Memorandum

Date . JUN 22 1995

From June Gibbs Brown
Inspector General

Subject Review of the Indian Health Service's Billings and Collections from Private Health Insurance Companies (A-06-93-00080)

To Philip R. Lee, M.D.
Assistant Secretary for Health

Attached is a copy of the Department of Health and Human Services, Office of Inspector General's final report entitled, "Review of the Indian Health Service's Billings and Collections from Private Health Insurance Companies." The objectives of this review were to determine whether the Indian Health Service (IHS) accurately billed private health insurance companies and collected for all covered services provided to patients served in IHS medical facilities. To accomplish our objectives, we audited claims prepared at IHS facilities for services provided to eligible Indian patients during the 3-month period ended March 31, 1993.

We found that IHS had not established the controls necessary to ensure that (1) the amounts billed were accurate; and (2) all covered services were billed. As a result, for the 3-month period tested, we estimate that IHS underbilled private insurers by $7,332,191.

The reasons that IHS did not file claims or filed inaccurate claims with private health insurers for covered services included:

- an absence of internal controls that allowed errors and omissions to be made and go undetected;
- business offices that did not have sufficient resources to keep up with the workload;
- business office staff that were not adequately trained; and
- business offices that used outdated fee schedules and pharmaceutical price lists to prepare claims.

In addition to the $7,332,191 underbilled, IHS business offices had not contacted private health insurance companies nor followed up on an estimated $1,237,970 of unpaid claims. These claims were also for services provided during the 3-month period ended March 31, 1993. This occurred because IHS did not (1) identify and track the claims needing follow-up; (2) assign sufficient staff to perform follow-up activities; or (3) provide complete follow-up instructions.

To maximize collections, we recommend that IHS establish the necessary internal controls, assign adequate resources to its business offices, and provide additional training to business office staff to ensure that claims for all covered services are filed and accurate. One way to establish the necessary internal controls is for IHS to complete automation of its claims processing system. In addition, we recommend that IHS distribute fee schedules on a timely basis, and implement complete and timely follow-up procedures.

On May 16, 1995, the Public Health Service provided its response to our March 14, 1995 draft report. In concurring with all of our recommendations, it indicated that IHS had specific actions underway to address each of them.

We would appreciate being advised of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please call me or have your staff contact Joseph E. Vengrin, Acting Assistant Inspector General for Public Health Service Audits, at 301-443-3582.

To facilitate identification, please refer to Common Identification Number A-06-93-00080 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF THE INDIAN HEALTH SERVICE'S BILLINGS AND COLLECTIONS FROM PRIVATE HEALTH INSURANCE COMPANIES

JUNE GIBBS BROWN
Inspector General

JUNE 1995
A-06-93-00080

Memorandum

Date . JUN 22 1995

From June Gibbs Brown
Inspector General

Subject Review of the Indian Health Service's Billings and Collections from Private Health Insurance Companies (A-06-93-00080)

To Philip R. Lee, M.D.
Assistant Secretary for Health

The Indian Health Service (IHS) facilities are missing an opportunity to significantly increase revenues for services provided to patients with private insurance. The IHS could increase billings and collections by millions of dollars if it would aggressively pursue billing private health insurance companies for covered services. These additional funds could be used to improve the delivery of health care to the Indian people. Increased revenues are vitally necessary because IHS is facing declining budgets and increasing health care needs.

This final report provides you with the results of our audit of IHS' efforts to bill and collect for services covered by private insurance companies. To fully recover all funds due from third parties, such as private insurers, IHS began establishing business offices at its facilities in 1991. One of the primary functions of these business offices is to bill third parties for covered services through a fully automated claims processing system. Although not fully automated, these business offices started billing private health insurance companies and collected over $18 million during Fiscal Year (FY) 1993.

The objectives of this review were to determine whether IHS accurately billed private health insurance companies and collected for all covered services provided to patients served in IHS medical facilities. We tested IHS' practices for the 3-month period ended March 31, 1993.

The IHS had not established the controls necessary to ensure that (1) the amounts billed were accurate; and (2) all covered services were billed. As a result, for the 3-month period tested, we estimate that IHS underbilled private insurers by $7,332,191.

The reasons that IHS did not file claims or filed inaccurate claims with private health insurers for covered services included:

- an absence of internal controls that allowed errors and omissions to be made and go undetected;
- business offices that did not have sufficient resources to keep up with the workload;

- o business office staff that were not adequately trained; and
- o business offices that used outdated fee schedules and pharmaceutical price lists to prepare claims.

In addition to the $7,332,191 underbilled, IHS business offices had not contacted private health insurance companies nor followed up on an estimated $1,237,970 of unpaid claims. These claims were also for services provided during the 3-month period ended March 31, 1993. This occurred because IHS did not (1) identify and track the claims needing follow-up; (2) assign sufficient staff to perform follow-up activities; or (3) provide complete follow-up instructions.

