Office of the Public Auditor
Commonwealth of the Northern Mariana Islands

Audit and Investigation of Health Insurance Payments to Megaplus International CNMI, Inc. for Physical Therapy Services June 1993 to December 1999

Audit Report
AR-01-01

Office of the Public Auditor

Commonwealth of the Northern Mariana Islands
World Wide Web Site: http://opacnmi.com
2nd Floor J. E. Tenorio Building, Chalan Pale Arnold
Gualo Rai, Saipan, MP 96950

Mailing Address:
P.O. Box 501399
Saipan, MP 96950

E-mail Address:
mail@opacnmi.com

Phone: (670) 234-6481
Fax: (670) 234-7812

January 30, 2001

Mr. Juan S. Torres
Administrator
Northern Mariana Islands Retirement Fund
P.O. Box 501247 CK
Saipan, MP 96950

Dear Mr. Torres:

Subject: Final Report on the Audit and Investigation of Health Insurance Payments to Megaplus International CNMI, Inc. for Physical Therapy Services (Report No. AR-01-01)

The enclosed audit report presents the results of our audit and investigation of health insurance payments to Megaplus International CNMI, Inc. (Megaplus) from June 1993 to December 1999. Megaplus is a local company providing physical therapy services to patients enrolled under the Group Health Insurance Plan (GHIP) which is administered by the Northern Mariana Islands Retirement Fund's Group Health & Life Insurance Branch (GHLIB). The objectives of the audit and investigation were to (1) determine whether GHLIB paid Megaplus for fraudulent health insurance claims of physical therapy services, (2) establish the amounts and circumstances which allowed the payment of any fraudulent claims, and (3) determine the adequacy of existing internal controls over the processing and payment of health insurance claims for physical therapy services.

Our audit and investigation showed that GHLIB paid Megaplus for fraudulent health insurance claims of physical therapy services. The fraudulent claims were supported by falsified doctors' prescriptions or referral forms. The results of a prior audit and investigation also showed that Megaplus was "padding" health insurance claims by billing unperformed and unnecessary treatments. In addition, Megaplus was also paid for claims without the required doctors' prescriptions or referral forms. As a result, GHLIB incurred losses amounting to $313,516 in fraudulent claims. At least $548,744 in unsupported claims was also improperly paid to Megaplus.

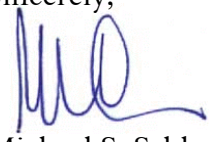
We recommended that the Northern Mariana Islands Retirement Fund Administrator (1) expedite the hiring of a utilization review specialist either on a contract or employment basis, (2)

instruct the GHLIB Manager to prepare written guidelines for the review and processing of claims, and (3) adopt measures to improve internal controls over the processing and payment of health insurance claims as follows: (a) qualification requirements for the position of claims examiner should be improved by requiring sufficient training and experience in the medical field; (b) supporting claim documents should be marked paid after completion of check processing to prevent duplicate payments; (c) for proper segregation of duties, signed checks for distribution to vendors should be mailed directly or distributed by the administrative assistant without being returned to persons who have access to accounting and payment records; and (d) written filing procedures should be prepared to control and monitor the locations of accounting records and claim documents.

In his letter response dated December 18, 2000, the Deputy Administrator responded that the NMIRF Board endorses prompt resolution and implementation of OPA recommendations. According to the Deputy Administrator, the following actions were taken to address our recommendations: (1) a firm has been selected to perform utilization reviews, however, NMIRF is presently awaiting funding from the CNMI Legislature before executing the contract; (2) a qualified utilization review specialist will be hired by NMIRF and a job vacancy announcement for this position has already been advertised; and (3) written operating procedures for processing of medical claims have been drafted to address inadequacies of existing practices. The Administrator is currently reviewing the draft procedures and would appreciate OPA's comments or additional recommendations.

Based on the Deputy Administrator's response, we consider Recommendations 1 and 2 as resolved, and Recommendation 3 as open. The additional information or actions required to consider Recommendations 1, 2, and 3 closed are presented in **Appendix B**.

Sincerely,



Michael S. Sablan
Public Auditor

cc: Governor
Lt. Governor
Twelfth CNMI Legislature (27 copies)
Manager, Group Health and Life Insurance Branch
Secretary of Finance
Attorney General
Special Assistant for Management and Budget
Press Secretary
Press

Contents

EXECUTIVE SUMMARY

Our audit and investigation showed that the Government Health Life Insurance Branch (GHLIB) paid Megaplus for fraudulent health insurance claims of physical therapy services. The fraudulent claims were supported by falsified doctors' prescriptions or referral forms. The results of a prior audit and investigation also showed that Megaplus was "padding" health insurance claims by billing unperformed and unnecessary treatments. In addition, Megaplus was also paid for claims without the required doctors' prescriptions or referral forms. As a result, GHLIB incurred losses amounting to $313,516 in fraudulent claims. At least $548,744 in unsupported claims was also improperly paid to Megaplus.

