Report No. DODIG-2019-108

Inspector General

U.S. Department of Defense

SEPTEMBER 16, 2019

Audit of the DoD's Management of the Third Party Collection Program for Medical Claims

INTEGRITY ★ INDEPENDENCE ★ EXCELLENCE

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Results in Brief

Audit of the DoD's Management of the Third Party Collection Program for Medical Claims

September 16, 2019

Objective

The objective of this audit was to determine whether the DoD collected the cost of providing health care services from medical claims within the Third Party Collection Program. We reviewed claims from nine DoD medical treatment facilities (medical facilities) across the Army, Navy, Air Force, and National Capital Region Medical Directorate.

Background

Section 1095, Title 10, United States Code authorizes medical facilities to recover the cost of providing health care services to DoD beneficiaries from insurance providers. Medical facility Uniform Business Offices (UBOs) bill the beneficiaries' other health insurance (OHI) directly for the cost of care, minus the applicable deductible or copayment amount, because beneficiaries are not responsible for deductibles or copayments when care is received at a medical facility. UBOs seek to ensure that billable services are identified, payer information is available, accurate and complete claims are generated, and appropriate collections are received. OHI is any health insurance policy covering medical, dental, or pharmacy services that a beneficiary may have through their employer or private insurance provider.

The money collected from the insurance provider directly supports the operation and maintenance budget of the medical facility where care was received and can help improve the quality of health care within the Military Health System (MHS) by providing additional funding for administrative, operating, and equipment costs; readiness training; or trauma consortium activities.

Background (cont'd)

The Army, Navy, Air Force, and National Capital Region Medical Directorate establish and operate the UBOs to manage the cost recovery programs at their medical facilities throughout the world.

The Army, National Capital Region Medical Directorate, and Air Force awarded contracts to assist some medical facilities with third party collections; however, the Navy did not use contractors to support its Third Party Collection Program.

Finding

DoD medical facility UBO and Defense Health Agency (DHA) UBO personnel did not adequately manage the Third Party Collection Program to ensure collection of all available funds from delinquent medical claims for providing health care services. From October 1, 2015, to June 30, 2018, 250,932 claims, valued at $86.9 million, were more than 120 days old at nine medical facilities. We nonstatistically selected and reviewed 70 of these claims, valued at $3.6 million, and found that medical facility personnel did not:

- collect beneficiaries' OHI information at all medical facilities because commanders at medical facilities did not enforce OHI collection;
- process and generate bills for services rendered on 26,236 potentially billable patient encounters due to inaccurate coding because front desk personnel at medical facilities using the MHS GENESIS system selected or maintained incorrect patient category codes, and medical facility personnel did not assign providers to all patient encounters;
- generate and submit timely, accurate claims and follow up on unpaid claims because Services' Medical Commands did not establish standard procedures to implement Federal and DoD regulations related to the collection of third party claims; or
- use the Department of the Treasury or local Judge Advocate support to collect delinquent debt because commanders at the medical facilities did not implement procedures for transferring delinquent debt to the Department of the Treasury or ensure that sufficient legal support was made available to pursue required collection actions.

Results in Brief

Audit of the DoD's Management of the Third Party Collection Program for Medical Claims

Finding (cont'd)

Furthermore, third party collection contractors did not conduct timely followup, document followup actions, or elevate claims in accordance with Federal and DoD regulations for 18 of 23 claims in our sample. This occurred because Army, National Capital Region Medical Directorate, and Air Force medical facility and contracting personnel did not structure the contracts to align with Federal and DoD regulations or implement adequate oversight procedures to identify and address deficiencies in the contractor's performance.

We determined that without proper management of the Third Party Collection Program, the nine medical facilities did not collect up to $70.7 million of the $86.9 million over 120 days old, including up to $1.0 million for the 70 claims reviewed. As a result, substantial uncollected funds were not available for the medical facilities to use to improve the quality of health care.

Furthermore, additional funds could be collected when medical facility personnel collect OHI information at all clinics and process the 26,236 potentially billable encounters. Unless DoD MHS management takes prompt and aggressive actions to pursue collections and make improvements to the collection process of the delinquent debt among the Third Party Collection Program, medical facilities will continue to experience rising delinquent balances for future medical service and miss the opportunity to use the money collected to support the quality of health care.

Recommendations

We make several recommendations to address our findings, including that the DHA Director initiate a review of all medical facilities in the MHS to determine which medical facilities are not:

- collecting OHI information at all clinics and coordinate with commanders of those medical facilities to enforce existing OHI regulations and, as appropriate, take administrative action for noncompliance;
- conducting followup in compliance with the requirements of the DHA Procedures Manual 6015.01, and coordinate with commanders of those medical facilities to immediately revise procedures to ensure claims are followed up on in accordance with applicable DoD requirements; and
- providing legal support to the UBO and coordinate with commanders of those medical facilities to provide legal support to collect on third party collection program claims, and report on the benefits of the DHA providing centralized legal resources for all DoD medical facilities to support cost recovery programs.

Additionally, we make 72 recommendations to the commanders or directors of the nine medical facilities reviewed, including recommendations to:

- direct personnel at all medical facility clinics and clinical support activities to collect hardcopy or electronic versions of DD Form 2569, and as appropriate, take administrative action for noncompliance;
- review and modify procedures for claim followup so debt can be transferred to the appropriate debt collection agency when claims become 120 days delinquent;
- provide sufficient legal support to pursue collections through the Third Party Collection Program; and
- review, research, and pursue collection on the delinquent third party claims that remain open.

Furthermore, we recommend that the Commanding General of Regional Health Command–Atlantic, Director of DHA National Capital Region Medical Directorate, and the Commander of the Air Force Medical Operations Agency review the contract language in the Third Party Collection Program contracts, and as appropriate, align the contract terms with all applicable Federal and DoD regulations related to the Third Party Collection Program. In addition, they should implement oversight procedures

Results in Brief

Audit of the DoD's Management of the Third Party Collection Program for Medical Claims

Recommendations (cont'd)

to monitor contractor performance in accordance with the applicable Federal and DoD regulations and contract terms. We recommend that they hold any contracting personnel assigned oversight responsibility accountable for not appropriately performing the oversight procedures necessary to ensure the contractor complied with Federal and DoD regulations and contract terms.

Management Comments and Our Response

The Deputy Assistant Secretary of the Navy (Military Manpower and Personnel), responding for the Commanders of Naval Hospital Bremerton and Naval Medical Center San Diego, agreed with and provided comments that address the specifics for 8 of 10 recommendations. These recommendations are resolved and will remain open until adequate documentation has been submitted showing that all agreed-upon actions have been completed. In addition, the Deputy Assistant Secretary provided comments that addressed the potential monetary benefits. However, the Deputy Assistant Secretary disagreed with or did not provide comments that address the specifics for 2 of 10 recommendations. Therefore, the recommendations related to providing legal support are unresolved.

The Chief of Staff, Army Office of the Surgeon General, responding for the Commanders of Madigan Army Medical Center, Brooke Army Medical Center, Kimbrough Ambulatory Care Center, and Regional Health Command–Atlantic, agreed with and provided comments that address the specifics for 11 of 18 recommendations. These recommendations are resolved and will remain open until adequate documentation has been submitted showing that all agreed-upon actions have been completed. In addition, the Chief of Staff provided comments that addressed the potential monetary benefits. However, the Chief of Staff disagreed with or did not provide comments that address the specifics for 7 of 18 recommendations. Therefore, the recommendations related to resolving patient encounters, reviewing and modifying procedures for obtaining pre-authorization, reviewing and modifying procedures for claim followup, and providing legal support are unresolved.

The Deputy Surgeon General of the Air Force, responding for the Commanders of the 59th Medical Wing at Lackland Air Force Base, the 75th Medical Group at Hill Air Force Base, and Air Force Medical Operations Agency, agreed with and provided comments that address the specifics for 10 of 15 recommendations. These recommendations are resolved and will remain open until adequate documentation has been submitted showing that all agreed-upon actions have been completed. However, the Deputy Surgeon General did not respond to the potential monetary benefits and disagreed with or did not provide comments that address the specifics for 5 of 15 recommendations. Therefore, the recommendations related to reviewing and modifying procedures for claim followup, reviewing all outstanding third party claims to determine eligibility for collection assistance, providing legal support, and holding contracting personnel assigned oversight responsibility accountable are unresolved.

The DHA Director, Director of Walter Reed National Military Medical Center, and Commander of Fort Belvoir Community Hospital did not respond to 29 recommendations and the potential monetary benefits in the draft report. Therefore, these recommendations are unresolved.

Please see the Recommendations Table on the next page for the status of recommendations.

Recommendations Table

Management	Recommendations Unresolved	Recommendations Resolved	Recommendations Closed
Director, Defense Health Agency	1.a.1, 1.a.2, 1.a.3, 1.a.4, 1.a.5, 1.a.6, 1.a.7, 1.b, 1.c, 1.d, 1.e, 1.f, 1.g, 1.h, 1.i, 1.j		
Commanding General, Army Regional Health Command–Atlantic		11.a, 11.b, 11.c	
Director, Defense Health Agency National Capital Region Medical Directorate	11.a, 11.b, 11.c, 12		
Commander, Air Force Medical Operations Agency	11.c	11.a, 11.b	
Commander, Naval Hospital Bremerton	2.g	2.a, 2.b, 2.c, 2.d, 2.e, 2.f	
Commander, Naval Medical Center San Diego	3.c	3.a, 3.b	
Commander, Madigan Army Medical Center	4.b, 4.c, 4.d, 4.f	4.a, 4.e, 4.g	
Commander, Brooke Army Medical Center	5.b, 5.c	5.a, 5.d, 5.e	
Commander, Kimbrough Ambulatory Care Center	10.a	10.b, 10.c	
Commander, 59th Medical Wing, Lackland Air Force Base	6.b, 6.c, 6.d	6.a	
Commander, 75th Medical Group, Hill Air Force Base	7.h	7.a, 7.b, 7.c, 7.d, 7.e, 7.f, 7.g	
Director, Walter Reed National Military Medical Center	8.a, 8.b, 8.c, 8.d, 8.e		
Commander, Fort Belvoir Community Hospital	9.a, 9.b, 9.c, 9.d		

Please provide Management Comments by October 16, 2019.

Note: The following categories are used to describe agency management's comments to individual recommendations.

- **Unresolved** – Management has not agreed to implement the recommendation or has not proposed actions that will address the recommendation.
- **Resolved** – Management agreed to implement the recommendation or has proposed actions that will address the underlying finding that generated the recommendation.
- **Closed** – OIG verified that the agreed upon corrective actions were implemented.

INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
4800 MARK CENTER DRIVE
ALEXANDRIA, VIRGINIA 22350-1500

September 16, 2019

MEMORANDUM FOR ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS
DIRECTOR, DEFENSE FINANCE AND ACCOUNTING SERVICE
DIRECTOR, DEFENSE HEALTH AGENCY
AUDITOR GENERAL, DEPARTMENT OF THE NAVY
AUDITOR GENERAL, DEPARTMENT OF THE ARMY
AUDITOR GENERAL, DEPARTMENT OF THE AIR FORCE

SUBJECT: Audit of the DoD's Management of the Third Party Collection Program for Medical Claims (Report No. DODIG-2019-108)

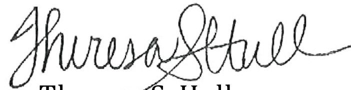
This final report provides the results of the DoD Office of Inspector General's audit. We previously provided copies of the draft report and requested written comments on the recommendations. We considered management's comments on the draft report when preparing the final report. These comments are included in the report.

This report contains 43 recommendations that are considered unresolved because management either disagreed with or did not fully address the recommendations, or did not provide a response to the report. Therefore, as discussed in the Recommendations, Management Comments, and Our Response section of this report, these recommendations will remain unresolved until an agreement is reached on the actions to be taken to address the recommendations. Once an agreement is reached, the recommendations will be considered resolved but will remain open until adequate documentation has been submitted showing that the agreed-upon action has been completed. Once we verify that the action is complete, the recommendations will be closed.

This report contains 29 recommendations that are considered resolved but open because management agreed with and provided comments that fully address the recommendations presented in the report. Therefore, as discussed in the Recommendations, Management Comments, and Our Response section of this report, these recommendations will remain open until adequate documentation has been submitted showing that the agreed-upon action has been completed. Once we verify that the action is complete, the recommendations will be closed.

DoD Instruction 7650.03 requires that recommendations be resolved promptly. Therefore, for the unresolved recommendations, please provide us within 30 days your response concerning specific actions in process or completed on the recommendations or alternative corrective actions proposed. For the resolved recommendations, please provide us within 90 days your response concerning specific actions in process or completed on the recommendations. Your response should be sent as a PDF file to aud-colu@dodig.mil.

We appreciate the cooperation and assistance received during the audit. Please direct questions to me at [redacted].



Theresa S. Hull
Assistant Inspector General for Audit
Acquisition, Contracting, and Sustainment

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Introduction

Objective

The objective of this audit was to determine whether the DoD collected the cost of providing health care services from insurance providers for medical claims within the Third Party Collection Program.

We selected and reviewed third party collection claims at nine DoD medical treatment facilities (medical facilities) across the Military Services and the National Capital Region Medical Directorate (NCR MD). The nine medical facilities and the collection rate for claims billed between FYs 2015 and 2017 were:[1]

- Naval Hospital Bremerton (NH Bremerton), Washington – 71.73 percent;
- Naval Medical Center San Diego (NMC San Diego), California – 17.35 percent;
- Madigan Army Medical Center (Madigan AMC), Washington – 58.76 percent;
- Brooke Army Medical Center (Brooke AMC), Texas – 26.57 percent;
- Kimbrough Ambulatory Care Center (Kimbrough ACC), Maryland – 33.18 percent;
- 75th Medical Group at Hill Air Force Base, Utah (75th Medical Group) – 47.77 percent;
- 59th Medical Wing at Lackland Air Force Base, Texas (59th Medical Wing) – 18.90 percent;
- Walter Reed National Military Medical Center (Walter Reed NMMC), Washington D.C. – 30.55 percent; and
- Fort Belvoir Community Hospital (Fort Belvoir CH), Virginia – 30.62 percent.

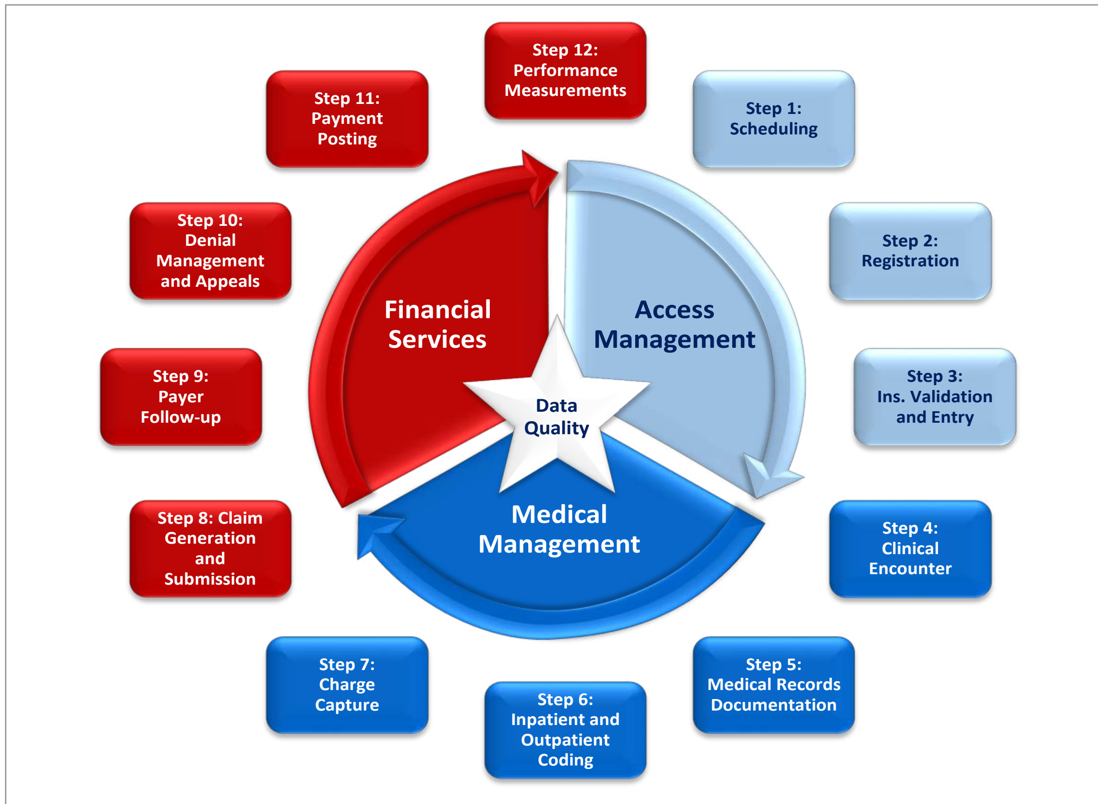
Background

Military Health System Revenue Cycle Management

The Military Health System (MHS) revenue cycle starts with patient scheduling and registration and leads to reimbursement to the medical facility. The cycle consists of three phases: (1) access management, (2) medical management, and (3) financial services, with each phase including steps to complete the revenue cycle. Revenue cycle management is intended to improve the efficiency and quality of the collection operations in order to maximize the recovery of reasonable charges provided to non-Uniformed Service beneficiaries. See Figure for the 12 steps of the MHS revenue cycle.

[1] The medical facility collection rate was calculated by dividing total amount collected by the total amount billed minus adjustments and write-offs.

Figure. The Military Health System Revenue Cycle



Source: The Defense Health Agency.

Third Party Collection Program and Other Health Insurance

Section 1095, title 10, United States Code, authorizes medical facilities to recover the cost of providing health care services to DoD beneficiaries from insurance providers. Other health insurance (OHI) is any health insurance policy covering medical, dental, or pharmacy services that a beneficiary may have through their employer or private insurance provider. Examples of insurance providers are CVS Caremark, Blue Cross, and Express Scripts. OHI is not TRICARE, TRICARE Supplemental Plans, Medicare, Medicaid, or certain Government-sponsored programs.[2] The money collected from the insurance providers directly supports the operation and maintenance budget of the medical facility where care was received and is intended to be used to improve the quality of health care within the MHS by providing additional funding for administrative, operating, and equipment costs; readiness training; or trauma consortium activities. All beneficiaries, excluding those on active duty, are required annually to provide information regarding OHI coverage, or when their coverage status changes by completing DD Form 2569, "Third Party Collection Program/Medical Services Account/Other

[2] TRICARE is the health care program that provides comprehensive coverage for Uniformed Service members, retirees, and their families.

Health Insurance." The information provided on DD Form 2569 is used to properly route a health care claim to a beneficiary's insurance provider. See Appendix B for an example of DD Form 2569. Medical facility Uniform Business Offices (UBOs) bill the beneficiaries' OHI directly for the cost of care, minus the applicable deductible or copayment amount. The deductible and copayment amounts are deducted because beneficiaries are not responsible for these amounts when care is received at a DoD medical facility.

Military Health System Roles, Responsibilities, and Chain of Command

Defense Health Agency

The Defense Health Agency (DHA) is a joint, integrated combat support agency that enables the Army, Navy, and Air Force medical services to provide a medically ready force. In addition, the DHA ensures a ready medical force is available for combatant commands in both peace and wartime. One of the DHA's goals is to improve operations across the MHS.

The National Defense Authorization Act for FY 2017 established the DHA as the authority for administration of all DoD medical facilities beginning on October 1, 2018.[3] DHA officials stated, during our audit, that they would implement a phased approach to the transition beginning on October 1, 2018, with planned completion of 2020. The Under Secretary of Defense for Personnel and Readiness and Assistant Secretary of Defense (Health Affairs) oversee the DHA.

U.S. Army Medical Command and Army Medical Treatment Facilities

The U.S. Army Medical Command provides sustained health services and research. The vision for the command is to be the Nation's premier expeditionary and globally integrated medical force, ready to meet the ever-changing challenges of today and tomorrow. U.S. Army medical facilities report to Regional Health Commands, which report to the U.S. Army Medical Command. The U.S. Army Medical Command reports to the Surgeon General of the Army.

Air Force Medical Operations Agency and Air Force Medical Treatment Facilities

The Air Force Medical Operations Agency provides policies for medical care and mission support across its medical services. Among other responsibilities, the Air Force Medical Operations Agency implements the Air Force Surgeon General policies and coordinates best practices, performs data analysis, and provides clinical expertise for efficient patient-centered health care. The medical facilities

[3] Public Law 114-328, "National Defense Authorization Act for Fiscal Year 2017," December 23, 2016.

report to a medical wing or medical group, which reports to Air Force Major Commands. The Air Force Major Commands have a reporting requirement to the Surgeon General of the Air Force.

Navy Bureau of Medicine and Surgery and Naval Medical Treatment Facilities

The Navy Bureau of Medicine and Surgery is the headquarters command for Navy Medicine. The Navy Bureau of Medicine and Surgery develops policy and direction to implement the patient and family care vision carried out by Navy, Marine Corps, and civilian personnel throughout the world. Navy medical facilities report to Regional Commands, which report to the Navy Bureau of Medicine and Surgery. The Navy Bureau of Medicine and Surgery reports to the Surgeon General of the Navy.

National Capital Region Medical Directorate

On October 1, 2013, the NCR MD was established to provide authority, direction, and control over the Walter Reed NMMC, Fort Belvoir CH, and other subordinate clinics. The NRC MD serves the largest population in the MHS. The medical facilities report directly to the NCR MD, which reports to the DHA.

Uniform Business Office

The Army, Navy, Air Force, and NCR MD establish and operate the UBOs at medical facilities throughout the world that manage the Third Party Collections, Medical Services Account, and Medical Affirmative Claim Programs (cost recovery programs). The UBOs ensure that billable services are identified, payer information is available, accurate and complete claims are generated, and appropriate collections are received.

The cost recovery programs provide the business processes for cost recovery, including collections control, accounts receivable, and deposits. The DHA Procedures Manual provides the operational guidelines for the medical facility UBOs.[4] The Manual establishes the uniform billing procedures and accounting practices for the management and followup of patient accounts, including collecting, depositing, posting, and reconciliation.

Judge Advocates Office

The local Judge Advocates (JAs) support each medical facility UBO in collecting medical claims through the cost recovery programs, among other responsibilities. The DHA Procedures Manual requires UBO personnel to refer all accounts receivables to the local Judge Advocate General office or the Department of the

[4] DHA-PM 6015.01, "Military Medical Treatment Facility (MTF) Uniform Business Office (UBO) Operations," October 24, 2017.

Treasury (the Treasury) when all efforts to collect on a valid claim have been exhausted and the claim is delinquent for more than 120 days.[5] All collections made by the local JA or an external agent are deposited into the medical facilities operations and maintenance account.

Third Party Collection Contracts

The Army, NCR MD, and Air Force used contracts to assist some medical facilities with third party collections.[6] Under these contracts, the contractor is responsible for performing various tasks to ensure medical facilities receive payment for services provided to non-active duty DoD beneficiaries who have OHI coverage and receive medical treatment from DoD medical facilities. These tasks include pre-certification and verification of OHI coverage, claims billing and collection, claims followup, and managing claim denials. Government employees, assigned as the contracting officer's representatives, oversee the contractor's performance. Our sample included claims covered by active Army, NCR MD, and Air Force contracts.[7]

The DoD's Medical and Billing Systems

DoD Electronic Health Records Systems

The Composite Health Care System allows clinicians to electronically perform patient appointment processing and scheduling, order laboratory tests, authorize radiology procedures, and prescribe medications. The system enables DoD providers to document patient health information and history.

MHS GENESIS, the new electronic health record for the MHS, will replace select DoD legacy health care systems, including the Composite Health Care System. MHS GENESIS was designed to provide enhanced, secure technology to manage the patient's health information. The system integrates inpatient and outpatient solutions that will connect medical and dental information across the continuum of care, from point of injury to the medical facilities. When fully deployed, MHS GENESIS will provide a single health record for service members, veterans, and their families.

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[5] We interpret DHA Procedures Manual requirement of transferring delinquent debt to the local Judge Advocate General, as requiring the transfer to the local Judge Advocates that support the medical facility commanders.

[6] U.S. Army Regional Health Command–Atlantic awarded task orders W91YTZ-17-D-0005-0001 and W91YTZ-17-D-0005-0002 on July 1, 2017, and August 31, 2017. The Defense Health Agency awarded task order HT0014-15-F-0029 on July 1, 2015. The Air Force Installation Contracting Agency awarded task orders FA8052-17-F-0005, FA8052-17-F-0008, FA8052-17-F-0013 on March 8, 2017, and March 20, 2017. The Navy did not award contracts to assist medical facilities with third party collections.

[7] The claims were part of the Army's Kimbrough ACC, Fort Belvoir CH, 59th Medical Wing at Lackland Air Force Base, and 75th Medical Group at Hill Air Force Base.

On April 30, 2018, the Director, Operational Test and Evaluation, released a partial Initial Operational Test and Evaluation Report for MHS GENESIS. The report concluded that MHS GENESIS was neither operationally effective nor operationally suitable. MHS GENESIS was not operationally effective because it did not demonstrate enough workforce functionality to manage and document patient care. It was not operationally suitable because of poor system usability, insufficient training, and inadequate help desk support.

Armed Forces Billing and Collection Utilization Solution

The MHS uses the Armed Forces Billing and Collection Utilization Solution (ABACUS) system to manage the billing and collection activities for the Services' UBO cost recovery programs. According to the MHS, these programs recoup an average of $400 million annually for DoD medical facilities. The money recouped through the cost recovery programs directly supports the operation and maintenance budget of the medical facility where care was received and is intended to be used to improve the quality of health care within the MHS by providing additional funding for administrative, operating, and equipment costs; readiness training; or trauma consortium activities. All medical facilities, central billing locations, and medical cost recovery programs use ABACUS.

U.S. Department of the Treasury Cross-Servicing Program

The Cross-Servicing Program is a consolidated Government-wide program operated by the Debt Management Services at the Treasury. The Cross-Servicing Program fulfills the requirement of the Debt Collection Improvement Act of 1996 to collect delinquent, non-tax debt on behalf of Federal agencies.[8] The Digital Accountability and Transparency Act of 2014 amended the Debt Collection Improvement Act and requires an agency to refer any eligible debt that is delinquent for more than 120 days to the Treasury Cross-Servicing Program.[9] Any non-tax debt can be transferred to the Treasury Cross-Servicing Program unless the debt:

- is in litigation or foreclosure;
- will be disposed of under an asset sales program;
- was referred to a private collection contractor for a collection for a period of time determined by the Treasury;
- has been referred to a Debt Collection Center with the consent of the Treasury; or
- will be collected under internal offset if the offset is sufficient to collect the debt within 3 years.

[8] Public Law 104-134, chapter 10, section 31001, "The Debt Collection Improvement Act of 1996," April 26, 1996.

[9] On May 9, 2014, Public Law 113-101, "Digital Accountability and Transparency Act of 2014," amended sub-section 3716(c)(6) of section 37, title 31, United States Code by reducing the time period for transferring debt from 180 days to 120 days.

As part of the Cross-Servicing Program, Debt Management Services must take appropriate action to service, collect, suspend, or terminate collection action on the debt.