To maximize collections, we recommend that IHS establish the necessary internal controls, assign adequate resources to its business offices, and provide additional training to business office staff to ensure that claims for all covered services are filed and accurate. One way to establish the necessary internal controls is for IHS to complete automation of its claims processing system. In addition, we recommend that IHS distribute fee schedules timely, and implement complete and timely follow-up procedures.

On May 16, 1995, the Public Health Service (PHS) provided its response to our March 14, 1995 draft report. In concurring with all of our recommendations, it indicated that specific actions were underway to address each of them. Details of these actions are contained in the PHS Comments and OIG Response Section of this report. The PHS comments are included in their entirety in Appendix C to this report.

BACKGROUND

The mission of IHS is to elevate the health status of the American Indian and Alaska Native to its highest possible level. The IHS is divided administratively into 12 area offices to provide health care services to approximately 1.3 million American Indians and Alaska Natives. The area offices are responsible for operating IHS programs within a designated geographic area. Delivery of health services at the local level is the responsibility of a service unit, an administrative subdivision of an area office. There are 73 service units nationwide providing services through 41 hospitals, 66 health centers, 44 health stations, and 4 school health centers (facilities).

The IHS funds health care to American Indians and Alaska Natives through appropriations by Congress and collections from third party resources. These third party resources include Medicare, Medicaid, and private health insurance. The appropriations and third party resources are used to provide care through IHS and tribally operated facilities. The IHS and tribes provide care directly to patients and also contract with other health care organizations in the community to provide care. The Health Resources

and Services Administration (HRSA) developed the accounting procedures that IHS follows in recording insurance claims and collections in the health accounting system.

The IHS was authorized by Public Law 100-713, the Indian Health Care Amendments of 1988, to bill third parties for both inpatient and outpatient services. Facilities at 11 areas prepared private insurance claims for services totaling $38 million and collected over $18 million during FY 1993. Any revenues collected by a facility remain with that facility to supplement its budget. For the twelfth area office--the California area office--tribal organizations were responsible for billing private insurance companies because they operated all of IHS' facilities in that area. According to the Deputy Director of IHS, reimbursements received from private health insurance for patients in IHS operated facilities are to be used to implement business offices and purchase medical supplies and equipment.

The business office is a relatively new organizational concept in IHS. The concept originated as a quality management initiative in FY 1990. The IHS' Office of Health Programs is responsible for implementing the business office concept. The purpose of the business office is to identify and maximize the collection of third party benefits for which American Indians and Alaska Natives are eligible. This is accomplished through a claims management system that has four main sections:

- patient registration;
- patient benefits coordination;
- patient admissions; and
- claims processing.

The IHS began establishing business offices in 1991 at all of its area offices, service units, and medical facilities. Each IHS area office is responsible for the staffing and operation of the business offices within its area. Although claims could be prepared manually, the full implementation of the business office system envisioned the use of an automated billing system. The first full year of operations for all business offices was FY 1992.

A business office manual was developed by IHS' Strategic Initiative Team to provide guidance to business office personnel. This manual presents standardized policies, procedures, and practices for the implementation and continuance of business offices in all IHS service units and facilities.

The Office of Inspector General (OIG) issued a memorandum, dated August 16, 1993 (CIN: A-06-93-00028), to IHS, which discussed several problems identified during a review of IHS' Oklahoma City area office. Subsequent to that

review, IHS worked closely with OIG to develop objectives for this expanded review of private insurance billings and collections.

On March 15, 1994, OIG issued an early alert memorandum to IHS' Deputy Associate Director of the Office of Health Programs. The purpose of this memorandum was to alert IHS that the problems identified earlier in the Oklahoma City Area Office were occurring throughout IHS.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The objectives of this review were to determine whether IHS accurately billed private health insurance companies and collected for all covered services provided to patients served in IHS medical facilities.

Scope

We reviewed claims prepared at IHS facilities for services provided to eligible Indian patients during the 3-month period ended March 31, 1993. To test the claims sent to private health insurance companies, we identified 100 IHS patients who had private health insurance and received at least 1 service covered by their insurance plans during the 3-month period. During the 3-month period, there were 106,569 patients nationwide who were identified as having private insurance. Our initial review disclosed that not all of the 106,569 patients who had private health insurance received a covered service during the quarter tested. Therefore, we had to expand our sample to 227 in order to select 100 patients with private insurance who actually received a covered service during the 3-month period. Officials at IHS agreed that these 100 patients received a service covered by private health insurance. These 100 patients received services from 51 facilities located in 11 of the 12 IHS area offices. (See Appendix A and Appendix B for a description of our sampling methodology and our sample results.)

Methodology

Our audit was performed in accordance with generally accepted government auditing standards. To perform our review, we:

- compared the medical records with the insurance claims to determine if the claims were complete and accurate;
- verified the accuracy of the amounts billed; and
- traced unpaid claims to determine whether adequate follow-up procedures had been performed.

We conferred with various IHS headquarters officials from the Office of Health Programs and the Division of Resource Management to obtain background information, current IHS practices, and reasons why services were not billed or were not accurately billed.