Background

On or about April 1996, the Office of the Public Auditor (OPA) began an investigation of Megaplus International CNMI, Inc. (Megaplus) for possible fraudulent transactions involving the Group Health Insurance Program (GHIP). Megaplus is a local company providing physical therapy services to patients enrolled under the GHIP which is administered by the Northern Mariana Islands Retirement Fund's Group Health & Life Insurance Branch (GHLIB). The investigation was initiated based upon certain information provided by the former Director of Labor. The results of the investigation showed that Megaplus was overcharging the CNMI Government by "padding" health insurance claims submitted for payment. Megaplus padded the claims by billing unperformed and unnecessary treatments. The case was referred to the Attorney General's Office for local prosecution on June 3, 1997 but no substantive actions have been taken since that date.

On or about January 2000, OPA received another complaint from a confidential informant that Megaplus was still providing unnecessary physical therapy services to patients. A follow-up investigation disclosed that this time, Megaplus was falsifying prescriptions for physical therapy services to support health insurance claims submitted to GHLIB for payment. Because of possible federal law violations, the case was referred to the OPA Joint Task Force with the Federal Bureau of Investigation (FBI). The FBI led the investigation of the case with OPA auditors and investigators providing assistance.

On March 28, 2000, two Megaplus officials were arrested by the FBI. Subsequently, the two individuals entered into separate plea agreements and were charged with health care fraud violations under Title 18, Section 1347 of the United States Code. The two individuals were eventually sentenced on July 25, 2000, receiving jail terms of up to four years. They were also required to reimburse GHLIB more than $700,000, which was the estimated amount of false and unsupported claims initially determined by OPA.

Group Health Insurance Plan

The CNMI Government provides its eligible employees, retirees, and their eligible family members with an optional Group Health Insurance Plan. The purpose of the plan is to provide finan-

cial assistance to enrollees to help them pay for necessary health care. GHIP is being underwritten exclusively by the CNMI Government and was initially managed by the Personnel Office. On August 24, 1994, in accordance with the Governor's Executive Order No. 94-3, all functions of the Personnel Office relating to the management of the GHIP were transferred to the Department of Finance. Subsequently, on June 21, 1996, administration of GHIP was once again transferred this time from the Department of Finance to the Northern Mariana Islands Retirement Fund pursuant to Public Law 10-19.

GHIP offers four types of enrollment options, as follows, (1) self only - high option, (2) self and family - high option, (3) self only - low option, and (4) self and family - low option. The insurance benefits (including maximums, limitations, and exclusions) to which the enrollees are entitled are based on the option selected and the kind of medical expense incurred.

For physical therapy services, the amount covered under GHIP for both the high and low options was limited to $60 per visit effective January 1, 1998. Previously, physical therapy services were covered as follows, (1) 100% of the first $500 allowable expenses plus 80% of the excess up to a maximum of $50,000 for the high option, and (2) 100% of the first $250 allowable expenses plus 75% of the excess up to a maximum of $25,000 for the low option.

Under the GHIP, physical therapy is classified as an outpatient service provided by a licensed physical therapist or licensed chiropractors for the administration of physical therapy in accordance with a referral and specific instructions by a doctor of medicine as to treatment type and duration.

Physical Therapy Regulations

Physical therapists are described as health care professionals who evaluate, treat, and instruct patients with health problems resulting from injury or disease in order to help prevent, correct, and alleviate pain, discomfort, and dysfunctions (*see www.apta.org - American Physical Therapy Association*). In the CNMI, physical therapy services are provided in diverse settings such as the hospital, outpatient clinics, and public schools, as well as the homes of the patients.

In the past, no regulations existed governing the practice of physical therapy in the CNMI. On July 23, 1999, however, the Medical Professional Licensure Board (MPLB) adopted Physical Therapy Regulations to govern the practice of physical therapy in the CNMI (Commonwealth Register Volume 21 Number 07, Pages 16860 - 16870). The regulations require all physical therapists and physical therapist assistants practicing in the CNMI to be duly licensed by the MPLB.

Among other things, the new regulations provide that applicants for licensure as a physical therapist must possess the following qualifications: (1) must be a graduate of a program accredited by the American Physical Therapy Association or the Canadian Physiotherapy Association leading to a degree in physical therapy, (2) have completed the application for licensure in the CNMI, (3) have successfully passed the Physical Therapy Licensing Examination in the

United States or Canada, and (4) possess a valid license in a state of the United States or a province of Canada. Also, any person educated, trained, and licensed in a jurisdiction outside the United States or Canada must have successfully completed the Physical Therapy Licensing Examination in the United States or Canada, and hold a current license to practice physical therapy in a state of the United States or a province of Canada, in order to obtain a license in the CNMI.

