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Report to the Chairman and Ranking Minority Member, Subcommittee on Military Personnel, Committee on Armed Services, and the Honorable Charles W. Stenholm, House of Representatives

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DEFENSE HEALTH CARE

Claims Processing Improvements Are Under Way but Further Enhancements Are Needed

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The Honorable Steve Buyer
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Ranking Minority Member
Subcommittee on Military Personnel
Committee on Armed Services
House of Representatives

The Honorable Charles W. Stenholm
House of Representatives

Today, about 8.2 million active duty personnel, their dependents, and retirees are eligible to receive health care through the $15.6 billion-per-year military health system. Medical care is provided by Department of Defense (DOD) personnel in military facilities and through civilian contractors. Civilian-provided care requires that providers or beneficiaries submit claims to DOD contractors who, in turn, adjudicate the claim and pay according to established rules and policies.

Concerns about claims processing timeliness and accuracy have plagued the military health care system since the advent of TRICARE, DOD's managed care program. During the 1-year period ending June 1998, the contractors we reviewed processed approximately 19 million claims worth over $1.7 billion. Health care providers and beneficiaries have frequently complained that claims were being processed too slowly and that many errors were occurring. While DOD contractors have acknowledged that they experienced problems processing claims in a timely manner during the start-up phase of health care delivery, they contend that they are now meeting standards. In response to your request, we evaluated the timeliness and accuracy of claims processing. We also evaluated the effectiveness of DOD's use of ClaimCheck™, a claim editing software package DOD requires its contractors to use. We performed our work between April 1998 and June 1999 in accordance with generally accepted government auditing standards. For a further description of our scope and methodology, see appendix I.

Results in Brief

Between July 1, 1997, and June 30, 1998, DOD's contractors processed 86 percent of claims (or 16 million) within 21 days. This met DOD's timeliness standard of processing 75 percent of claims within 21 days. Even so, nearly

3 million claims took more than 21 days to process, which prompted complaints from some providers and beneficiaries about what they considered to be payment delays. DOD has several initiatives under way to improve timeliness, including adopting the payment and penalty standards used by the Medicare program. If these standards are properly implemented and met by contractors, they should help reduce providers' complaints.

While DOD adequately measures contractors' performance in claims processing timeliness, it does not know the extent to which contractors are accurately paying claims. Less than half the claims are subject to its payment accuracy audit, and the methodology used to calculate the payment error rate is statistically invalid. All contractors experienced problems with payment accuracy when they began processing TRICARE claims, often because they did not have enough time to adequately prepare to administer the program. Although contractors addressed these problems, they acknowledged that many factors affect the accuracy of claims processing—primarily the complexity of the program, compounded by numerous program changes. We also found that some claims processing problems were due to mistakes made by providers and beneficiaries when filing their claims. Furthermore, because they do not always understand the program, providers and beneficiaries sometimes complain about adjudication decisions on claims that had actually been processed correctly.

To help ensure payment accuracy, DOD requires its contractors to use ClaimCheck™, a commercial software program designed to ensure that professional providers are appropriately paid for services rendered. ClaimCheck™'s use resulted in changes to only 3.5 percent of professional claims in fiscal year 1998 and saved over $53 million. Nonetheless, some providers complain about its use because ClaimCheck™'s review criteria are not published and available to them. Without this information, they expressed doubt that the criteria comply with industry claims review standards. We found that, although ClaimCheck™'s review criteria are based on industry standards, its use has resulted in some inappropriate denials to TRICARE claims. These errors occurred because DOD was slow to direct contractors to incorporate TRICARE policy changes into their claims processing systems. This report makes a number of recommendations to the Secretary of Defense to improve claims processing timeliness and accuracy.

Background

DOD's primary medical mission is to maintain the health of 1.6 million active duty service personnel and to provide them with health care during military operations. DOD also offers health care to 6.6 million non-active duty beneficiaries, including dependents of active duty personnel, military retirees, and dependents of retirees. Under TRICARE, care is provided in military-operated hospitals and clinics worldwide and is supplemented by civilian providers.[1] TRICARE is a triple-option benefit program designed to give beneficiaries a choice among a health maintenance organization, a preferred provider organization, and a fee-for-service benefit. The health maintenance organization option, called TRICARE Prime, is the only option for which beneficiaries must enroll. TRICARE Extra is the preferred provider organization option, and TRICARE Standard is the fee-for-service option. Contractors, who are referred to as managed care support contractors (MCSC), must create networks of providers for the Prime and Extra options. During network development MCSCs recruit providers, negotiate reimbursement rates, and verify professional credentials.

TRICARE is organized geographically into 11 health care regions administered by 5 MCSCs. The MCSCs' many responsibilities include processing claims, providing customer service, and developing and maintaining an adequate network of civilian providers. While the MCSCs are ultimately responsible for claims processing, all of the MCSCs have subcontracted with one of two companies to process claims, as shown in table 1.

[1]DOD previously provided health care under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), a fee-for-service program.

Table 1: TRICARE MCSCs and Subcontractors Responsible for Claims Processing

	TRICARE MCSC	MCSCs' subcontractors
Regions included in our review		
Northwest	Foundation Health Federal Services, Inc.	Wisconsin Physicians Service
Southwest	Foundation Health Federal Services, Inc.	Wisconsin Physicians Service
Southern California, Golden Gate, and Hawaii-Pacific	Foundation Health Federal Services, Inc.	Palmetto Government Benefits Administrators
Southeast and Gulf South	Humana Military Healthcare Services, Inc.	Palmetto Government Benefits Administrators
Central	TriWest Healthcare Alliance, Inc.	Palmetto Government Benefits Administrators
Regions not included in our review[a]		
Northeast	Sierra Military Health Services	Palmetto Government Benefits Administrators
Mid-Atlantic and Heartland	Anthem Alliance for Health, Inc.	Palmetto Government Benefits Administrators

[a]These regions were not included because they did not have at least 1 year of claims processing experience as of July 1998.

Claims processing involves timely, accurate, and appropriate adjudication of health care claims based on TRICARE rules and policies. Claims processing tasks include receipt of the claim form, data entry, claims adjudication, and claim payment or denial.

DOD requires MCSCs to meet specific timeliness and accuracy standards for claims processing. MCSCs must process 75 percent of claims within 21 days. This standard applies to all claims, even when MCSCs must obtain additional information to process them. DOD verifies whether MCSCs are meeting timeliness standards through its database of health care service records (HCSR), which are the final records of the claims. DOD requires the MCSCs to send an electronic HCSR to DOD for each claim processed to completion. DOD also requires MCSCs to maintain a 98-percent payment accuracy rate and a 97-percent data input accuracy rate. DOD conducts quarterly external audits to monitor whether MCSCs meet these standards.

DOD requires MCSCs to use ClaimCheck™, a commercial claims editing software package that performs a pre-payment review of professional claims and helps prevent overpayment by analyzing relationships between medical procedure codes. For example, ClaimCheck™ contains review criteria, known as edits, to prevent "unbundling," a process whereby

providers use two or more procedure codes to describe a service when a single, more comprehensive code exists. Generally, providers receive higher reimbursement for unbundled codes compared to a single, comprehensive code. The basic ClaimCheck™ software package contains approximately 5 million edits. However, companies that purchase ClaimCheck™ may customize the edits to reflect their plan's benefit structure. DOD purchased ClaimCheck™ software in March 1994 and had it customized to edit for TRICARE's benefit structure. DOD refers to its customized version as TRICARE ClaimCheck (TCC). DOD does not require the use of TCC for anesthesia, pharmacy, physical therapy, or institutional claims (except ambulatory surgery facility claims), or for adjustments to claims that were processed prior to the use of TCC. As a result, TCC affects only about 60 percent of claims.

