Overseas Healthcare Payments[1]

The Scenario

The auditor was reviewing Tricare Overseas Program (Tricare) claims data and observed increasing payments for several countries during the past three years. Specifically, the auditor noted the number of Country X's claims rose over 200 percent, while the number of Tricare beneficiaries remained constant. Country X also experienced substantial increases in charges for common surgical procedures and medical diagnoses such as tonsillitis and diabetes.

Because of the analysis, the auditor limited the scope of the review to reimbursement claims for beneficiaries living in Country X during the past five years. The auditor examined a sample of provider bills submitted for each paid claim, and then evaluated the accuracy of payments made by overseas claims processors and third party billing agencies. Interviews were also conducted with claims processing managers during audit fieldwork. The review disclosed the following information:

- Overseas-claims-processing contractors made duplicate payments totaling over $7 million dollars. The duplicate claims were caused by an absence of internal controls and processing errors including the use of multiple provider numbers for a single provider, the absence of an automatic reject control for duplicate institutional claims, and processor overrides of system controls. The auditor's report concluded that existing controls over duplicate payments were designed to identify errors after they occurred, instead of preventing them from occurring.

- Processing errors and an absence of internal controls resulted in overpayments totaling $6 million dollars. Overpayments were caused by mathematical errors, payment of value added taxes on exempt medical services, and the absence of internal guidance for payment of administrative charges and other fees.

- Corporation ABC, an owner and operator of hospitals and clinics throughout Country X, consistently inflated provider claims for Tricare reimbursement. In most cases, the claims were increased by 300%. The auditor referred this information to an investigative organization during audit fieldwork. A subsequent criminal investigation disclosed a kickback agreement between Corporation ABC and medical providers, in which the provider paid 50% of the amount of bills for medical services for Tricare patients referred by Corporation ABC back to company officials. As part of the legal settlement, the company was ordered to liquidate its assets and pay millions of dollars to the United States government.

[1] The Tricare Management Activity Overseas Program is the Department of Defense managed healthcare program for care outside of the continental United States. Traditional foreign claims are claims for healthcare provided to Tricare beneficiaries who reside overseas in nonremote locations except for active-duty service members and family and Medicare-eligible individuals living in Puerto Rico.

General Comments / Lessons Learned. The Tricare Overseas Program supports approximately 479,000 beneficiaries overseas. Total healthcare costs for the Overseas Program were $187.3 million in FY 2005 and $210.9 million in FY 2006, while administrative contract costs for the Overseas Program were $21.3 million in FY 2005 and $25.3 million in FY 2006. The Department of Defense, Office of Inspector General, is proactive in its efforts to identify healthcare fraud and has worked with other Federal and state agencies including the Tricare Program Integrity Office, Defense Criminal Investigative Service, Naval Criminal Investigative Service, the U.S. Postal Inspection Service, the Internal Revenue Service, and the Office of the United States Attorney, Western District of Wisconsin, on healthcare fraud cases. Auditors interested in obtaining more information on Tricare Overseas Program audits are encouraged to review the Department of Defense, Office of Inspector General, completed audit reports, which are available on the agency's web page, at www.dodig.mil.

FRAUD INDICATORS

- **The number of reimbursement claims increases significantly, while the beneficiary population remains constant.**

- **Substantial increases in charges for common surgical procedures and diagnoses for medical illnesses, without any significant changes in the beneficiary population.**

- **Comparison of provider bills and payments made by overseas claims processors show numerous duplicate payments caused by an absence of internal controls or processing errors such as the use of multiple provider numbers for a single provider, the absence of an automatic reject control for duplicate institutional claims, and processor overrides of system controls.**

- **Existing internal controls over duplicate payments that are designed to identify errors after they occur, instead of preventing them.**

- **Comparison of provider bills and payments made by overseas claims processors discloses an excessive number of overpayments caused by mathematical errors, payment of value added taxes on exempt medical services, and the absence of internal guidance for payment of administrative charges and other fees.**

- **A pattern of inflated provider claims submitted by third party billing agencies or healthcare facility owners.**

- **Healthcare facility owners refer patients to specific healthcare providers in exchange for financial compensation.**