The regulations also define physical therapy as the care and services provided by or under the direction and supervision of a licensed physical therapist, and physical therapist as a person who has met all the conditions of the regulations for licensure and is licensed in the CNMI to practice physical therapy.

Objectives and Scope

The objectives of our audit and investigation were to (1) determine whether GHLIB paid Megaplus for fraudulent health insurance claims of physical therapy services, (2) establish the amounts and circumstances which allowed the payment of any fraudulent claims, and (3) determine the adequacy of existing internal controls over the processing and payment of health insurance claims for physical therapy services.

The scope of our audit included all health insurance payments to Megaplus covering the period June 1993 to December 1999. To accomplish our objective, we examined health insurance payments and supporting claim documents. We also engaged the services of a licensed physical therapist to assist us in evaluating physical therapy services performed by Megaplus. In addition, we reviewed applicable laws, regulations, and operating procedures related to the processing and payment of health insurance claims. We also interviewed knowledgeable officials and employees of GHLIB, CNMI Department of Finance, Office of Personnel Management, Commonwealth Health Center, Pacific Medical Center, Saipan Health Clinic, Tinian Health Center and Rota Health Center. However, the scope of our audit was limited because the GHLIB health insurance payment records were incomplete.

Megaplus Was Paid for Fraudulent Health Insurance Claims

GHLIB should ensure that only valid health insurance claims are paid. Our audit and investigation showed, however, that GHLIB paid Megaplus for fraudulent health insurance claims of physical therapy services. The fraudulent claims were supported by falsified doctors' prescriptions or referral forms. The results of a prior audit and investigation also showed that Megaplus was "padding" health insurance claims by billing unperformed and unnecessary treatments. In addition, Megaplus was also paid for claims without the required doctors' prescriptions or referral forms. This condition occurred because Megaplus officials engaged in an illegal scheme to obtain undeserved health insurance payments from GHLIB. The scheme was not detected by GHLIB employees primarily because of insufficient training and experience in reviewing health insurance claims. As a result, GHLIB incurred losses amounting to $313,516 in fraudulent claims. At least $548,744 in unsupported claims was also improperly paid to Megaplus.

Accordingly, we recommend that the NMIRF Administrator:

1. Expedite the hiring of a utilization review specialist either on a contract or employment basis. The utilization review specialist should be well qualified and experienced in reviewing of health insurance claims, and should be at least a health care professional, preferably a duly licensed nurse or physician.

2. Instruct the GHLIB Manager to prepare written guidelines for the review and processing of claims. The guidelines should include specific documentation requirements to justify claims for patients who have been undergoing extended medical treatments.

3. Adopt measures to improve internal controls over the processing and payment of health insurance claims as follows: (a) qualification requirements for the position of claims examiner should be improved by requiring sufficient training and experience in the medical field, (b) supporting claim documents should be marked paid after completion of check processing to prevent duplicate payments, (c) for proper segregation of duties, signed checks for distribution to vendors should be mailed directly or distributed by the administrative assistant without being returned to persons who have access to accounting and payment records, and (d) written filing procedures should be prepared to control and monitor the locations of accounting records and claim documents.

Northern Mariana Islands Retirement Fund Response

The Deputy Administrator responded that the NMIRF Board endorses prompt resolution and implementation of OPA recommendations. According to the Deputy Administrator, the following actions were taken to address our recommendations; (1) a firm has been selected to perform utilization reviews, but NMIRF is presently awaiting funding from the CNMI Legislature before executing the contract, (2) a qualified utilization review specialist will be hired by NMIRF and a job vacancy announcement for this position has already been advertised, and (3) written operating procedures for processing of medical claims have been drafted to address inadequacies of existing practices. The Administrator is currently reviewing the draft procedures and would appreciate OPA's comments or additional recommendations.

OPA Comments

Based on the Deputy Administrator's response, we consider Recommendations 1 and 2 as resolved, and Recommendation 3 as open. The additional information or actions required to consider Recommendations 1, 2, and 3 closed are presented in **Appendix B**.

Recommendation 1 is considered resolved pending further actions. The NMIRF has undertaken two separate plans of action to address Recommendation 1. These plans are (1) contracting with a utilization review firm, and (2) hiring a utilization review specialist. In a subsequent discussion with the Deputy Administrator, we learned that the plan for contracting with a utilization review firm will transfer generally all functions

concerning medical claims processing to the firm. However, this plan is tentative and cannot be immediately implemented at the present time. We, therefore, suggest that NMIRF pursue the hiring of the utilization review specialist instead of contracting with the firm. NMIRF should also consider advertising outside the CNMI, including the U.S. mainland, to attract qualified applicants and immediately fill the position. To close this recommendation, NMIRF should provide sufficient documentation to OPA evidencing that a utilization review specialist has been hired.