In response to beneficiary and provider concerns, DOD intends to make changes to future TRICARE contracts that could improve the timeliness and accuracy of claims processing. However, because the next round of contracts is not anticipated to be awarded until 2001, DOD recently decided to implement selected changes in advance by amending current contracts. This effort, called work simplification, involves adopting timeliness standards similar to Medicare's and changing the way incomplete claims are handled. In addition, DOD has contracted with a consulting firm to evaluate its claims processing procedures and make recommendations for improvement. The consultant's report is due by October 1999.

MCSCs Are Meeting DOD's Claims Processing Timeliness Standard, but Complaints About Slow Payments Continue

Each of the MCSCs experienced problems with claims processing timeliness during the early months of health care delivery. This was partially due to a higher-than-expected claims volume—for example, two contracts received 40 to 50 percent more claims than anticipated. As a result, the claims processing subcontractor had to recruit, hire, and train additional staff—a process that took approximately 4 months. During this time, the backlog of incoming claims continued to grow.

Claims processing timeliness has improved as MCSCs have gained more experience with the TRICARE program. We analyzed over 19 million claim records and determined that during the period between July 1, 1997, and June 30, 1998, MCSCs met DOD's contractual timeliness standard by processing 86 percent of claims within 21 days. Despite this, nearly 3 million claims took longer than 21 days to process and therefore some providers and beneficiaries experienced what they considered to be payment delays.

Timeliness Standards Met Overall, but Differences Exist by Claim Characteristics

Processing time was affected by characteristics such as type of claim (professional, pharmacy, or institutional), submission method (electronic or paper), and amount allowed for payment.[2] We found that institutional claims did not meet the standard; however, MCSCs did meet the standard overall because higher-than-required percentages of claims in other categories were paid in less than 21 days. To improve claims processing timeliness in the future, DOD has proposed several initiatives, including the adoption of some Medicare standards.

Tables 2 through 4 display various statistics by claim category. As table 2 shows, professional and pharmacy claims met the standard, but only 66 percent of institutional claims were processed within 21 days. Pharmacy claims are usually for small dollar amounts, as are many professional claims. High-dollar claims, often from hospitals, are usually the most complicated and often require medical review, adding to processing time. For example, as shown in table 3, only 30 percent of claims over $10,000 were paid within 21 days. Because institutional claims comprise only 4 percent of all claims, MCSCs were still able to meet standards overall. And even though professional claims met the standard, they comprise 83 percent of the claims that took more than 21 days to process, which may explain why some providers complain about delinquent payments.

Table 2: Processing Time by Category of Claim

	Claims processed				
	0 to 21 days		More than 21 days		
Category of claims	Number	Percentage	Number	Percentage	All claims
Professional	9,480,983	81	2,265,093	19	11,746,076
Pharmacy	6,506,867	97	215,252	3	6,722,119
Institutional	473,964	66	243,382	34	717,346
All claims	**16,461,814**	**86**	**2,723,727**	**14**	**19,185,541**

[2]Professional claims represent care rendered by physicians and other health care providers, such as physical therapists. Most institutional claims represent care provided by hospitals. Pharmacy claims are claims for prescription drugs.

Table 3: Processing Time by Cost of Claim

	Claims processed				
	0 to 21 days		More than 21 days		
Cost of claim	Number	Percentage	Number	Percentage	All claims[a]
Less than $100	13,913,061	89	1,750,311	11	15,663,372
$100 to $999	2,335,391	75	781,886	25	3,117,277
$1,000 to $9,999	205,395	54	178,397	46	383,792
$10,000 or more	5,149	30	12,120	70	17,269
All claims	**16,458,996**	**86**	**2,722,714**	**14**	**19,181,710**

[a]The total number of claims for this table does not match that of table 2 because it excludes claims with missing cost data.

The method of submission—paper or electronic—also affected timeliness. Forty-three percent of all claims were submitted electronically, three-fourths of which were pharmacy claims. As shown in table 4, we found that 95 percent of electronic claims met the timeliness standard compared with 79 percent of paper claims. Institutional and professional claims can be harder to submit electronically because they sometimes require additional documentation that cannot be submitted with the electronic form. Furthermore, providers may choose not to invest in the software needed to submit TRICARE claims electronically if TRICARE is a small percentage of their business.

Table 4: Electronic and Paper Claims Processed in 21 Days by Category of Claim

	Claims processed in 21 days				
	Paper claims		Electronic claims		
Category of claims	Number	Percentage	Number	Percentage	All claims[a]
Professional	7,829,368	80	1,651,614	87	9,480,982
Pharmacy	548,386	84	5,958,481	98	6,506,867
Institutional	332,525	65	141,439	70	473,964
All claims	**8,710,279**	**79**	**7,751,534**	**95**	**16,461,813**

[a]The total number of claims for this table does not match that of table 2 because it excludes claims for which the method of submission was unknown and all claims that took longer than 21 days to process.

We also analyzed the effect on timeliness when MCSCs needed to obtain information from other health insurers or liable third parties before

processing claims to completion.[3] We found that compensation from other health insurers was obtained for about 10 percent of claims and that MCSCs met the 75-percent timeliness standard even when they had to obtain this information from the insurers. In contrast, the timeliness standard was not met for claims that involved third-party liability. There were fewer than 3,000 of these claims in the 19 million that we evaluated. Although few claims were actually found to involve third-party liability, many more were investigated to determine whether they fell into this category. These investigations are one reason claims may be paid after 21 days.

Efforts Under Way to Improve Timeliness

Although MCSCs have been meeting timeliness standards overall, beneficiaries and providers have expressed concerns about claims processing timeliness. DOD and MCSC officials have identified several initiatives they believe have the potential to improve claims processing timeliness. One of the proposed changes will adopt revised timeliness standards similar to those used by Medicare.[4] Under these revised standards, MCSCs will be required to pay 95 percent of complete claims within 30 days and 100 percent of them within 60 days. MCSCs will be required to pay interest on claims taking longer than 30 days to process to completion. As shown in table 5, MCSCs are already close to meeting this standard because they processed 92 percent of claims within 30 days. Although DOD expects to implement these revised standards in September 1999, they will require changes to each MCSC contract—a time-consuming process that could result in delays. Nonetheless, it is important that DOD follow through with this initiative, which will help improve providers' view of TRICARE by mirroring a more familiar program.

[3]When a beneficiary has additional health insurance, TRICARE is usually the secondary payer. The only time TRICARE is not the secondary payer is when Medicaid is involved, or if the beneficiary has a health insurance policy that is specifically designated as a TRICARE supplemental policy. Third-party liability claims involve treatment for injury or illness resulting from circumstances that created a legal liability for a third party to pay damages for the care.

[4]This proposal is contained in draft legislation for DOD's fiscal year 2000 authorization bill.

Table 5: Number of Days to Process Claims

Number of days	Number of claims	Percentage processed	Cumulative percentage processed
0 to 13	13,533,876	71	71
14 to 21	2,927,938	15	86
22 to 30	1,146,999	6	92
31 to 60	1,108,031	6	98
61 or more	468,697	2	100
All claims	**19,185,541**	**100**	

Another of the proposed changes, which was implemented in June 1999, allows MCSCs to return incomplete claims for needed information without counting them against the timeliness standard. Previously, DOD required claims processors to permit claimants 35 days to provide the information needed to process their claim. If information was not received within this time, the claim was denied and would need to be resubmitted in order to be processed. This requirement automatically forced some claims to exceed DOD's 21-day timeliness standard.

