'd)

My points of contact regarding this matter are [redacted].

Joseph B. Marshall, Jr.

Attachment:
As stated

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Office of the Assistant Secretary of Defense (Health Affairs) (cont'd)

DEPARTMENT OF DEFENSE OFFICE OF THE INSPECTOR GENEAL
DRAFT REPORT – DATED SEPTEMBER 29, 2014
PROJECT NO. D2014-D000CJ-0098.000
"DEFENSE HEALTH AGENCY DID NOT HAVE ADEQUATE CONTROLS IN THE NORTH REGION TO DETECT IMPROPERT PAYMENT SFOR CLAIMS SUBMTTED BY SKILLED NURSING FACILITIES"

DEFENSE HEALTH AGENCY COMMENTS
TO THE RECOMMENDATIONS

RECOMMENDATION 1: Conduct comprehensive medical reviews on a statistically valid number of skilled nursing facility claims to ensure an adequate number of claims are reviewed. Reviews should compare the patients' medical records to the skilled nursing facility claims to determine whether all required documentation exists and is adequate.

DOD RESPONSE: The Defense Health Agency (DHA) is committed to taking action to increase reviews of skilled nursing facility claims to determine proper payments based upon the report findings and recommendations. DHA plans to leverage current internal audit capabilities to conduct comprehensive medical reviews on skilled nursing facility claims across the DHA in order to assure that skilled nursing facility claims are documented, billed and paid appropriately.

RECOMMENDATION 2: Review and pursue appropriate action on the claims in our sample for which we received insufficient or no documentation from the skilled nursing facilities or whose eligibility we were unable to determine.

DOD RESPONSE: The DHA has taken the appropriate action required on the claims in the Department of Defense Inspector General (DoD IG) sample reported as having insufficient or no documentation from skilled nursing facilities or whose eligibility was undetermined.

In accordance with TRICARE policy, DHA initiated recovery action against skilled nursing facilities that failed to provide adequate medical record documentation that supported the adjudication of the associated claim(s). Recoupment actions totaling $131,764 were initiated on April 3, 2014, with full recoveries through direct recoupment from skilled nursing facilities or as financial offset from future claims reimbursements, was accomplished in June 2014.

RECOMMENDATION 3: Revise system controls to ensure that a qualifying 3-day inpatient stay is documented before payments are made for skilled nursing facility claims.

DOD RESPONSE: Actions associated with this recommendation have already been implemented by DHA. Upon finding that the Palmetto Government Benefits Administrators (PGBA) claims processing system did not look for a 3-day qualifying stay, PGBA immediately responded by implementing a manual review process on April 14, 2014, the same day the DoD-IG identified the problem. Work instructions related to claims processing were modified and claims processing staff was instructed to manually review keyed dates for accuracy and search claims history for a 3-day inpatient qualifying stay. If the qualifying stay was not identified in

Office of the Assistant Secretary of Defense (Health Affairs) (cont'd)

the claims history, the claim was disallowed and denied. PGBA then conducted a query of processed skilled nursing facility claims with less than 3-days in the occurrence span date and examined them for accuracy of processing and potential overpayment identification. Steps taken prior to recoupment action included: verifying keying for accuracy, searching patient history for a 3-day inpatient qualifying stay, and provider outreach as a supplemental quality measure when unsuccessful at locating a qualifying stay in patient history.

Recoupments were initiated for 29 claims, valued at $194,938, from the start date of the contract (April 1, 2011) through May 9, 2014. A system change automating the validation of the occurrence span dates was implemented May 9, 2014.

RECOMMENDATION 4: Identify and take action to collect improper payments made that did not meet the 3-day inpatient qualifying stay requirement.

DOD RESPONSE: Prior to the DoD-IG's report of findings, payments that did not meet the 3-day inpatient qualifying stay requirement were identified and action was taken to collect improper payments. Recoupments were initiated for 29 claims, valued at $194,938, from the start date of the contract through May 9, 2014, the date that automated system changes were implemented to validate the occurrence span dates of the qualifying inpatient stay.

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Acronyms and Abbreviations

ASD(HA)	Assistant Secretary of Defense (Health Affairs)
CMS	Centers for Medicare and Medicaid Services
DHA	Defense Health Agency
EIC	External Independent Contractor
GAO	Government Accountability Office
HHS	Department of Health and Human Services
MDR	Military Health System Data Repository
MDS	Minimum Data Set
OIG	Office of the Inspector General
SNF	Skilled Nursing Facility


INSPECTOR GENERAL
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