Review of Internal Controls

DoD Instruction 5010.40 requires DoD organizations to implement a comprehensive system of internal controls that provides reasonable assurance that programs are operating as intended and to evaluate the effectiveness of the controls.[10] We identified internal control weaknesses within the management of the revenue cycle at multiple medical facilities, including UBO personnel not adequately managing delinquent third party claims. We also identified weaknesses with contract language and compliance with Federal and DoD regulations, and the oversight of Third Party Collection Program contractors by contracting officer's representatives. We will provide a copy of the report to the senior officials responsible for internal controls in the DHA, Army, Navy, Air Force, and NCR MD.

[10] DoD Instruction 5010.40, "Managers' Internal Control Program Procedures," May 30, 2013.

Finding

DoD's Management of Third Party Collection Program Needs Improvement to Collect on Delinquent Medical Claims

DoD medical facility Uniform Business Office (UBO) and Defense Health Agency (DHA) UBO personnel did not adequately manage the Third Party Collection Program to ensure collection of all available funds from delinquent medical claims for providing health care services.[11] From October 1, 2015, to June 30, 2018, 250,932 claims, valued at $86.9 million, were more than 120 days old at nine medical facilities. We nonstatistically selected and reviewed 70 of these claims, valued at $3.6 million, and found that medical facility personnel did not:[12]

- collect beneficiaries' other health insurance (OHI) information, as required by the DHA Procedures Manual, because commanders at the medical facilities did not enforce OHI collection at all medical facility clinics;[13]
- process and generate bills for services rendered on 26,236 potentially billable patient encounters due to inaccurate coding because front desk personnel at medical facilities using the MHS GENESIS system selected or maintained incorrect patient category codes and medical facility personnel did not assign providers to all patient encounters;
- generate and submit accurate claims in a timely manner and follow up on unpaid claims because the Services' Medical Commands did not establish standard procedures to implement Federal and DoD regulations related to the collection of third party claims;[14] or

[11] Claims were deemed delinquent if they were more than 120 days old.

[12] We selected 72 claims to review, valued at $4.7 million, to determine compliance with Federal and DoD regulations. During our review, we identified two claims that were miscoded and should not have been billed through the Third Party Collection Program. As a result, we reviewed 70 claims for compliance with Federal and DoD regulations. Of these claims, 66 were more than 120 days old.

[13] DHA-PM 6015.01, "Military Medical Treatment Facility (MTF) Uniform Business Office (UBO) Operations," October 24, 2017.

We define clinics as anywhere care was received, including all inpatient, outpatient, and pharmacy encounters.

[14] The Service Medical Commands include U.S. Army Medical Command, Air Force Medical Operations Agency, the Navy Bureau of Medicine and Surgery, and the National Capital Region Medical Directorate.

- use the Treasury Cross-Servicing Program or local Judge Advocate (JA) support, as required by public law and the DHA Procedures Manual, because the commanders at the medical facilities did not implement procedures to transfer delinquent debt to the Treasury Cross-Servicing Program or ensure that sufficient legal support was made available to pursue required collection actions.[15]

Furthermore, the DoD's third party collection contractor (contractor) did not conduct followup, document followup actions on claims, or elevate claims in accordance with Federal and DoD regulations for 18 of 23 claims in our sample.[16] This occurred because Army, NCR MD, and Air Force medical facility and contracting personnel did not structure the contracts to align with Federal and DoD regulations. Furthermore, Army, NCR MD, and Air Force contracting personnel did not implement adequate oversight procedures to identify and address deficiencies in the contractor's performance.

As a result, we determined that without proper management of the Third Party Collection Program, the nine medical facilities missed opportunities to collect up to $70.7 million of the $86.9 million over 120 days old, including up to $1.0 million for the 70 claims reviewed. Therefore, substantial uncollected funds were not available for the medical facilities to use to improve the quality of health care. Furthermore, additional funds could be collected when medical facility personnel collect OHI information at all clinics and process the 26,236 potentially billable encounters. The deficiencies in the management of the Third Party Collection Program resulted in missed opportunities to improve collections, which could increase operation and maintenance budgets and ultimately improve the quality of health care within the MHS. Unless DoD MHS management takes prompt and aggressive actions to pursue collections and make improvements to the collection process of the delinquent debt among the Third Party Collection Program, medical facilities will continue to experience rising delinquent balances for future medical service and miss the opportunity to use the money collected to improve the quality of health care.

[15] Public Law 104-134, chapter 10, section 31001, "The Debt Collection Improvement Act of 1996." On May 9, 2014, Public Law 113-101, "Digital Accountability and Transparency Act of 2014," amended sub-section 3716(c)(6) of section 37, title 31, United States Code by reducing the time period for transferring debt from 180 days to 120 days.
DHA-PM 6015.01, "Military Medical Treatment Facility (MTF) Uniform Business Office (UBO) Operations," October 24, 2017.

[16] The Army, NCR MD, and Air Force awarded third party collections contracts and task orders to the same contractor. The 23 claims reviewed for contractor performance fell within the scope of the review and active contracts open during the scope of the review. Twelve other claims were also billed under third party collections contracts; however, the contracts were inactive during the scope of the review.

Management of the Third Party Collection Program Needs Improvement

Medical facility UBO and DHA UBO personnel did not adequately manage the Third Party Collection Program to ensure collection of all available funds from claims for providing health care services. The purpose of the Third Party Collection Program is for medical facilities to recover the costs of providing health care services to DoD beneficiaries who have OHI. One way to ensure that this occurs is through the management of the MHS revenue cycle. The MHS revenue cycle consists of three phases: (1) access management, (2) medical management, and (3) financial services, with each phase including steps that are required to complete the revenue cycle. An efficiently managed MHS revenue cycle will maximize funds collected through the Third Party Collection Program, providing the medical facilities with additional funding for administrative, operating, and equipment costs; readiness training; or trauma consortium activities.

We reviewed 70 claims, valued at $3.6 million, and found that medical facility and DHA personnel did not adequately manage the Third Party Collection Program to ensure collection of all available funds. At the nine medical facilities reviewed, medical facility personnel did not always collect OHI information; bill all patient encounters; submit accurate claims in a timely manner and followup on unpaid claims; and use the additional required collection efforts, such as the local JA office or the Treasury Cross-Servicing Program, to improve collection efforts. In addition, contracted personnel were also not conducting timely followup, documenting followup actions, or elevating claims back to the medical facility UBO for collection assistance.

Collection of Other Health Insurance Information

Medical facility personnel did not always collect beneficiaries' OHI information at eight medical facilities, and six medical facilities did not attempt to collect OHI information in any of the pharmacies, as required by the DHA Procedures Manual.[17] Collection of a beneficiary's information and accurate registration is a crucial first step in the MHS revenue cycle, and allows medical facilities to bill and collect from insurance providers, when applicable. Federal law authorizes medical facilities to recover the cost of providing health care services to DoD beneficiaries from insurance providers.[18] The DHA Procedures Manual requires:

- UBO personnel to identify beneficiaries with OHI, document a patient's OHI coverage, and submit claims to insurance providers for reimbursement; and

[17] We assessed only claims at Kimbrough ACC for third party collection contractor performance. We did not assess hospital operations at Kimbrough ACC, including the collection of OHI information.

[18] Section 1095, title 10, United States Code, authorizes the DoD to collect reasonable charges from insurance providers for covered beneficiaries.

- medical facility personnel to collect either signed hardcopies or electronic versions of DD Form 2569 annually from 100 percent of beneficiaries.

Although the eight medical facilities complied with the DHA Procedures Manual to have a process to collect either hardcopy or electronic versions of DD Form 2569, actual collection of the OHI information did not always occur. For example, Madigan AMC personnel stated that some patients do not understand the Third Party Collection Program and refuse to provide their health insurance information through the paper forms. While Navy Medicine West and NH Bremerton UBO personnel attempted to improve collection of OHI information by simplifying the form to one page and printing it on colored paper, 8 of 26 NH Bremerton clinics reported zero DD Form 2569 collections from October 2017 through July 2018.[19]

Madigan AMC personnel stated that some patients do not understand the Third Party Collection Program and refuse to provide their health insurance information through the paper forms.

NH Bremerton, NMC San Diego, Madigan AMC, Brooke AMC, 59th Medical Wing, and Fort Belvoir CH personnel did not attempt to collect OHI information at all in pharmacies, despite the DHA UBO User Guide referring to the pharmacy as a significant revenue opportunity for the UBO.[20] The 75th Medical Group and Walter Reed NMMC were the only medical facilities collecting OHI information at pharmacies, and the 75th Medical Group was the only medical facility collecting OHI information consistently. The 75th Medical Group collected patient OHI information at pharmacies by linking the OHI of beneficiaries to “MED Cards,” which beneficiaries can use to expedite picking up prescriptions. Personnel in the 75th Medical Group stated that linking patient OHI to “MED Cards” encourages front desk personnel to update patient OHI information when it expires. Walter Reed NMMC also took action to improve OHI information collection by assigning one UBO staff member to collect beneficiary information in the two main pharmacies. The UBO staff member visits one of the two main pharmacies 4 days a week to collect patient OHI information. However, the UBO staff member does not visit the satellite pharmacy. Because UBO personnel are visiting only one main pharmacy a day to collect OHI information, Walter Reed NMMC is still missing opportunities to collect OHI information at its other two pharmacies.

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[19] Navy Medicine West is the Navy’s health care system in the Western Pacific, providing medical care at medical facilities and dental clinics on the northern and southern U.S. West Coast, Hawaii, Japan, and Guam. NH Bremerton is a subordinate command to Navy Medicine West.

[20] “Defense Health Agency Uniform Business Office User Guide,” May 2018.

Medical facility personnel did not collect the OHI information of beneficiaries because commanders at medical facilities did not enforce the OHI collection process at all clinics. At multiple medical facilities, pharmacy managers stated that they did not want to inconvenience a patient with an administrative task of collecting OHI information. In addition, pharmacy personnel stated that adding an administrative task, such as collecting hardcopy or electronic versions of DD Form 2569, would increase workload for the pharmacy staff and patient wait times, and increase the risk of pharmacy staff missing medication issues. However, at multiple locations, we observed patients waiting to pick up prescriptions at the pharmacy; the beneficiary could use this wait time to fill out the DD Form 2569. Commanders at seven medical facilities should direct personnel at all medical facility clinics and clinical support activities to collect hardcopy or electronic versions of DD Form 2569, and as appropriate, take administrative action for noncompliance. The DHA Director should review all medical facilities in the MHS to determine which medical facilities are not collecting OHI information at all clinics in accordance with DoD regulations, enforce existing OHI collection regulations, and as appropriate, take administrative action for noncompliance.

At multiple locations, we observed patients waiting to pick up prescriptions at the pharmacy; the beneficiary could use this wait time to fill out the DD Form 2569.

In September 2017, NMC San Diego personnel took action to improve collection of OHI information across NMC San Diego clinics by performing a Lean Six Sigma study to identify weaknesses and improve the patient check-in process.[21] NMC San Diego identified that a non-standard patient check-in process may lead to incorrect or inconsistent information, reducing the reimbursement from insurance providers. On April 30, 2019, NMC San Diego issued a Command Instruction to standardize the front desk patient check-in process.[22] The Instruction requires facility personnel to collect hardcopy or electronic versions of DD Form 2569 at all outpatient clinics and pharmacies, at the emergency department, and during inpatient encounters. Because NMC San Diego took action to improve the collection of DD Form 2569, we are not making any recommendations related to the collection of OHI information.

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[21] Lean Six Sigma is a fact-based, data driven philosophy of improvement. Lean Six Sigma drives customer satisfaction and bottom-line results by reducing variation and waste, while promoting the use of work standardization and flow.

[22] NAVMEDCEN San Diego Instruction 6010.45, "Standardized Front Desk Patient Check-In Procedures," April 30, 2019.

Patient Category Code and Encounter Errors at MHS GENESIS Locations Limited Collections

NH Bremerton, Madigan AMC, and DHA personnel did not effectively manage the processing and billing of 26,236 patient encounters processed through MHS GENESIS. For example, patient category code errors on 7,757 patient encounters at NH Bremerton resulted in delayed bills and a significant increase in workload for UBO personnel. In addition, NH Bremerton and Madigan AMC reported 18,479 potentially billable patient encounters missing a credentialed provider, medical coding, or doctor's notes in MHS GENESIS, resulting in potential missed opportunities to collect additional dollars through cost recovery programs.

Patient Category Code Errors

NH Bremerton UBO personnel did not generate bills in a timely manner for 7,757 third party patient encounters with patient category code errors. The DHA Procedures Manual defines a patient category code as a classification that tells whether a patient is billable or not billable, and if billable, the appropriate payment method and rates to apply. Front desk personnel at medical facilities using MHS GENESIS register patients and check the Defense Enrollment Eligibility Reporting System to determine a patient's eligibility and identify the applicable patient category code.[23] If the patient category code field in MHS GENESIS is blank, front desk personnel must select the patient category code before completing the patient's registration; however, the field may already contain the patient category code assigned during the patient's last visit to the medical facility. According to NH Bremerton UBO personnel, the front desk personnel select the patient category code they believe is correct based on the patient's eligibility in the Defense Enrollment Eligibility Reporting System, and rarely challenge an existing patient category if the field is already populated. If front desk personnel select or maintain incorrect patient category codes, every future encounter processed through MHS GENESIS is impacted. When claims are processed, UBO personnel can identify patient category code errors and manually change the patient category code in the Armed Forces Billing and Collection Utilization Solution (ABACUS) system to generate bills through the appropriate cost recovery program. However, this action affects the current claim only and does not correct the patient category code in MHS GENESIS for future encounters. Patient category codes in MHS GENESIS and

[23] The Defense Enrollment Eligibility Reporting System is a personnel data repository of identity, enrollment and eligibility verification data and associated contact information for members of DoD Components, members of the Uniformed Services, and other personnel, as designated by the DoD and their eligible dependents and associated contact information. A dependent is an individual whose relationship to the sponsor leads to entitlement to benefits and privileges.

ABACUS must match for a patient encounter to generate a billable claim in ABACUS. When the codes do not match, ABACUS places the patient encounter in an error listing that awaits resolution.

As of August 7, 2018, NH Bremerton UBO personnel did not generate bills for the 7,757 patient encounters with inaccurate patient category codes. NH Bremerton UBO personnel stated that they must work the 7,757 patient encounters individually to generate a billable claim, at which point ABACUS assigns a dollar value to the encounter and sends the bill to the insurance provider. NH Bremerton UBO personnel stated that it takes on average 5 minutes to clear a patient category code error, requiring an estimated 646 additional staff hours (over 80 workdays) to generate bills for the 7,757 patient encounters with errors.

As of August 7, 2018, NH Bremerton UBO personnel did not generate bills for the 7,757 patient encounters with inaccurate patient category codes.

Due to the patient category codes errors in MHS GENESIS, NH Bremerton UBO incorrectly billed a retired member of the Navy for the total charges of his medication, $95.30. Because the patient was a DoD beneficiary with OHI, NH Bremerton should have billed $95.30 to the patient's insurance provider, at no cost to the retired service member. NH Bremerton UBO personnel identified the claim was billed in error and corrected the patient category code to bill the encounter through the beneficiary's OHI. However, because front desk personnel did not correct the patient category code in MHS GENESIS, NH Bremerton UBO personnel were required to correct this beneficiary's patient category code seven times in the ABACUS system.

The patient category code errors occurred because front desk personnel did not receive clear direction or training on patient category code assignments, and either selected incorrect patient category codes or maintained incorrect patient category codes that were already populated without confirming that the patient category code was accurate. Furthermore, there was no process in place to correct the patient category code in MHS GENESIS when UBO personnel identified the correct patient category code and made the necessary corrections in ABACUS. Until NH Bremerton front desk personnel receive proper training to select the correct patient category codes based on the patient's eligibility in the Defense Enrollment Eligibility Reporting System, and the facility implements a process to correct patient category codes in MHS GENESIS when UBO personnel identify errors, NH Bremerton will continue to operate inefficiently and require significant additional staff hours to generate accurate medical claims. The DHA Director

should coordinate with commanders at all medical facilities operating MHS GENESIS to identify whether other facilities have patient category code errors similar to NH Bremerton, and as appropriate, require front desk personnel to take patient category training at least annually. The DHA Director should also coordinate with commanders at all medical facilities operating MHS GENESIS to develop and implement procedures for correcting patient category codes in MHS GENESIS when patient category code errors are identified. In addition, NH Bremerton will continue to miss opportunities to collect payments through the Third Party Collection Program until UBO personnel resolve the 7,757 patient category code errors and process the claims through ABACUS. We are unable to quantify the dollar impact on the NH Bremerton Program until the patient encounters are converted to proper bills. The Commander of NH Bremerton should resolve the 7,757 encounters with patient category code errors and process the claims through the appropriate cost recovery program.

Patient Encounter Errors

NH Bremerton and Madigan AMC personnel did not manage 18,479 patient encounters missing medical coding or doctor's notes. The DHA Procedures Manual identifies medical records, such as encounter documentation and accurate coding, as an important function of an effective Third Party Collection Program. Medical facility clinic personnel are responsible for assigning the correct resources to a patient's encounter in MHS GENESIS.[24] NH Bremerton personnel stated that after a patient sees the doctor at a medical facility that uses MHS GENESIS, the doctor is responsible for assigning the correct medical code for the visit and signing off on medical notes. Medical facility personnel further stated that MHS GENESIS does not release patient encounter data to the medical coding system until the assigned resource is a credentialed provider and the provider included medical coding and signed notes.[25]

NH Bremerton and Madigan AMC have 18,479 potentially billable patient encounters that are missing medical coding, doctor's notes, or both.

NH Bremerton and Madigan AMC have 18,479 potentially billable patient encounters that are missing medical coding, doctor's notes, or both. NH Bremerton reported that 2,236 patient encounters were

[24] Resources include doctors, nurses, and rooms within the medical facility.

[25] Credentialed providers include medical doctors, nurse practitioners, nurse anesthetists, nurse midwives, podiatrists, optometrists, clinical dietitians, clinical pharmacists, clinical social workers, clinical psychologists, physical therapists, occupational therapists, audiologists, speech pathologists, and physician assistants with the appropriate education, training, licensure, experience, and expertise for the clinical privileges requested.

missing medical coding or signed doctor's notes at the Family Medicine Clinic between September 23, 2017, and August 25, 2018. Madigan AMC reported that 16,243 patient encounters were missing medical coding or signed doctor's notes at all clinics from October 1, 2018, through December 31, 2018. NM Bremerton and Madigan AMC personnel stated that due to system limitations they could not identify which of the 18,479 encounters were billable through the Third Party Collection Program. We reviewed only one clinic at NH Bremerton and only a three-month period for all clinics at Madigan AMC. By running reports covering all clinics from the implementation of MHS GENESIS to the present, NH Bremerton and Madigan AMC could identify thousands more unbilled patient encounters that may be eligible for collection within the Third Party Collection Program.[26]

The unbilled patient encounters occurred because medical facility clinic personnel are not assigning a credentialed provider to a patient's appointment. For example, at Madigan AMC in October 2018, 1,052 patient encounters were scheduled to see "MRI Room 1" or "MRI Room 2" in MHS GENESIS, instead of the credentialed provider who performed the MRI or read the results. Because clinic personnel are not assigning the credentialed provider, these encounters have not been turned into potential billable encounters. Clinic personnel must update the resource information in MHS GENESIS to a credentialed provider for the patient encounter data to flow from MHS GENESIS to the medical coding system. As of January 2019, DHA personnel planned to take action by changing the name of the field in MHS GENESIS so front desk personnel realize they must include a credentialed provider on the patient encounter. While DHA personnel identified this as a "quick win," there was no timetable for implementing their planned solution. The DHA Director should determine whether changing the field name in MHS GENESIS to assist front desk personnel resolved credentialed provider errors at all medical facilities using MHS GENESIS and if not, identify an alternative course of action to assign credentialed providers to patient encounters.

Without processing all patient encounters, NH Bremerton and Madigan AMC are potentially missing the opportunity to collect thousands of additional dollars through cost recovery programs. NH Bremerton and Madigan AMC are unable to quantify the total dollar value of the 18,479 patient encounters and the impact on the Third Party Collection Program until the patient encounters are processed through the medical coding system and the UBO personnel generate bills. The Commanders of NH Bremerton and Madigan AMC should develop a plan and

[26] MHS GENESIS was deployed at NH Bremerton on September 23, 2017, and at Madigan AMC on October 21, 2017.

take action to process, and as applicable, bill all claims not assigned a credentialed provider, or patient encounters missing medical coding or doctor's notes, including the 18,479 patient encounters identified during this audit. The DHA Director should coordinate with commanders at all medical facilities operating MHS GENESIS to identify all patient encounters that are not assigned a credentialed provider or are missing medical coding or doctor's notes, and develop a course of action to process and bill the claims through the appropriate cost recovery program.

DHA and Medical Facility Commanders Need to Provide More Oversight of UBO Personnel's Pursuit of Collection on Third Party Claims

Medical facility UBO personnel did not generate and submit accurate claims in a timely manner and follow up on unpaid claims within the financial services phase of the MHS revenue cycle to improve collections for the Third Party Collection Program. Financial services is the third phase of the revenue cycle and includes claim generation and submission, payer followup, denial management and appeals, payment posting, and performance measurement. The DHA is required to ensure that medical facility UBO operations are cost-effective, result in maximizing authorized collections, and comply with existing Federal laws and regulations.[27] Medical facility personnel supporting the Third Party Collection Program are required to:

- submit insurance claims to insurance providers for reimbursement in compliance with all insurance provider submission requirements;
- follow up to ensure collection activities are processed in accordance with Federal laws, regulations and policies;
- document and report collection activities;
- implement and apply guidelines for complying with the Third Party Collection Program; and
- follow guidance provided in the DHA Procedures Manual and the DoD Financial Management Regulation (FMR).

Medical facility UBO personnel did not submit accurate and timely claims, obtain pre-authorizations, collect on pharmaceutical claims dispensing more than 30 days of pharmaceuticals, follow up on claims in accordance with DoD guidance, challenge

[27] DHA-PM 6015.01, "Military Medical Treatment Facility (MTF) Uniform Business Office (UBO) Operations," October 24, 2017.

invalid denials, or process refunds in a timely manner for 65 of the 70 claims reviewed.[28] See Appendix C for details on the 70 claims reviewed. Table 1 illustrates instances where UBO personnel did not comply with DoD regulations.

Table 1. Claims Where UBO Personnel Did Not Comply With DoD Regulations

	Army	Navy	Air Force	NCR MD	Totals
Coding or Billing Error	7	5	8	7	27
Did Not Transmit Claim	0	0	0	3	3
Did Not Obtain Pre-Authorization	2	0	4	0	6
Did Not Collect Reasonable Charges on Prescriptions	0	0	2	1	3
Did Not Follow Up	17	11	17	8	53
Did Not Challenge Denials	3	1	2	0	6

Note: The table illustrates all reasons UBO personnel did not comply with DoD regulations on a claim. Therefore, the total number of reasons in the table exceeds the total number of claims reviewed.

Source: The DoD OIG.

Claims Were Billed With Errors

UBO personnel at nine medical facilities did not ensure bills were accurate on 27 claims, valued at $1.8 million, before sending the claim to the insurance provider. The DHA Procedures Manual requires billing personnel to accurately prepare and submit third party claims to insurance providers. The Manual also states that for newly identified billable OHI, medical facility personnel should check applicable medical records, the Composite Health Care System, the billing and collection application, and future electronic health record solutions, for prior billable events and verify that claims were filed and payment was received for all services provided during the plan or policy effective dates.

For example, from the 59th Medical Wing, claims 180117P0033410 and 180117P0033394 were both originally billed to the incorrect insurance provider for $17,672 each on April 24, 2018. UBO personnel wrote off both claims in response to the insurance provider's denial. However, when the correct insurance provider was later identified, claim 180117P0033410 was rebilled, and the medical facility received payment of $12,473. UBO personnel did not identify claim 180117P0033394 to be rebilled after it had been written off. UBO personnel stated that they do not review claims once they are written off. During the

[28] DHA-PM 6015.01, "Military Medical Treatment Facility (MTF) Uniform Business Office (UBO) Operations," October 24, 2017.

DoD Financial Management Regulation (FMR) 7000.14-R, Volume 16, Chapter 2, "General Instructions for Collection of Debt Owed to the Department of Defense (DoD)."

"Defense Health Agency Uniform Business Office User Guide," May 2018.

retrieval of documentation for our audit request, UBO personnel re-submitted claim 180117P0033394 to the correct insurance provider and received payment of $12,332 on September 22, 2018.

These 27 claims were billed inaccurately because UBO and DHA personnel did not implement procedures to ensure billing personnel submitted accurate claims to insurance providers. Medical facility UBO personnel stated that they speculate that bills were submitted in error because of incorrect data input into ABACUS. Without checking to ensure claims are accurate before billing, medical facilities will continue to run the risk of not receiving proper reimbursement for the care provided. The DHA Director, in coordination with medical facility commanders, should implement procedures to ensure claims are accurate before submission to the insurance provider. In addition, the DHA Director should coordinate with medical facility commanders to develop a course of action and enforce existing DHA requirements for UBO personnel to review previous patient encounters for potentially billable events when new OHI is identified for a beneficiary.

Claims Were Not Transferred to Insurance Providers

UBO personnel at Walter Reed NMMC did not transfer three claims, valued at $801,586, to the insurance provider until October 2018, after we initiated our audit. The DHA Procedures Manual, dated October 24, 2017, requires billing personnel to prepare and send inpatient claims to the insurance provider immediately upon completion of the medical record and coding. It also requires billing personnel to prepare and send outpatient claims to the insurance provider within 15 business days after the outpatient encounter information and coding for billing is obtained. Before the version published on October 24, 2017, the Manual required billing personnel to prepare and send inpatient claims to the insurance provider within 10 business days following completion of the medical record and coding, and outpatient claims to be prepared and sent within 17 business days after the outpatient encounter information and coding for billing is obtained.[29]

UBO personnel at Walter Reed NMMC did not transfer three claims, valued at $801,586, to the insurance provider until October 2018, after we initiated our audit.

The ABACUS system automatically generates and submits electronic claims for billable encounters to insurance providers. UBO personnel at Walter Reed NMMC stated that the ABACUS system sets aside high dollar claims for UBO personnel to

[29] Of the 70 claims reviewed, 20 claims were billed after October 24, 2017, requiring UBO personnel to follow DHA Procedure Manual 6015.01, dated October 24, 2017. Two claims were duplicates and were not billed to an insurance provider. The remaining 48 claims were billed on or before October 24, 2017, requiring UBO personnel to follow the requirements in DoD Manual 6010.15-M, dated November 2006.

review before transmittal to the insurance provider. The purpose of the review was to identify any errors that may have caused the claim to reach a high dollar threshold and to increase the likelihood of claim approval. UBO personnel further stated that they occasionally overlook these claims and never submit them to the insurance providers.

For example, from Walter Reed NMMC, claims 170067P0175624 and 170067P0183468 were originally generated in ABACUS on July 13, 2017, and August 2, 2017, for $263,413 each. ABACUS set these claims aside for UBO personnel to review due to the high dollar values, but UBO personnel did not identify and review the claims until the audit team's request. Once UBO personnel identified these claims, they also identified a pharmaceutical quantity error on each claim, and as a result, the billed amounts were reduced to $65,853 each. The UBO personnel could not identify the cause of the quantity error. UBO personnel then submitted the claims to the insurance provider on October 27, 2018, 352 and 332 days after the claims were initially generated. As of March 12, 2019, Walter Reed NMMC had not received payment on the two claims.