In addition to DOD's proposed changes, impending changes in industry standards should also improve timeliness by making it easier for providers to submit claims electronically. The Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) requires the industrywide adoption of uniform standards for electronic transactions, including claims filing. Uniform standards for electronic filing will enable providers to submit claims for any health insurance plan in the same format, eliminating the need for plan-specific software. The Department of Health and Human Services (HHS), the agency responsible for implementing the act, reported that this effort should be under way in late 1999.

Extent of Claims Processing Accuracy Is Unknown

DOD does not know the extent to which MCSCs are meeting contractual requirements for claims processing payment accuracy because its primary assessment tool yields statistically invalid results. As with timeliness, all MCSCs experienced problems with claims processing accuracy during the early months of health care delivery and subsequently improved. However, even when problems are identified and corrected, several factors—such as TRICARE's complex program structure and frequent program changes—add to the difficulty of processing claims accurately. TRICARE's complex rules can also cause providers and beneficiaries to misunderstand requirements and submit incorrect information.

Audit Methods Do Not Adequately Measure Processing Accuracy

A DOD contractor conducts quarterly audits of claims processing accuracy for each TRICARE contract to assess the rate of incorrect payments and data input errors. The payment error rate, which is a combined rate for both denied and paid claims, is computed by adding the absolute value of underpayments and overpayments and dividing this amount by the total billed charges for the sampled claims. The data input error rate, called the occurrence error rate, is based on the total number of errors found in the audited claims, divided by the total number of data fields. DOD has established standards of 2 percent for payment error rates and 3 percent for occurrence error rates. DOD gives financial rewards to MCSCs who achieve a payment error rate of 1 percent or less, and penalizes them for a rate of 4 percent and above. Likewise, DOD financially rewards contractors if their occurrence error rate is 2.4 percent or less and penalizes them if it is 5 percent or more.

We identified three problems with DOD's method for determining claim payment error rates. First, more than half of the claims are excluded from the audit process. DOD does not sample from claims under $100 for the payment audit because they represent a relatively small percentage (about 12 percent) of the dollars paid on TRICARE claims. However, about 60 percent of all claims fall into this category and therefore are not subject to this quality assurance procedure. Including these claims in the audit would better describe the quality of MCSCs' claims processing operations because the error rate would apply to the entire population of claims, regardless of claim amount.

Second, the calculation of the payment error rate is not properly adjusted to account for DOD's stratified sampling and, as a result, its error rates are statistically invalid. DOD samples claims from defined dollar ranges of claim payments. Each range contains a different number of claims. However, DOD does not use statistical adjustments in its error rate calculation to account for these differences.[5] As a result, DOD's calculated error rate may be higher or lower than the actual payment error rate. Table 6 illustrates the effect these statistical adjustments would have on the error rates for the quarterly audits we reviewed for the MCSCs included in our evaluation. The third column contains the error rate as computed with DOD's methodology. The fourth column shows the error rate recomputed with statistical adjustments. A comparison (fifth column) shows that all but one rate changed.

[5]These adjustments, called weights, are necessary to correct for the fact that some ranges may be over-represented in the sample while others may be under-represented.

Table 6: Effect of Statistical Adjustment on Error Rates for the Most Recently Available Finalized Audits for a 1-Year Period

Contract[a]	Quarter	DOD error rate[b] (percent)	Corrected error rate with statistical adjustments[c] (percent)	Comparison between rates (percent)
A	1	5.7	5.7	0.0
	2	5.5	7.8	2.3
	3	11.3	7.3	–4.0
	4	4.7	3.5	–1.2
B	1	5.0	4.9	–0.1
	2	4.0	3.7	–0.3
	3	6.1	4.1	–2.0
	4	6.1	3.6	–2.5
C	1	1.1	2.5	1.4
	2	3.2	3.8	0.6
	3	1.5	2.3	0.8
	4	1.4	2.6	1.2
D	1	3.6	3.2	–0.4
	2	4.6	5.0	0.4
	3	3.1	3.4	0.3
	4	3.7	3.5	–0.2
E	1	4.6	4.7	0.1
	2	3.0	3.9	0.9
	3	3.2	2.9	–0.3

Note: The earliest audit began in November 1996 and the latest ended in December 1997. For one of the TRICARE contracts, only three finalized audits were available.

[a]The letters in this column represent five contracts for the three MCSCs we reviewed.

[b]DOD audit reports.

[c]GAO calculations based on the same data used in DOD's audit reports.

Third, DOD inappropriately uses billed charges as the denominator to calculate payment error rates instead of actual payment amounts. Because providers' billed charges are typically much higher than the corresponding payment amounts, DOD's practice of using billed charges instead of paid amounts for error calculations results in payment error rates that are artificially low. For example, suppose a claim was billed at $500, and the amount paid on the claim was $300.[6] During the audit, a $50 payment error was discovered. Calculating the error rate with the billed charges, as DOD

[6]This example is based on TRICARE allowable charges being about 60 percent of billed charges on average.

does, results in a 10-percent error rate. Calculating it using the paid amount results in a 17-percent error rate. We found that paid charges were also used in calculating payment error rates for some commercial industry audits as well as in audits of Medicare claims conducted by HHS' Inspector General. A common method used in industry audits for calculating this type of payment error is to divide the total dollars in error by the total dollars actually paid. This calculation is illustrated in the fourth column of table 7. These error rates are 3.6 to 12.7 percentage points higher than DOD's calculated rates.

Table 7: Comparison Between Quarterly Payment Error Rates Calculated by Contract for the Most Recently Available Finalized Audits for a 1-Year Period

Contract[a]	Quarter	DOD error rate[b] (percent)	Statistically accurate error rate based on actual dollars paid[c] (percent)	Comparison between rates (percent)
A	1	5.7	13.5	7.8
	2	5.5	18.2	12.7
	3	11.3	17.0	5.7
	4	4.7	8.9	4.2
B	1	5.0	14.3	9.3
	2	4.0	10.2	6.2
	3	6.1	11.5	5.4
	4	6.1	10.6	4.5
C	1	1.0	5.2	4.1
	2	3.2	8.5	5.3
	3	1.5	5.3	3.8
	4	1.4	6.3	4.9
D	1	3.6	8.6	5.0
	2	4.6	14.0	9.4
	3	3.1	9.0	5.9
	4	3.7	9.4	5.7
E	1	4.6	11.8	7.2
	2	3.0	9.7	6.7
	3	3.2	6.8	3.6

Note: The earliest audit began in November 1996 and the latest ended in December 1997. For one of the TRICARE contracts, only three finalized audits were available.

[a]The letters in this column represent five contracts for the three MCSCs we reviewed.

[b]DOD audit reports.

[c]GAO calculations based on the same data used in DOD's audit reports.

Beyond these technical weaknesses, DOD's measures for payment accuracy and data input, or occurrence, accuracy give only a partial picture of MCSCs' performance. These error rates provide some information on the extent of error but not on the percentage of claims affected. Therefore, a useful companion measure, which could easily be calculated from the same data, is an error rate representing the percentage of claims processed incorrectly. For payment error, this calculation is shown in the fourth column of table 8. As illustrated by the first entry for Contract A, when the error rate is computed correctly using paid amounts, the error rate is 13.5 percent. When we calculated the corresponding percentage of claims affected, the error rate is 16.5 percent. Together, these two measures—the statistically accurate error rate based on actual dollars paid and the corresponding percentage of claims processed incorrectly—provide a more complete picture of payment errors. Although we did not find methodological flaws in the occurrence audit, a corresponding measure of the percentage of claims affected could also be calculated for it. Collectively, these measures, which are also used in some industry audits, would give a more comprehensive indication of the quality of MCSCs' claims processing performance.