We contacted by telephone business office personnel at various facilities, service units, and area offices to ascertain IHS' billing practices and procedures for claiming reimbursement from private health insurers. We also contacted these same IHS personnel to determine why claims were inaccurate, not billed, or not followed up in a timely manner.

Our review of internal controls was limited to testing the accuracy and completeness of IHS' billing process. Our review did not include an assessment of the use of funds collected.

Our field work was performed from November 1993 through August 1994. Work was performed at IHS headquarters in Rockville, Maryland; the area offices in Oklahoma City, Oklahoma and Billings, Montana; the Gallup Indian Medical Center in the Navajo area; and at the IHS Business Office Conference in Albuquerque, New Mexico.

Subsequent to the completion of our audit, during the period between the issuance of the draft and final reports, the working papers for this effort were destroyed in the bombing of the Oklahoma City Alfred P. Murrah Federal building. It is important to note that, prior to the draft report's issuance, we had completed all internal quality control procedures to ensure the fairness and accuracy of the audit report and audit working papers, including an independent verification of the evidence supporting the findings, conclusions, and recommendations in our report. In addition, we had conducted an exit conference with the auditee where all findings and recommendations had been discussed.

DETAILED FINDINGS

The IHS facilities are missing an opportunity to significantly increase revenues for services provided to patients with private insurance. These additional revenues could be used to improve the delivery of health care to the Indian people.

For the 3-month period ended March 31, 1993, IHS did not:

- aggressively and accurately file claims with private health insurance companies for covered services; or
- distribute its fee schedules on a timely basis and keep its pharmaceutical price lists current.

We estimate that IHS underbilled private insurers $7,332,191 during this 3-month period. This $7,332,191 resulted from IHS not billing for certain services ($6,661,055), making errors on the claims ($400,972), and using outdated fee schedules or price lists ($270,164).

In addition to the $7,332,191 underbilled, IHS facilities had not followed up with private health insurance companies on an estimated $1,237,970 of claims that remained unpaid for at least 6 months.

PROBLEM: IHS' FACILITIES DID NOT AGGRESSIVELY AND ACCURATELY FILE CLAIMS WITH PRIVATE HEALTH INSURERS FOR COVERED SERVICES

The IHS facilities reviewed did not file claims for all covered services provided to patients with private health insurance. Additionally, for those claims that were filed, many were inaccurate. Of the 100 patient files reviewed, we identified 63 patient files where covered services were either not billed or were billed inaccurately. For 46 patients, there was no claim filed for at least 1 entire medical visit. Other claims had mathematical errors, transpositions, or omissions.

The Effect: Estimated Underclaim of $7,062,027 for 3-Month Period

Based on our sample, we estimate that claims sent to private health insurance companies did not include all covered services or were underclaimed in the amount of $7,062,027 for services provided to an estimated 29,576 patients during the 3-month period ended March 31, 1993. For 63 patients in our sample, IHS business offices did not file insurance claims for all covered services or filed inaccurate claims. This resulted in IHS underbilling private health insurance companies $15,043 for these 63 patients. The $15,043 underclaim included $14,189 where facilities' business offices did not file claims for covered services and $854 where facilities' business offices filed inaccurate claims.

The Causes:

The IHS did not provide an internal control structure, adequate resources, or the training necessary to ensure that all covered services were timely billed and were billed accurately. Officials at both IHS headquarters and area offices agreed that the absence of controls, resources, and training were areas that need to be addressed if IHS is going to maximize recoveries from private insurers.

The IHS' Strategic Initiative Team in 1992 and 1993 evaluated the implementation of the IHS business office concept and identified certain control weaknesses in the operation of the business offices. This team also identified resources and training as areas that needed improvements.

Business office staff throughout IHS stated that in order to establish the type of internal controls needed and to maximize collections with the staff available, IHS needs to automate its billing system. This automation, according to IHS officials, would generate a complete claim and allow business office staff the time to review and approve claims, and thus provide the control structure needed.

The following sections discuss in more detail the three principle causes for problems related to the filing of claims.

Inadequate Controls Allowed Errors to Be Made and Go Undetected

The IHS had not established adequate controls at its business offices to ensure that (1) all covered services were billed; or (2) claims submitted were accurate. A goal of IHS was to implement an automatic claims processing system at all of its facilities. This system was designed with internal controls that were intended to ensure complete and accurate billing. However, 22 of the 51 facilities in our sample prepared claims manually. Even for the 29 facilities with automated systems, some manual processes were still needed to prepare claims. The controls established over these manual processes were not adequate to preclude errors from being made or detect them once they occurred.

Many of the errors were the result of weak controls. Business offices at each of the facilities reviewed did not always receive the information and cooperation needed to bill for all covered services and prepare accurate claims. To illustrate:

- the IHS' Health Care Administration Branch staff authorized fee schedules that did not include fees for all covered services;
- medical records staff at some facilities did not always record all of the services on documents used in the billing process;
- some IHS employees and patients sometimes received services without reporting to patient registration to initiate a record of the visit for the business office; and
- staff did not always communicate with insurance companies to determine if a service would be covered or to obtain prior authorization for hospitalization.