ABACUS set these claims aside for UBO personnel to review due to the high dollar values, but UBO personnel did not identify and review the claims until the audit team's request.

These claims were not transmitted to the insurance provider before our audit because UBO personnel relied on ABACUS's automated billing functions and did not verify that all claims in the high dollar review bucket were billed. Walter Reed NMMC personnel stated that they did not implement standard procedures for reviewing claims held by ABACUS for review. Until the DHA and medical facility commanders implement standard procedures for reviewing claims held by ABACUS, medical facilities may not collect all billable encounters. The Director of Walter Reed NMMC should implement procedures requiring UBO personnel review and submit bills to insurance providers in compliance with the time requirements in the DHA Procedures Manual, including procedures for high dollar claims held for review within ABACUS. The DHA Director should review all medical facilities within the MHS to determine which medical facilities are not submitting claims to insurance providers in compliance with the time requirements in the DHA Procedures Manual, and coordinate with those commanders to implement additional controls to enforce the requirements.

Claims Did Not Receive Proper Pre-Authorization

UBO personnel at three medical facilities did not obtain pre-authorization on six claims, valued at $168,797. Additionally, UBO personnel at one medical facility did not submit three of the claims in accordance with the DHA Procedures Manual, which would have allowed adequate time for billing personnel to obtain pre-authorization.[30] The DHA UBO User Guide explains that some payers require approval of an admission, a procedure, a drug, or supply before furnishing it or at the time of service before they will reimburse a medical facility. The Guide recommends that processes be in place for admissions personnel to notify billing personnel when a patient is admitted and for billing personnel to identify procedures that require pre-authorization. The Guide also states that failure to obtain pre-authorization may require additional "clinical review" and subject claims to a reduction in reimbursement. According to some UBO personnel, they pursue retroactive authorizations when they receive denials for pre-authorization.

From the 75th Medical Group, claim 160119P0012427, valued at $20,408, was lost because medical facility personnel did not obtain pre-authorization. The DHA Procedures Manual required the transmission of the outpatient claim to be prepared and sent within 17 business days; however, the claim was not transmitted to the insurance provider until 213 days after the encounter. Filing of the initial claim in accordance with the DHA Procedures Manual would have provided billing personnel sufficient time to obtain retroactive authorization for the claim, and increased the likelihood of full reimbursement.

From the 75th Medical Group, claim 160119P0012427, valued at $20,408, was lost because medical facility personnel did not obtain pre-authorization.

These six claims did not receive reimbursement because UBO and DHA personnel did not implement procedures that require UBO personnel to submit timely pre-authorization requests to insurance providers. Additionally, UBO personnel at the 75th Medical Group stated that there were no processes in place to inform the billing personnel when a medical facility admits a patient with OHI and pre-authorization is required. Without procedures to make certain UBO personnel obtain pre-authorization when required, medical facilities will continue to receive denials from insurance providers for care requiring pre-authorization. The Commanders of Madigan AMC, Brooke AMC, and the 75th Medical Group should review and modify procedures for obtaining pre-authorization when beneficiaries receive services at the medical facility that require pre-authorization from the

[30] The November 2006 DHA Procedures Manual required the third party collection office to prepare and send inpatient claims to the insurance provider within 10 business days following completion of the medical record and coding, and outpatient claims to be prepared and sent within 17 business days after the outpatient encounter information and coding for billing is obtained.

insurance provider. The DHA Director should review all medical facilities within the MHS to determine which medical facilities are not obtaining pre-authorization for treatment, and coordinate with those medical facility commanders to develop and implement a process for obtaining pre-authorization when services rendered for a beneficiary require a pre-authorization from the insurance provider.

Medical Facility UBO Personnel Did Not Collect Reasonable Charges on Pharmaceutical Claims

UBO personnel at three medical facilities did not collect on three pharmaceutical claims, valued at $82,947.40, for which the pharmacies dispensed more than a 30-day supply of pharmaceuticals. Section 1095, title 10, United States Code, authorizes medical facilities to collect reasonable charges for health care services incurred. The DHA UBO User Guide identifies pharmaceuticals as a significant opportunity for medical facility revenue; however, DHA guidance does not address pursuing collection for allowable charges on a 90-day prescription when an insurance policy may cover only a 30-day prescription. For example, from Fort Belvoir CH, claim 176201P0118702 was billed for $19,688 on May 15, 2018, for a 90-day supply of pharmaceuticals. The same day, the medical facility received a denial from the insurance provider stating that the maximum supply covered by the insurance policy was 30 days. On August 9, 2018, billing personnel wrote off the claim entirely, instead of attempting to collect at least a third of the total amount by working with the insurance provider. UBO personnel stated that some insurance providers were willing to pay for at least 30 days.

UBO personnel at three medical facilities did not collect on three pharmaceutical claims, valued at $82,947.40, for which the pharmacies dispensed more than a 30-day supply of pharmaceuticals.

Billing personnel did not collect on these three claims because medical facilities and the DHA did not enforce collection of reasonable charges from the insurance providers as allowed by section 1095, title 10, United States Code, and did not require billing personnel to follow up to collect the allowable portion of the three claims. Until the DHA and billing personnel work with insurance providers to collect reasonable charges for the allowable portion of pharmaceutical claims, medical facilities will continue to lose money and will not improve collections on pharmaceutical claims that are ordered for more than a 30-day supply. The DHA Director should report the dollar impact of not collecting on prescriptions written for more than a 30-day supply and implement procedures to require medical facility UBO personnel to collect at least the reasonable charges on pharmaceutical claims equal to the allowable portion covered by insurance policies.

Medical Facility UBO Personnel Did Not Comply With DoD Regulations to Follow Up on Claims

UBO personnel at nine medical facilities did not follow up on 53 claims, valued at $2.1 million, as required by the DHA Procedures Manual and DoD FMR. The DHA Procedures Manual, October 24, 2017, states that billing personnel must conduct written or telephone followup if reimbursement is not received within 30 calendar days of the date the claim was generated or other intervals as specified by Military Department or DHA-specific guidance. Before October 24, 2017, the DHA Procedures Manual required billing personnel to follow up by telephone or in writing if reimbursement was not received within 60 days of the initial claim submission and again at 90 days. Furthermore, the DoD FMR requires the agency to promptly and aggressively initiate collection action on all established debts owed to the DoD and complete followup actions to ensure successful repayment to the DoD.[31] While the FMR does not define "aggressive," DHA UBO training presentations define ideal followup activity at 30, 45, 60, and 90 days. The DHA UBO training presentations further explain that effective followup seeks to bring accounts to full resolution. Followup is crucial to establishing due process before using alternative collection procedures. Billing personnel waited as long as 863 days to follow up on the 53 claims. Table 2 lists the claim at each medical facility reviewed with the longest period without followup.

Table 2. Longest Period Without Follow up on a Sample Claim by Medical Facility

Site	Longest Period Without Followup on a Sample Claim (Days)
NH Bremerton	277
NMC San Diego	379
Madigan AMC	479
Brooke AMC	458
Kimbrough ACC	302
75th Medical Group	863
59th Medical Wing	747
Walter Reed NMMC	731
Fort Belvoir CH	287

Source: The DoD OIG.

[31] DoD Financial Management Regulation (FMR) 7000.14-R, Volume 16, Chapter 2 "General Instructions for Collection of Debt Owed to the Department of Defense (DoD)."

For example, from Walter Reed NMMC, claim 170067P0067583 was initially billed on January 31, 2017, for $36,920. Medical facility UBO personnel did not followup on this claim until October 22, 2018, 629 days later. The UBO manager stated that limited resources within the UBO resulted in the failure to followup on this claim, and the 101,042 claims, valued at $39.2 million, that were more than 120 days old as of June 30, 2018. The UBO at Walter Reed NMMC has yet to receive payment or denial on claim 170067P0067583; therefore, the claim remains open and potentially collectible.

Medical facility UBO personnel did not followup on this claim until October 22, 2018, 629 days later.

These 53 claims did not comply with the DHA Procedures Manual and DoD FMR regulations to follow up on claims and pursue aggressive collection efforts because UBO and DHA personnel did not implement procedures to ensure billing personnel followed up on claims in accordance with DoD FMR and DHA guidance. For 19 of the 53 claims, UBO personnel could not provide a reason why claims had no followup. Until billing personnel comply with followup requirements outlined in the DoD FMR and the DHA Procedures Manual, medical facilities will continue to not collect on claims as well as meet due process requirements in order to use alternative collection procedures. Commanders at the nine medical facilities should review and modify procedures for followup so claims can be transferred to the appropriate debt collection agency once they are 120 days delinquent. The DHA Director should review all medical facilities within the MHS to determine which medical facilities are not conducting followup in compliance with the DHA Procedures Manual, and coordinate with medical facility commanders to immediately revise procedures to ensure claims are followed up on in accordance with the DHA Procedures Manual and DoD FMR requirements. Finally, the DHA Director should review and verify at least annually that billing personnel across the MHS are meeting the DHA Procedures Manual and DoD FMR requirements to follow up on delinquent debt.

UBO Personnel Did Not Challenge Denials

UBO personnel at three medical facilities did not challenge six potentially invalid denials, valued at $87,102, to pursue further collection with insurance providers. The DHA Procedures Manual requires medical facilities to have denial management protocols and processes to review and adjudicate all insurance provider denials. The Manual further requires followup on all invalid claim denials.

For example, from the 75th Medical Group, claim 170119P0017768, valued at $5,884, was billed on August 31, 2017, and denied on September 1, 2017, because the insurance provider required that a specialty drug be filled at

a specific pharmacy.[32] The total claim of $5,884 was written off on January 18, 2018. In response to our audit, the 75th Medical Group personnel reprocessed the sample claim, and the medical facility received full payment. The beneficiary on claim 170119P0017768 had 30 other similar claims outside our sample with dates of service both before and after the date of service for the claim in our sample. In these 30 other claims, the 75th Medical Group personnel billed the insurance providers and received $74,935 on 15 of the claims, but the other 15 claims were either fully written off or awaiting resolution. The Commander of the 75th Medical Group should review the remaining 15 claims to determine whether they are still awaiting resolution or were written off for valid reasons, and if not, re-bill the claims to the insurance provider.

In response to our audit, the 75th Medical Group personnel reprocessed the sample claim, and the medical facility received full payment.

Medical facility UBO personnel did not collect up to $87,102 on these six claims because UBO and DHA personnel did not implement procedures to ensure billing personnel scrutinized or aggressively appealed insurance provider denials. UBO billing personnel stated that some insurance providers routinely denied claims to delay payment. Without implementing procedures to challenge potentially invalid denials, medical facilities will continue to write off claims that should have received reimbursement. Commanders at NH Bremerton, Madigan AMC, and the 75th Medical Group should develop and implement procedures for reviewing and validating denials before writing off claims, and implement procedures to process denials by beneficiary. The DHA Director should review the denials management programs of all medical facilities and, when applicable, coordinate with medical facility commanders to develop and implement procedures for reviewing and validating denials before writing off claims, and implement procedures to process denials by beneficiary.

Refunds Were Not Processed Back to Insurance Providers in Accordance With the DHA Procedures Manual

UBO personnel at the 75th Medical Group did not process refunds back to the insurance provider in accordance with the DHA Procedures Manual. In the 70 claims reviewed, we identified one refund from the 75th Medical Group, valued at $168,099, which was not processed back to the insurance provider. In addition to the claim in our sample, we identified two more claims on which refunds were not processed back to the insurance provider, valued at $337,688, when reviewing all claims processed by the 75th Medical Group between October 1, 2015, and

[32] Claim 170119P0017768 was for a 60-day supply of Tecfidera, which was considered a specialty drug by the beneficiary's insurance plan.

June 30, 2018. The DHA Procedures Manual requires refunds to be processed through the medical facility's supporting Defense Finance and Accounting Service office. In addition, the DHA UBO User Guide requires medical facility personnel to use the ABACUS refund reconciliation program when overpayments are received for claims. The refund reconciliation program allows users to locate and track accounts with a negative balance that may need to be refunded to the original source after approval from the Defense Finance and Accounting Service.

From the 75th Medical Group, claim 160119P0010208 was overpaid $168,099 due to a pharmaceutical quantity error on the original bill. The 75th Medical Group personnel identified the overpayment on January 25, 2017, and notified the insurance provider to request a refund. However, the 75th Medical Group personnel have not taken action on the claim since January 2017, and the insurance provider has not submitted a refund request for the overpayment. Furthermore, the beneficiary had two other claims with similar billed amounts and overpayments awaiting refund requests within the medical facility data. The three claims total $505,787 of overpayments and are equal to approximately 35 percent of the average annual third party collections at the medical facility.[33] For claim 160119P0010208, UBO billing personnel have not taken action on the overpaid claim for 589 days.

The three claims total $505,787 of overpayments and are equal to approximately 35 percent of the average annual third party collections at the medical facility.

Medical facility UBO personnel did not issue refunds to insurance providers for overpaid claims because they stated that they are unable to process refunds through the Defense Finance and Accounting Service without a refund request from the insurance provider. However, billing personnel explained that insurance providers do not always provide refund requests even after prompting from billing personnel. Without procedures for processing refunds that require a request for funds from the insurance provider, medical facilities will continue spending funds they are not entitled to spend. The Commander of the 75th Medical Group should identify the impact a $505,787 refund would have on the 75th Medical Group's operations and maintenance budget and take appropriate action to mitigate any impact on its mission. The DHA Director should review all medical facilities within the MHS to determine which medical facilities are not managing claims requiring refunds, and as appropriate, coordinate with medical facility commanders to

[33] The average annual third party collections for the 75th Medical Group from FYs 2015 through 2017 was $1.44 million.

initiate refunds to insurance providers, identify funds spent that the medical facility was not entitled to spend, and take action to mitigate any risk to the medical facilities' mission.

Claims Were Not Transferred to the Treasury Cross-Servicing Program or the Local Judge Advocate Office

UBO personnel at nine medical facilities did not transfer delinquent debts to the Treasury Cross-Servicing Program or local JA office as required by the public law and the DHA Procedures Manual. Public law requires agencies to transfer debts to the Treasury Cross-Servicing Program for collection when debts are delinquent for more than 120 days.[34] The DHA Procedures Manual requires that when all efforts to collect on a valid claim have been exhausted, the responsible Third Party Collection Program office must refer accounts receivable to its local JA office or the Treasury Cross-Servicing Program for action if the claims are delinquent for more than 120 days.

For the 70 claims reviewed, UBO officials did not transfer 33 of the 70 claims to the Treasury for collection assistance and did not transfer 30 of 70 claims to the local JA office.[35]

Medical Facilities Did Not Transfer Claims to the Treasury Cross-Servicing Program for Collection Assistance

UBO personnel at nine medical facilities did not transfer 33 of the 70 claims reviewed, valued at $1.3 million, to the Treasury Cross-Servicing Program for additional collection assistance, as required by public law and the DHA Procedures Manual. For example, as of October 23, 2018, claim 170123T0124376 at Fort Belvoir CH, was 319 days old with a balance of $14,740. On September 7, 2017, Fort Belvoir CH received a partial payment from the insurance provider; however, the remaining balance of $14,740 was denied for out-of-network services. Public law states that insurance providers may not require a medical facility to enter into a participation agreement or other contractual vehicle as a condition of payment, or deny claims or reduce payment because a Government medical facility rendered care.[36] Between September 12, 2017, and October 23, 2018, Fort Belvoir UBO personnel followed up with the insurance provider nine times and requested the insurance provider escalate to a manager five times. The insurance provider ignored written appeals and did not pay the remaining balance owed. The UBO at Fort Belvoir CH could

[34] Public Law 104-134, Chapter 10, section 31001, "The Debt Collection Improvement Act of 1996." On May 9, 2014, Public Law 113-101, "Digital Accountability and Transparency Act of 2014," amended subsection 3716 (c)(6) of section 37, title 31, United States Code, by reducing the time period for transferring debt from 180 days to 120 days.

[35] Of the 70 claims, 37 claims did not meet the criteria to be sent to the Treasury or local JA office for collection assistance.

[36] Section 1095, title 10, United States Code.

send the remaining balance of $14,740 to the Treasury Cross-Servicing Program as required by public law and the DHA Procedures Manual, once due process was completed. However, Fort Belvoir CH UBO personnel stated that they did not have procedures to send claims to the Treasury Cross-Servicing Program.

NH Bremerton and NMC San Diego were the only two medical facilities that transferred claims to the Treasury Cross-Servicing Program for collections assistance, but they did not transfer all claims that were delinquent for more than 120 days.

NH Bremerton and NMC San Diego were the only two medical facilities that transferred claims to the Treasury Cross-Servicing Program for collections assistance, but they did not transfer all claims that were delinquent for more than 120 days. In April 2018, Navy Medicine West established procedures for transferring Third Party Collection Program claims to the Treasury Cross-Servicing Program. Following the Navy Medicine West guidance, NH Bremerton transferred 772 claims, valued at $85,884, to the Treasury Cross-Servicing Program between August 23, 2018, and October 23, 2018. As of September 17, 2018, NMC San Diego transferred 90 claims, valued at $46,059, to the Treasury Cross-Servicing Program.

We determined that 33 of the 70 claims reviewed were not transferred to the Treasury Cross-Servicing Program because DHA and the UBO personnel at seven of the nine medical facilities did not have procedures in place to implement Federal and DoD regulations to transfer claims to the Treasury Cross-Servicing Program. While Navy Medicine West established guidance, and NH Bremerton and NMC San Diego both transferred claims to the Treasury Cross-Servicing Program, additional work across the DHA is needed to transfer all third party claims that are delinquent for more than 120 days to the Treasury Cross-Servicing Program for additional collections. Personnel from the Air Force and NCR MD stated that they were not aware that they could transfer Third Party Collection Program claims to the Treasury Cross-Servicing Program. Commanders at the nine medical facilities should review all outstanding third party claims that are delinquent for more than 120 days to determine which claims are eligible for transfer to the Treasury Cross-Servicing Program or local JA office, and transfer eligible claims for collection assistance. The DHA Director should review all medical facilities in the MHS and determine which facilities are not transferring eligible third party claims that are delinquent for more than 120 days to the Treasury Cross-Servicing Program, and enforce Public Laws 104-134 and 113-101, which require medical facilities to transfer eligible delinquent claims to the Treasury Cross-Servicing Program. As appropriate, the DHA Director should take administrative action for noncompliance.

Medical Facilities Did Not Use Local Judge Advocate Offices for Collection Assistance

UBO personnel at the nine medical facilities did not transfer 30 of the 70 claims reviewed, valued at $1 million, to local JA offices for collection assistance, as required by the DHA Procedures Manual. The DHA Procedures Manual requires the responsible Third Party Collection Program office to refer accounts receivable that are delinquent for more than 120 days to its local JA office or the Treasury for collection assistance. However, at eight of the nine medical facilities, medical facility UBO personnel stated that they did not have legal support to work claims related to their Programs. Some medical facility UBO personnel stated that the local JA office will support only the Medical Affirmative Action or Medical Service Account programs, and not Third Party Collection Program claims, because third party collection does not return enough money for the effort.

For example, on April 26, 2017, Madigan AMC UBO personnel submitted claim 170125T0038494, valued at $162,050, to an insurance provider and were denied payment, despite making 13 attempts to collect. On January 16, 2018, Madigan AMC placed this claim in the "Pending Transfer to Legal" status within ABACUS. UBO personnel stated that they did this despite knowing that the legal personnel at Madigan AMC do not use ABACUS and would not take action on the claim. Madigan AMC legal personnel stated that they do not have the personnel to process claims unless the claims resulted from a systemic problem that covers multiple providers. As of August 8, 2018, the claim remained open for 469 days. In May 2019, Madigan AMC UBO personnel stated that they began a process of transferring claims with systemic issues to the local JA staff for collection action.

On January 16, 2018, Madigan AMC placed this claim in the "Pending Transfer to Legal" status within ABACUS. UBO personnel stated that they did this despite knowing that the legal personnel at Madigan AMC do not use ABACUS and would not take action on the claim.

As a result of our audit, in August 2018, Brooke AMC UBO personnel started working with an Army paralegal working on behalf of the U.S. Army Medical Command Staff Judge Advocate, and under the supervision of an attorney, who has experience helping UBOs to compromise, waive, or settle third party claims with insurance providers. Of the six claims reviewed at Brooke AMC, three claims were transferred to the Army paralegal, resulting in Brooke AMC receiving a payment of $30,085.

Outside of the 70 claims we reviewed, the Army paralegal worked directly with numerous insurance providers to resolve systemic problems, including out-of-network denials, professional fee denials, and pharmacy denials impacting collections across Army and DoD medical facilities.[37] For example, the paralegal worked with CVS Caremark to address wrongly denied claims that the insurance provider should have automatically reprocessed, but did not. After the paralegal brought the issue to the insurance provider's attention, CVS Caremark corrected the problem and reprocessed 68,104 denied claims across all DoD medical facilities, which resulted in an estimated $5 million in collections. In addition, the paralegal's efforts helped DoD medical facilities collect $16.2 million from eight insurance providers for problems related to out-of-network, professional fee, and pharmacy denials.

In addition, the paralegal's efforts helped DoD medical facilities collect $16.2 million from eight insurance providers for problems related to out-of-network, professional fee, and pharmacy denials

Medical facilities did not transfer claims to local JA offices because UBO personnel at the medical facilities stated that they did not have the legal support to perform additional collection activities on claims. Local JA support can have a positive impact on collections, as shown by the efforts of the Army paralegal, and without adequate legal support, medical facilities will continue leaving millions of dollars uncollected within the Third Party Collection Program and mismanaging delinquent claims. Commanders at the nine medical facilities should provide sufficient legal support to pursue collections through the Third Party Collection Program. Furthermore, the DHA Director should review all medical facilities in the MHS to determine which medical facilities are not providing legal support to the UBO, coordinate with commanders at medical facilities to provide legal support to collect on Third Party Collection Program claims, and report on the benefits of the DHA providing centralized legal resources for all DoD medical facilities to support cost recovery programs.

[37] The Army paralegal helped other DoD medical facilities resolve outstanding claims with insurance providers by identifying and resolving systemic problems related to Army medical facilities.

Insufficient Contract Terms and Lacking Oversight Led to Deficiencies in the Contractor's Performance

The DoD's third party collection contractor did not conduct followup, document followup actions, or elevate claims for collection assistance in accordance with Federal and DoD regulations for 18 of 23 claims in our sample.[38] The Army, NCR MD, and Air Force used a contractor to perform billing functions on 23 of our sample claims, valued at $404,250. The 23 claims included:

- 6 claims, valued at $185,480, from Kimbrough ACC;
- 6 claims, valued at $132,141, from Fort Belvoir CH;
- 6 claims, valued at $26,692, from the 75th Medical Group at Hill Air Force Base; and
- 5 claims, valued at $59,937, from the 59th Medical Wing at Lackland Air Force Base.[39]

The deficiencies occurred because Army, NCR MD, and Air Force medical facility and contracting personnel did not write the third party collection contract to fully comply with Federal and DoD regulations governing the Third Party Collection Program. Additionally, Army, NCR MD, and Air Force contracting personnel did not implement adequate oversight procedures to identify and address deficiencies in the contractor's performance, ensure medical facility compliance with Federal and DoD regulations, and collect all available funds through the Third Party Collection Program.

The DoD Did Not Adequately Structure Third Party Collection Contracts

Army, NCR MD, and Air Force medical facility and contracting personnel did not write the third party collection contracts to require the contractor to promptly and aggressively initiate collection action, conduct followup, and elevate claims for collection assistance.

[38] Public Law 104-134, chapter 10, section 31001, "The Debt Collection Improvement Act of 1996." On May 9, 2014, Public Law 113-101, "Digital Accountability and Transparency Act of 2014," amended sub-section 3716(c)(6) of section 37, title 31, United States Code, by reducing the time period for transferring debt from 180 days to 120 days.
DoD Financial Management Regulation (FMR) 7000.14-R, Volume 16, Chapter 2, "General Instructions for Collection of Debt Owed to the Department of Defense (DoD)."
DoD 6010.15-M, "Military Treatment Facility Uniform Business Office Manual," November 2006.
DHA-PM 6015.01 "Military Medical Treatment Facility (MTF) Uniform Business Office (UBO) Operations," October 24, 2017.

[39] The 23 claims reviewed for contractor performance fell within the scope of the review and were covered under active third party collection contracts. Twelve additional claims were covered under third party collection contracts; however, those contracts were inactive during the scope of the review.

Army and NCR MD Contracts

Army and NCR MD medical facility and contracting personnel did not write the contract performance work statements to ensure that the contractor conducted followup, input notes in ABACUS to document evidence of followup, or elevated claims for collection assistance in accordance with Federal and DoD regulations.[40] Specifically, the contract performance work statements required the contractor to follow up on claims if payment was not received within 60 days from the date the original claim was submitted to the insurance provider. These contract terms only partially complied with the DHA Procedures Manual requirement in place at the time the contract was awarded, which required UBO personnel to follow up within 60 days of claim submission and again at 90 days, and did not comply with the revised DHA Procedures Manual requirement to conduct followup within 30 days.[41] Additionally, the contract performance work statements did not require the contractor to coordinate with medical facility UBOs to transfer claims that are delinquent for more than 120 days to the Treasury Cross-Servicing Program for collection assistance in accordance with public law and the DoD FMR.[42] The contract performance work statements required the contractor to coordinate with medical facility UBOs to refer delinquent claims to the local JA offices if the claims were not resolved within 180 days after initial billing but no more than 270 days after the date of service unless there is clear evidence the claim would be paid. These requirements complied with the DHA Procedures Manual requirement in place at the time the contract was awarded, but did not comply with the revised DHA Procedures Manual requirement to refer claims for collection assistance if they are delinquent for more than 120 days.

Air Force Contract

The contract performance work statement required the contractor to perform active and aggressive followup for all unpaid or underpaid claims at least every 30 days, and annotate notes within ABACUS to provide evidence of followup.

[40] A performance work statement is a document that accurately describes a service in terms of job performance requirements and the required quality level or standard of acceptable performance of those outputs.

[41] DoD 6010.15-M, "Military Treatment Facility Uniform Business Office Manual," November 2006.
DHA-PM 6015.01, "Military Medical Treatment Facility (MTF) Uniform Business Office (UBO) Operations," October 24, 2017.

[42] Public Law 104-134, chapter 10, section 31001, "The Debt Collection Improvement Act of 1996." On May 9, 2014, Public Law 113-101, "Digital Accountability and Transparency Act of 2014," amended sub-section 3716(c)(6) of section 37, title 31, United States Code, by reducing the time period for transferring debt from 180 days to 120 days.
DoD Financial Management Regulation (FMR) 7000.14-R, Volume 16, Chapter 2 "General Instructions for Collection of Debt Owed to the Department of Defense (DoD)."