Table 8: Error Rates Calculated With GAO-Proposed Measures for the Most Recently Available Finalized Audits for a 1-Year Period

Contract[a]	Quarter	Statistically accurate error rate based on actual dollars paid[b] (percent)	Sampled claims processed incorrectly (percent)
A	1	13.5	16.5
	2	18.2	25.3
	3	17.0	15.0
	4	8.9	14.2
B	1	14.3	15.6
	2	10.2	14.4
	3	11.5	17.6
	4	10.6	16.1
C	1	5.2	14.3
	2	8.5	14.7
	3	5.3	13.4
	4	6.3	10.0
D	1	8.6	8.0
	2	14.0	11.8
	3	9.0	10.6
	4	9.4	10.4
E	1	11.8	11.7
	2	9.7	11.1
	3	6.8	8.2

Note: The earliest audit began in November 1996 and the latest ended in December 1997. For one of the TRICARE contracts, only three finalized audits were available.

[a]The letters in this column represent five contracts for the three MCSCs we reviewed.

[b]GAO calculations based on the same data used in DOD's audit reports.

Inadequate Contract Transition Time Contributed to Early Claim Difficulties

A major factor contributing to early claims processing inaccuracies was the short transition period allowed for MCSCs to prepare for delivering health care. For its initial TRICARE contracts, DOD tried to recover time lost in procurement delays by reducing the scheduled 8- to 9-month transition period to 6 months. Previously, we reported that DOD had experienced serious problems with contractors' inability to process claims by the start-work date of the contract because the 6-month transition period was too short.[7] In August 1995, we recommended that DOD adhere

[7]CHAMPUS Has Improved Its Methods for Procuring and Monitoring Fiscal Intermediary Services to Process Medical Claims (GAO/HRD-85-56, Aug. 23, 1985); Implementation of the CHAMPUS Reform Initiative (GAO/T-HRD-89-25, June 5, 1989).

to the 8- to 9-month scheduled transition period and discontinue reducing such periods.[8] However, DOD did not extend the transition period to 9 months, and MCSCs continued to experience problems completing the preparatory tasks needed to deliver health care and accurately process claims by the health care delivery start date. DOD officials have recently stated that, because MCSCs have been struggling to fully prepare for health care delivery, they now believe a longer transition period—9 to 12 months—is needed.

During the transition period, MCSCs are required to build complete networks of physicians and others for providing medical care. Typically, these networks consist of thousands of providers and hundreds of hospitals and pharmacies, and the network has to be in place 30 to 60 days prior to the start of health care delivery. MCSCs generally did not assemble a complete network in the allotted time. In addition to recruiting providers, DOD required MCSCs to conduct an extensive verification of providers' credentials, a process that sometimes took months to complete. Because health care delivery began before providers' professional credentials could be verified and entered into the claims processing system, some claims were erroneously paid as non-network. These errors sometimes took months to rectify. Not only did this irritate providers, but it also created additional, unnecessary work for the claims processors—especially since the vast majority of providers were eventually certified to provide care.

TRICARE's Complexity and Frequent Program Changes Affect Accuracy

Many claims processing errors are caused by program complexities and frequent changes. MCSCs told us that, of the many programs they administer—including Medicare and private plans—TRICARE is unique and the most complicated, contributing to claims processing difficulties. The following features contribute to TRICARE's complexity:

- Each of TRICARE's three options has a different array of benefits, copayments, deductibles, and adjudication procedures. For example, each option has different cost shares, provider payments, and authorization requirements, creating added difficulty in processing claims and increasing the potential for processing errors. Sometimes, even within an option, different claims processing rules apply. For example, a Prime beneficiary could elect to use a provider without authorization and pay a higher cost share for the care.

[8] Despite TRICARE Procurement Improvements, Problems Remain (GAO/HEHS-95-142, Aug. 3, 1995).

- For the Prime and Extra options, it is difficult to maintain accurate provider reimbursement information because payment agreements are complicated and individual providers may belong to multiple practices with different agreements.
- Claims submitted under the Standard option can be complex to process because providers can either accept TRICARE's allowable amount as payment in full or charge up to an additional 15 percent on a claim-by-claim basis.
- For each claim, MCSCs' subcontractors must connect with and rely on selected DOD databases to verify eligibility, deductibles, and enrollment. MCSCs stated that this requirement complicates claims processing and increases the likelihood of errors. In contrast, most private insurers maintain their own files for these purposes.
- TRICARE is almost never the primary payer when other health insurance is involved. Thus, MCSCs' subcontractors must understand the requirements of many other programs' benefit structures and obtain reimbursement information before a claim can be processed to completion.
- TRICARE is subject to many special demonstration programs, such as TRICARE Prime Remote and TRICARE Senior Prime, which have different claims processing requirements.[9]

TRICARE's frequent program changes further complicate claims processing. Program changes, which include changes to health care benefits as well as administrative changes, are generally communicated throughout the year in the form of contract modifications. As of October 1998, DOD had instructed the MCSCs we reviewed to implement about 650 contract modifications—an average of about 130 per contract since 1995. DOD and subcontractor officials stated that most contract modifications have an impact on claims processing. MCSCs stated that their ability to process claims accurately is impeded because most changes affect claims processing and require system reprogramming and testing as well as staff retraining within a relatively short time—generally a month or less.

DOD's recently established work simplification initiative calls for program benefit changes to be implemented on an annual basis, with 8 to 9 months of lead time provided prior to implementation. In addition, DOD plans to implement administrative changes on a quarterly basis with the same

[9]The TRICARE Senior Prime program is a 3-year demonstration project under which Medicare will reimburse DOD for care provided to Medicare-eligible beneficiaries under the TRICARE Prime option. The TRICARE Prime Remote program provides medical care comparable to coverage under the TRICARE Prime program to active duty members assigned to remote locations.

amount of lead time as benefit changes.[10] This should reduce claims processing errors resulting from frequent program changes.

MCSCs Are Not Responsible for All Claim Errors

Although DOD and its MCSCs are responsible for the majority of claims processing errors, about 16 percent of adjustments to claims were due to filing errors. If providers and their office staff do not understand the TRICARE program, their claims may be submitted with inaccurate or incomplete information. After these claims are processed to completion, the providers may disagree with the outcomes and submit additional information. Once this information is provided, the claims must be reprocessed.

MCSCs are required to conduct educational seminars and to publish provider handbooks and newsletters communicating TRICARE issues, including claims filing. We found that MCSCs were providing training seminars semiannually for their network providers and annually for their non-network providers. However, they told us that because TRICARE is usually a small percentage of providers' businesses, providers have little incentive to participate in educational seminars or to read the many bulletins and updates to stay current on the frequent program changes. For example, in some urban areas providers may accept patients from 20 different health insurers—and need to understand all their requirements—with TRICARE often being a small portion of their practices. MCSCs stated that TRICARE is the most complicated plan in which providers participate. Consequently some providers do not express an interest in learning about the program until they have questions about their claims.

Because beneficiaries and providers do not always understand the TRICARE program, they may file their claims incorrectly or complain about adjudication decisions on claims that have been processed correctly. For example, misunderstandings can arise when a covered service is processed but no check or a smaller-than-expected check is issued. This could happen when annual deductibles have not been met, and beneficiaries do not understand that they are responsible for paying for the covered services. This could also occur when other health insurance has paid as much as TRICARE allows, but the provider expects additional payment from TRICARE as the secondary carrier. In addition, because of negotiated discounts, providers are sometimes paid less under TRICARE than under DOD's previous civilian health program, CHAMPUS.