Also, services were overlooked because medical records were difficult to read. In one instance, a service was not claimed because the items listed on the medical records were not clear on the fourth carbon. This carbon copy was used to enter the claims data.

Further, medical personnel at some IHS facilities did not always completely identify the services on patient charts. The business office coordinator for one area office stated that over 3,000 claims of one facility were on hold because the level of care had not been identified. Medical personnel are required to identify the level of care in the patients' charts in order for the proper amount to be claimed. Identifying the level of care provided is an important step in the claims process. For example, reimbursement for an established patient's office visit ranges from $22 to $84, depending on the level of care provided.

The current system often requires business office staff to manually search through medical records and copy patient care information onto insurance forms. At the 29 facilities that are automated, some manual steps are still required to claim x-rays, lab services, pharmaceuticals, emergency room and inpatient medicines, and dental and medical procedures. Additionally, staff must manually identify Medicare reimbursements for patients who also have private insurance in order to file supplemental claims.

Internal controls could have been substantially improved if IHS had implemented a fully automated billing system. Such a billing system could automatically generate a claim form for covered patients, and could be designed to ensure that claims:

- o are prepared for all patients identified as having private health insurance;
- o include all services provided; and
- o are billed using a consistent pricing mechanism.

Manual Processes, Combined With Staff, Hardware, and Software Shortages, Created Backlogs

Business office staff at several facilities stated that they often fall behind and backlogs of unclaimed services occur. According to business office staff, the extensive manual process of preparing claims requires "inordinate" amounts of time. Additionally, because staff assigned often spend most of their time trying to keep up with the workload, little time is available for quality review. As a result, errors go undetected. Further, business office staff at several locations indicated that staff, hardware, and software shortages also contribute to backlogs of unclaimed services.

We believe that the error rate on claims filed by the business offices is partly attributable to the extensive manual process required to prepare the claims and the absence of needed software and hardware. To illustrate:

- business office staff at several locations stated that they did not always claim the costs of drugs because the manual process for billing pharmaceuticals was "tedious." Business office staff were responsible for reading the medical records, identifying the units dispensed, computing the costs, and listing the services on claims.

- business office managers at all facilities contacted agreed that significant numbers of services were not billed because facilities were not able to keep up with the workload. For example, one manager of a facility stated that a backlog of as many as 4,000 claims existed. This manager stated that the facility needed additional staff or an automated billing system to keep up with the workload.

- another facility's business office, with over 3,000 visits each week, instituted a policy to only prepare outpatient claims after a patient's sixth outpatient visit. Until the patient reached the sixth visit, no claims would be filed. Once the sixth visit occurred, all claims, including those for the first five visits, would be filed. The business office manager stated that this was done to keep up with the workload since the business office did not have an automated billing system and had only one person available to process outpatient claims.

- a significant backlog resulted at one service unit when software problems occurred on two personal computers. These two computers were out of service for 4 months before IHS could correct the software problem. The amount the service unit billed private insurers increased an average of $8,600 monthly after the software was corrected and the two computers were placed in service.

- a large facility had to process all claims manually in 1993 because the computers available were not capable of running the billing package. A backlog of unprocessed claims developed. In 1994, the facility received new computers, but still processed all claims manually because it did not have the space or the number of terminals needed to use the automated billing package. The business office's acting manager told us that the backlog continues and will remain until the facility moves into new space.

One other factor which impacted on billings was that business office staff at the various facilities did not routinely provide or receive information about patients' insurance coverage, with the result that the facilities were not always filing insurance claims. Although IHS requires that each patient be asked about private insurance coverage during each visit, IHS business office managers at several facilities stated that the facilities often did not have sufficient staff assigned to

obtain this information. In cases where the facilities providing the services were not aware that patients had private health insurance, claims were not filed.

Inadequate Training

During the period covered by our review, some business office staff were not adequately trained to prepare complex inpatient claims and physical therapy claims. They also had not been instructed on how to handle releases and assignment of benefits. Further, business office staff had not been fully trained in the operation of an automated billing system.

Staff at one business office were not taught how to code difficult inpatient claims and physical therapy claims. For example, since the business office staff did not know which current physician terminology code to use, they did not prepare a claim for these services.

Business office staff throughout IHS had not received the latest guidance regarding releases and assignment of benefits. Claims were not prepared for patients who did not sign releases and assignment of benefits forms because business office staff erroneously believed these release forms were required before a claim could be prepared.

In addition to not being adequately trained in the manual processing of complex claims and in assignments and releases, IHS officials responsible for training stated that business office staff received almost no formal training in the operation of the automated billing system. In May 1994, IHS set up a training facility in its Albuquerque office to train staff in the automated billing system. In July 1994, business office staff of several facilities of one area office received this training. The IHS is developing plans to provide this training to each of its area offices; however, there is no formal schedule for such training.

THE PROBLEM: FEE SCHEDULES AND PHARMACEUTICAL PRICE LISTS WERE OUTDATED

The IHS business offices prepared claims using outdated fee schedules and price lists. The business offices also made manual errors in pricing some claims.