However, Air Force medical facility and contracting personnel did not write the contract to require the contractor to comply with Federal and DoD regulations to elevate claims for collection assistance. Specifically, the contract performance work statement required the contractor to stop collection activity on claims that are delinquent for more than 150 days and transfer the claims back to the Government for transfer to the local JA office or Treasury Cross-Servicing Program. This requirement complied with the DHA Procedures Manual requirement in place at the time the contract was awarded to transfer claims to the local JA office within 180 days post initial billing, but did not comply with the revised requirement to transfer claims that are delinquent for more than 120 days to the local JA office. In addition, the performance work statement requirement did not align with public law and the DoD FMR requirements to transfer claims that are delinquent for more than 120 days to the Treasury Cross-Servicing Program for collection assistance.

Air Force medical facility and contracting personnel did not write the contract to require the contractor to comply with Federal and DoD regulations to elevate claims for collection assistance.

The DoD Did Not Implement Adequate Contractor Oversight Procedures

Army, NCR MD, and Air Force contracting personnel did not implement adequate oversight procedures to certify that the contractor complied with Federal and DoD regulations and contract performance work statement requirements to promptly and aggressively initiate collection action, conduct followup, and elevate claims for collection assistance.

Army Oversight

The Army contract included a quality assurance surveillance plan, which required the contracting officer's representative to perform surveillance of the contractor's performance.[43] Army contracting personnel prepared monthly reports on the contractor's quality of work, including whether the contractor was up-to-date in submitting or performing required activities, and report on contract progress and contractor deficiencies identified. Army contracting personnel also prepared a contractor performance assessment report that measured the contractor's performance in the areas of quality, schedule, cost control, and management for

[43] The quality assurance surveillance plan is a Government-developed document used to determine whether the contractor's performance meets the performance standards outlined in the contract and performance work statement. The quality assurance surveillance plan establishes procedures on how to conduct surveillance and inspections to ensure successful performance work statement performance.

Army contracting personnel did not identify any deficiencies in the contractor's performance in the monthly reports or the most recent contractor performance assessment report to indicate the Army was aware that the contractor did not meet the requirements of the contract performance work statement.

the period of July 1, 2017, through June 30, 2018.[44] However, Army contracting personnel did not identify any deficiencies in the contractor's performance in the monthly reports or the most recent contractor performance assessment report to indicate the Army was aware that the contractor did not meet the requirements of the contract performance work statement. For example, the contractor did not bill the six claims reviewed for Kimbrough ACC in accordance with the DHA Procedures Manual. According to contractor personnel, for four of the six claims, the contractor experienced difficulties submitting bills to the insurance providers because of the changes the providers put in place for claims submission, and the contracted personnel had to relearn how to submit claims. This resulted in the contractor not resubmitting the claims for 175 to 302 days after the original bill dates. Additionally, the contractor did not conduct any followup on the claims after resubmitting them to the insurance providers, resulting in up to 150 additional days without followup as of October 22, 2018. Because Army contracting personnel did not identify and address these deficiencies in performance by the contractor, Kimbrough ACC may not collect up to $126,224.

NCR MD Oversight

The NCR MD contract included a quality assurance surveillance plan, which required the contracting officer's representative to perform surveillance of the contractor's performance. However, the contracting officer for the NCR MD third party collections contract stated that he did not assign a contracting officer's representative for the NCR MD third party collections contract. The contracting officer also stated that because the physical location of the contractor was not at Fort Belvoir CH, it was his understanding that the NCR MD did not need a contracting officer's representative.

According to the Federal Acquisition Regulation, the contracting officer is responsible for retaining and executing the contracting officer's representative duties if the contracting officer does not assign a representative.[45] Instead of performing those duties directly, the contracting officer unofficially assigned an official to perform some duties normally performed by a contracting officer's representative, but the official did not perform all surveillance required by

[44] The Federal Acquisition Regulation requires agencies to prepare past performance evaluations in the Contractor Performance Assessment Reporting System at least annually and at the time the work under a contract or order is completed. Source selection officials rely on clear and timely evaluations of contractor performance to make informed business decisions when awarding government contracts and orders.

[45] Federal Acquisition Regulation Subpart 1.602-2, "Responsibilities," January 22, 2019.

the quality assurance surveillance plan. For example, the quality assurance surveillance plan required the contracting officer's representative to maintain a log to ensure the contractor complied with all tasks in the performance work statement. According to NCR MD personnel, the contracting officials did not maintain the log. Furthermore, NCR MD personnel stated that the contractor conducted its own surveillance and there is nothing to observe because NCR MD personnel did not instruct the contractor how to conduct day-to-day operations. The contractor provided NCR MD personnel with monthly performance reports that NCR MD personnel used to assess the contractor's performance. However, NCR MD personnel did not ensure the performance reports included metrics necessary to identify whether the contractor conducted followup, documented followup actions, or elevated claims for collection assistance in accordance with Federal and DoD regulations. In addition, the contracting officer did not prepare contractor performance assessment reports for this contract, as required by the Federal Acquisition Regulation and Defense Federal Acquisition Regulation Supplement.[46] Therefore, the contracting officer did not identify and document that the contractor did not conduct followup, document followup actions, or elevate claims for collection assistance.

NCR MD personnel did not ensure the performance reports included metrics necessary to identify whether the contractor conducted followup, documented followup actions, or elevated claims for collection assistance.

Air Force Oversight

We identified that Air Force contracting personnel did not conduct any reviews to ensure the contractor followed up on unpaid or underpaid claims at least every 30 days or annotated followup actions within ABACUS. Air Force contracting personnel also stated that they relied on ABACUS-generated notifications to remind the contractor to conduct followup actions. The Air Force contract performance work statement required the contractor to perform followup actions for all unpaid or underpaid claims at least every 30 days and annotate all followup efforts within ABACUS. The performance work statement also required the contractor to complete and close claims before the 150th day of delinquency and transfer all remaining open claims back to the Government on the 151st day of delinquency. However, the contractor did not perform followup actions at least every 30 days or annotate evidence of followup actions for 8 of 11 Air Force claims reviewed. The contractor also did not complete and close 5 of 11 claims before

[46] Federal Acquisition Regulation Subpart 42.15, "Contractor Performance Information," January 22, 2019. Defense Federal Acquisition Regulation Supplement Subpart 242.15, "Contractor Performance Information," April 13, 2018.

to the 150th day of delinquency or transfer the claims back to the medical facility UBO. Air Force contracting personnel stated that the contractor has not transferred a single claim back to the Air Force, and Air Force contracting personnel have not taken any action to correct the contractor's deficient performance.

Air Force contracting personnel stated that the contractor has not transferred a single claim back to the Air Force, and Air Force contracting personnel have not taken any action to correct the contractor's deficient performance.

The quality assurance surveillance plan included a summary surveillance report template that the contracting officer's representative was required to complete on a monthly basis to assess the performance standards in the performance work statement. However, Air Force contracting personnel stated that they did not fill out the monthly summary surveillance reports and they relied on the contractor to self-report on its performance. The contracting officer's representative used performance reports that the contractor provided each month to identify whether the contractor was performing in accordance with the contract performance work statement. However, the performance reports did not include metrics that identified whether the contractor followed up on claims at least every 30 days and annotated notes within ABACUS, or whether the contractor complied with Federal and DoD regulations. Therefore, it was not adequate for Air Force contracting personnel to rely on these reports alone to assess the contractor's compliance with all performance work statement requirements and Federal and DoD regulations.

In addition, the contractor's performance reports clearly identified areas where the contractor was not performing in accordance with the contract performance work statement. For example, a performance objective stated that the contractor's gross collected-to-billed ratio should not drop below 35 percent. According to the performance reports, the contractor's gross collected-to-billed ratio was below 35 percent for several months. However, Air Force contracting personnel have not taken action to remedy the deficiencies with the contractor's performance. Air Force contracting personnel stated that they plan to remove several performance objectives from the contract performance work statement for the next Air Force third party collections contract because they believe the objectives were not measurable. Air Force contracting personnel also stated that they intend to reduce the requirements of some performance objectives because the contractor consistently did not meet the standards. Air Force contracting personnel did not identify the contractor's deficiencies in performance on its most recent contractor performance assessment report.

Contracting Personnel Should Ensure Contract Terms Comply With Federal and DoD Regulations and Improve Contractor Oversight

As a result of insufficient contract terms and inadequate contract oversight, the Army, NCR MD, and Air Force did not collect allowable delinquent claims billed by the contractor. In addition, the Army, NCR MD, and Air Force are not using all available resources to collect funds through the Third Party Collection Program. The Regional Health Command–Atlantic, Director of DHA NCR MD, and Air Force Medical Operations Agency should review the contract language and align the contract terms with all applicable Federal and DoD regulations. The Regional Health Command–Atlantic, Director of DHA NCR MD, and Air Force Medical Operations Agency should implement oversight procedures to monitor contractor performance in accordance with all applicable Federal and DoD regulations and contract terms. In addition, the Regional Health Command–Atlantic, Director of DHA NCR MD, and Air Force Medical Operations Agency should hold any contracting personnel assigned oversight responsibility accountable for not appropriately performing oversight procedures necessary to ensure the contractor complied with Federal and DoD regulations and contract terms. Lastly, the Director of DHA NCR MD should require the contracting officer to prepare contractor performance assessment reports for third party collection contracts, in accordance with the Federal Acquisition Regulation and Defense Federal Acquisition Regulation Supplement.

DoD Medical Facilities Missed Opportunities to Improve the Third Party Collection Program

Without proper management of the Third Party Collection Program and MHS revenue cycle, the nine medical facilities did not collect up to $70.7 million, including up to $1.0 million for the 70 claims reviewed. Therefore, the funds were not available for the medical facilities to use to improve the quality of health care within the MHS. If collected, these funds could be applied to the operations and maintenance budget and provide additional funding for administrative, operating, and equipment costs; readiness training; or trauma consortium activities. The medical facilities also were not aware of the amount of collections they missed because personnel did not obtain OHI information at all clinics or process the 26,236 potentially billable patient encounters at the two MHS GENESIS sites that we reviewed. Finally, improving the management of the Third Party Collection Program will also result in lower delinquent balances among the Third Party Collection Program. See Appendix D for details on potential monetary benefits.

Management Comments on Potential Monetary Benefits

A summary of management comments on potential monetary benefits and our responses is in Appendix D.

Recommendations, Management Comments, and Our Response

Recommendation 1

We recommend that the Director of the Defense Health Agency:

a. **Review all medical facilities in the Military Health System to determine which medical facilities are not:**

   1. **Collecting other health insurance information at all clinics in accordance with Defense Health Agency Procedures Manual 6015.01, and coordinate with commanders of those medical facilities to enforce existing other health insurance collection regulations, and as appropriate, take administrative action for noncompliance.**
   2. **Submitting claims to insurance providers in compliance with the time requirements in Defense Health Agency Procedures Manual 6015.01, and coordinate with commanders of those medical facilities to implement additional controls that enforce the requirements.**
   3. **Obtaining pre-authorization for treatment, and coordinate with commanders of those medical facilities to develop and implement a process for obtaining pre-authorization when services rendered for a beneficiary require a pre-authorization from the insurance provider.**
   4. **Conducting followup in compliance with the requirements in Defense Health Agency Procedures Manual 6015.01, and coordinate with commanders of those medical facilities to immediately revise procedures to ensure claims are followed up on in accordance with Defense Health Agency Procedures Manual 6015.01 and DoD Financial Management Regulation Volume 16, Chapter 2, requirements.**
   5. **Managing claims requiring refunds, and as appropriate, coordinate with commanders of those medical facilities to initiate refunds to insurance providers, identify funds spent that the medical facility was not entitled to spend, and take action to mitigate any risk to the medical facilities’ mission.**

6. **Transferring eligible third party claims that are delinquent for more than 120 days to the Treasury Cross-Servicing Program, and coordinate with commanders of those medical facilities to enforce Public Laws 104-134 and 113-101, which require medical facilities to transfer eligible delinquent claims to the Treasury Cross-Servicing Program. As appropriate, take administrative action for noncompliance.**
7. **Providing legal support to the Uniform Business Office and coordinate with commanders of those medical facilities to provide legal support to collect on Third Party Collection Program claims, and report on the benefits of the Defense Health Agency providing centralized legal resources for all DoD medical facilities to support cost recovery programs, and take action as appropriate.**

b. **Coordinate with commanders at all medical facilities operating MHS GENESIS to identify whether other facilities have patient category code errors similar to Naval Hospital Bremerton, and as appropriate, require front desk personnel to take patient category training at least annually.**

c. **Coordinate with commanders at all medical facilities operating MHS GENESIS to implement procedures to correct patient category codes in MHS GENESIS when patient category code errors are identified.**

d. **Determine whether changing the field name in MHS GENESIS to assist front desk personnel resolved credentialed provider errors at medical facilities using MHS GENESIS and if not, identify an alternative course of action to assign credentialed providers to patient encounters.**

e. **Coordinate with commanders at all medical facilities operating MHS GENESIS to identify all patient encounters that are not assigned a credentialed provider or are missing medical coding or doctor's notes, and develop a course of action to process and bill the claims through the appropriate cost recovery program.**

f. **Coordinate with medical facility commanders to implement procedures to ensure claims are accurate before submission to the insurance provider.**

g. **Coordinate with medical facility commanders to develop a course of action and enforce existing Defense Health Agency requirements that Uniform Business Office personnel review previous patient encounters for potentially billable events when new other health insurance is identified for a beneficiary.**

h. **Report the dollar impact of not collecting on prescriptions written for more than a 30-day supply and as appropriate, implement procedures to require Uniform Business Office personnel to collect at least the reasonable charges on pharmaceutical claims equal to the allowable portion covered by insurance policies.**

i. **Review and verify, at least annually, that billing personnel at all medical facilities in the Military Health System are meeting the Defense Health Agency Procedures Manual 6015.01 and the DoD Financial Management Regulation Volume 16, Chapter 2, requirements for following up on delinquent debt.**

j. **Review denials management programs of all medical treatment facilities and, when applicable, coordinate with facility commanders to develop and implement procedures for reviewing and validating denials before writing off claims, along with implementing an approach for reviewing denials by beneficiary.**

Management Comments Required

The DHA Director did not respond to the recommendations in the report. Therefore, the recommendations are unresolved. We request that the Director provide comments on the final report that address the actions the Director will take in response to all parts of Recommendation 1. The Director should also provide estimated completion dates for these actions.

Recommendation 2

We recommend that the Commander of Naval Hospital Bremerton:

a. **Direct personnel at all medical facility clinics and clinical support activities to collect hardcopy or electronic versions of DD Form 2569, and as appropriate, take administrative action for noncompliance.**

Naval Hospital Bremerton Comments

The Deputy Assistant Secretary of the Navy (Military Manpower and Personnel), responding for the Commander of NH Bremerton, partially agreed with the recommendation and stated that, according to the DHA Procedures Manual, MTFs may obtain evidence of OHI by either obtaining a DD Form 2569 or performing OHI discovery. The Deputy Assistant Secretary further stated that Navy Bureau of Medicine and Surgery (BUMED) will direct its MTFs to use evidence of OHI discovery from ABACUS as proof that the MTF searched for OHI on a patient. The Deputy Assistant Secretary stated that the third party collection standard operating procedures will be published by September 30, 2019.

Our Response

Comments from the Deputy Assistant Secretary of the Navy (Military Manpower and Personnel) addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we obtain Navy BUMED's third party collection standard operating procedures, verify that the procedures include direction on using the OHI tool in ABACUS to identify patient OHI, and verify what administrative actions were taken for any clinic that did not comply.

b. Resolve the 7,757 encounters with patient category code errors in the Armed Forces Billing and Collection Utilization Solution system and process the claims through the applicable cost recovery program.

Naval Hospital Bremerton Comments

The Deputy Assistant Secretary of the Navy (Military Manpower and Personnel), responding for the Commander of NH Bremerton, agreed with the recommendation and stated that Navy BUMED directed NH Bremerton to resolve the 7,757 encounters by January 31, 2020.

Our Response

Comments from the Deputy Assistant Secretary of the Navy (Military Manpower and Personnel) addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we verify that NH Bremerton resolved all 7,757 encounters with patient category code errors.

c. Develop a plan and take action to process, and as appropriate, bill through the applicable cost recovery program, all patient encounters at Naval Hospital Bremerton that are not assigned a credentialed provider or are missing medical coding or doctor's notes, including the 2,236 patient encounters in the Family Medicine clinic.

Naval Hospital Bremerton Comments

The Deputy Assistant Secretary of the Navy (Military Manpower and Personnel), responding for the Commander of NH Bremerton, agreed with the recommendation and stated that Navy BUMED directed NH Bremerton to completely code all encounters according to DHA coding guidelines, and also process the 2,236 uncoded encounters by January 31, 2020.

Our Response

Comments from the Deputy Assistant Secretary of the Navy (Military Manpower and Personnel) addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we verify that NH Bremerton processed all 2,236 patient encounters.

d. Review and modify procedures for claim followup so debt can be transferred to the appropriate debt collection agency when claims become 120 days delinquent.

Naval Hospital Bremerton Comments

The Deputy Assistant Secretary of the Navy (Military Manpower and Personnel), responding for the Commander of NH Bremerton, agreed with the recommendation and stated that Navy BUMED will include guidance on Treasury transfers in its third party collection standard operating procedures. The Deputy Assistant Secretary stated that the third party collection standard operating procedures will be published by September 30, 2019.

Our Response

Comments from the Deputy Assistant Secretary of the Navy (Military Manpower and Personnel) addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we obtain Navy BUMED's third party collection standard operating procedures and verify that the procedures include guidance on Treasury transfers.

e. Develop and implement procedures to review and validate denials before writing off claims, and implement procedures to process denials by beneficiary.

Naval Hospital Bremerton Comments

The Deputy Assistant Secretary of the Navy (Military Manpower and Personnel), responding for the Commander of NH Bremerton, agreed with the recommendation and stated that Navy BUMED will include guidance on validating denials in its third party collection standard operating procedures. The Deputy Assistant Secretary stated that the third party collection standard operating procedures will be published by September 30, 2019.

Our Response

Comments from the Deputy Assistant Secretary of the Navy (Military Manpower and Personnel) addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we obtain Navy BUMED's third party collection standard operating procedures and verify that the procedures include guidance on processing and validating denials.

f. Review all outstanding third party claims that are delinquent for more than 120 days to determine which claims are eligible for transfer to the Treasury Cross-Servicing Program or local Judge Advocate office, and transfer all eligible claims for collection assistance.

Naval Hospital Bremerton Comments

The Deputy Assistant Secretary of the Navy (Military Manpower and Personnel), responding for the Commander of NH Bremerton, agreed with the recommendation and stated that Navy BUMED will include guidance on Treasury transfers in its third party collection standard operating procedures. The Deputy Assistant Secretary also stated that Navy BUMED directed NH Bremerton to transfer all delinquent third party claims to the Treasury by January 31, 2020. The Deputy Assistant Secretary stated that the third party collection standard operating procedures will be published by September 30, 2019.

Our Response

Comments from the Deputy Assistant Secretary of the Navy (Military Manpower and Personnel) addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we obtain Navy BUMED's third party collection standard operating procedures, verify that the procedures include guidance on Treasury transfers, and obtain documentation to support that NH Bremerton transferred all eligible claims, of the 881 claims we identified as delinquent for more than 120 days, to the Treasury Cross-Servicing Program.

g. Provide sufficient legal support to pursue collections through the Third Party Collection Program.

Naval Hospital Bremerton Comments

The Deputy Assistant Secretary of the Navy (Military Manpower and Personnel), responding for the Commander of NH Bremerton, partially agreed with the recommendation and stated that, in accordance with the United States Code, delinquent debt and claims older than 120 days must be transferred to the U.S. Treasury. The Deputy Assistant Secretary further stated that there is no

mandate that delinquent debt first undergo internal legal review. The Deputy Assistant Secretary stated that Navy BUMED will include guidance on Treasury transfers for delinquent claims in its third party collection standard operating procedures. The Deputy Assistant Secretary stated that the third party collection standard operating procedures will be published by September 30, 2019.

Our Response

Comments from the Deputy Assistant Secretary of the Navy (Military Manpower and Personnel) did not address the specifics of the recommendation; therefore, the recommendation is unresolved. While the United States Code does not require using legal assistance in the collection of third party claims, using legal assistance would significantly benefit the MTFs in decreasing their unresolved third party claims. While not all claims require internal legal review, there are many instances when legal review and assistance would be a benefit and more timely than the use of the Treasury Cross-Servicing Program. For example, if many claims are denied by a specific provider for an invalid reason, similar to how the Army addressed the denials, Navy MTFs could use their legal resources to challenge the denials and receive reimbursement before sending the claims to the Treasury Cross-Servicing Program. We request that the Deputy Assistant Secretary of the Navy (Military Manpower and Personnel) provide additional comments in response to the final report that resolve the recommendation.

Recommendation 3

We recommend that the Commander of Naval Medical Center San Diego:

a. **Review and modify procedures for claim followup so debt can be transferred to the appropriate debt collection agency when claims become 120 days delinquent.**

Naval Medical Center San Diego Comments

The Deputy Assistant Secretary of the Navy (Military Manpower and Personnel), responding for the Commander of NMC San Diego, agreed with the recommendation and stated that Navy BUMED will include guidance on Treasury transfers in its third party collection standard operating procedures. The Deputy Assistant Secretary stated that the third party collection standard operating procedures will be published by September 30, 2019.

Our Response

Comments from the Deputy Assistant Secretary of the Navy (Military Manpower and Personnel) addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the

recommendation once we obtain Navy BUMED's third party collection standard operating procedures and verify that the procedures include guidance on Treasury transfers.

b. Review all outstanding third party claims that are delinquent for more than 120 days to determine which claims are eligible for transfer to the Treasury Cross-Servicing Program or local Judge Advocate office, and transfer all eligible claims for collection assistance.

Naval Medical Center San Diego Comments

The Deputy Assistant Secretary of the Navy (Military Manpower and Personnel), responding for the Commander of NMC San Diego, agreed with the recommendation and stated that Navy BUMED will include guidance on Treasury transfers in its third party collection standard operating procedures. The Deputy Assistant Secretary also stated that Navy BUMED directed NMC San Diego to transfer all delinquent third party claims to the U.S. Treasury by January 31, 2020. The Deputy Assistant Secretary stated that the third party collection standard operating procedures will be published by September 30, 2019.

Our Response

Comments from the Deputy Assistant Secretary of the Navy (Military Manpower and Personnel) addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we obtain Navy BUMED's third party collection standard operating procedures, verify that the procedures include guidance on Treasury transfers, and obtain documentation to support that NMC San Diego transferred all eligible claims, of the 7,715 claims we identified as delinquent for more than 120 days, to the Treasury Cross-Servicing Program.

c. Provide sufficient legal support to pursue collections through the Third Party Collection Program.

Naval Medical Center San Diego Comments

The Deputy Assistant Secretary of the Navy (Military Manpower and Personnel), responding for the Commander of NMC San Diego, partially agreed with the recommendation and stated that, in accordance with the United States Code, delinquent debt and claims older than 120 days must be transferred to the U.S. Treasury. The Deputy Assistant Secretary further stated that there is no mandate that delinquent debt first undergo internal legal review. The Deputy Assistant Secretary stated that Navy BUMED will include guidance on Treasury transfers for delinquent claims in its third party collection standard operating

procedures. The Deputy Assistant Secretary stated that the third party collection standard operating procedures will be published by September 30, 2019.

Our Response

Comments from the Deputy Assistant Secretary of the Navy (Military Manpower and Personnel) did not address the specifics of the recommendation; therefore, the recommendation is unresolved. While the United States Code does not require using legal assistance in the collection of third party claims, using legal assistance would significantly benefit the MTFs in decreasing their unresolved third party claims. While not all claims require internal legal review, there are many instances when legal review and assistance would be a benefit and more timely than the use of the Treasury Cross-Servicing Program. For example, if many claims are denied by a specific provider for an invalid reason, similar to how the Army addressed the denials, Navy MTFs could use their legal resources to challenge the denials and receive reimbursement before sending the claims to the Treasury Cross-Servicing Program. We request that the Deputy Assistant Secretary of the Navy (Military Manpower and Personnel) use legal resources when legal assistance would benefit the collection process and provide additional comments in response to the final report that resolve the recommendation.

Recommendation 4

We recommend that the Commander of Madigan Army Medical Center:

> **a. Direct personnel at all medical facility clinics and clinical support activities to collect hardcopy or electronic versions of DD Form 2569, and as appropriate, take administrative action for noncompliance.**

Madigan Army Medical Center Comments

The Chief of Staff, Army Office of the Surgeon General, responding for the Commander of Madigan AMC, agreed with the recommendation and stated that Madigan AMC will develop a policy to enforce collection of DD Form 2569 at each clinic. The Chief of Staff further stated that the Madigan AMC UBO will provide training to Madigan AMC staff members to ensure their understanding of the DD Form 2569 collection process. The Chief of Staff stated that the Madigan AMC UBO will also develop a process to verify each clinic's compliance every quarter, and report findings to the Commander of Madigan AMC for appropriate action. The Chief of Staff stated that these actions are expected to be complete by January 1, 2020.

Our Response

Comments from the Chief of Staff, Army Office of the Surgeon General, addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we obtain Madigan AMC's policy to enforce collection of DD Form 2569, verify that training was provided to Madigan AMC staff, and verify Madigan AMC's process for ensuring each clinic's compliance.

b. Develop a plan and take action to process, and as appropriate, bill through the applicable cost recovery program, all patient encounters at Madigan Army Medical Center that are not assigned a credentialed provider or are missing medical coding or doctor's notes, including the 16,243 patient encounters between October 1, 2018, and December 31, 2018.

Madigan Army Medical Center Comments

The Chief of Staff, Army Office of the Surgeon General, responding for the Commander of Madigan AMC, agreed with the recommendation and stated that Madigan AMC will implement work around processes to allow for billing through the applicable cost recovery program. The Chief of Staff stated that some encounters with no attributed resource can have a resource assigned post-patient check-in using a work around. Furthermore, the Chief of Staff stated that Madigan AMC Clinical Operations will develop training to assist with implementing this solution, and implementation is expected to be complete by August 31, 2019.

The Chief of Staff stated that the MHS GENESIS report used to identify the 16,243 patient encounters does not show the patient, patient category, or insurance information, and Madigan AMC cannot determine how many of the encounters are billable through the Third Party Collection Program. The Chief of Staff stated that there is an ABACUS report of uncoded outpatient encounters pending that includes the parameters needed. The Chief of Staff stated that for October 1, 2018, through December 31, 2018, there are currently 74 uncoded encounters. The Chief of Staff further stated that Madigan AMC will research the 74 encounters and will provide any encounters that have not been billed to coding for processing by July 31, 2019. The Chief of Staff stated that a process to regularly review the ABACUS report and will be developed and in place by July 31, 2019.

Our Response

Comments from the Chief of Staff, Army Office of the Surgeon General, partially addressed the recommendation; therefore, the recommendation is unresolved. While the Chief of Staff agreed to implement a process to bill all patient encounters going forward, he did not provide a planned action to review, process, and potentially bill the third party claims from all 16,243 patient encounters between

October 1, 2018, and December 31, 2018. Madigan AMC should review the 16,243 encounters individually to determine whether they are billable through the Third Party Collection Program or a separate cost recovery program, and take action to process and bill all encounters, as appropriate. Furthermore, Madigan AMC should elevate the issue to DHA to identify a solution to provide the necessary data elements to prevent unbilled encounters from occurring in the future. Doing so will maximize collection efforts and increase collections for the MTF. We request that the Chief of Staff develop a plan and take action to process all 16,243 patient encounters and provide additional comments in response to the final report.

c. **Review and modify procedures for obtaining pre-authorization when beneficiaries receive services at the medical facility that require pre-authorization from the insurance provider.**

Madigan Army Medical Center Comments

The Chief of Staff, Army Office of the Surgeon General, responding for the Commander of Madigan AMC, did not agree with the recommendation and stated that while Madigan AMC agrees with maximizing third party collections by obtaining pre-authorization, the DHA UBO User Guide is not official policy and does not set requirements for MTFs. The Chief of Staff further stated that DoD policy does not currently require MTFs to obtain pre-authorization for services provided to beneficiaries when required by their insurance provider.