[10]A similar proposal is contained in draft legislation for DOD's fiscal year 2000 authorization bill.

While these differences are the result of policy changes and not processing errors, some providers may not recognize this.

DOD's Slowness in Implementing Policy Changes Has Led to Complaints About TCC

TCC software, which is used to prevent overpayments on professional claims, saved DOD over $53 million during fiscal year 1998. While providers have frequently complained about TCC determinations, TCC determinations changed only a small percentage (3.5 percent) of professional claims during this time. Providers have also expressed concern that they have no assurance that the software's edits comply with industry standards. We found that the basic product was developed based on industry standards and that TCC—DOD's modified version—essentially mirrors the standard commercial product. Nonetheless, in spite of its effectiveness, TCC inappropriately denied procedures on some claims because DOD has been slow to direct MCSCs to reflect policy changes affecting TCC outcomes in their claims processing systems. MCSCs also occasionally provided incomplete and inaccurate information, which led providers to believe they had no recourse over TCC outcomes.

ClaimCheck™ Is Used by Many Commercial Plans and Is Based on Industry Standards

ClaimCheck™ is a leader in the claim editing software industry and has more than 200 customers nationwide, including the Department of Veterans Affairs and over 60 percent of Blue Cross Blue Shield carriers. In October 1998, HHS' Health Care Financing Administration (HCFA) started supplementing its Correct Coding Initiative (CCI) edits with selected ClaimCheck™ edits to prevent overpayments in the Medicare program.[11]

Despite ClaimCheck™'s general acceptance in the insurance industry, the providers we spoke with expressed an overall concern about commercial code-editing software. They stated that because the edits are not published and available to them, they have no way of ensuring that the edits comply with the American Medical Association's (AMA) Physicians' Current Procedural Terminology (CPT) coding guidelines, which are the industry standard. Officials of McKesson/HBO & Company (HBOC), who market the software, stated that its edits are based upon CPT guidelines published by the AMA as well as guidelines published by HCFA and medical specialty societies. In addition, physicians retained by the HBOC Clinical Consulting

[11]The CCI was developed by Administar specifically for Medicare to help reduce provider overpayments.

Network were involved in the development of ClaimCheck™ and are also involved in the yearly software updates.[12]

ClaimCheck™ can be modified to reflect any health care plan's benefit structure and reimbursement policies. However, because purchasers of such software can customize the edits, some providers argue that they have no assurances that such modifications comply with industry standards. We found that TCC essentially mirrors the commercial product because DOD has made only 12 customizations to the software to reflect its benefit structure and reimbursement policies. DOD's customizations are described in appendix III. Furthermore, according to DOD officials, DOD centrally directs all TCC modifications, and MCSCs cannot independently customize it.

DOD Has Been Slow to Make Policy Changes Affecting TCC Determinations

MCSCs were unanimous that the biggest problem with TCC was the length of time it took for DOD to direct implementation of changes to reimbursement policies. Most program changes, including those affecting TCC, must be communicated and implemented through contract modifications. Policy changes can take a long time to issue because they must be drafted and priced, sent to MCSCs for comment, and then finalized and issued. Additional time is also needed for implementation.

DOD's decision to reimburse dermatologists for surgical pathology provides an example of this problem.[13] In April 1996—early into the implementation of TCC—DOD realized that the software's edits resulted in denials to dermatologists for surgical pathology procedures. Initially, DOD's policy supported this determination, but DOD subsequently decided that, unlike other providers, dermatologists were qualified to perform surgical pathology and should be reimbursed accordingly. Because ClaimCheck™'s auditing logic does not accommodate physician specialties, this change had to be accommodated within the MCSCs' claims processing systems in order to prevent inappropriate TCC denials. However, it took DOD almost 2 years to finalize the modification and provide it to MCSCs. One MCSC stated that dermatologists left its network solely because of DOD's inability to react quickly to this needed change.

[12]HBOC's Clinical Consulting Network, which currently consists of more than 180 members, represents a cross-section of physicians with extensive clinical practice, academic, and medical management experience.

[13]Surgical pathology is the gross and microscopic examination of sampled tissue.

Confusion About the Ability to Challenge TCC Determinations Adds to Providers' Frustration

Misleading communication regarding the proprietary nature of TCC edits has fueled providers' frustration because they have sometimes been unable to obtain explanations from MCSCs concerning the edits that affected their claims. However, HBOC officials stated that ClaimCheck™ is not a "black box" because purchasers receive narrative descriptions on how every edit works. DOD officials added that providers can request and receive information on specific edits from MCSCs. MCSCs have on-line access to explanations about the edits that result in the most frequent adjustments and denials. HBOC also provides a toll-free telephone number MCSCs can call to obtain explanations for all other types of edits. However, DOD officials acknowledged that MCSCs have incorrectly told providers that the edits cannot be explained to them. To ensure that MCSCs share appropriate information with health care providers, DOD stated that it recently reminded them of the availability of the on-line rationale and the toll-free hotline. The extent to which DOD's reminder addresses this problem remains to be seen.

Providers' frustration was further compounded by DOD's and MCSCs' poor communication regarding the available recourse over TCC determinations. As part of its allowable charge review process, DOD has established a process for reconsidering claims denied by software edits; however, this process has not been well communicated to providers and beneficiaries. As a result, many providers and beneficiaries who questioned TCC determinations were incorrectly informed that these determinations accurately reflected TRICARE policy and that no recourse for review was available to them. DOD's Medical Director for the Southwest Region said that the failure to inform providers of the TCC determination review process created significant problems for the network, including some providers' decisions to leave it.

Beneficiaries' and providers' complaints that DOD and its MCSCs did not make a review process available to them prompted the Congress to mandate, in the Strom Thurmond National Defense Authorization Act for Fiscal Year 1999 (P.L. 105-261), that DOD establish an appeals process for TCC denials. In response, DOD has proposed a two-level appeals process for TCC determinations. DOD has informed MCSCs that they are to advise beneficiaries and providers that they can request a TCC appeal if they are dissatisfied with a TCC determination. If beneficiaries or providers are dissatisfied with the results of the initial review, DOD has proposed a second level of TCC appeals.

Claim-Editing Software May Not Be Required in Future Contracts

In order to be less prescriptive and to allow MCSCs to use best industry practices, DOD is considering eliminating the requirement that MCSCs use TCC or any other claim-editing software from the next round of TRICARE contracts. DOD officials stated that, in the future, interested companies would probably offer to use code-editing software whether or not they are required to do so. They would most likely choose ClaimCheck™ because it is the industry leader, and it is already being used by current MCSCs for TRICARE as well as by many other potential MCSCs for their commercial health care plans.

DOD officials added that, even though MCSCs would be permitted to use different code-editing software, the claim outcomes would be required to accurately reflect the TRICARE benefit. Because differences in the types of software used and individual MCSC customization could result in inconsistently processed claims, DOD will need to closely monitor claim outcomes to ensure that MCSCs adhere to the TRICARE benefit.

Conclusions

MCSCs are meeting DOD's timeliness standard for processing claims. However, the overall timeliness measure masks weaker performance in processing certain types of claims, such as those submitted by hospitals and other institutions. Furthermore, many providers and beneficiaries continue to complain about slow claims payment, perhaps because some 3 million claims took more than 21 days to process. DOD has proposed initiatives to improve claims processing timeliness. These initiatives include adopting timeliness standards similar to Medicare's, paying interest on claims unresolved after 30 days, and not including incomplete claims in measuring performance against the timeliness standard. These initiatives appear to be steps in the right direction as they mirror standards in both Medicare and the health insurance industry. If these initiatives improve payment timeliness, DOD will enhance TRICARE's image to providers and encourage more confidence in the program.