The Effect: Estimated Underclaim Totaling $270,164

Based on our sample, we estimated that the total amount claimed from private health insurance companies was understated by $270,164 during the 3-month period ended March 31, 1993. We also estimated that 30,046 of the 106,569 patients in our universe had claims that were either based on outdated fee schedules or included other pricing errors. The facilities' business offices used outdated fee schedules and pharmaceutical

price lists, and made other errors in pricing claims for 64 of the patients sampled. This resulted in a net underclaim of $575.

The Causes:

Fee Schedule Was Not Updated

Delays in updating and distributing the fee schedules occurred primarily because IHS headquarters did not obtain the required approval in a timely manner. For all services other than pharmaceuticals, IHS authorizes fee schedules for pricing claims. It was IHS' intent to update and distribute fee schedules by January each year. The IHS, however, distributed the 1993 fee schedules to its business offices in September, almost 9 months late. The fee schedule updating process includes the purchase of software licensing agreements from the American Medical Association. The IHS did not obtain this approval for the licensing agreements in a timely manner. As a result, the fee schedules used for the first 9 months of 1993 were outdated and incorrect.

The IHS improved in this area in 1994. It distributed the 1994 fee schedule in February 1994.

Pharmaceutical Price Lists Were Not Current

Pharmaceutical price lists used by the facilities contacted during our review did not always include current costs. For pharmaceutical claims, facilities bill for services using price lists containing current pharmaceutical cost. Facility pharmacists are required to update the price lists to ensure that they reflect current costs. Pharmacists, however, often fell behind in their work and did not always update the price lists timely. As a result, the price lists were sometimes outdated and did not include current costs.

Other Errors Occurred

Additional errors occurred because IHS (1) used inappropriate price lists instead of the authorized fee schedule; and (2) made clerical mistakes in the manual pricing of claims.

THE PROBLEM: INCONSISTENT AND INEFFECTIVE FOLLOW-UP ON UNPAID CLAIMS

The IHS did not always follow up with private insurers on claims that had not been paid or that had been denied. Follow-up is needed to ensure that insurance companies have properly reimbursed IHS for the services provided and to resolve disputed claims.

The Effect: Claims Totaling $1,237,970 Did Not Receive Adequate Follow-up

Based on our sample, we estimate that claims for 6,573 patients totaling $1,237,970 did not receive follow-up during the 3-month period ending March 31, 1993. The facilities' business office staff did not follow up on outstanding claims totaling $2,637 for 14 patients in our sample.

The Causes:

Unpaid Claims Needing Follow-up Were Not Identified

Unpaid claims needing follow-up were not identified through the official accounting systems of the area finance offices. The accounting procedures established by HRSA only required that area finance offices record collections. Area finance offices were not required to record bills sent to private insurance companies. Therefore, reports of unpaid claims could not be produced through IHS' official accounting system. The accounting procedures were established before IHS was authorized to bill and collect from private health insurance companies, and have not been revised since the Indian Health Care Amendments became law in 1988.

Number of Staff Assigned to Perform Follow-up Activities Was Insufficient

Several business office coordinators told us that they did not have sufficient staff to post collections or perform adequate follow-up work. Most follow-up was to be done at the area offices. Area office staff spent most, if not all, of their time posting collections. As a result, little follow-up activity took place.

Follow-up Instructions Were Not Adequate

The IHS did not provide facilities' business office staff with adequate instructions regarding the timing of follow-up actions. The IHS business office manual was developed by various IHS headquarters components with input from several area offices. This manual contains some information about following up on unpaid claims; however, the instructions are not complete. The manual includes instructions about how to obtain from the automated system reports of unpaid claims and mailing labels. However, the manual does not specify how many days after claims have been filed with insurance companies that follow-up letters should be mailed. Only 3 of the 11 area offices provided written policies that stated when follow-up should be performed.

CONCLUSIONS AND RECOMMENDATIONS

The IHS could increase billings and collections by millions of dollars if it would aggressively pursue billing private health insurance companies for covered services and also follow up with them on claims not paid or denied. These additional funds could be used to improve the delivery of health care to the Indian people. Because IHS has not established adequate controls, allocated sufficient resources, or adequately trained its staff, IHS has been unable to bill private health insurance companies for all covered services.

To maximize collections, we recommend that IHS:

- o establish the necessary internal controls to ensure that all covered services are billed timely and accurately;
- o allocate sufficient resources to the business offices to keep up with the workload; and
- o provide training to business office staff in all aspects of the business office operations.

One alternative that would help achieve the necessary internal controls is for IHS to fully implement its automated billing system. If adequate resources and training are provided, an automated billing system may be the most economical and effective way to maximize collections.

In addition to establishing internal controls, assigning adequate resources and providing training, IHS needs to take other specific steps to maximize collections. We recommend that IHS:

- o ensure that appropriate fee schedules are updated and distributed to IHS business offices prior to January each year and that pharmaceutical price lists are kept current;
- o ensure that amounts billed and collected for each patient are identified and recorded timely in the official accounting records;
- o assign resources to the business offices to effectively perform follow-up on unpaid claims; and
- o revise its follow-up instructions to include guidance for scheduling follow-up activities.