The Chief of Staff stated that Madigan AMC strives to maximize third party collections, but also highlighted that many encounters are not known to require pre-authorizations until care has already been provided. In addition, the Chief of Staff stated that a new module could potentially address this area but is not expected to be implemented at initial operating capability sites until 2022. The Chief of Staff stated that Madigan AMC technicians currently review MHS GENESIS reports, such as inpatient admissions and surgery schedules, to identify billable care that may require pre-authorization under the Third Party Collection Program. The Chief of Staff further stated that Madigan AMC has insurance verification technicians who update a tracking spreadsheet with patient names, insurance information, dates of service, and types of service, and UBO utilization review nurses who review the spreadsheet throughout the day to contact insurance providers to obtain authorizations. The Chief of Staff also stated that as of July 1, 2019, both Madigan AMC insurance verification technician positions and one of the two utilization review nurse positions are vacant.

Our Response

Comments from the Chief of Staff, Army Office of the Surgeon General, did not address the specifics of the recommendation; therefore, the recommendation is unresolved. The DHA UBO User Guide includes processes to identify and obtain pre-authorizations, when possible. Using these procedures have the potential to increase collections; therefore, MTFs should use these procedures as a best practice. Furthermore, the MTF should request a retro-authorization for claims denied for a missing pre-authorization if Madigan AMC could not reasonably identify the need before the encounter. Without processes in place to ensure UBO or clinical personnel obtain required pre-authorizations for all services, medical facilities will continue to receive denials from insurance providers for care requiring pre-authorization. We request that the Chief of Staff pro-actively implement processes regarding pre-authorizations while coordinating with DHA personnel to improve this process, and provide additional comments in response to the final report that resolve the recommendation.

d. Review and modify procedures for claim followup so debt can be transferred to the appropriate debt collection agency when claims become 120 days delinquent.

Madigan Army Medical Center Comments

The Chief of Staff, Army Office of the Surgeon General, responding for the Commander of Madigan AMC, did not agree with the recommendation and stated that Madigan AMC agreed with the intent of the recommendation and has processes in place to follow up on claims in accordance with DoD policy and guidance. The Chief of Staff stated that the UBO will take action to ensure the processes are being followed.

The Chief of Staff stated that Madigan AMC contacts the insurance provider if it does not receive a response to a claim, and a third party recovery technician closes the claim if the policy was not active at the time of service. The Chief of Staff further stated that the recovery technician resubmits the claim if it was not received, or provides additional information as necessary. The Chief of Staff stated that claims are prioritized and processed based on age and amount billed, and that it is a time-consuming process. The Chief of Staff also stated that each recovery technician can follow up on only about 25 to 30 claims per day and, as of July 1, 2019, there were 7,150 third party collection claims over 30 days old, and of these, 3,713 have not been followed up on in the past 90 days. The Chief of Staff stated that following up on just the 3,713 claims within 1 month would require six recovery technicians working full time; however, Madigan AMC has only three recovery technician positions, and one position is vacant.

Our Response

Comments from the Chief of Staff, Army Office of the Surgeon General, did not address the specifics of the recommendation; therefore, the recommendation is unresolved. While Madigan AMC has policies in place to follow up on claims in accordance with DoD policy and guidance, based on our findings, none of the six Madigan AMC third party claims we reviewed were transferred, and 5,918 claims at Madigan AMC were over 120 days old, demonstrating that UBO personnel were not complying with its policies. In addition, claims were not being transferred to the appropriate collection agency at 120 days according to Public Laws 104-134 and 113-101. Therefore, procedures for claim followup need to be reviewed and enforced to ensure claims are followed up on in accordance with Federal and DoD regulations so debt can be transferred as soon as claims become 120 days delinquent. Furthermore, the Chief of Staff, Army Office of the Surgeon General, should review and prioritize the MTF need for staffing increases to resolve the backlog of delinquent claims over 120 days. We request that the Chief of Staff provide additional comments in response to the final report that resolve the recommendation.

e. **Develop and implement procedures to review and validate denials before writing off claims, and implement procedures to process denials by beneficiary.**

Madigan Army Medical Center Comments

The Chief of Staff, Army Office of the Surgeon General, responding for the Commander of Madigan AMC, partially agreed with the recommendation and stated that Madigan AMC agrees with the intent of the recommendation and already has processes in place to review and validate denials by beneficiary before writing off claims. The Chief of Staff stated that valid write-offs, such as coinsurance, deductible, or co-pay, are automatically verified by ABACUS when posted by accounting technicians, and unverified write-offs are reviewed by third party collection recovery technicians, and notes, Explanations of Benefits, and automated responses are reviewed. The Chief of Staff stated that if the denials are valid, recovery technicians verify the write-off in ABACUS and close the claim. The Chief of Staff stated that if the validity of a write-off is questioned, a recovery technician calls the insurance provider to obtain additional details and address any areas of dispute. Furthermore, the Chief of Staff stated that if the claim is still in dispute, the insurance representative is notified and a letter is sent to the insurance provider outlining the statutes, laws, and regulations that support payment. The Chief of Staff stated that if the dispute is not settled once the claim is 120 days old, it is marked for legal review in ABACUS.

The Chief of Staff stated that each recovery technician can address only about 12 to 15 disputed claims a day and, as of July 1, 2019, there were 475 potential

third party collection disputed claims. The Chief of Staff stated that it would take the two recovery technicians working full time for 18 days to verify these claims.

Our Response

Comments from the Chief of Staff, Army Office of the Surgeon General, addressed the specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we obtain documentation to support that the 475 potential third party collection disputed claims were addressed and successfully disputed or written off and closed appropriately.

f. Review all outstanding third party claims that are delinquent for more than 120 days to determine which claims are eligible for transfer to the Treasury Cross-Servicing Program or local Judge Advocate office, and transfer all eligible claims for collection assistance.

Madigan Army Medical Center Comments

The Chief of Staff, Army Office of the Surgeon General, responding for the Commander of Madigan AMC, did not agree with the recommendation and stated that Madigan AMC already has processes in place to review outstanding claims and is currently working with the U.S. Army Medical Command Staff Judge Advocate to prioritize claims and complete due process by carrier and denial reasons in order to facilitate a legal resolution. The Chief of Staff also stated that the U.S. Army Medical Command has a contract to assist MTFs with reviewing unprocessed claims and invalid denials, and marking claims eligible for legal action.

Our Response

Comments from the Chief of Staff, Army Office of the Surgeon General, did not address the specifics of this recommendation; therefore, the recommendation is unresolved. While Madigan AMC has a process in place, our findings showed that its policies and processes were not being followed. Specifically, Madigan AMC third party claims were not followed up on in a timely manner, transferred to U.S. Army Medical Command Staff Judge Advocate or the Treasury Cross-Servicing Program, and Madigan AMC had 5,918 claims over 120 days old. Furthermore, while the comments provided a solution for reviewing claims for possible legal assistance, they did not address how Madigan AMC will review all claims delinquent for more than 120 days to determine which insurance providers require referral to the Treasury Cross-Servicing Program for collection assistance. We request that the Chief of Staff provide additional comments in response to the final report that resolve the recommendation.

g. Provide sufficient legal support to pursue collections through the Third Party Collection Program.

Madigan Army Medical Center Comments

The Chief of Staff, Army Office of the Surgeon General, responding for the Commander of Madigan AMC, did not agree with the recommendation and stated that Madigan AMC is working with the U.S. Army Medical Command on a centralized process and training program for pursuing delinquent claims. The Chief of Staff stated that the process, created in collaboration with the U.S. Army Medical Command Staff Judge Advocate, is for Madigan AMC to transfer disputed claims to the William Beaumont AMC paralegal through ABACUS, and the paralegal consolidates claims and takes legal collection action.

Our Response

Although the Chief of Staff, Army Office of the Surgeon General, disagreed with the recommendation, the comments addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we obtain documentation to support that Madigan AMC has a process in place to transfer claims to the U.S. Army Medical Command Staff Judge Advocate.

Recommendation 5

We recommend that the Commander of Brooke Army Medical Center:

a. **Direct personnel at all medical facility clinics and clinical support activities to collect hardcopy or electronic versions of DD Form 2569, and as appropriate, take administrative action for noncompliance.**

Brooke Army Medical Center Comments

The Chief of Staff, Army Office of the Surgeon General, responding for the Commander of Brooke AMC, agreed with the recommendation and stated that a Brooke AMC memorandum will be updated to strengthen the requirement to collect DD Form 2569. The Chief of Staff further stated that Brooke AMC will include the requirement in its UBO compliance audit cycle and test the requirement during quarterly audits to ensure compliance. The Chief of Staff stated that these actions will be complete by January 6, 2020.

Our Response

Comments from the Chief of Staff, Army Office of the Surgeon General, addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we obtain Brooke AMC's memorandum strengthening the requirement to collect DD Form 2569, and verify Brooke AMC's process to ensure compliance.

b. Review and modify procedures for obtaining pre-authorization when beneficiaries receive services at the medical facility that require pre-authorization from the insurance provider.

Brooke Army Medical Center Comments

The Chief of Staff, Army Office of the Surgeon General, responding for the Commander of Brooke AMC, did not agree with the recommendation and stated that the DHA UBO User Guide is not official guidance and MTFs are not bound by its procedures. The Chief of Staff stated that Brooke AMC conducts pre-authorizations for a number of medical services, including those used by veterans, admissions, and some same-day surgery encounters, because these services have proven cost effective. The Chief of Staff further stated that when authoritative guidance is issued directing staff to expand pre-authorization for additional services, Brooke AMC will update its processes accordingly.

Our Response

Comments from the Chief of Staff, Army Office of the Surgeon General, did not address the specifics of the recommendation; therefore, the recommendation is unresolved. The DHA UBO User Guide includes processes to identify and obtain pre-authorizations, when possible. Using these procedures have the potential to increase collections; therefore, MTFs should use the procedures as a best practice. Without processes in place to ensure that UBO or clinical personnel obtain required pre-authorizations for all services, medical facilities will continue to receive denials from insurance providers for care requiring pre-authorization. We request that the Chief of Staff pro-actively implement processes regarding pre-authorizations while coordinating with DHA personnel to improve this process, and provide comments on the final report that resolve the recommendation.

c. Review and modify procedures for claim followup so debt can be transferred to the appropriate debt collection agency when claims become 120 days delinquent.

Brooke Army Medical Center Comments

The Chief of Staff, Army Office of the Surgeon General, responding for the Commander of Brooke AMC, did not agree with the recommendation and stated that, in accordance with section 1095, title 10, United States Code, the Government has the right to collect reasonable charges for health care services from a third-party payer, but a covered beneficiary may not be required to pay an additional amount to the United States for health care services by reason of that section. In addition, the Chief of Staff stated that 32 Code of Federal Regulations 220.9 states, "...uniformed service beneficiaries will not be required to pay to the

facility of the uniformed services any amount greater than the normal medical services or subsistence charges…" and that "In every case in which payment from a third-party payer is received, it will be considered as satisfying the normal medical services or subsistence charges, and no further payment from the beneficiary will be required." The Chief of Staff stated that it is therefore inappropriate to transfer third party collection debt to a debt collection agency. Furthermore, the Chief of Staff stated that section 1095, title 10, United States Code, states that the Government may institute and prosecute legal proceedings against a third-party payer to enforce their requirement to provide payment, but there are already procedures in place for transferring invalid third party collection denials to the appropriate Staff Judge Advocate office. The Chief of Staff stated that Brooke AMC will complete a review of those procedures to ensure it is properly followed by January 6, 2020.

Our Response

Comments from the Chief of Staff, Army Office of the Surgeon General, did not address the specifics of the recommendation; therefore, the recommendation is unresolved. We are not requesting that MTFs send individual beneficiaries to the Treasury Cross-Servicing Program. Insurance providers can be sent to the Treasury Cross-Servicing Program once due process is provided, as evidenced by the U.S. Navy sending 862 claims to the Treasury Cross-Servicing Program. In addition, the comments did not address procedures for claim followup. While Brooke AMC has procedures in place to follow up on claims, based on our findings, 29,819 claims at Brooke AMC were over 120 days old, demonstrating that UBO personnel were not complying with these procedures. In addition, claims were not being transferred to the appropriate collection agency at 120 days per Public Laws 104-134 and 113-101. Therefore, procedures for claim followup need to be reviewed and enforced to ensure claims are followed up on in accordance with Federal and DoD regulations. We request that the Chief of Staff provide additional comments in response to the final report that resolve the recommendation.

d. Review all outstanding third party claims that are delinquent for more than 120 days to determine which claims are eligible for transfer to the Treasury Cross-Servicing Program or local Judge Advocate office, and transfer all eligible claims for collection assistance.

Brooke Army Medical Center Comments

The Chief of Staff, Army Office of the Surgeon General, responding for the Commander of Brooke AMC, agreed with the recommendation and stated that Brooke AMC will review all outstanding claims that are more than 120 days

old to determine which claims are eligible for transfer to the U.S. Army Medical Command Staff Judge Advocate. The Chief of Staff stated that working the current backlog of claims remains a priority for Brooke AMC UBO, and Brooke AMC staff are taking steps to address the older claims. The Chief of Staff stated that the U.S. Army Medical Command issued a contract to augment Brooke AMC staff for determining transfer eligibility of the claims. The Chief of Staff further stated that the contract covers all unpaid claims that are more than 120 days old with a date of service of October 1, 2016, and earlier, and the contract will assist with coding eligible claims for legal review in ABACUS. The Chief of Staff stated that the estimated date of completion for the review of outstanding claims is July 31, 2021.

Our Response

Comments from the Chief of Staff, Army Office of the Surgeon General, addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we receive claim documentation to support that Brooke AMC reviewed all 29,819 claims we identified as delinquent for more than 120 days, as of June 30, 2018, and either closed or transferred them for collection assistance.

e. Provide sufficient legal support to pursue collections through the Third Party Collection Program.

Brooke Army Medical Center Comments

The Chief of Staff, Army Office of the Surgeon General, responding for the Commander of Brooke AMC, did not agree with the recommendation and stated that Brooke AMC agrees with the intent of the recommendation to ensure legal support for collection of third party claims; however, the U.S. Army Medical Command is working with Brooke AMC on a centralized process and training program for pursuing delinquent claims. The Chief of Staff stated that Brooke AMC will modify procedures requiring unpaid third party claims categorized with invalid denials and meeting other appropriate criteria to be marked in ABACUS for legal review and action by the U.S. Army Medical Command Staff Judge Advocate, as appropriate.

Our Response

Although the Chief of Staff, Army Office of the Surgeon General, disagreed with the recommendation, the comments addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we obtain Brooke AMC's modified procedures, verify the procedures include a requirement to send unpaid third party claims to the

U.S. Army Medical Command Staff Judge Advocate, and obtain claim documentation to support that Brooke AMC transferred claims to the U.S. Army Medical Command Staff Judge Advocate. We request that the Chief of Staff, Army Office of the Surgeon General, provide an estimated date of completion for all of these actions.

Recommendation 6

We recommend that the Commander of the 59th Medical Wing at Lackland Air Force Base:

a. **Direct personnel at all medical facility clinics and clinical support activities to collect hardcopy or electronic versions of DD Form 2569, and as appropriate, take administrative action for noncompliance.**

59th Medical Wing Comments

The Deputy Surgeon General of the Air Force, responding for the Commander of the 59th Medical Wing at Lackland Air Force Base, agreed with the recommendation and stated that the 59th Medical Wing will continue to maintain responsibility for establishing and sustaining the Third Party Collection Program. The Deputy Surgeon General stated that the Commander will ensure full compliance with the OHI intake program and will direct all appropriate personnel to support activities for collecting OHI from all non-active duty patients to complete a DD Form 2569 or electronic version of the DD Form 2569.

Our Response

Comments from the Deputy Surgeon General of the Air Force addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we verify the Commander directed all medical facility clinics and clinical support activities to collect hardcopy or electronic versions of DD Form 2569.

b. **Review and modify procedures for claim followup so debt can be transferred to the appropriate debt collection agency when claims become 120 days delinquent.**

59th Medical Wing Comments

The Deputy Surgeon General of the Air Force, responding for the Commander of the 59th Medical Wing at Lackland Air Force Base, did not agree with the recommendation and stated that a review of the claims presented in the report reveal the claim balances shown were not the result of delinquent bills. The Deputy Surgeon General stated that the claim balances were

predominately patient co-payments and deductible amounts remaining after the insurance company paid the covered amount. The Deputy Surgeon General further stated that the patient's portion should be written off in accordance with Federal, DoD, and Air Force regulations, and never transferred to debt collection agencies.

Our Response

Comments from the Deputy Surgeon General of the Air Force did not address the specifics of the recommendation; therefore, the recommendation is unresolved. Claims received from the Air Force remained open when we selected the claims for review. Air Force claims were not closed in accordance with Federal, DoD, and Air Force regulations. Furthermore, based on our findings, there are 39,848 other claims delinquent for more than 120 days from the 59th Medical Wing that need reviewed and procedures modified to determine which claims can be transferred to the appropriate debt collection agency. We request that the Deputy Surgeon General provide additional comments in response to the final report that specifically state the actions the Deputy Surgeon General will take to review and modify procedures for claim followup. The Deputy Surgeon General should also provide estimated completion dates for these actions.

c. Review all outstanding third party claims that are delinquent for more than 120 days to determine which claims are eligible for transfer to the Treasury Cross-Servicing Program or local Judge Advocate office, and transfer all eligible claims for collection assistance.

59th Medical Wing Comments

The Deputy Surgeon General of the Air Force, responding for the Commander of the 59th Medical Wing at Lackland Air Force Base, did not agree with the recommendation and stated that Third Party Collection Program participants are beneficiaries, dependents, and retirees, and shall not be balance billed or transferred to collection agencies. The Deputy Surgeon General stated that, pursuant to section 1095, title 10, United Stated Code, any balances remaining after OHI has paid covered amounts will be written off. Furthermore, the Deputy Surgeon General stated that Third Party Collection Program patients are beneficiaries and should never be referred to debt collection for balances beyond the plan's coverage or patient's cost share.

Our Response

Comments from the Deputy Surgeon General of the Air Force did not address the specifics of the recommendation; therefore, the recommendation is unresolved. We recommended that the 59th Medical Wing review all delinquent third party claims and transfer the insurance providers, not the beneficiaries, that owe the DoD to the Treasury Cross-Servicing Program or local Judge Advocate for collection assistance. This applies not only to the claims in this report, but to all 39,848 claims delinquent for more than 120 days at the 59th Medical Wing. We request that the Deputy Surgeon General provide additional comments in response to the final report that resolve the recommendation.

d. Provide sufficient legal support to pursue collections through the Third Party Collection Program.

59th Medical Wing Comments

The Deputy Surgeon General of the Air Force, responding for the Commander of the 59th Medical Wing at Lackland Air Force Base, agreed with the recommendation and stated that insurance providers cannot be placed in the Treasury Cross-Servicing Program. The Deputy Surgeon General further stated that the program is for first party individual out-of-service debt; therefore, the only recourse for adjudicating claims when the insurance company is unresponsive or provides invalid denials is to forward to the local Judge Advocate. The Deputy Surgeon General stated that, at that point, the potential for collecting any part of the debt, minus co-pays and deductibles, will be out of the MTF's control and the Air Force Medical Service.

Our Response

Comments from the Deputy Surgeon General of the Air Force did not address the specifics of the recommendation; therefore, the recommendation is unresolved. The comments did not address how legal support will be provided to pursue collections of delinquent claims in the Third Party Collection Program. Further, insurance providers can be sent to the Treasury Cross-Servicing Program, as evidenced by the U.S. Navy sending 862 claims to the Treasury Cross-Servicing Program. We request that the Deputy Surgeon General provide additional comments in response to the final report that specifically state the actions the Deputy Surgeon General will take to provide sufficient legal support. The Deputy Surgeon General should also provide estimated completion dates for these actions.

Recommendation 7

We recommend that the Commander of the 75th Medical Group at Hill Air Force Base:

a. **Direct personnel at all medical facility clinics and clinical support activities to collect hardcopy or electronic versions of DD Form 2569, and as appropriate, take administrative action for noncompliance.**

75th Medical Group Comments

The Deputy Surgeon General of the Air Force, responding for the Commander of the 75th Medical Group at Hill Air Force Base, agreed with the recommendation and stated that the 75th Medical Group has established a new plan to track non-compliance and improve accountability with Flight Commanders briefing non-compliance to the Medical Group's Executive Staff.

Our Response

Comments from the Deputy Surgeon General of the Air Force addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we obtain the new plan to track non-compliance with DD Form 2569 collection, a copy of the Flight Commanders' briefings, and documentation to support that all clinics and clinical support activities are collecting hardcopy or electronic versions of DD Form 2569.

b. **Review and modify procedures for obtaining pre-authorization when beneficiaries receive services at the medical facility that require pre-authorization from the insurance provider.**

75th Medical Group Comments

The Deputy Surgeon General of the Air Force, responding for the Commander of the 75th Medical Group at Hill Air Force Base, agreed with the recommendation and stated that the 75th Medical Group's staff are not trained to request pre-authorization for care. The Deputy Surgeon General stated that to obtain full compliance, this issue needs to be addressed as an enterprise level process improvement. The Deputy Surgeon General stated that the Air Force Medical Readiness Agency (AFMRA) UBO will engage with the AFMRA Referral Management Function for evaluation of this process and will develop guidance in compliance with DoD Instructions and DHA policies, with an estimated completion date of January 31, 2020.

Our Response

Comments from the Deputy Surgeon General of the Air Force addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we obtain documentation that training for personnel to request pre-authorization was addressed at the enterprise level, documentation that the AFMRA UBO engaged the AFMRA Referral Management Function to evaluate the process of pre-authorizations, and documentation to support that new guidance was issued.

c. **Review and modify procedures for claim followup so debt can be transferred to the appropriate debt collection agency when claims become 120 days delinquent.**

75th Medical Group Comments

The Deputy Surgeon General of the Air Force, responding for the Commander of the 75th Medical Group at Hill Air Force Base, agreed with the recommendation and stated that this activity is managed by a centralized Air Force Medical Service contract and the 75th Medical Group is not staffed to manage locally. The Deputy Surgeon General referred to the responses for recommendations 11.b and 11.c.

Our Response

Comments from the Deputy Surgeon General of the Air Force addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once Recommendations 11.b and 11.c are fully resolved.

d. **Review the 15 claims with potential invalid denials or awaiting resolution to determine whether they are still awaiting resolution or were written off for valid reasons, and if not, re bill the claims to the insurance provider.**

75th Medical Group Comments

The Deputy Surgeon General of the Air Force, responding for the Commander of the 75th Medical Group at Hill Air Force Base, agreed with the recommendation and stated that the 75th Medical Group UBO will work with the third party collections contractor to review these claims and complete any required action, with an estimated completion date of December 31, 2019.

Our Response

Comments from the Deputy Surgeon General of the Air Force addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we obtain documentation to support that all 15 claims were either written off for valid reasons or re-billed to the insurance provider.

e. Develop and implement procedures to review and validate denials before writing off claims, and implement procedures to process denials by beneficiary.

75th Medical Group Comments

The Deputy Surgeon General of the Air Force, responding for the Commander of the 75th Medical Group at Hill Air Force Base, agreed with the recommendation and stated that this function is managed by a centralized Air Force Medical Service contract and the 75th Medical Group is not staffed locally to manage. The Deputy Surgeon General stated that the AFMRA UBO is the contracting office representative for this contract and will evaluate the contractor's performance of the denial management function and ensure compliance, with an estimated completion date of January 31, 2020.

Our Response

Comments from the Deputy Surgeon General of the Air Force addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we obtain documentation to support that AFMRA evaluated the denial management function and implemented new procedures.

f. Identify the impact a $505,787 refund to an insurance provider will have on the 75th Medical Group's operations and maintenance budget, and take appropriate action to mitigate any impact on the medical facility's mission.

75th Medical Group Comments

The Deputy Surgeon General of the Air Force, responding for the Commander of the 75th Medical Group at Hill Air Force Base, agreed with the recommendation and stated that the 75th Medical Group had already completed the review and processed 2 of the 3 transactions. The Deputy Surgeon General stated that the refunds will not affect the 75th Medical Group's Operations and Maintenance

budget as the refunds were for past FY collection. Further, the Deputy Surgeon General stated that the 75th Medical Group analyzed the affected year's budget and found that, due to contract de-obligations, there will still be approximately $20,000 in margin after refunds are issued.

Our Response

Comments from the Deputy Surgeon General of the Air Force addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we verify that all three refunds were issued.

g. Review all outstanding third party claims that are delinquent for more than 120 days to determine which claims are eligible for transfer to the Treasury Cross-Servicing Program or local Judge Advocate office, and transfer all eligible claims for collection assistance.

75th Medical Group Comments

The Deputy Surgeon General of the Air Force, responding for the Commander of the 75th Medical Group at Hill Air Force Base, agreed with the recommendation and stated that the 75th Medical Group UBO will work with the contractor to review all outstanding third party claims that are over 120 days delinquent.

Our Response

Comments from the Deputy Surgeon General of the Air Force addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we verify that the 75th Medical Group, in coordination with the contractor, reviewed all 7,803 claims delinquent for more than 120 days and either closed or transferred the claims for collection assistance.

h. Provide sufficient legal support to pursue collections through the Third Party Collection Program.

75th Medical Group Comments

The Deputy Surgeon General of the Air Force, responding for the Commander of the 75th Medical Group at Hill Air Force Base, agreed with the recommendation and stated that insurance providers cannot be placed in the Treasury Cross-Servicing Program. The Deputy Surgeon General further stated that the program is for first party individual out-of-service debt; therefore, the only recourse for adjudicating claims when the insurance company is unresponsive or provides invalid denials

is to forward to the local Judge Advocate. The Deputy Surgeon General stated that, at that point, the potential for collecting any part of the debt, minus co-pays and deductibles, will be out of control of the MTF and the Air Force Medical Service.

Our Response

Comments from the Deputy Surgeon General of the Air Force did not address the specifics of the recommendation; therefore, the recommendation is unresolved. The comments did not address how the legal resources will be provided to support the collection of delinquent claims in the Third Party Collection Program. Furthermore, insurance providers can be sent to the Treasury Cross-Servicing Program, as evidenced by the U.S. Navy sending 862 claims to the Treasury Cross-Servicing Program. We request that the Deputy Surgeon General provide additional comments in response to the final report.