Although DOD attempts to assess claims processing accuracy, we found limitations in its methodology, which currently yields statistically invalid results. It is imperative that DOD accurately measure payment error rates to better identify and correct problems as well as assess MCSCs' performance. However, the TRICARE program structure, with its many complexities, means that claims processing difficulties are not always easily resolved. Inappropriate claim denials have sometimes been made because of DOD's slowness to direct MCSCs to make policy changes. In addition, impediments such as inadequate startup time and frequent program changes can cause

claims processing errors. Expediting the policy change process, providing additional startup time, and consolidating program changes could help improve claims processing accuracy.

Overall, claims processing problems have caused some providers to become disillusioned with the TRICARE program. DOD and MCSCs are taking steps to address these problems. If these steps are not successful, DOD could face increasing problems attracting the number of civilian providers necessary to ensure that beneficiaries have adequate access to health care.

Recommendations

In order to better measure and improve claims processing accuracy, the Secretary of Defense should direct the Assistant Secretary of Defense for Health Affairs to do the following:

- Restructure the methodology used for claims processing accuracy audits so that performance measures more accurately and completely reflect MCSCs' performance and are more comparable to those generally used in the industry. This restructuring should include (1) ensuring that claims of all dollar amounts are subject to the payment accuracy audit, (2) ensuring that error rate computations are statistically accurate and meaningful, and (3) adding additional measures of program performance, such as the percentage of claims processed with errors.
- Grant new MCSCs a longer transition period—9 to 12 months—between contract award and the start of health care delivery.

To ensure that needed program changes are made in a timely manner, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to expedite the process used to direct MCSCs to implement program changes. To help eliminate confusion resulting from frequent program changes, we also recommend that the Secretary consolidate contract modifications and direct MCSCs to implement them on a quarterly basis.

Agency Comments and Our Evaluation

In commenting on a draft of this report, the Assistant Secretary of Defense for Health Affairs stated that DOD concurs with the report's findings regarding past problems associated with processing TRICARE claims. DOD also stated that the report is supportive of its efforts to improve the accuracy and timeliness of claims payment and the implementation of program changes. In response to our recommendations, DOD agreed to

provide new MCSCs a longer transition period between contract award and the start of health care delivery, to expedite the process used to direct MCSCs to implement program changes, and to consolidate contract modifications and direct MCSCs to implement them on a quarterly basis. However, DOD only partially concurred with our recommendation that it restructure the methodology used for claims processing accuracy audits.

We recommended that DOD ensure that claims of all dollar amounts, including those under $100, be subject to the payment accuracy audit. In response, DOD stated that because of the significant amount of expense involved with auditing these small claims, the return on investment would be very low and would not affect the overall impact of errors. In our opinion, the expense involved in sampling these claims should not be prohibitive because the low variance in this category (the size of errors can range only from 1 cent to $99.99) means that it could be sampled at a much lower rate compared with the higher-dollar claim categories. In fact, when DOD recalculates the required sample size, it may find the existing sample could be redistributed to include low-dollar claims so that the number of claims sampled overall remains the same. While we agree that including these claims may not result in a large financial effect on the government, it is an important quality assurance procedure because these low-dollar claims comprise 60 percent of the claims paid and consequently affect a large number of beneficiaries and providers. Sampling claims under $100 is also important in describing the quality of operations because the resulting error rate would include the entire population of claims. Surprisingly, despite its concerns about the value of auditing low-dollar claims, DOD said it would review its current quarterly sampling methodology to determine the costs and benefits of reviewing claims of all dollar amounts.

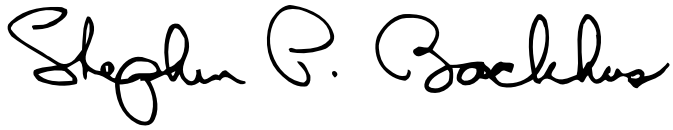
DOD stated that there are other mechanisms in place to ensure payment accuracy, such as internal quality assurance audits conducted by each MCSC and on-site surveillance by TRICARE Management Activity representatives. However, while these mechanisms provide some useful information, DOD does not use them to measure MCSC's performance against contract standards.

DOD also disagreed with our recommendation that it use paid amounts rather than billed amounts to calculate payment error rates, stating that while it might result in higher error rates, no additional information would be gained. Our point is not that the use of paid charges results in a higher payment error rate, but that paid amounts are a more logical and

meaningful measure that will provide better information on MCSCs' performance. Payments under TRICARE are usually based on a fee schedule or negotiated amounts, not billed amounts. Therefore, when computing payment error rates, using actual amounts paid seems more appropriate and useful.

As agreed with your offices, we are sending copies of this report to the Honorable William S. Cohen, Secretary of Defense, and will make copies available to others upon request. Please contact me on (202) 512-7101 if you or your staff have any questions concerning this report. Staff contact and other contributors are listed inappendix IV.

Sincerely,



Stephen P. Backhus
Director, Veterans' Affairs and
Military Health Care Issues

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Abbreviations

AMA	American Medical Association
CCI	Correct Coding Initiative
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CPT	Physicians' Current Procedural Terminology
DOD	Department of Defense
E&M	evaluation and management
HBOC	McKesson/HBO & Company
HCFA	Health Care Financing Administration
HCSR	health care service record
HHS	Department of Health and Human Services
MCSC	managed care support contractor
TCC	TRICARE ClaimCheck
TMA	TRICARE Management Activity

Scope and Methodology

To assess claims processing timeliness, we obtained a health care service record (HCSR) file from the Department of Defense (DOD) containing 19,185,541 records of completed claims that were processed between July 1, 1997, and June 30, 1998, for the managed care support contractors (MCSC) that had at least 1 year's experience in processing claims as of July 1998. Thus, we included claims from 8 of the 11 regions but did not include claims processed in the 3 regions that began health care delivery in 1998. (See table 1 (page 4) for a list of the regions that were and were not included in our analyses. See appendix II for timeliness statistics on the 3 regions that did not have at least 1 year's experience processing claims as of July 1998.) The information for each claim represented the status of the claim at the time we received it and did not contain all data that may have been used to process the claim. For example, if the claim was adjusted multiple times, only the most recent adjustment information was on the database. In addition, while we did not independently verify the accuracy of the data, we conducted reliability tests to ensure the consistency of the information with DOD's internal reports. We also reviewed the computer programs used to prepare their timeliness reports.

To identify the time taken to process a claim, we used DOD's formula for calculating the number of days between the date the claim was filed and the date it was processed to completion. We performed this calculation for all claims and summarized the calculations for several groups of claims. These groups were claim category (professional, pharmacy, and institutional), method of submission (electronic or paper), amount allowed for payment, and whether other health insurers or third parties were liable for health care costs. To identify DOD's activities to improve timeliness, we also met with TRICARE Management Activity (TMA) officials to discuss the work simplification initiatives relating to claims processing.