PHS COMMENTS AND OIG RESPONSE

In its May 16, 1995 response to our March 14, 1995 draft report, PHS fully concurred with each of our recommendations and delineated IHS actions to address them. The PHS specifically indicated that IHS is in the process of, or has plans for:

- Implementing an automated system to achieve the necessary internal controls. Currently, IHS is testing the new Resource and Patient Management (RPMS) System Accounts Receivable Package, an automated system designed to meet the internal control requirements for ensuring complete and accurate billing. The IHS expects to certify the system in July 1995, and distribute it in October 1995.

- Allocating resources to improve methods for billing and collections. The IHS plans to use the Health Care Recovery Services Contract, which was awarded by the General Services Administration, to obtain the technical personnel assistance needed for improving billings and collections. The contract will be used to obtain software developers, programmers, and technical support.

- Meeting the training needs of business office staff. Managers at IHS will be asked to identify training needs for business office staff and medical records personnel. Quarterly educational meetings have been established at many area offices to keep staff current with ever-changing state and Federal regulations. In addition, IHS' Office of Information Resources Management has prepared a training manual and on-line documentation.

- Implementing fee schedules on a timely basis. The IHS has established a newly automated process designed to enhance its ability to process fee schedules on a timely basis, and to allow the schedules to be distributed at the beginning of each calendar year.

- Ensuring adequate accounting and medical records are maintained for each patient. The new RPMS, described above, has an accounts receivable package designed to serve this purpose. Also, medical personnel and other staff are performing follow-up on incomplete medical records to improve claims submissions and billings for services rendered.

- Providing adequate resources to carry out the follow-up function. The IHS intends to identify staffing needs for claims follow-up, and then recommend contracting for recovery services. The RPMS contract will be a vehicle for obtaining the needed assistance.

- Improving policies and procedures for follow-up of unpaid claims. The IHS has developed follow-up policies and procedures for use in its business offices. The agency also expects follow-up procedures to be improved with the implementation of aging reports generated from the accounts receivable package. Further, IHS intends to provide continuing training on the techniques of performing follow-up procedures.

We believe IHS' current and planned actions, if fully implemented, should adequately address each of our recommendations, and ultimately help the agency bolster its level of private insurance recoveries.

To facilitate identification, please refer to Common Identification Number A-06-93-00080 in all correspondence relating to this report.

APPENDICES

SAMPLE DESCRIPTION

Sample Objective: The objective of our sample was to determine whether IHS accurately billed private insurance companies and collected for all covered services provided to patients who were served in IHS operated facilities during the quarter ended March 31, 1993.

Background Information: On November 23, 1988, the President signed Public Law 100-713, the Indian Health Care Amendments of 1988. This law gave IHS the right to recover the reasonable expenses incurred in providing health services to any individual to the same extent that such individual would be eligible to receive reimbursement if the services had been provided by a nongovernmental provider.

To maximize reimbursements from private health insurance and other third-party sources of revenue, IHS began establishing business offices at its facilities in 1991, and 1992 was the first full year of operations for these offices. The business offices are responsible for preparing insurance claims and collecting reimbursements from insurance companies.

Population: The population consisted of 106,569 patients who received services from IHS during the quarter ended March 31, 1993, and who were identified as having had private health insurance. The list did not specify whether the services provided were covered by private health insurance or whether each patient's insurance was in effect for the period of our review. These 106,569 patients made 278,423 visits to IHS facilities during the period reviewed.

Sample Design: A sample was selected using simple random sampling.

Sample Size: We randomly selected and reviewed 227 patients from the 106,569 patients in the population. The sample included 100 patients who had private health insurance and were provided a covered service during the review period.

Source of Random Numbers:	The OIG, Office of Audit Services' (OAS) statistical sampling software was used to determine the random numbers for drawing the sample.
Characteristics to Be Measured:	To compute the amount of covered services not claimed, we measured the fee schedule amounts for the services provided, but not claimed. To compute the amount not claimed because outdated fee schedules were used or other errors were made, we measured the difference between the amount claimed and the correct fee schedule amount. To compute the amount of claims not adequately followed up, we measured the dollar amount of claims for which IHS made no second attempt to collect. For projections, the values assigned were zero for patients who did not receive a covered service.
Other Evidence:	None.
Estimation Methodology:	The IHS filed $23,668 of claims with private insurance companies for the 227 patients files reviewed. The sample results showed that (1) $15,043 was not billed for 63 patients because claims were not filed or were incomplete and/or inaccurate; (2) $575 was not claimed for 64 patients because pricing errors were made; and (3) $2,637 of claims for 14 patients did not receive adequate follow-up. Using OAS' statistical software, we estimated that the population sampled was provided (1) $7,062,027 of services that were not claimed because claims were not filed or were incomplete/inaccurate; (2) $270,164 of services that were understated because of pricing errors; and (3) $1,237,970 of claims that were not adequately followed up.