Recommendation 8

We recommend that the Director of the Walter Reed National Military Medical Center:

a. **Direct personnel at all medical facility clinics and clinical support activities to collect hardcopy or electronic versions of DD Form 2569, and as appropriate, take administrative action for noncompliance.**

b. **Implement procedures requiring Uniform Business Operations personnel to review and submit bills to insurance providers in compliance with the time requirements outlined in the Defense Health Agency Procedures Manual 6015.01, including procedures for high dollar claims held for review within the Armed Forces Billing and Collection Utilization Solution.**

c. **Review and modify procedures for claim followup so debt can be transferred to the appropriate debt collection agency when claims become 120 days delinquent.**

d. **Review all outstanding third party claims that are delinquent for more than 120 days to determine which claims are eligible for transfer to the Treasury Cross-Servicing Program or local Judge Advocate office, and transfer all eligible claims for collection assistance.**

e. **Provide sufficient legal support to pursue collections through the Third Party Collection Program.**

Management Comments Required

The Director of Walter Reed National Military Medical Center did not respond to the recommendations in the report. Therefore, the recommendations are unresolved. We request that the Director provide comments on the final report that address the actions the Director will take in response to the five specific parts of Recommendation 8. The Director should also provide estimated completion dates for these actions.

Recommendation 9

We recommend that the Commander of the Fort Belvoir Community Hospital:

a. **Direct personnel at all medical facility clinics and clinical support activities to collect hardcopy or electronic versions of DD Form 2569, and as appropriate, take administrative action for noncompliance.**

b. **Review and modify procedures for claim followup so debt can be transferred to the appropriate debt collection agency when claims become 120 days delinquent.**

c. **Review all outstanding third party claims that are delinquent for more than 120 days to determine which claims are eligible for transfer to the Treasury Cross-Servicing Program or local Judge Advocate office, and transfer all eligible claims for collection assistance.**

d. **Provide sufficient legal support to pursue collections through the Third Party Collection Program.**

Management Comments Required

The Commander of Fort Belvoir Community Hospital did not respond to the recommendations in the report. Therefore, the recommendations are unresolved. We request that the Commander provide comments on the final report that address the actions the Commander will take in response to the four specific parts of Recommendation 9. The Commander should also provide estimated completion dates for these actions.

Recommendation 10

We recommend that the Commander of the Kimbrough Ambulatory Care Center:

a. **Review and modify procedures for claim followup so debt can be transferred to the appropriate debt collection agency when claims become 120 days delinquent.**

Kimbrough Ambulatory Care Center Comments

The Chief of Staff, Army Office of the Surgeon General, responding for the Commander of Kimbrough ACC, did not agree with the recommendation and stated that Army MTFs are not authorized to use debt collection agencies for third party claims. The Chief of Staff stated that delinquent claims are identified in ABACUS and electronically submitted to the U.S. Army Medical Command for additional review and action. The Chief of Staff further stated that the Army Regional Health Command-Atlantic will remind Kimbrough ACC of this process and the requirement to submit delinquent claims as directed.

Our Response

Comments from the Chief of Staff, Army Office of the Surgeon General, did not address the specifics of the recommendation; therefore, the recommendation is unresolved. The Chief of Staff's comments did not acknowledge that the current procedures for claim followup were not working, as evidenced by our findings of 28,212 claims at Kimbrough ACC over 120 days old. In addition, claims were not being transferred to the appropriate collection agency at 120 days, as required by Public Laws 104-134 and 113-101. Both Public Laws allow for the transfer of debt once due process is provided, as evidenced by the U.S. Navy sending 862 claims to the Treasury Cross-Servicing Program. Furthermore, the Chief of Staff stated that the Army Regional Health Command-Atlantic will remind Kimbrough ACC of the process of transferring claims to the U.S. Army Medical Command for additional review and action. The Chief of Staff's comments to "remind personnel at Kimbrough ACC" of their responsibility to follow the laws and Army procedures did not demonstrate that the Chief of Staff considered 28,212 claims over 120 days old as a significant problem. Therefore, procedures for claim followup need to be reviewed and enforced to ensure claims are followed up on in accordance with Federal and DoD regulations so debt can be transferred as soon as claims become 120 days delinquent. We request that the Chief of Staff provide additional comments in response to the final report that specifically state the actions he will take to resolve the recommendation.

b. Review all outstanding third party claims that are delinquent for more than 120 days to determine which claims are eligible for transfer to the Treasury Cross-Servicing Program or local Judge Advocate office, and transfer all eligible claims for collection assistance.

Kimbrough Ambulatory Care Center Comments

The Chief of Staff, Army Office of the Surgeon General, responding for the Commander of Kimbrough ACC, agreed with the recommendation and stated that Army Regional Health Command-Atlantic will coordinate with Kimbrough ACC to ensure procedures are modified to reflect current guidance related to reviewing and transferring delinquent claims. In addition, the Chief of Staff stated that Army Regional Health Command-Atlantic, in coordination with the third party collection contractor and Kimbrough ACC, will review all third party claims that are delinquent for more than 120 days and mark eligible claims for legal review and action, as appropriate by the U.S. Army Medical Command Staff Judge Advocate. The Chief of Staff stated that changes to the performance work statement and review of all third party claims delinquent for more than 120 days are expected to be completed by March 31, 2020.

Our Response

Comments from the Chief of Staff, Army Office of the Surgeon General, addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we verify that Kimbrough ACC transferred all eligible delinquent third party claims to the U.S. Army Medical Command Staff Judge Advocate for collection assistance.

c. Provide sufficient legal support to pursue collections through the Third Party Collection Program.

Kimbrough Ambulatory Care Center Comments

The Chief of Staff, Army Office of the Surgeon General, responding for the Commander of Kimbrough ACC, did not agree with the recommendation and stated that Kimbrough ACC agrees with the intent of the recommendation, but will do so with the assistance of the U.S. Army Medical Command Staff Judge Advocate. The Chief of Staff stated that Kimbrough ACC will modify procedures to include a requirement to send unpaid third party claims categorized with an invalid denial code and other appropriate criteria to the U.S. Army Medical Command Staff Judge Advocate for additional action. The Chief of staff stated that these actions will be completed by January 13, 2020.

Our Response

Although the Chief of Staff, Army Office of the Surgeon General, disagreed with the recommendation, the comments addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we obtain Kimbrough ACC's modified procedures, verify that the procedures include a requirement to send unpaid third party claims to the U.S. Army Medical Command Staff Judge Advocate, and obtain claim documentation to support that the U.S. Army Medical Command Staff Judge Advocate took action to resolve Kimbrough ACC's unpaid third party claims.

Recommendation 11

We recommend that the Commanding General of Army Regional Health Command–Atlantic; the Director of the Defense Health Agency, National Capital Region Medical Directorate; and Commander of the Air Force Medical Operations Agency:

- **a. Review the contract language for the Third Party Collection Program contracts, and align the contract terms with all applicable Federal and DoD regulations.**

Army Regional Health Command–Atlantic Comments

The Chief of Staff, Army Office of the Surgeon General, responding for the Commanding General of Army Regional Health Command-Atlantic, agreed with the recommendation and stated that the contracting officer will review the current language in the third party collection contract to align with applicable Federal and DoD regulations. The Chief of Staff stated that Army Regional Health Command-Atlantic legal staff will also conduct a review. The Chief of Staff stated that the contract language will be changed by issuing a contract modification and the performance work statement will be revised to reflect new language to ensure proper surveillance of the contractor's performance. The Chief of Staff further stated that the estimated completion date for these actions is January 13, 2020.

Our Response

Comments from the Chief of Staff, Army Office of the Surgeon General, addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we obtain the updated third party collection contract and performance work statement and verify that the Army Regional Health Command-Atlantic modified the contract language to align with all applicable Federal and DoD regulations.

Air Force Medical Operations Agency Comments

The Deputy Surgeon General of the Air Force, responding for the Commander of the Air Force Medical Operations Agency, agreed with the recommendation and stated that the AFMRA UBO reviewed the contract language contained in the performance work statement of the Air Force third party collections contract. The Deputy Surgeon General stated that the current performance work statement states that the contractor will cease collection activities after 150 days of delinquency. The Deputy Surgeon General stated that the performance work statement was updated to state that the contractor should cease collection activity on claims more than 120 days delinquent and notify the MTF for further Government action.

Our Response

Comments from the Deputy Surgeon General of the Air Force addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we obtain a copy of the updated performance work statement and verify that the contract language was modified to align with all applicable Federal and DoD regulations.

Management Comments Required

The Director of the Defense Health Agency, National Capital Region Medical Directorate, did not respond to the recommendations in the report. Therefore, the recommendations are unresolved. We request that the Director provide comments on the final report that specifically state the actions the Director will take to review the contract language for the Third Party Collection Program contract, and align the contract terms with all applicable Federal and DoD regulations. The Director should also provide completion dates for these actions.

b. Implement oversight procedures to monitor contractor performance in accordance with the terms of the contract and all Federal and DoD regulations.

Army Regional Health Command–Atlantic Comments

The Chief of Staff, Army Office of the Surgeon General, responding for the Commanding General of Army Regional Health Command-Atlantic, agreed with the recommendation and stated that new processes were put in place to ensure additional oversight of the contract. The Chief of Staff stated that the UBO Regional Consultant; contracting officer's representative; Chief, Patient Administration Division; contractor; and contracting officer, as necessary, will hold telephone conferences on the second Tuesday of each month. The Chief of Staff stated that additional information will be provided by the contractor on the monthly reports

that Army Regional Health Command–Atlantic already receives to assist with identifying claims that are approaching delinquent status and the contractor's effort to resolve those claims. The Chief of Staff stated that, upon completion of the contract language review, Army Regional Health Command–Atlantic will revise the quality assurance surveillance plan to reflect changes and to ensure appropriate evaluation metrics are in place to monitor, measure, and assess the contractor's performance. The Chief of Staff stated that the estimated completion date for these actions is January 31, 2020.

Our Response

Comments from the Chief of Staff, Army Office of the Surgeon General, addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we obtain the updated quality assurance surveillance plan and verify that the Army Regional Health Command-Atlantic made changes to ensure appropriate evaluation metrics are in place to monitor, measure, and assess the contractor's performance.

Air Force Medical Operations Agency Comments

The Deputy Surgeon General of the Air Force, responding for the Commander of the Air Force Medical Operations Agency, agreed with the recommendation and stated that there are no reporting tools currently available in ABACUS that complete contract performance oversight for this procedure. The Deputy Surgeon General stated that AFMRA will modify an ABACUS report query to improve visibility for third party claims that have been delinquent for more than 120 days. Furthermore, the Deputy Surgeon General stated that the contractor will use this report to inform the government of any claims returned for further action, and the MTFs can use the report to initiate research, transfer to local JAG, and any other appropriate government actions. The Deputy Surgeon General stated that this report modification is available for each MTF's ABACUS database; however, additional assistance from the DHA ABACUS program office is required to develop a report that provides necessary information on an enterprise level. The Deputy Surgeon General stated that the estimated completion date is December 31, 2019.

Our Response

Comments from the Deputy Surgeon General of the Air Force addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we obtain documentation showing that AFMRA modified the ABACUS report query to improve contractor, Air Force MTF UBO, and AFMRA visibility for third party

claims that have been delinquent for more than 120 days, obtain documentation confirming that the Air Force requested and received assistance from the DHA ABACUS program office to develop the report on an enterprise level, and receive the results of the request for assistance from DHA.

Management Comments Required

The Director of the Defense Health Agency, National Capital Region Medical Directorate, did not respond to the recommendations in the report. Therefore, the recommendations are unresolved. We request that the Director provide comments on the final report that specifically state the actions the Director will take to implement oversight procedures to monitor contractor performance in accordance with the terms of the contract and all Federal and DoD regulations. The Director should also provide completion dates for these actions.

c. Hold any contracting personnel assigned oversight responsibility accountable for not appropriately performing oversight procedures necessary to ensure the contractor complied with Federal and DoD regulations and contract terms.

Army Regional Health Command–Atlantic Comments

The Chief of Staff, Army Office of the Surgeon General, responding for the Commanding General of Army Regional Health Command-Atlantic, agreed with the recommendation and stated that new processes have been put in place to ensure additional oversight of the contract, to which all contracting personnel assigned oversight responsibility will be held accountable. The Chief of Staff stated that the UBO Regional Consultant; contracting officer's representative; Chief, Patient Administration Division; contractor; and contracting officer, as necessary, will hold telephone conferences on the second Tuesday of each month. The Chief of Staff stated that additional information will be provided by the contractor on the monthly reports that Army Regional Health Command–Atlantic already receives to assist in assessing the contractor's performance as it relates to production, aged accounts, and delinquent claims. The Chief of Staff stated that, upon completion of the contract language review, Army Regional Health Command–Atlantic will revise the quality assurance surveillance plan to reflect changes and to ensure appropriate evaluation metrics are in place to monitor, measure, and assess the contractor's performance. In addition, the Chief of Staff stated that the contracting officer's representative will be given access to ABACUS to assist in monitoring the contractor's performance. The Chief of Staff stated that the estimated completion date for these actions is January 31, 2020.

Our Response

Comments from the Chief of Staff, Army Office of the Surgeon General, addressed all specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we obtain documentation to support that contracting personnel assigned oversight responsibility were held accountable for not appropriately performing oversight procedures necessary to ensure the contractor complied with Federal and DoD regulations and contract terms.

Air Force Medical Operations Agency Comments

The Deputy Surgeon General of the Air Force, responding for the Commander of the Air Force Medical Operations Agency, agreed with the recommendation and stated that contracting personnel assigned oversight responsibility are accountable for appropriately performing oversight procedures necessary to ensure compliance with Federal and DoD regulations and contract terms. The Deputy Surgeon General stated that the contractor should abide by the contracting officer's representative guidelines pertaining to delinquent debt balances, including transferring to the Government all correspondence between the contractor and insurance providers that reflect the contractor's efforts to obtain payment. The Deputy Surgeon General stated that the contracting officer's representative validates monthly contractor compliance with this key performance objective by samples obtained from ABACUS and any known discrepancies are reported to the contracting officer.

Our Response

Comments from the Deputy Surgeon General of the Air Force did not address the specifics of the recommendation; therefore, the recommendation is unresolved. While the Deputy Surgeon General agreed with the recommendation, the comments did not identify how contracting personnel who were not performing adequate oversight will be held accountable. We request that the Deputy Surgeon General provide additional comments in response to the final report.

Management Comments Required

The Director of the Defense Health Agency, National Capital Region Medical Directorate, did not respond to the recommendations in the report. Therefore, the recommendations are unresolved. We request that the Director provide comments on the final report that specifically state the actions the Director will take to hold contracting personnel assigned oversight responsibility accountable for not appropriately performing oversight procedures. The Director should also provide completion dates for these actions.

Recommendation 12

We recommend that the Director of the Defense Health Agency, National Capital Region Medical Directorate, require the contracting officer to prepare contractor performance assessment reports for Third Party Collection Program contracts, in accordance with the Federal Acquisition Regulation and Defense Federal Acquisition Regulation Supplement.

Management Comments Required

The Director of the Defense Health Agency, National Capital Region Medical Directorate did not respond to the recommendation in the report. Therefore, the recommendation is unresolved. We request that the Director provide comments on the final report that specifically state the actions the Director will take to prepare contractor performance assessment reports for the Third Party Collection Program contracts. The Director should also provide completion dates for these actions.

Appendix A

Scope and Methodology

We conducted this performance audit from July 2018 through June 2019 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Review of Documentation and Interviews

To obtain information and source documentation on the Third Party Collection Program, we interviewed personnel from the DHA, Navy Bureau of Medicine and Surgery, U.S. Army Medical Command, Air Force Medical Operations Agency, and NCR MD. In addition, we interviewed UBO, Patient Administration, clinical and legal personnel from:[47]

- Fort Belvoir CH, Fort Belvoir, Virginia;
- Walter Reed NMMC, Bethesda, Maryland;
- NH Bremerton, Bremerton, Washington;
- NMC San Diego, San Diego, California;
- Madigan AMC, Joint Base Lewis-McChord, Washington;
- Brooke AMC, Fort Sam Houston, Texas;
- Kimbrough ACC, Fort Meade, Maryland;
- 75th Medical Group, Hill Air Force Base, Utah; and
- 59th Medical Wing, Lackland Air Force Base, Texas.

While at the medical facilities, we observed daily procedures performed by UBO, Patient Administration, and front desk personnel at various clinics, such as family medicine, pharmacies, and emergency rooms. In addition, we examined key documents related to the audit objectives, including bills generated by ABACUS, explanation of benefits forms from insurance providers, and medical facility UBO personnel and contractor documented followup notes.

[47] We interviewed contractor personnel at Fort Belvoir CH, 75th Medical Group, Hill Air Force Base, and at the 59th Medical Wing, Lackland Air Force Base.

We obtained, reviewed, and analyzed Federal, DoD, and Service-level guidance related to the Third Party Collection Program at the above sites. We focused our review on:

- Public Law 104-134, section 31001, "Debt Collection Improvement Act of 1996";
- Public Law 113-101, "Digital Accountability and Transparency Act of 2014";
- DoD Financial Management Regulation, Volume 16, Chapter 2, "General Instructions for Collection of Debt Owed to the Department of Defense (DoD)," June 2017;
- DoD 6010.15-M, "Military Treatment Facility Uniform Business Office Manual," November 2006; and
- Defense Health Agency Procedures Manual 6015.01, "Military Medical Treatment Facility Uniform Business Office Operations," October 2017.

Our review included claims from nine medical facilities across the Services, including the NCR MD. We nonstatistically selected two medical facilities within each Service by identifying a medical facility with a low collection rate and a medical facility with a high collection rate for claims billed between FY 2015 and FY 2017, and the two medical facilities in the NCR MD. We also selected six claims from Kimbrough ACC to assess contractor performance. We selected third party claims at the nine medical facilities that were open between October 1, 2015, and June 30, 2018. Those third party claims represented a universe of 250,932 claims, valued at $86.9 million that were open 120 days from the original bill date in ABACUS. We nonstatistically selected the three highest dollar inpatient and three highest dollar outpatient claims at each medical facility.[48] We also nonstatistically selected additional claims at various medical facilities based on preliminary observations in the data, such as negative balances owed and adjustment and write-off codes. The additionally selected claims included claims that were closed as of June 30, 2018; four that were closed within 120 days of the billed date and three that were closed more than 120 days after the billed date. In total, we selected 72 third party claims, with an original billed amount of $4.7 million, across the nine medical facilities. During our audit, we identified that two claims were not part of the Third Party Collection Program and that the UBO should pursue these claims through the other cost recovery programs. Therefore, we reviewed 70 third party claims, valued at $3.6 million, to determine whether the DoD collected the cost of providing health care services from medical claims and whether the medical facilities and contracted personnel complied with the public law and DoD requirements. For the 70 third party claims, we identified the status of the claim, current balance, and reasons why collection was not successful or why the claim remained open during our visits to each medical facility.

[48] For DoD medical facilities without inpatient claims, the audit team reviewed six high dollar outpatient claims.

Third Party Collection Contracts

The Army, NCR MD, and Air Force executed contracts for their third party collection programs. We reviewed the following contracts.

- Army – Regional Health Command–Atlantic awarded contract W91YTZ-17-D-0005 on May 16, 2017, with a total award value of $1.4 million, to provide collection support for the 14 Atlantic Region medical facilities. Based on expected third party collections workload and available UBO personnel, the medical facilities have the option to opt in or out of the contract at the beginning of each contract year. Eleven of the 14 medical facilities have opted in to receive contractor support for the third party collections program during the base year of the contract. The period of performance for the base year of this contract was between July 1, 2017, and June 30, 2018. We selected six claims, valued at $185,480.20, billed within the period of performance for Kimbrough ACC to determine whether the contractor complied with Federal and DoD regulations and the contract performance work statement.
- NCR MD – Under contract GS23F0186L, DHA awarded delivery order HT0014-15-F-0029 on July 1, 2015, with a total award value of $3.7 million, to provide collection support for Fort Belvoir CH. The delivery order included an option for Walter Reed NMMC; however, Walter Reed NMMC did not opt in to receive support from the contract until the fourth option period, from September 30, 2018, to September 29, 2019. The period of performance on this delivery order was between July 1, 2015, and September 29, 2019. Fort Belvoir CH was the only NCR MD medical facility supported by the delivery order as of June 30, 2018; therefore, we selected six claims, valued at $132,140.65, billed between October 1, 2015, and June 30, 2018, to determine whether the contractor complied with Federal and DoD regulations and the contract performance work statement.
- Air Force – The 773 Enterprise Sourcing Squadron awarded three delivery orders on contract FA8052-15-D-0002 to provide collection support for all Air Force medical facilities.[49] The three task orders, awarded between March 8, 2017, and March 20, 2017, with a total award value of $5.4 million, support the 73 Air Force medical facilities. The periods of performance on the three delivery orders were March 12, 2017, through March 11, 2019; March 30, 2017, through March 29, 2019; and March 31, 2017, through March 30, 2019. We selected 11 claims, valued at $86,629.02, billed for the 59th Medical Wing, Lackland Air Force Base, and 75th Medical Group, Hill Air Force Base, between March 12, 2017,

[49] Task order FA8052-17-F-0005, awarded on March 8, 2017, with a value of $854,881 for the base and option years, supports the 22 medical facilities in Region 1; task order FA8052-17-F-0008, awarded on March 20, 2017, with a value of $3.3 million for the base and option years, supports the 28 medical facilities in Region 2; and task order FA8052-17-F-0013, awarded on March 20, 2017, with a value of $1.2 million for the base and option years, supports the 23 medical facilities in Region 3.

and June 30, 2018. We reviewed the 11 claims to determine whether the contractor complied with Federal and DoD regulations and the contract performance work statement.

We reviewed the level of oversight provided by the contracting officer and contracting officer's representative by conducting interviews and reviewing actions on claims to make collections. In addition, we reviewed the contracts and performance work statements to determine whether language maximized the contractor's collection efforts and complied with public law and DoD regulations, and included processes to elevate claims for further collection support once a claim was delinquent for more than 120 days.

Use of Computer-Processed Data

We relied on computer-processed data from ABACUS to select a nonstatistical sample of 70 claims for the medical facilities included in the audit scope.

To assess the reliability of the claims and data provided, we compared the ABACUS data provided by the Services and NCR MD to supporting documentation, including:

- patient information,
- medical facility-generated bills,
- insurance provider correspondence, and
- personnel notes and documentation on attempted collections.

Of the claims reviewed, we identified some discrepancies between the ABACUS data provided and the claim files requested at various medical facilities. These discrepancies were generally caused by ABACUS system errors, UBO personnel not working claims placed in ABACUS review buckets within the required time frames, and duplicate claims not sent to the insurance providers. Medical facility UBO personnel were able to adequately explain why the discrepancies occurred and we determined the data was sufficiently reliable for the purposes of this report.

Prior Coverage

During the last 5 years, the DoD OIG and Naval Audit Service issued nine reports discussing medical accounts. Unrestricted DoD OIG reports can be accessed at http://www.dodig.mil/reports.html/.

Naval Audit Service reports are not available over the Internet.

DoD OIG

Report No. DODIG-2019-038, "Followup of Delinquent Medical Service Account Audits," December 19, 2018

> Medical treatment facilities implemented some corrective actions from the prior audit reports and improved billing processes for accounts with the implementation of the DoD medical billing system, ABACUS; collection of patient billing information; and transfer of debt to the Treasury for collection. However, additional actions are needed to further improve the processes the Services' use to review and pursue collections on open and delinquent accounts. The Services were unable to determine the total number and dollar value of delinquent accounts, and they have not fully pursued opportunities to collect a potential $80.1 million on delinquent accounts and accounts not billed.

Report No. DODIG-2017-045, "Medical Service Accounts at U.S. Army Medical Command Need Additional Management Oversight," January 27, 2017

> U.S. Army Medical Command officials did not effectively manage delinquent medical service accounts because they did not have adequate procedures to process the transferred account. Unless U.S. Army Medical Command personnel review the remaining accounts, they risk missing the opportunity to collect up to $38.4 million to fund administrative, operation, and equipment costs; readiness training; and trauma consortium activities.

Report No. DODIG-2016-079, "Delinquent Medical Service Accounts at Landstuhl Regional Medical Center Need Additional Management Oversight," April 28, 2016

> U.S. Army Medical Command and Regional Health Command Europe UBO officials did not effectively manage delinquent medical service accounts for Landstuhl Regional Medical Center. Unless U.S. Army Medical Command and Regional Health Command Europe management acts to collect $4.4 million in delinquent debt and improves its collection process, Landstuhl's medical service accounts will continue to incur rising delinquent balances.

Report No. DODIG-2015-179, "Delinquent Medical Service Accounts at David Grant Air Force Medical Center Need Additional Management Oversight," September 24, 2015

> David Grant U.S. Air Force Medical Center UBO management did not effectively manage delinquent medical service accounts. Unless David Grant U.S. Air Force Medical Center UBO management acts to collect $707,591 in delinquent debt and improves its collection process, its medical service accounts will continue to incur rising delinquent balances.

Report No. DODIG-2015-151, "Followup Audit: DoD Military Treatment Facilities Continue to Miss Opportunities to Collect on Third Party Outpatient Claims," July 24, 2015

DoD Military treatment facility officials did not conduct initial followup, document claim write-offs, refer outstanding claims to their legal office, or obtain necessary precertification or preauthorization. Opportunities exist to increase collections for the DoD military treatment facilities because officials generally did not conduct compliance audits to identify discrepancies.

Report No. DODIG-2015-087, "Delinquent Medical Service Accounts at Naval Medical Center Portsmouth Need Additional Management Oversight," March 4, 2015

Naval Medical Center Portsmouth UBO management did not effectively manage delinquent medical service accounts. Unless the Naval Medical Center Portsmouth UBO acts to collect $770,746 in delinquent debt and improves its collection process, its medical service accounts will continue to incur rising delinquent balances.

Report No. DODIG-2014-112, "Delinquent Medical Service Accounts at William Beaumont Army Medical Center Need Additional Management Oversight," September 16, 2014

William Beaumont Army Medical Center UBO management did not effectively manage delinquent medical service accounts. Unless William Beaumont Army Medical Center UBO management acts to collect $669,546 in delinquent debt and improves its collection process, its medical service accounts will continue to incur rising delinquent balances.

Report No. DODIG-2014-101, "Delinquent Medical Service Accounts at Brooke Army Medical Center Need Additional Management Oversight," August 13, 2014

Brooke Army Medical Center UBO management did not effectively manage delinquent medical service accounts. Unless Brooke Army Medical Center UBO management acts to collect $73.1 million in delinquent debt and improves its collection process, its medical service accounts will continue to incur rising delinquent balances.

Navy

Report N2015-0034, "(Unclassified/FOUO) Third Party Collection Program," September 8, 2015

The audit objective was to verify that the Navy's military treatment facilities were managing the Third Party Collection Program as intended.

Appendix B

DD Form 2569

THIRD PARTY COLLECTION PROGRAM/MEDICAL SERVICES ACCOUNT/ OTHER HEALTH INSURANCE

(Read Privacy Act Statement before completing this form.)

OMB No. 0720-0055
OMB approval expires
31 Aug, 2019

The public reporting burden for this collection of information is estimated to average 4 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Directives Division, 4800 Mark Center Drive, East Tower, Suite 02G09, Alexandria, VA 22350-3100 (0720-0055). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. **PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO REQUESTING MILITARY TREATMENT FACILITY.**

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC, Sections 1079b, Procedures for charging fees for care provided to civilian; retention and use of fees collected;1095, Health care services incurred on behalf of covered beneficiaries: collection from thirdparty payers; 42 USC. Chapter 32, Third Party Liability For Hospital and Medical Care; EO 9397 (SSN) as amended.