We assessed DOD's process for determining claims processing accuracy by analyzing the four most recently completed audit reports for each of the TRICARE contracts we reviewed.[14] We gathered information from officials at DOD and from its external auditor, Meridian Resource Corporation, about the audit process, including methods used to draw the samples and calculate the error rates. We also acquired from DOD both the audit reports and the corresponding sample data. To calculate sampling weights, we obtained the files containing necessary data on the populations from which the samples were drawn. To ensure that the correct files were

[14]At the time we initiated our review, the earliest audit began in November 1996 and the latest ended in December 1997. For one of the TRICARE contracts, only three finalized audits were available.

received, we replicated findings on the audit reports from the data we received; however, we did not verify the accuracy of the audit process itself.

To assess the effect of contract modifications on claims processing, we met with the TMA officials responsible for developing, implementing, and monitoring them. We also met with representatives from MCSCs and their claims processing subcontractors to learn how they were affected by contract modifications. We obtained and analyzed schedules of these modifications to TRICARE contracts to determine their volume. We obtained information from DOD on MCSCs' responsibilities for provider education to assess their efforts to teach correct claims filing. We interviewed and obtained information from each of the MCSCs to determine what efforts were under way to educate providers and to identify the effect of provider education on claims processing accuracy. We also interviewed the claims processing subcontractors, who sometimes assist the MCSCs with education efforts.

To assess the magnitude of filing errors, we obtained computerized files from Wisconsin Physicians Service and Palmetto Government Benefits Administrators, the two claims processing subcontractors. These files contained records of all adjustments to claims submitted between July 1, 1997, and June 30, 1998, in the eight regions with at least 1 year's experience in processing claims as of July 1998. The records identified whether an error(s) was made by the contractor or by the person filing the claim.

We met with officials of McKesson/HBO & Company (HBOC), the distributors of ClaimCheck™, to discuss the development and features of their claims editing software and to obtain statistics on its market penetration. To identify specific physician complaints about TRICARE ClaimCheck (TCC), we reviewed extensive documentation of physicians' complaints provided by various medical societies, individual physician practices, and TMA. We also interviewed officials from the American Medical Association, the Texas Medical Association, and the American Academy of Dermatology, who were identified as having specific concerns about the software. In addition, we contacted individual physician practices, which were referred to us by the various advocacy groups, to discuss their concerns and to obtain supporting claim documentation. To assess whether physicians' complaints were valid, we met with DOD's TCC policy officials to discuss the implementation and customization of ClaimCheck™ software for the TRICARE program. We obtained

documentation on DOD's policy for using the software, including instances in which a specific edit could be overridden by a contractor to allow payment in certain circumstances.

To determine how the TCC software is actually working, we met with MCSC officials as well as their claims processing subcontractors. We discussed the yearly updates as well as notifications of interim changes to TCC decisions, such as policy changes, that DOD would like for contractors to make within their own claims processing systems. We obtained information on how the contractors communicate with providers about TCC. We also discussed the process through which a provider can question TCC decisions on specific claims as well as how MCSCs' customer service representatives are trained to respond to these inquiries.

We performed our work between April 1998 and June 1999 in accordance with generally accepted government auditing standards.

Claims Processing Timeliness for the Northeast, Mid-Atlantic, and Heartland Regions

This appendix provides information on claims processing timeliness for the three regions that did not have at least 1 year of processing experience. We obtained data from DOD's HCSR database to determine the timeliness of claims processing in the Northeast region, managed by Sierra Military Health Services, and the Mid-Atlantic and Heartland regions, managed by Anthem Alliance for Health, Inc. However, we could not use this file to independently verify timeliness because approximately 20 percent of the records were missing. Therefore, to assess timeliness for these regions, we used DOD's monthly analyses of MCSCs' claims records, which are based on a more complete version of this same file.

As shown in table II.1, the MCSC for the Northeast region met the timeliness standard of processing 75 percent of claims within 21 days in 5 of their first 9 months. However, during this time, nearly half a million claims took longer than 21 days to process.

Table II.1: Claims Processing Time in the Northeast Region

Month and year	Claims processed	Percentage paid within 21 days
July 1998	87,692	79.57
August 1998	100,823	81.33
September 1998	178,700	73.61
October 1998	211,376	78.36
November 1998	120,661	70.85
December 1998	364,582	76.95
January 1999	294,538	70.35
February 1999	375,865	84.45
March 1999	219,082	71.48
Total for 9 months	**1,953,319**	**76.60**

As table II.2 shows, the MCSC for the Mid-Atlantic and Heartland regions met the timeliness standard for 4 of the first 10 months of processing claims. About 1 million of the over 4 million claims processed during this time took longer than 21 days to process.

Table II.2: Claims Processing Time in the Mid-Atlantic and Heartland Regions

Month and year	Claims processed	Percentage paid within 21 days
June 1998	153,888	89.40
July 1998	356,405	76.83
August 1998	359,420	74.47
September 1998	514,561	72.73
October 1998	420,357	70.77
November 1998	245,086	72.08
December 1998	667,272	70.50
January 1999	504,915	72.77
February 1999	550,796	77.89
March 1999	547,471	83.55
Total for 10 months	**4,320,171**	**75.27**

DOD's Customization of TRICARE ClaimCheck

To ensure that ClaimCheck™'s edits reflected TRICARE policy, DOD officials compared the auditing logic in the ClaimCheck™ manual to TRICARE policy.[15] When conflicts were identified, DOD officials either adopted the ClaimCheck™ determination as policy or customized the ClaimCheck™ determination to conform to TRICARE policy. For example, the generic version of ClaimCheck™ always denies reimbursement for procedures billed with modifiers –24, –25, and –79, which are used in conjunction with procedure codes to better describe the circumstances under which medical services were performed.[16] During its review of the auditing logic, DOD decided to always allow payment for procedures correctly billed with these modifiers. DOD calls the customized product TCC. Contractors receive annual TCC updates, which are customized centrally by HBOC based on DOD direction. To ensure uniformity, MCSCs are not permitted to individually customize TCC except by direction from DOD. DOD's customizations to date are listed in this section.

DOD-Directed Customizations

1. Deleted the incidental edit for Physicians' Current Procedural Technology (CPT) 76818 (fetal biophysical profile) with CPT 76805 (complete fetal and maternal evaluation) so that both procedures will be paid when billed together.

2. Added the following CPT codes for payment of the following cosmetic/experimental procedures: 15775 (skin graft), 15776 (skin grafts), 89329 (sperm evaluation), 65771 (radial keratotomy), 95961 (functional cortical mapping), and 52510 (dilation of prostatic urethra).

3. Customized the mutually exclusive edit to allow reimbursement for the most clinically intensive procedure as opposed to the procedure with the highest charges or the procedure with the lowest charges.

4. Added TRICARE-specific procedure codes for payment.

5. Customized to always allow reimbursement for modifiers –24, –25, and –79.

[15]DOD's TCC policy officials stated that, because ClaimCheck™'s software logic was well documented and supported, they did not perform an edit-by-edit review for each of the 5 million edits.

[16]Modifier –24 is used to describe an unrelated evaluation and management service by the same physician during a postoperative period. Modifier –25 is used to describe a significant, separately identifiable evaluation and management service performed by the same physician on the same day of a procedure or other service. Modifier –79 describes an unrelated procedure or service by the same physician during a postoperative period.

6. Added all Health Care Financing Administration Common Procedural Coding System modifiers for system recognition.[17]

7. Customized CPT 94150 (vital capacity) to be found incidental to all evaluation and management (E&M) procedure codes since payment for this code is included in the allowable amount of the E&M codes.

8. Deleted the edit that found CPT 90887 (interpretation of psychiatric exam) incidental to CPT 90845 (psychoanalysis) so that they will both be paid when billed together.

9. Customized system to recognize modifiers –26, –27, –59, and –90.

10. Deleted incidental edit associated with CPT 62278 and 62279 (epidural codes) when billed with maternity codes so that they will be paid.