SAMPLE RESULTS
AND PROJECTIONS TO THE POPULATION

Population	106,569
Sample Size	227
Value of Claims Filed for Patients Sampled	$23,668
Number of Sample Patients with Visits Not Claimed and Incomplete/Inaccurate Claims	63
Estimated Number of Patients in the Population at the 90% Confidence Level	
Upper Limit	35,229
Lower Limit	24,393
Amount of Unclaimed Services for 63 Patients with Visits Not Claimed and Incomplete/Inaccurate Claims	$15,043
Estimated Unclaimed Amount in the Population at the 90% Confidence Level	
Upper Limit	$11,548,264
Lower Limit	$2,575,790
Point Estimate of the Number of Patients in the Population with Visits Not Claimed and Incomplete/Inaccurate Claims	29,576
Point Estimate of the Amount of Unclaimed Services in the Population Because Visits Were Not Claimed and Claims Were Incomplete/Inaccurate	$7,062,027
Precision Amount	$4,486,237
Precision Percent	63.53%

SAMPLE RESULTS
AND PROJECTIONS TO THE POPULATION

Population	106,569
Sample Size	227
Value of Claims Filed for Patients Sampled	$23,668
Number of Sample Patients with Claims Filed with Pricing Errors	64
Estimated Number of Patients in the Population at the 90% Confidence Level	
Upper Limit	35,719
Lower Limit	24,832
Amount Unclaimed for 64 Patients with Pricing Errors	$575
Estimated Unclaimed Amount in the Population at the 90% Confidence Level	
Upper Limit	$453,270
Lower Limit	$ 87,058
Point Estimate of the Number of Patients in the Population with Pricing Errors	30,046
Point Estimate of the Amount Unclaimed in the Population Because of Pricing Errors	$270,164
Precision Amount	$183,106
Precision Percent	67.78%

SAMPLE RESULTS
AND PROJECTIONS TO THE POPULATION

Population	106,569
Sample Size	227
Value of Claims Filed for Patients Sampled	$23,668
Number of Sample Patients with Claims that Were Not Adequately Followed-up	14
Estimated Number of Patients in the Population at the 90% Confidence Level	
Upper Limit	10,092
Lower Limit	4,017
Amount of 14 Patients' Claims that Were Not Adequately Followed-up	$2,637
Estimated Amount in the Population at the 90% Confidence Level	
Upper Limit	$2,018,035
Lower Limit	$457,906
Point Estimate of the Number of Patients in the Population with Inadequate Follow-up	6,573
Point Estimate of the Amount Unresolved in the Population Because Adequate Follow-up Was Not Performed	$1,237,970
Precision Amount	$780,064
Precision Percent	63.01%

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Memorandum

Date MAY 16 1995

From Deputy Assistant Secretary for Health (Management and Budget)

Subject Office of Inspector General (OIG) Draft Report "Review of Indian Health Service's Billings and Collections from Private Health Insurance Companies," A-06-93-00080

To Inspector General, OS

Attached are the Public Health Service comments on the subject draft report. We have carefully reviewed the report's findings and conclusions, and concur with its recommendations. Our comments describe the actions taken or planned to implement these recommendations.

Anthony L. Itteilag

Attachment

PUBLIC HEALTH SERVICE (PHS) COMMENTS ON THE OFFICE OF INSPECTOR GENERAL (OIG) DRAFT REPORT "REVIEW OF INDIAN HEALTH SERVICE'S BILLINGS AND COLLECTIONS FROM PRIVATE HEALTH INSURANCE COMPANIES," A-06-93-00080, MARCH 1995

OIG Recommendation

1. Establish the necessary internal controls to ensure that all covered services are billed timely and accurately.

PHS Comment

We concur. The Indian Health Service (IHS) acknowledges that the controls necessary to assure that the amounts billed are accurate have not been fully implemented, and that not all covered services were billed. We agree with the OIG that one way to achieve the necessary internal controls is for IHS to fully implement its automated billing system.

The IHS is currently testing the new Resource and Patient Management System (RPMS) Accounts Receivable Package (Version 1.0). The RPMS provides for a collections register to track all billed items, with aging reports to monitor the status of bills, a posting register for deposits, and disposition of checks collected. The system generates manual or automated bills and letters of notice, and accepts automated feed-in of bills from a third party billing package. The software allows the IHS business office supervisor to review and accept/reject the collection processing of bills and collections. The accounts receivable package is designed to meet internal control requirements to ensure complete and accurate billing.

The software application consists of several deliverable modules including:

- Collections Register - Provides the entry and tabulation of funds into the system as received either by check or cash from insurance companies, patients, and other parties. It batches printouts and totals for making bank deposits as well as software registers from which payments are posted, updating the bills and their associated accounts.

- Third Party Upload - Provides automatic and manual methods of uploading current and past billing information from the RPMS third party billing system. When bills are uploaded, a variety of reports are available that include letters to debtors/insurance companies.

- Posting - Provides the ability to update payments and adjust bills/accounts according to the information provided to them by the debtors/insurance companies.