PURPOSE(S): Your information is collected to allow recovery from third parties for medical care provided to you in a Military Treatment FacilityROUTINE USE(S): Your records may be disclosed outside of DoD to healthcare clearinghouses, commercial insurances providers, and other third parties in order to collect amounts owed to the Department of Defense. Your records may also be used and disclosed in accordance with 5 USC 552a(b) of the Privacy Act of 1974, a amended, which incorporates the DoD Blanket Routine Uses published at: http://dpcld.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx.

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

DISCLOSURE: Voluntary. Failure to provide complete and accurate information may result in disqualification for health care services from MTFs.

PATIENT INFORMATION

1. PATIENT NAME *(Last, First, Middle Initial)*

2. SSN

3. DATE OF BIRTH *(YYYY/MM/DD)*

4a. MAILING ADDRESS *(Include ZIP Code)*

b. HOME TELEPHONE NO. ( )

5a. FAMILY MEMBER PREFIX

b. SPONSOR SSN

6a. PATIENT'S EMPLOYER'S NAME

b. EMPLOYER TELEPHONE NUMBER

INSURANCE INFORMATION

7. ARE YOU ELIGIBLE FOR VETERANS AFFAIRS BENEFITS?

a. **YES.** *(If you have an insurance card (e.g., Veterans Health Identification Card (VHIC), Veterans Choice Card), that can be copied or scanned by the MTF representative, please provide it and proceed to Item 8; otherwise, please complete items 7.a.(1) through (5) below.)*

(1) Member ID

(2) Plan ID

(3) Expiration Date *(YYYY/MM/DD)*

(4) VA Facility Name *(e.g., primary care/specialty clinic)* that assists in coordinating your care

(5) VA Facility Address and Telephone Number ( )

b. NO. *(Proceed to Item 8.)*

8. DO YOU HAVE OTHER HEALTH INSURANCE? *(This includes employer health insurance benefits, other commercial health insurance coverage, and Medicare Supplement.)*

a. **YES.** *(Complete Item 9 and the remaining sections below.)*

b. **NO**, I am a DoD beneficiary and rely solely on TRICARE, Medicare, or Medicaid. *(Proceed to Item 13.)*

c. **NO**, but I am not a DoD beneficiary. *(Proceed to Item 12.)*

9. PRIMARY MEDICAL INSURANCE INFORMATION. If you have an insurance card that can be copied or scanned by the MTF representative, please provide it and proceed to Item 11; otherwise, please complete the blocks below.

a. NAME OF POLICY HOLDER *(Last, First, Middle Initial)*

b. DATE OF BIRTH *(YYYY/MM/DD)*

c. RELATIONSHIP TO POLICY HOLDER

d. POLICY HOLDER'S EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER

e. INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

f. CARD HOLDER ID

g. POLICY ID

h. GROUP POLICY ID

i. GROUP PLAN NAME

j. ENROLLMENT/PLAN CODE

k. INSURANCE TYPE

l. POLICY EFFECTIVE DATE *(YYYY/MM/DD)*

m. POLICY END DATE *(YYYY/MM/DD)*

n.(1) Pharmacy (Rx) Insurance Company Name, Address and Telephone Number

(2) Rx Policy ID

(3) Rx Bin Number

(4) Rx PCN Number

DD FORM 2569, SEP 2016 PREVIOUS EDITION IS OBSOLETE. Adobe Professional XI

DD Form 2569 (cont'd)

10. SECONDARY MEDICAL INSURANCE INFORMATION. If you have an insurance card that can be copied or scanned by the MTF representative, please provide it and proceed to Item 11; otherwise, please complete the blocks below.

a. NAME OF POLICY HOLDER *(Last, First, Middle Initial)*		b. DATE OF BIRTH *(YYYY/MM/DD)*	c. RELATIONSHIP TO POLICY HOLDER
d. POLICY HOLDER'S EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER			
e. INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER			
f. CARD HOLDER ID	g. POLICY ID	h. GROUP POLICY ID	i. GROUP PLAN NAME
j. ENROLLMENT/PLAN CODE	k. INSURANCE TYPE	l. POLICY EFFECTIVE DATE *(YYYY/MM/DD)*	m. POLICY END DATE *(YYYY/MM/DD)*

n. (1) Pharmacy (Rx) Insurance Company Name, Address and Telephone Number

(2) Rx Policy ID	(3) Rx Bin Number	(4) Rx PCN Number

11. ARE THERE OTHER FAMILY MEMBERS COVERED UNDER THIS POLICY HOLDER?

a. **YES** *(Complete 11c.-f. and proceed to Item 13.)* b. **NO** *(Proceed to Item 13.)*

c. NAME *(Last, First, Middle Initial)*	d. SSN	e. DATE OF BIRTH *(YYYY/MM/DD)*	f. RELATIONSHIP TO POLICY HOLDER	c. NAME *(Last, First, Middle Initial)*	d. SSN	e. DATE OF BIRTH *(YYYY/MM/DD)*	f. RELATIONSHIP TO POLICY HOLDER

12. MEDICARE OR MEDICAID INFORMATION

a. MEDICARE PART A NUMBER	b. MEDICARE PART B NUMBER	c. MEDICARE MANAGED CARE PLAN NAME
d. MEDICARE PART D NUMBER AND PLAN NAME		e. MEDICAID NUMBER/MANAGED CARE PLAN NAME/ISSUING STATE

13. CERTIFICATION, RELEASE, AND ASSIGNMENT

a. I certify that the information on this form is true and accurate to the best of my knowledge. Falsification of information is covered by Title 18, United States Code, Section 1001, which provides for a maximum fine of $250,000 or imprisonment for five years, or both.

b. I acknowledge that the authority to bill third party payers has been conveyed to the medical facility within the Department of Defense by Title 10, United States Code, Sections 1095 and 1079b, and that no personal entitlement to reimbursement or payment has been granted to me by virtue of this act.

c. NON-UNIFORMED SERVICES PATIENTS: I authorize and request that the proceeds of any and all benefits be paid directly to the MTF for healthcare services provided me and/or my minor dependents. ACKNOWLEDGEMENT: I hereby agree to pay for any service not covered in whole or in part by my third-party insurer.

d. NON-DoD MEDICARE, MEDICAID AND VETERANS AFFAIRS PATIENTS: I authorize and request that the proceeds of any and all benefits be paid directly to the MTF for healthcare services provided to me and/or my family member. I acknowledge I am responsible for full payment of any services not covered by Medicare, Medicaid and Veterans Affairs, including but not limited to patient copayments and deductibles.

e. UNIFORMED SERVICES BENEFICIARIES: I hereby acknowledge that the proceeds of any and all benefits shall be paid directly to the facility of the Uniformed Service for services provided to me and/or my family member.

f. ALL PATIENTS: I authorize portions of my medical records necessary to support claims for reimbursement for the cost of care rendered to be released to my insurance carriers.

14a. PATIENT OR ADULT FAMILY MEMBER SIGNATURE	b. DATE *(YYYY/MM/DD)*
15a. IF PATIENT REFUSES TO SIGN THIS FORM: MTF REPRESENTATIVE SIGNATURE	b. DATE *(YYYY/MM/DD)*

16. ANNUAL PATIENT INSURANCE VERIFICATION

a. If any information on this form has changed, a new form must be completed and signed. Otherwise, after initial signature, verify with your initials and date at least annually.

b. I certify that the information on this form has been verified on the date(s) specified below, and that all information is true and accurate to the best of my knowledge.

17a. SIGNATURE *(Patient or Adult Family Member)*	b. DATE *(YYYY/MM/DD)*

18. VERIFICATION a. (1) Date *(YYYY/MM/DD)*	(2) Initials	b.(1) Date *(YYYY/MM/DD)*	(2) Initials	c.(1) Date *(YYYY/MM/DD)*	(2) Initials

DD FORM 2569 (BACK), SEP 2016

Appendix C

Sample Claims

The table shows the results of our review of the 70 nonstatistically selected third party collection claims. Specifically, it shows the total billed amount and remaining outstanding balance for each claim. Additionally, the table shows whether UBO personnel (and the contractor) complied with public law, DoD FMR, and DHA Procedures Manual requirements for conducting timely followup, and elevating claims to the Treasury Cross-Servicing Program or legal offices for collection assistance.

Location	Claim Number	Billed Amount	Complied With Followup Requirements[1]	Longest Period Without Follow Up (Days)[2]	Transferred to the Treasury[3]	Transferred to Legal Office[4]	Remaining Balance[5]
Fort Belvoir CH	180123P0032601[6]	$ 20,590.40	No	287	N/A	N/A	$ 0
Fort Belvoir CH	186200P0006188[6]	19,752.90	No	186	No	No	19,752.90
Fort Belvoir CH	176201P0118702[6]	19,687.70	No	274	N/A	N/A	0
Fort Belvoir CH	170123T0055255[6]	15,198.79	No	88	No	No	15,198.79
Fort Belvoir CH	170123T0124376[6]	29,508.70	Yes	N/A	No	No	14,739.80
Fort Belvoir CH	180123T0051729[6]	27,402.16	Yes	N/A	No	No	13,701.07
Walter Reed NMMC	180067P0072468	274,760.34	N/A[7]	N/A	N/A	N/A	0
Walter Reed NMMC	170067P0175624	263,413.04	N/A[7]	N/A	N/A	N/A	65,852.76
Walter Reed NMMC	170067P0183468	263,413.04	N/A[7]	N/A	N/A	N/A	65,852.76
Walter Reed NMMC	170067T0031198	131,108.77	No	657	N/A	N/A	0
Walter Reed NMMC	170067T0196601	108,697.35	N/A[7]	N/A	N/A	N/A	0
Walter Reed NMMC	170067T0015517	93,362.84	No	731	No	No	93,362.84
Walter Reed NMMC	170067P0021898	700.80	No	527	N/A	N/A	0
Walter Reed NMMC	170067T0123844	33,537.67	N/A[7]	N/A	N/A	N/A	0
Walter Reed NMMC	170067P0067583	36,919.69	No	629	No	No	36,919.69
NH Bremerton	180126P0003041	5,288.44	No	209	N/A	N/A	0
NH Bremerton	170126P0018228	2,694.80	No	277	No	No	2,694.80

Table of Sample Claims (cont'd)

Location	Claim Number	Billed Amount	Complied With Followup Requirements[1]	Longest Period Without Follow Up (Days)[2]	Transferred to the Treasury[3]	Transferred to Legal Office[4]	Remaining Balance[5]
NH Bremerton	170126P0023384	2,520.75	No	98	N/A	N/A	0
NH Bremerton	170126P0022485	1,946.00	No	189	No	No	1,946.00
NH Bremerton	180126P0004421	1,917.20	No	109	No	No	1,917.20
NH Bremerton	180126P0000324	1,881.20	No	182	No	No	1,881.20
NH Bremerton	170126T0026597	28,109.93	No	89	N/A	N/A	0
NH Bremerton	160126P0021237	42,843.60	Yes	N/A	N/A	N/A	0
NMC San Diego	170029T0039582	112,137.19	No	127	N/A	N/A	0
NMC San Diego	180029T0013303	103,272.75	Yes	N/A	N/A	N/A	0
NMC San Diego	170029T0021913	97,929.24	No	198	N/A	N/A	0
NMC San Diego	170407P0032100	12,302.96	Yes	N/A	N/A	N/A	0
NMC San Diego	170029P0039662	11,852.54	No	288	No	No	11,852.54
NMC San Diego	180029P0007640	11,852.54	No	177	No	No	11,852.54
Madigan AMC	160125P0095021	26,344.20	No	479	N/A	N/A	26,344.20
Madigan AMC	180125P0009594	17,872.40	No	141	No	No	0
Madigan AMC	170125P0069210	12,513.05	No	172	N/A	N/A	12,513.05
Madigan AMC	170125T0038494	162,049.95	Yes	N/A	No	No	162,049.95
Madigan AMC	170125T0028992	44,292.75	No	110	No	No	41,192.26
Madigan AMC	160125T0067959	336,754.47	No	162	N/A	N/A	0
Brooke AMC	170109P0093735	103,626.88	No	399	No	No	0
Brooke AMC	160109P0091311	86,870.26	No	343	No	No	0
Brooke AMC	160109P0015796	79,600.60	No	289	No	No	7,959.66
Brooke AMC	170109T0058839	79,988.76	No	92	No	Yes	0
Brooke AMC	170109T0081713	117,370.62	No	81	No	Yes	116,054.62

Table of Sample Claims (cont'd)

Location	Claim Number	Billed Amount	Complied With Followup Requirements[1]	Longest Period Without Follow Up (Days)[2]	Transferred to the Treasury[3]	Transferred to Legal Office[4]	Remaining Balance[5]
Brooke AMC	160109T0078660	105,636.51	No	458	No	Yes	104,376.51
Kimbrough ACC	180308P0001533[6]	37,478.00	No	220	No	No	37,478.00
Kimbrough ACC	180309P0003861[6]	35,553.62	No	153	No	No	5,925.60
Kimbrough ACC	180069P0002194[6]	32,785.40	No	211	No	No	32,785.40
Kimbrough ACC	170069P0066310[6]	32,215.70	No	302	No	No	32,215.70
Kimbrough ACC	180308P0009407[6]	23,744.40	No	175	No	No	23,744.40
Kimbrough ACC	180308P0006750[6]	23,703.08	No	189	No	No	23,703.08
75th Medical Group	160119P0002158	29,685.20	No	796	No	No	2,970.32
75th Medical Group	160119P0012427	20,407.80	No	849	N/A	N/A	0
75th Medical Group	160119P0002127	12,431.00	No	863	No	No	0
75th Medical Group	160119P0019207	652.51	No	728	No	No	592.16
75th Medical Group	160119P0019543	249.30	No	716	N/A	N/A	0
75th Medical Group	180119P0007904[6]	235.76	No	210	N/A	N/A	0
75th Medical Group	160119P0010208	169,738.96	No	589	N/A	N/A	(168,098.70)[9]
75th Medical Group	170119P0011543[6]	9,465.60	No	423	No	No	3,631.10
75th Medical Group	170119P0017768[6]	5,884.40	N/A[8]	N/A	N/A	N/A	0
75th Medical Group	170119P0019472[6]	4,993.40	Yes	N/A	N/A	N/A	0
75th Medical Group	180119P0008533[6]	4,593.72	Yes	N/A	N/A	N/A	0
75th Medical Group	170119P0018748[6]	1,519.40	Yes	N/A	N/A	N/A	0
59th Medical Wing	160117P0060699	18,095.44	No	698	No	No	18,095.44
59th Medical Wing	160117P0050131	18,036.56	No	747	N/A	N/A	18,036.56
59th Medical Wing	170117P0042740[6]	16,994.00	No	248	N/A	N/A	16,994.00
59th Medical Wing	170117P0069627[6]	4,190.50	No	324	N/A	N/A	0

Table of Sample Claims (cont'd)

Location	Claim Number	Billed Amount	Complied With Followup Requirements[1]	Longest Period Without Follow Up (Days)[2]	Transferred to the Treasury[3]	Transferred to Legal Office[4]	Remaining Balance[5]
59th Medical Wing	170117P0024001	3,672.84	No	438	N/A	N/A	1,884.04
59th Medical Wing	170117P0009605[6]	3,409.20	No	401	N/A	N/A	0
59th Medical Wing	160117P0038189	2,505.36	No	504	No	No	0
59th Medical Wing	170117P0001644	2,450.86	No	426	N/A	N/A	0
59th Medical Wing	160117P0055788	53,794.10	Yes	N/A	N/A	N/A	0
59th Medical Wing	180117P0033410[6]	17,671.52	Yes	N/A	N/A	N/A	0
59th Medical Wing	180117P0033394[6]	17,671.52	No	87	N/A	N/A	0
Totals		**$3,551,352.93**					**$877,972.24**

[1] DoD 6010.15-M, "Military Treatment Facility Uniform Business Office Manual," November 2006.
DHA-PM 6015.01, "Military Medical Treatment Facility (MTF) Uniform Business Office (UBO) Operations," October 24, 2017.
DoD Financial Management Regulation (FMR) 7000.14-R, Volume 16, Chapter 2, "General Instructions for Collection of Debt Owed to the Department of Defense (DoD)."

[2] We included only numbers of days for claims that UBO personnel did not follow up on in accordance with requirements.

[3] Public Law 104-134, chapter 10, section 31001, "The Debt Collection Improvement Act of 1996." On May 9, 2014, Public Law 113-101, "Digital Accountability and Transparency Act of 2014," amended sub-section 3716(c)(6) of section 37, title 31, United States Code, by reducing the time period for transferring debt from 180 days to 120 days.

[4] DoD 6010.15-M, "Military Treatment Facility Uniform Business Office Manual," November 2006.
DHA-PM 6015.01, "Military Medical Treatment Facility (MTF) Uniform Business Office (UBO) Operations," October 24, 2017.

[5] The remaining balance equals the billed amount minus payments and any adjustments/write-offs that UBO personnel posted or planned to post due to incorrect original billed amounts.

[6] This claim was covered under an active third party collection contract.

[7] It was not applicable for UBO personnel to conduct followup for this claim because the claim was not submitted to the provider.

[8] It was not applicable for UBO personnel to conduct followup on this claim because the insurance provider denied the claim for an acceptable denial the same day the claim was billed.

[9] UBO personnel submitted this claim to the insurance provider with an incorrect billed amount. The insurance provider paid the entire incorrect billed amount. UBO personnel adjusted the original billed amount and resubmitted the claim, which resulted in a negative remaining balance. UBO personnel submitted a refund request for the negative remaining balance on this claim.

Appendix D

Potential Monetary Benefits

Recommendation	Type of Benefit*	Amount of Benefit	Account
4.f, 5.d, and 10.b	Economy and Efficiency. Madigan AMC, Brooke AMC, and Kimbrough ACC collection of services rendered could be used for administrative, operating, and equipment costs; readiness training; or trauma consortium activities.	$17,540,364.57	97 9 0130 1881 021
6.c and 7.g	Economy and Efficiency. The 59th Medical Wing and the 75th Medical Group collection of services rendered could be used for administrative, operating, and equipment costs; readiness training; or trauma consortium activities.	$9,824,535.71	97 9 0130 1883 181
2.f and 3.b	Economy and Efficiency. NH Bremerton and NMC San Diego collection of services rendered could be used for administrative, operating, and equipment costs; readiness training; or trauma consortium activities.	$1,943,545.95	97 9 0130 1882 007
8.d and 9.c	Economy and Efficiency. Walter Reed NMMC and Fort Belvoir CH collection of services rendered could be used for administrative, operating, and equipment costs; readiness training; or trauma consortium activities.	$41,405,859.87	97 9 0130 D71 P19

* Potential monetary benefits are funds put to better use or questioned costs.

Management Comments on Potential Monetary Benefits and Our Response

Army Office of the Surgeon General Comments

The Chief of Staff, Army Office of the Surgeon General, did not agree with the potential monetary benefits calculation assuming full payment of billed amounts. The Chief of Staff stated that, historically at Madigan AMC, collection ranges between 42 to 48 percent, with a ratio of 46.12 percent over the past 12 months. The Chief of Staff further stated that Brooke AMC's historical rate was 56.5 percent during FY 2018 and, using that rate, Brooke AMC estimates the true value of all aged claims, at best, is $5.3 million once all collection efforts have been exhausted.

Our Response

Comments from the Chief of Staff, Army Office of the Surgeon General, addressed the potential monetary benefits. The audit team acknowledges that using historical collection rates is one method to estimate monetary benefits. However, Madigan AMC, Brooke AMC, and Kimbrough ACC had a combined 63,949 accounts, valued at $17.54 million, which were not transferred to the U.S. Treasury for collection or local legal offices for assistance. Until Madigan AMC, Brooke AMC, and Kimbrough ACC collect reasonable charges for the debt or transfer the debt to the U.S. Treasury or a local legal office, the full balance of the debt is considered potentially collectible.

Management Comments Required

The Commander of the 59th Medical Wing at Lackland Air Force Base and Commander of the 75th Medical Group at Hill Air Force Base did not respond to the potential monetary benefits. We request that the Commanders provide comments on the final report.

Navy Bureau of Medicine and Surgery Comments

The Deputy Assistant Secretary of the Navy (Military Manpower and Personnel) responded to potential monetary benefits by stating that until NMC San Diego and NH Bremerton complete detailed reviews of the un-transferred encounters, they cannot determine whether the potential monetary benefit of $1.943 million is accurate. The Deputy Assistant Secretary stated that Navy BUMED directed these two facilities to provide the total billed amounts, once their reviews are complete on January 31, 2020.

Our Response

Comments from the Deputy Assistant Secretary of the Navy (Military Manpower and Personnel) addressed the potential monetary benefits. NH Bremerton and NMC San Diego had a combined 8,582 accounts, valued at $1.94 million, which were not transferred to the U.S. Treasury for collection or local legal offices for assistance. Until NH Bremerton and NMC San Diego collect reasonable charges for the debt or transfer the debt to the U.S. Treasury or a local legal office, the full balance of the debt is considered potentially collectible.

Management Comments Required

The Director of Walter Reed NMMC and Commander of Fort Belvoir CH did not respond to the potential monetary benefits. We request that the Director and Commander provide comments on the final report.

Management Comments

U.S. Department of the Navy

DEPARTMENT OF THE NAVY
OFFICE OF THE ASSISTANT SECRETARY
(MANPOWER AND RESERVE AFFAIRS)
1000 NAVY PENTAGON
WASHINGTON, D.C. 20350-1000

JUL 11 2019

MEMORANDUM FOR DEPARTMENT OF DEFENSE INSPECTOR GENERAL

SUBJECT: DoD OIG Draft Report - Audit of the DoD's Management of the Third Party Collection Program for Medical Claims - Project No. D2018-D000AX-0174.000

The Department of the Navy (DON) appreciates the opportunity to provide a response to the Department of Defense (DoD) Office of the Inspector General Draft Report, "Audit of the DoD's Management of the Third Party Collection Program for Medical Claims," (Project No. D2018-D000AX-0174.000). The DON's response to recommendations are attached and provided for your consideration. My point of contact for this matter is

Russell W. Beland
Deputy Assistant Secretary of the Navy
(Military Manpower and Personnel)

Attachment:
As stated

U.S. Department of the Navy (cont'd)

DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
7700 ARLINGTON BOULEVARD
FALLS CHURCH VA 22042

IN REPLY REFER TO
7000
Ser M8/2019 UGEN-001442h
JUL 03 2019

MEMORANDUM FOR ASSISTANT SECRETARY OF THE NAVY (MANPOWER AND RESERVE AFFAIRS)

SUBJECT: FOLLOW-UP AUDIT OF DELINQUENT MEDICAL SERVICES ACCOUNTS AUDITS

Reference: (a) DoDIG Draft Report D2018-D000AX-0074.000 of 12 Jun 2019

1. In response to reference (a), Bureau of Medicine and Surgery (BUMED) provides the following comments and statement of actions that will be taken to address the findings.

a. Recommendation 2.a: We partially agree with this recommendation. As per the Defense Health Agency Procedures Manual (DHA-PM) 6015.01 paragraph 4.c.(4), Military Treatment Facilities (MTFs) may obtain evidence of Other Health Insurance (OHI) by either obtaining a DD Form 2569 or performing OHI discovery. As such, as part of a Third Party Collections (TPC) Standard Operating Procedure (SOP), BUMED will direct its MTFs to use evidence of OHI discovery from the Armed Forces Billing and Collection Utilization Solution (ABACUS) as proof that the MTF searched for OHI on a patient. The TPC SOP will be published by 30 Sep 2019.

b. Recommendation 2.b: We agree with this recommendation and have directed NH Bremerton to resolve the 7,757 encounters by 31 Jan 2020.

c. Recommendation 2.c: We agree with this recommendation and have directed NH Bremerton to completely code all encounters according to DHA coding guidelines, and then also process the 2,236 uncoded encounters by 31 Jan 2020.

d. Recommendations 2.d and 3.a: We agree with these recommendations and will include guidance on Treasury transfers in our TPC SOP.

e. Recommendation 2.e: We agree with this recommendation and will include guidance on validating denials in our TPC SOP.

f. Recommendations 2.f and 3.b: We agree with these recommendations and will include guidance on Treasury transfers in our TPC SOP. We have also directed NMC San Diego and NH Bremerton to transfer all delinquent TPC encounters to Treasury by 31 Jan 2020.

g. Recommendations 2.g and 3.c: We partially agree with these recommendations. As per 31 USC 3711/16, delinquent debt and claims older than 120 days must be transferred to the Secretary of the Treasury; there is no mandate that delinquent debts first undergo internal legal review. As such, we will include guidance on Treasury transfers for delinquent claims in our TPC SOP.

U.S. Department of the Navy (cont'd)

Subj: FOLLOW-UP AUDIT OF DELINQUENT MEDICAL SERVICES ACCOUNTS AUDITS

2. Potential monetary benefit. Until NMC San Diego and NH Bremerton complete detailed reviews of the untransferred encounters, it is not possible to determine whether or not the potential monetary benefit of $1.943 million is accurate. As such, we have directed these facilities to provide the total billed amounts, once their reviews are complete on 31 Jan 2020.

3. Releasability. We have reviewed the draft report for any sensitive/non-releasable material; we have no objection to releasing the report to the public as written.

4. My point of contact for this memorandum is

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U.S. Army Office of the Surgeon General

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
7700 ARLINGTON BOULEVARD
FALLS CHURCH, VA 22042-5140

DASG-CS

30 JUL 2019

MEMORANDUM FOR Department of Defense Inspector General, Contract Management and Payments, ATTN: [redacted] 4800 Mark Center Drive, Alexandria, VA 22350-1500

SUBJECT: Reply to DODIG Draft Report, DOD's Management of the Third Party Collection Program for Medical Claims (Project Number D2018-000AX-0174.000)

1. Thank you for the opportunity to review this draft report.

2. Our comments are enclosed for your consideration.

4. Our point of contact is [redacted]

FOR THE SURGEON GENERAL:

Encls

RICHARD R. BEAUCHEMIN
Chief of Staff

U.S. Army Office of the Surgeon General (cont'd)

U.S. Army Medical Command (MEDCOM) and
Office of the Surgeon General (OTSG)

Comments on DODIG Draft Report
DoD's Management of the Third Party Collection Program for Medical Claims
(Project No. D2018-D000AX-0174.000)

RECOMMENDATION 4a: Commander, Madigan Army Medical Center (MAMC) direct personnel at all medical facility clinics and clinical support activities to collect hardcopy or electronic versions of DD Form 2569, and as appropriate, take administrative action for noncompliance.

RESPONSE: Concur. MAMC will develop a local policy to enforce the required collection of DD Form 2569 at each clinic. The Uniform Business Office (UBO) will provide training for Madigan staff to ensure understanding of the DD Form 2569 collection process. UBO will also develop an audit process to verify compliance at each clinic every quarter and report findings to MAMC Commander for action as appropriate. Actions are expected to be complete by 1 January 2020.

RECOMMENDATION 4b: Commander, Madigan Army Medical Center develop a plan and take action to process, and as appropriate, bill through the applicable cost recovery program, all patient encounters at Madigan Army Medical Center that are not assigned a credentialed provider or are missing medical coding or doctor's notes, including the 16,243 patient encounters between October 1, 2018, and December 31, 2018.