11. Effective January 1, 1998, deleted the incidental edit associated with CPT 54150 (newborn circumcision) and E&M codes to allow payment for the circumcision when billed with an E&M code.[18]

12. Effective December 1, 1998, added TRICARE-specific codes W0002-W0019 for automated multi-channel laboratory tests so that they will be paid.

[17]System recognition does not mean that these procedure codes will be paid. It means that the claims will be able to pass through the system without having to stop for manual review.

[18]In January 1999, DOD directed MCSCs to make this change by February 1999. However, some MCSCs did not make the change until March 1999. With a retroactive effective date, MCSCs may adjust claims, when brought to their attention, back to January 1, 1998.

Comments From the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

19 JUL 1999

Mr. Stephen P. Backhus
Director, Veterans' Affairs and Military Health Care Issues
Health, Education and Human Services Division
U. S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Backhus:

This is the Department of Defense (DoD) response to the General Accounting Office (GAO) DRAFT REPORT, "DEFENSE HEALTH CARE: Claims Processing Improvements Are Underway but Further Enhancements Are Needed," dated June 17, 1999, (GAO Code 101627/OSD Case 1848).

In general, the Department agrees with the comments contained in the draft report regarding past problems associated with the processing of TRICARE claims. As indicated, these problems have occurred primarily during the start up phase for each of the TRICARE contracts, and have been addressed continuously as the contractors have gained experience. The enhancements underway such as the implementation of claims processing standards similar to those used by Medicare will increase future performance. Similarly, the Department agrees with the GAO recommendation regarding the need for a 9-12 month transition period for new contracts and has already taken steps to assure this. Also, we agree with the need for expeditious implementation of Program changes and a consolidation of contract modifications on a regular basis whenever possible. The specific DoD response to each of the GAO recommendations is contained in the attachment to this letter.

The language in the report indicating the Department does not know the extent to which the contractors are accurately paying claims (page 2 of the report) is misleading. The methodology used by the Department to measure payment accuracy incorporates approximately 88 percent of the dollars paid out and yields the results required to assess contractor performance and conformance with current standards. It is our view that adding those claims with value of $100 or less will provide little useful information regarding the types of errors that the contractors may be making and would have little or no effect on the payment error rate itself. We acknowledge that there are different measurements that would be useful, and we intend to explore all of the GAO recommendations.

We sincerely appreciate the extensive efforts put forth by the GAO in the conduct of this review. The results are supportive of the Department's continuing efforts to improve the accuracy and timeliness of claims payment and the implementation of Program changes. Please feel free to address any questions to my project officer on this matter, Mr. Charles Gallegos, (functional) at (303) 676-3713 or Mr. Gunther J. Zimmerman (GAO/IG Liaison) at (703) 681-7889.

Dr. Sue Bailey

Attachment:
As stated

GAO DRAFT REPORT – DATED JUNE 17, 1999
GAO CODE 101627/OSD CASE 1848

"DEFENSE HEALTH CARE: CLAIMS PROCESSING IMPROVEMENTS ARE UNDERWAY BUT FURTHER ENHANCEMENTS ARE NEEDED"

DEPARTMENT OF DEFENSE COMMENTS TO THE RECOMMENDATIONS

RECOMMENDATION 1: The GAO recommended that the Secretary of Defense should direct the Assistant Secretary for Health Affairs to restructure the methodology used for claims processing accuracy audits so that performance measures more accurately and completely reflect MCSCs' performance and are more comparable to those generally used in the industry. The GAO noted that this restructuring should include (1) ensuring that claims of all dollar amounts are subject to the payment accuracy audit, (2) ensuring that error rate computations are statistically accurate and meaningful, and (3) adding additional measures of program performance, such as the percent of claims processed with errors. (pp. 32-33/GAO Draft Report)

DOD RESPONSE: Partially concur. The three GAO recommendations are addressed separately as follows:

(1) Ensuring that claims of all dollar amounts are subject to the payment accuracy audit:

The specific GAO recommendation is to include paid claims between $1 and $100 in the quarterly claims audits. It is our opinion that these small dollar claims (primarily pharmacy, office visits, etc.) are not subject to the same potential for error as the higher dollar claims; therefore, because of the significant expense involved in the claims audit, the return on investment is very low. In addition, there are already other mechanisms in place that serve to ensure payment accuracy of all claims. These include internal quality assurance audits conducted by each of the contractors; ongoing on-site surveillance by TMA representatives; review of beneficiary and provider concerns expressed in both written correspondence and received through the TRICARE Web Site Forum; and the formal TRICARE Appeals process.

However, we appreciate GAO's concerns over the number of claims this category represents. The TRICARE Management Activity (TMA) will review current quarterly sampling methodology to determine costs and benefits of reviewing claims of all dollar amounts. Based on that review, a decision will be made on the best approach for potentially using the audit process for these small dollar claims and to validate our assumptions of the usefulness of the findings and impact on the error rate.

(2) Ensuring that error rate computations are statistically accurate and meaningful:

TMA agrees that weighting each stratum when calculating the error rate should be done and will revise this methodology. We do not agree with the use of paid amounts instead

of billed amounts to determine error rates. While the use of paid amounts may result in a higher error rate calculation, it does not provide any additional information regarding performance by a contractor over what is currently obtained. Contractors are currently held to a standard of no more than a two percent payment error rate with a potential for positive and negative incentives for performance above and below this threshold. This is calculated by dividing the dollar amount in error by the total billed charge on the claim (except for inpatient claims reimbursed by DRG, Per Diem payment, or negotiated rate for which the amount allowed is used). It is our position that this is the appropriate method and represents the total potential liability of the beneficiary, and reflects the true charge before applicable cost shares or deductibles are subtracted.

(3) Adding additional measures of program performance, such as the percent of claims processed with errors:

We appreciate the GAO comments and suggestions. After completing reviews related to parts one and two, TMA will determine what additional performance measures will be added.

RECOMMENDATION 2: The GAO recommended that the Secretary of Defense should direct the Assistant Secretary for Health Affairs to provide new MCSCs a longer transition period –9 to 12 months—between contract award and the start of health care delivery. (p.33/GAO Draft Report)

DOD RESPONSE: Concur. The Department has recognized for some time that the "transition" period available to start-up new MCSCs should be longer. Throughout our planning process for the procurement of the next generation of MCSCs the transition period has been a prime consideration. After careful analysis, DoD has determined that a ten (10) month transition period will allow new MCSCs to successfully implement the purchased care segment of the TRICARE Program. This transition period has been incorporated into DoD's long term acquisition schedule and corresponds with the GAO's recommendation.

RECOMMENDATION 3: The GAO recommended that the Secretary of Defense should direct the Assistant Secretary for Health Affairs expedite the process used to direct MCSCs to implement program changes. (p.33/GAO Draft Report)

DOD RESPONSE: Concur. DoD concurs with GAO that faster implementation of changes should increase beneficiary and provider satisfaction by allowing quicker realization of the efficiencies resulting from each change. Management changes are already underway which will ensure timeliness, prioritization, compliance with policy, and the availability of funding for all Program changes.

RECOMMENDATION 4: The GAO recommended that the Secretary consolidate contract modifications and direct MCSCs to implement them on a quarterly basis. (p.33/GAO Draft Report)

DOD RESPONSE: Concur. DoD agrees with GAO that quarterly consolidated changes could enhance the effectiveness of program implementation. The change order process is under review at DoD and the concept of consolidation will be considered in developing process enhancements.

GAO Contact and Staff Acknowledgments

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