- Roll Over - Provides a mechanism to notify the RPMS third party billing package that the current debtor on a bill has completed their portion of payments and then seeks further payments.

- Reports - Provides fundamental reports for gathering of further report definitions, collection registers, aging of bills, account bill aging and others. A generic file manager reports menu is provided for generating other reports as needed.

Based on agreements made at the last IHS business officers meeting, and on project management estimates of the software implementation timeline, the RPMS will be submitted for certification in July, with distribution expected in October 1995.

OIG Recommendation

2. Allocate sufficient resources to the business offices to keep up with the work load.

PHS Comment

We concur. Staffing shortages have affected the business offices' ability to maximize collections. Automation of the claims management system as identified with the new accounts receivable package will be a most beneficial tool. In addition, IHS will update user training and technical manuals as needed.

Adequate software developers/programmers and technical support are essential for software enhancements, program modifications, maintenance, and training. The Health Care Recovery Services Contract approved by the Office of Management and Budget (OMB) and awarded by the General Services Administration (GSA) in October 1994 can be utilized for interface, assistance, and "turn-key" operations as downsizing and reduction of full-time equivalent (FTE) positions occur. The IHS will use this contract for determining effective and efficient methods for improving billing collections.

OIG Recommendation

3. Provide training to business office staff in all aspects of the business office operations.

PHS Comment

We concur. IHS managers will be asked to identify training needs for the business office and medical records personnel. Examples of the types of education and training to be provided include: interviewing techniques (public relations); basic computer training; preparation of billing forms, claims processing and accounts receivable management for private insurance, Medicare, and Medicaid; current procedural terminology (CPT) coding and international classification of diseases coding; and linkage between RPMS applications and patient registration.

Many of the Area Business Office Coordinators have established quarterly educational meetings in their respective Areas in order to keep current with the ever-changing State and Federal regulations. The Area Business Office Coordinators have established monthly conference calls with Blue Cross-Blue Shield to keep abreast of regulatory and billing changes.

In addition, IHS' Office of Information Resources Management (OIRM) has prepared a training manual and user friendly on-line help documentation. A model implementation package was provided to the accounts receivable workgroup for scheduling implementation and distribution to sites, as well as a costing formula that can be used to project implementation costs. Consideration will be given to increasing the usefulness of these materials as revisions are made.

OIG Recommendation

4. Ensure that appropriate fee schedules are updated and distributed to IHS business offices prior to January [of] each year and that pharmaceutical price lists are kept current.

PHS Comment

We concur. The FY 1994 was the first year the CPT codes and related fees used for billing were processed electronically at the data center in Albuquerque, using software purchased from McGraw Hill. This newly automated process will greatly enhance our ability to process each fee schedule on a timely basis.

The IHS will distribute fee schedules through the new automated system at the beginning of each calendar year. The fees for the new current procedural CPT codes for 1995 are pending from McGraw Hill.

In addition, the IHS has received the Veterans' Administration pharmaceutical pricing list and will pursue use of outside vendor pricing packages. The IHS expects to make a decision by August of this year on which packages will be used.

OIG Recommendation

5. Ensure that amounts billed and collected for each patient are identified and recorded timely in the official accounting records.

PHS Comment

We concur. The amounts billed and collected for each patient are to be entered into the RPMS accounts receivable package. This software system provides automatic and manual uploading of current and past billing information from the third party billing package. Reports are available on collection registers, aging of bills, account bill aging and others. This ensures accurate accounting records for all patients. It also provides a generic file manager reports menu for producing individual reports. See the PHS response to recommendation number 1 for more information on the expected implementation schedule for RPMS.

OIG Recommendation

6. Assign resources to the business offices to effectively perform follow-up on unpaid claims.

PHS Comment

We concur. The RPMS accounts receivable package is designed to track unpaid claims and to meet internal control requirements to ensure complete and accurate billing. The IHS recognizes the need to utilize the Health Care Recovery Services contract due to downsizing/FTE reductions and the need to perform reconciliation processes, research, and follow-up procedures. The IHS will identify staffing needs and recommend contracting for recovery services. The Health Care Cost Recovery Services contract, approved by the Office of Management and Budget and awarded by the General Services Administration will be utilized for determining effective and efficient methods for improving billing collections.

Medical records personnel, in conjunction with staff from the various health care disciplines, are performing follow-up on incomplete medical records in order to improve claims submissions and billings for services rendered.

OIG Recommendation

7. Revise its follow-up instructions to include guidance for scheduling follow-up activities.

PHS Comment

We concur. Follow-up policies and procedures have been developed for use in service unit business offices. Follow-up procedures will be improved with the implementation of the aging reports on the accounts receivable package. The aging reports can be generated at 30-, 60-, 90-, and 120-day intervals. Letters to debtors/insurance companies are submitted as part of the follow-up procedures. The IHS will provide continuing training on the techniques of performing follow-up procedures. Determination will be made in the business office conference scheduled for August 1995 on staffing needs/contracting of recovery services and internal control reviews to be performed.