RESPONSE: Concur. There is a known system defect within MHS GENESIS which results in staff being unable to attribute an encounter to a provider. This occurs when a patient checks in and was not assigned a provider, but were appointed to a generic resource. However, Madigan Army Medical Center will implement work around processes to allow for billing through the applicable cost recovery program.

Specifically, some encounters with no attributed resource can have a resource assigned post-patient check-in using a work around. For example, most outpatient encounters can have the resource attribution changed. MAMC Clinical Operations will develop training to assist with implementing this solution. Implementation is expected to be complete by 31 August 2019.

For those encounters missing coding or doctor's notes, MHS GENESIS has an auto-discharge function that closes out an outpatient encounter and sends it to ABACUS after 72 hours even if coding or notes are not complete. MHS GENESIS Revenue Expansion (RevX) billing functions directs any uncoded encounters to a work list to be processed. However, the MHS GENESIS report used to identify the referenced 16,243 encounters does not show the patient, patient category, or insurance information (attachment 4b-1), and there is no way to determine how many encounters are billable

Encl

U.S. Army Office of the Surgeon General (cont'd)

by third party collections. However, there is an ABACUS report of uncoded outpatient encounters pending which identifies the parameters needed. For 1 October 2018 through 31 December 2018, there are currently 74 uncoded encounters (attachment 4b-2). These encounters will be researched and any that have not been billed will provided to coding for processing by 31 July 2019. In addition, a process to regularly review this report will be developed and in place by 31 July 2019.

RECOMMENDATION 4c: Commander, Madigan Army Medical Center review and modify procedures for obtaining pre-authorization when beneficiaries receive services at the medical facility that require preauthorization from the insurance provider.

RESPONSE: Non-concur. While agrees with maximizing third party collections by obtaining pre-authorization, the DHA Uniform Business Office User Guide is not official policy and does not set requirements for MTFs. DOD policy does not currently require MTFs to obtain pre-authorization for services provided to beneficiaries when their insurance provider requires it.

MAMC strives to maximize third party collections; however, many encounters are not known to require pre-authorization until after care has been provided, billed, and denied by an insurance carrier. The RevX module could potentially address roadblocks to being proactive in this area but is not expected to be implemented at initial operating capability sites until 2022.

Currently, MAMC technicians review MHS GENESIS reports, such as inpatient admissions and surgery schedules, to identify third party collection billable care that may require pre-authorization. In addition, if a patient has billable insurance, insurance verification technicians update a tracking spreadsheet with patient name; insurance; dates of service; and type of service. UBO utilization review nurses review the spreadsheet throughout the day and contact the insurance company to obtain an authorization. As of 1 July 2019, both insurance verification technician positions and one of the two utilization review nurse positions are vacant. Currently, third party collection billing and recovery staff are rotating these review tasks.

RECOMMENDATION 4d: Commander, Madigan Army Medical Center review and modify procedures for claim followup so debt can be transferred to the appropriate debt collection agency when claims become 120 days delinquent.

RESPONSE: Non-concur. MAMC agrees with the intent of the recommendation and has processes in place to follow up on claims in accordance with DOD policy and guidance. However, the Uniform Business Office will take action to ensure the process are being followed.

Specifically, MAMC contacts the insurance company after no response to a claim and a third party recovery technician closes the claim if the policy wasn't active at the time of

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U.S. Army Office of the Surgeon General (cont'd)

service; resubmits the claim if it wasn't received; or provides additional information as necessary. Claims are prioritized and processed based on age and amount billed.

This is a time-consuming process; each recovery technician can only follow up on about 25-30 claims per day. As of 1 July 2019, there are 7,150 third party collection claims over 30 days old (attachment 4d-1) and, of these, 3,713 have not been followed up in the past 90 days (attachment 4d-2).

Claims status follow-up is only half of the third party collection recovery technician's workload; the other half is denial management. Following up on just the 3,713 claims within 1 month (22 working days) would require 6 recovery technicians working full time. During this time period, additional claims would fall into this category. However, MAMC only has three recovery technician positions, and one position is vacant.

RECOMMENDATION 4e: Commander, Madigan Army Medical Center develop and implement procedures to review and validate denials before writing off claims, and implement procedures to process denials by beneficiary.

RESPONSE: Partially concur. MAMC agrees with the intent of the recommendation, and already has processes in place to review and validate denials before writing off claims. In addition, denials are being processed by beneficiary.

Valid write-offs such as coinsurance, deductible or co-pay are automatically verified by ABACUS when posted by accounting technicians. Unverified write-offs are reviewed by third party collection recovery technicians, and notes, Explanation of Benefits (EOB), and automated responses are reviewed. If valid, recovery technicians will verify the write-off in ABACUS and close the claim. If the validity of a write-off is questioned, a recovery technician calls the insurance company to obtain additional details and address any areas of dispute. Valid write-offs are verified and the claim is closed. If the claim is still in dispute, the insurance representative is notified and a letter sent to the insurance company outlining the statutes, laws, and regulations that support payment. If the dispute is not settled once the claim is 120 days old, it is marked for legal review in ABACUS.

As noted previously, claims are prioritized and processed based on age and amount billed; multiple claims are addressed during each call, to the extent allowed by the carrier. Each recovery technician can only address about 12-15 disputed claims a day. As of 1 July 2019, there are 475 potential third party collection disputed claims. It would take the two recovery technicians working full time for 18 days to verify these claims and during that time, additional unverified claims would fall into this category.

RECOMMENDATION 4f: Commander, Madigan Army Medical Center review all outstanding third party claims that are delinquent for more than 120 days to determine

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U.S. Army Office of the Surgeon General (cont'd)

which claims are eligible for transfer to the Treasury Cross-Servicing Program or local Judge Advocate office, and transfer all eligible claims for collection assistance.

RESPONSE: Non-concur. Madigan Army Medical Center already has processes in place to review outstanding third party claims and is currently working with MEDOCM SJA to prioritize claims and complete due process by carrier and denial reasons in order to facilitate a legal resolution. In addition, MEDCOM has a contract in place to assist MTFs with reviewing unprocessed and invalidly denied claims and marking eligible claims for legal action as appropriate.

COMMENTS ON POTENTIAL MONETARY BENEFITS: Non-concur. DODIG's methodology to calculate potential collections assumes full payment of billed amounts. Historically, MAMC collects about 42 to 48 percent of total billed amounts. For the past 12 months, collection ratio is 46.12 percent (attachment 4f-3).

RECOMMENDATION 4g: Commander, Madigan Army Medical Center provide sufficient legal support to pursue collections through the Third Party Collection Program.

RESPONSE: Non-concur. MAMC is working with US Army Medical Command on a centralized process and training program for pursuing delinquent third party collections. Currently, the process created in collaboration with Army Medical Command Staff Judge Advocate is for MAMC to transfer disputed claims to the paralegal at William Beaumont Army Medical Center using ABACUS. The paralegal consolidates claims as appropriate and takes necessary legal collection action with third party carriers.

RECOMMENDATION 5a: Commander, Brooke Army Medical Center direct personnel at all medical facility clinics and clinical support activities to collect hardcopy or electronic versions of DD Form 2569, and as appropriate, take administrative action for noncompliance.

RESPONSE: Concur. BAMC Memo 40-67 will be modified to strengthen the requirement to collect DD Form 2569, including all ancillary services. In addition, BAMC will add this requirement to the Uniform Business Office Compliance audit cycle, and test it during quarterly audits to ensure compliance. We expect actions to implement this recommendation will be complete by 6 January 2020.

RECOMMENDATION 5b: Commander, Brooke Army Medical Center review and modify procedures for obtaining pre-authorization when beneficiaries receive services at the medical facility that require preauthorization from the insurance provider.

RESPONSE: Non-concur. The DHA Uniform Business Office User Guide is not official guidance and MTFs are not bound by its procedures. However, BAMC does conduct pre-authorizations for a number of medical services, including those used by Veterans;

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U.S. Army Office of the Surgeon General (cont'd)

admissions; and some same-day surgery encounters. Conducting pre-authorization for these services has proven cost-effective. When authoritative guidance is issued directing MTFs to expand pre-authorization for additional medical services, BAMC will modify its procedures accordingly.

RECOMMENDATION 5c: Commander, Brooke Army Medical Center review and modify procedures for claim followup so debt can be transferred to the appropriate debt collection agency when claims become 120 days delinquent.

RESPONSE: Non-concur. In accordance with 10 U.S.C. 1095, the government has the right to collect reasonable charges for health care services from a third-party payer, but a covered beneficiary may not be required to pay an additional amount to the United States for health care services by reason of that section. In addition, 32 CFR 220.9 states, "…uniformed service beneficiaries will not be required to pay to the facility of the uniformed services any amount greater than the normal medical services or subsistence charges…" and that "In every case in which payment from a third-party payer is received, it will be considered as satisfying the normal medical services or subsistence charges, and no further payment from the beneficiary will be required." Therefore, it is inappropriate to transfer third party collection debt to a debt collection agency.

10 U.S.C. 1095 states the government may institute and prosecute legal proceedings against a third-party payer to enforce their requirement to provide payment, but there are already procedures in place for transferring invalid third party collection denials to the appropriate Staff Judge Advocate office. BAMC will complete a review of those procedures to ensure they are properly followed by 6 January 2020.

RECOMMENDATION 5d: Commander, Brooke Army Medical Center review all outstanding third party claims that are delinquent for more than 120 days to determine which claims are eligible for transfer to the Treasury Cross-Servicing Program or local Judge Advocate office, and transfer all eligible claims for collection assistance.

RESPONSE: Concur. BAMC will review all outstanding claims that have aged past 120 days to determine which claims are eligible for transfer to the Staff Judge Advocate office. Working the current backlog of aged Third Party Collections Program claims remains a priority for our Uniform Business Office, and BAMC is taking steps to address these older claims. For example, Army Medical Command issued a contract to augment BAMC staff for determining transfer eligibility of these claims. The contract covers all unpaid claims over 120 days with a date of service of 1 October 2016 and earlier and assists with coding eligible claims for legal review in ABACUS. The anticipated target date to complete review of outstanding claims is 31 July 2021.

COMMENTS ON POTENTIAL MONETARY BENEFITS: BAMC non-concurs with the potential monetary benefit amount of $9.6 million, or its portion of the $17.5 million identified in the report. The methodology used by DODIG to calculate these potential

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U.S. Army Office of the Surgeon General (cont'd)

benefits does not properly account for claims that will be ultimately denied for valid reasons. During FY 18, BAMC billed about $17.3 million and collected about $9.8 million, or about 56.5 percent of the billed amount for all third party collection program claims. Using the most recent historical collection rates as a guide, BAMC estimates the true value of all aged claims is, at best, $5.3 million once all collection efforts have been exhausted.

RECOMMENDATION 5e: Commander, Brooke Army Medical Center provide sufficient legal support to pursue collections through the Third Party Collection Program.

RESPONSE: Non-concur. BAMC agrees with the intent of the recommendation to ensure legal support for collection of third party claims. However, MEDCOM is working with BAMC on a centralized process and training program for pursing these claims. BAMC will modify procedures requiring unpaid third party collection program claims categorized with an invalid denial code and meeting other appropriate criteria to be marked in ABACUS for legal review and action by the MEDCOM SJA as appropriate.

RECOMMENDATION 10a: Commander, Kimbrough Ambulatory Care Center review and modify procedures for claim follow up so debt can be transferred to the appropriate debt collection agency when claims become 120 days delinquent.

RESPONSE: Non-concur. Army MTFs are not authorized to use debt collection agencies for third party collection claims. Instead, delinquent accounts are identified in the ABACUS Recovery Module and electronically submitted to Army Medical Command for additional review and appropriate action. RHC-A will ensure that Kimbrough Ambulatory Care Center is reminded of this process and the requirement to submit delinquent claims as directed.

RECOMMENDATION 10b: Commander, Kimbrough Ambulatory Care Center review all outstanding third party claims that are delinquent for more than 120 days to determine which claims are eligible for transfer to the Treasury Cross-Servicing Program or local Judge Advocate office, and transfer all eligible claims for collection assistance.

RESPONSE: Concur. RHC-A will coordinate with KACC to ensure processes are modified to reflect current guidance regarding review and transfer of delinquent claims.

RHC-A, in coordination with the Third Party Collection Program contractor and Kimbrough Ambulatory Care Center, will review all TPC claims more than 120 days delinquent. All eligible claims will be marked for legal review and action as appropriate by MEDCOM SJA.

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U.S. Army Office of the Surgeon General (cont'd)

Changes to the Performance Work Statement and review of claims more than 120 days old are expected to be complete as of 31 March 2020.

RECOMMENDATION 10c: Commander, Kimbrough Ambulatory Care Center provide sufficient legal support to pursue collections through the Third Party Collection Program.

RESPONSE: Non-concur. Kimbrough Ambulatory Care Center agrees with the intent to ensure sufficient legal support to pursue collections, but will do so with assistance from MEDCOM SJA. KACC will modify procedures to include a requirement to send unpaid third party collection program claims categorized with an invalid denial code and meeting other appropriate criteria to the Army Medical Command Staff Judge Advocate office for additional action. Actions will be complete by 13 January 2020.

RECOMMENDATION 11a: Commanding General, Army Regional Health Command–Atlantic review the contract language for the Third Party Collection Program contracts, and align the contract terms with all applicable Federal and DoD regulations.

RESPONSE: Concur. The current language in the Third Party Collection Program is under review by the contracting officer for alignment with all applicable Federal and DoD regulations as well as in-scope determination. This matter will also be staffed for legal review within RHCO-A for further review and guidance. Pending legal review, the contract language will be changed by issuing a contract modification. In addition, the PWS will be revised accordingly to reflect any new language changes to ensure proper surveillance of the contractor's performance. The estimated date of completion for these actions is 13 January 2020.

RECOMMENDATION 11b: Commanding General, Army Regional Health Command–Atlantic implement oversight procedures to monitor contractor performance in accordance with the terms of the contract and all Federal and DoD regulations.

RESPONSE: Concur. The following new processes have been put into place to ensure additional oversight of the contract as well as to discuss and resolve issues that might arise during operational or administrative processes as they relate to the contract:

- Telephone conferences will be held on the 2nd Tuesday of each month with the Uniform Business Office Regional Consultant; the COR; the Chief, Patient Administration Division; and the contractor. The contracting officer will attend as needed to resolve or address any contractual issues.
- Additional information will be provided by the contractor on the monthly reports that already received from the contractor. This information will assist in identifying any accounts that are approaching delinquent status and the contractor's efforts to resolve the debt for the government.

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U.S. Army Office of the Surgeon General (cont'd)

- A review of the contract's language is currently under review to align the contract with Federal and DoD regulations. Upon completion of this review, the Quality Assurance Surveillance Plan will be revised accordingly to reflect the changes as well as to ensure that appropriate evaluation metrics are in place to monitor, measure, and assess the contractor's performance.

In addition, the following activities will continue: (i) bi-weekly telecoms with the Uniform Business Office Regional Consultant; MTFs; and the contractor. This will continue to be an opportunity to discuss issues the MTFs may have with submitting claims or receiving payments for submitted claims. In addition, MTF issues with ABACUS can be resolved or addressed for resolution by the contractor.

The estimated date of full completion 31 January 2020.

RECOMMENDATION 11c: Commanding General, Army Regional Health Command–Atlantic hold any contracting personnel assigned oversight responsibility accountable for not appropriately performing oversight procedures necessary to ensure the contractor complied with Federal and DoD regulations and contract terms.

RESPONSE: Concur. New processes have been put into place to ensure additional oversight of the contract to which all contracting personnel assigned oversight will be held accountable. These new processes include the following:

- Telephone conferences will be held on the second Tuesday of each month with the Uniform Business Office Regional Consultant; contracting officer representative (COR); the Chief of Patient Administration Division; and the contractor. The contracting officer will attend as needed to resolve or address any contractual issues. These meetings will provide a forum for review and discussion of issues or concerns identified either by the contractor's monthly report or the Third Party Collection Program bi-weekly meetings with the COR; Uniform Business Office Regional Consultant; MTFs; and contractor.

- Additional information will be provided by the contractor on the monthly reports already being received from the contractor. This information will assist in assessing performance of the contractor as it relates to production, as well as aged accounts and delinquent claims.

- The contract language is currently under review to align it with Federal and DoD regulations. Upon completion of this review, the Quality Assurance Surveillance Plan will be revised to reflect the changes, and ensure appropriate evaluation metrics are in place to monitor, measure, and assess the contractor's performance.

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U.S. Army Office of the Surgeon General (cont'd)

- The contracting officer's representative will be given access to ABACUS to assist in monitoring the contractor's performance.

These actions are expected to be complete by 31 January 2020.

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U.S. Air Force Surgeon General

DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON DC

MEMORANDUM FOR DEPARTMENT OF DEFENSE INSPECTOR GENERAL

FROM: HQ USAF/SG
1780 Air Force Pentagon
Washington, DC 20330-1780

SUBJECT: Air Force Response to DoD Office of Inspector General Draft Report, "Audit of the DoD's Management of the Third Party Collection Program for Medical Claims" (Project No. D2018-000AX-0174.000)

This is the Department of the Air Force Response to the DoDIG Draft Report, "Audit of the DoD's Management of the Third Party Collection Program for Medical Claims" (Project No. D2018-000AX-0174.000). The AF/SG concurs with the report as written and welcomes the opportunity to provide management comments.

The AF/SG, in coordination with the Air Force Medical Readiness Agency Commander (AFMRA/CC), will correct issues identified in this report, and develop and implement a corrective action plan outlined in the following recommendations:

RECOMMENDATION 6: We recommend that the Commander of the 59th Medical Wing (59 MDW/CC) at Lackland Air Force Base:

a. Direct personnel at all medical facility clinics and clinical support activities to collect hardcopy or electronic versions of DD Form 2569, and as appropriate, take administrative action for noncompliance.

AIR FORCE RESPONSE: Concur. The 59 MDW/CC will continue to maintain responsibility for establishing and sustaining the TPC program. The Commander will ensure full compliance with the Other Health Insurance (OHI) intake program as directed by 10 USC §1095, 32 CFR 220, and DHA-PM 6015.01. The Commander will direct all appropriate personnel to support activities for collecting OHI information from all non-active duty patients to complete a DD Form 2569 or electronic version of the DD Form 2569 (e-2569). ECD: Closed

b. Review and modify procedures for claim followup so debt can be transferred to the appropriate debt collection agency when claims become 120 days delinquent.

AIR FORCE RESPONSE: Non-Concur. A review of the AF MTF claims presented in the report reveal the claim balances shown are not the result of delinquent bills. Rather, they are predominately the TPC beneficiary patient co-payments and deductibles remaining after OHI paid the covered amount. The patient's portion should be written off IAW Federal, DoD, and USAF regulations, and never transferred to debt collection agencies. ECD: Closed

c. Review all outstanding third party claims that are delinquent for more than 120 days to determine which claims are eligible for transfer to the Treasury Cross-Servicing Program or local Judge Advocate office, and transfer all eligible claims for collection assistance.

U.S. Air Force Surgeon General (cont'd)

AIR FORCE RESPONSE: Non-Concur. TPC program participants are beneficiaries, dependents and retirees, and shall not be balance billed or transferred to collection agencies under any circumstances. Pursuant to 10 USC 1095, any balances remaining after OHI has paid the covered amounts will be written off. TPC program patients are beneficiaries and should never be referred to debt collection for balances beyond the plan's coverage or the patient's cost share. ECD: Closed

d. Provide sufficient legal support to pursue collections through the Third Party Collection Program.

AIR FORCE RESPONSE: Concur. Third-party insurance companies cannot be placed into the US Treasury's Cross Servicing Next Generation (CSNG) debt management program. The CSNG system (formerly FedDebt) is only for first party individual out-of-service debt. Therefore, the only recourse for adjudicating claims when the insurance company is unresponsive or provides invalid denials is to forward to the local JAG. At this point, the potential for collecting any part of the debt, minus co-pays and deductibles, will be out of the control of the MTF and the AFMS.

RECOMMENDATION 7: We recommend that the Commander of the 75th Medical Group (75 MDG/CC) at Hill Air Force Base:

a. Direct personnel at all medical facility clinics and clinical support activities to collect hardcopy or electronic versions of DD Form 2569, and as appropriate, take administrative action for noncompliance.

AIR FORCE RESPONSE: Concur. The 75 MDG has established a new plan to track non-compliance and improve accountability with Flight Commander's briefing non-compliance to the MDG Executive Staff. Of note, the report also states, "The 75th Medical Group was the only medical facility collecting OHI information consistently." ECD: Closed

b. Review and modify procedures for obtaining pre-authorization when beneficiaries receive services at the medical facility that require preauthorization from the insurance provider.

AIR FORCE RESPONSE: Concur. The 75 MDG Staff are not trained to request pre-authorization for care. To obtain full compliance, this issue needs to be addressed as an enterprise level process improvement. The AFMRA UBO office will engage with the AFMRA Referral Management Function for evaluation of this process and will develop guidance in compliance with DoDI and Defense Health Agency policies. ECD: 31 January 2020

c. Review and modify procedures for claim followup so debt can be transferred to the appropriate debt collection agency when claims become 120 days delinquent.

AIR FORCE RESPONSE: Concur. This activity is managed by a centralized AFMS contract and the 75 MDG is not staffed to manage locally. Refer to Air Force Response to Recommendation 11. b. and c.

d. Review the 15 claims with potential invalid denials or awaiting resolution to determine whether they are still awaiting resolution or were written off for valid reasons, and if not, re-bill the claims to the insurance provider.

AIR FORCE RESPONSE: Concur. The 75 MDG Uniform Business Office (UBO) will work with the Third Party Collections Contractor, Treefrog, to review these claims and complete any required actions. ECD: 31 December 2019

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U.S. Air Force Surgeon General (cont'd)

e. Develop and implement procedures to review and validate denials before writing off claims, and implement procedures to process denials by beneficiary.

AIR FORCE RESPONSE: Concur. This activity is managed by a centralized AFMS contract and the 75 MDG is not staffed to manage locally. The AFMRA UBO office is the contracting office representative for this contract and will evaluate the contractors performance of the 75 MDG's denial management function and ensure compliance. ECD: 31 January 2020

f. Identify the impact a $505,787 refund to an insurance provider will have on the 75 MDG operations and maintenance budget, and take appropriate action to mitigate any impact on the medical facility's mission.

AIR FORCE RESPONSE: Concur. The 75 MDG has already completed the review of these refunds and has processed 2/3 tranactions. These refunds will not affect the MDG's O&M Budget as these refunds are for past FY collections. We have analyzed the affected year budget's and found that due to contract deobiligations, there will still be ~$20K in margin after refunds are issued. ECD: Closed

g. Review all outstanding third party claims that are delinquent for more than 120 days to determine which claims are eligible for transfer to the Treasury Cross-Servicing Program or local Judge Advocate office, and transfer all eligible claims for collection assistance.

AIR FORCE RESPONSE: Concur. The 75 MDG UBO office will work with Benefit Recovery to review all outstanding third party claims that are over 120 days deliquent. ECD: Closed

h. Provide sufficient legal support to pursue collections through the Third Party Collection Program.

AIR FORCE RESPONSE: Concur. Third-party insurance companies cannot be placed into the US Treasury's Cross Servicing Next Generation (CSNG) debt management program. The CSNG system (formerly FedDebt) is only for first party individual out-of-service debt. Therefore, the only recourse for adjudicating claims when the insurance company is unresponsive or provides invalid denials is to forward to the local JAG. At this point, the potential for collecting any part of the debt, minus co pays and deductibles, will be out of the control of the MTF and the AFMS. ECD: Closed

RECOMMENDATION 11: We recommend that the Commanding General of Army Regional Health Command–Atlantic; the Director of the Defense Health Agency, National Capital Region Medical Directorate; and Commander of the Air Force Medical Operations Agency:

a. Review the contract language for the Third Party Collection Program contracts and align the contract terms with all applicable Federal and DoD regulations.

AIR FORCE RESPONSE: Concur. The AFMRA Uniform Business Office reviewed the contract language, for the Air Force Third Party Collection Program Contract, contained in the Performance Work Statement (PWS) dated 22 Dec 16. The current PWS states that the Contractor will cease collection activities after 150 days of delinquency. To be compliant with Federal and DoD regulations, the PWS has been updated to state that the Contractor shall cease collection activity on claims more than 120 calendar days delinquent and notify the MTF for further government action. ECD: Closed

b. Implement oversight procedures to monitor contractor performance in accordance with the terms of the contract and all Federal and DoD regulations.

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U.S. Air Force Surgeon General (cont'd)

AIR FORCE RESPONSE: Concur. There are no reporting tools currently available in the DoD's Armed Forces Billing and Collection Utilization Solution (ABACUS) that acomplete contract performance oversight for this procedure. AFMRA/SGAR will modify an ABACUS report query to improve visibility for TPC claims that have been delinquent for more than 120 days. The Contractor will use this report to inform the government of any claims returned for further action. The MTFs can use the report to initiate research, transfer to local JAG, and any other appropriate government actions. This report modification is available for each MTF's ABACUS database. Additional assistance from the DHA ABACUS program office is required to develop a report that provides necessary information on an enterprise level. ECD: 31 December 2019

c. Hold any contracting personnel assigned oversight responsibility accountable for not appropriately performing oversight procedures necessary to ensure the contractor complied with Federal and DoD regulations and contract terms.

AIR FORCE RESPONSE: Concur. Contracting personnel assigned oversight responsibility are accountable for appropriately performing oversight procedures necessary to ensure compliance with Federal and DoD regulations and contract terms. The Contractor shall abide by the COR guidelines pertaining to delinquent debt balances, including transferring to the Government all correspondence between the Contractor and insurance companies that reflect the Contractor's efforts to obtain payment. The Contracting Officer Representative validates monthly Contractor compliance with this key performance objective via samples obtained from ABACUS. Any known discrepancies are reported to the contracting officer. ECD: Closed

The AF/SG point of contact is

MURPHY.SEAN.
LEE.

SEAN L. MURPHY, MD
Major General, USAF, MC, FS
Deputy Surgeon General

Attachment:
DoD IG Draft Audit Report

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Acronyms and Abbreviations

ABACUS	Armed Forces Billing and Collection Utilization Solution
ACC	Ambulatory Care Center
AFMRA	Air Force Medical Readiness Agency
AMC	Army Medical Center
BUMED	Bureau of Medicine and Surgery
CH	Community Hospital
DHA	Defense Health Agency
FMR	Financial Management Regulation
JA	Judge Advocate
MHS	Military Health System
NCR MD	National Capital Region Medical Directorate
NH	Naval Hospital
NMC	Naval Medical Center
NMMC	National Military Medical Center
OHI	Other Health Insurance
UBO	Uniform Business Office

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Whistleblower Protection
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Whistleblower Protection safeguards DoD employees against retaliation for protected disclosures that expose possible waste, fraud, and abuse in government programs. For more information, please visit the Whistleblower webpage at http://www.dodig.mil/Components/Administrative-Investigations/Whistleblower-Reprisal-Investigations/Whisteblower-Reprisal/ or contact the Whistleblower Protection Coordinator at Whistleblowerprotectioncoordinator@dodig.mil

For more information about DoD OIG reports or activities, please contact us:

Congressional Liaison
703.604.8324

Media Contact
public.affairs@dodig.mil; 703.604.8324

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