We also consider Recommendation 2 as resolved pending further actions. The NMIRF should include in the written operating procedures the following: (1) submission of original referral letters from a doctor of medicine, (2) submission of health insurance claim forms duly signed by patients, and (3) submission of periodic treatment and evaluation reports by physicians to justify extended medical treatment. In addition, NMIRF should prepare a documentation checklist form to ensure that all requirements are completed before claims are processed. To close this recommendation, NMIRF should provide a copy of the final approved version of the written operating procedures to OPA.

Recommendation 3 is considered open because the Deputy Administrator's response did not contain any specific plan of action to address this recommendation.

Introduction

Background

On or about April 1996, the Office of the Public Auditor (OPA) began an investigation of Megaplus International CNMI, Inc. (Megaplus) for possible fraudulent transactions involving the Group Health Insurance Program (GHIP). Megaplus is a local company providing physical therapy services to patients enrolled under the GHIP which is administered by the Northern Mariana Islands Retirement Fund's Group Health & Life Insurance Branch (GHLIB). The investigation was initiated based upon certain information provided by the former Director of Labor. The results of the investigation showed that Megaplus was overcharging the CNMI Government by "padding" health insurance claims submitted for payment. Megaplus padded the claims by billing unperformed and unnecessary treatments. On June 3, 1997, OPA referred the results of the investigation to the Attorney General's Office (AGO) for local prosecution. On August 22, 2000, however, AGO informed OPA that it no longer intended to take further action.

On or about January 2000, OPA received another complaint from a confidential informant that Megaplus was still providing unnecessary physical therapy services to patients. A follow-up investigation disclosed that this time, Megaplus was falsifying prescriptions for physical therapy services to support health insurance claims submitted to GHLIB for payment. Because of possible federal violations, the case was referred to the OPA Joint Task Force with the Federal Bureau of Investigation (FBI). The FBI led the investigation of the case with OPA auditors and investigators providing assistance.

On March 28, 2000, two Megaplus officials were arrested by the FBI. Subsequently, the two individuals entered into separate plea agreements and were charged with health care fraud violations under Title 18, Section 1347 of the United States Code. The two individuals were eventually sentenced on July 25, 2000, receiving jail terms of up to four years. They were also required to reimburse GHLIB more than $700,000, which was the estimated amount of false and unsupported claims initially determined by OPA.

Group Health Insurance Plan

The CNMI Government provides its eligible employees, retirees, and their eligible family members with an optional Group Health Insurance Plan. The purpose of the plan is to provide financial assistance to enrollees to help them pay for necessary health care. GHIP is being underwritten exclusively by the CNMI Government and was initially managed by the Personnel Office. On August 24, 1994, in accordance with the Governor's Executive Order No. 94-3, all functions of the Personnel Office relating to the management of the GHIP were transferred to the Department of Finance. Subsequently, on June 21, 1996, administration of the GHIP was once again transferred this time from the Department of Finance to the Northern Mariana Islands Retirement Fund pursuant to Public Law 10-19.

GHIP offers four types of enrollment options, as follows, (1) self only - high option, (2) self and family - high option, (3) self only - low option, and (4) self and family - low option. The insurance benefits (including maximums, limitations, and exclusions) to which the enrollees are entitled are based on the option selected and the kind of medical expense incurred.

For physical therapy services, the amount covered under GHIP for both the high and low options was limited to $60 per visit effective January 1, 1998. Previously, physical therapy services were covered as follows, (1) 100% of the first $500 allowable expenses plus 80% of the excess up to a maximum of $50,000 for the high option, and (2) 100% of the first $250 allowable expenses plus 75% of the excess up to a maximum of $25,000 for the low option.

Under the GHIP, physical therapy is classified as an outpatient service provided by a licensed physical therapist or licensed chiropractors for the administration of physical therapy in accordance with a referral and specific instructions by a doctor of medicine as to treatment type and duration.

Physical Therapy Regulations

Physical therapists are described as health care professionals who evaluate, treat, and instruct patients with health problems resulting from injury or disease in order to help prevent, correct, and alleviate pain, discomfort, and dysfunctions (*see www.apta.org - American Physical Therapy Association*). In the CNMI, physical therapy services are provided in diverse settings such as the hospital, outpatient clinics, and public schools, as well as the homes of the patients.

In the past, no regulations existed governing the practice of physical therapy in the CNMI. On July 23, 1999, however, the Medical Professional Licensure Board (MPLB) adopted Physical Therapy Regulations to govern the practice of physical therapy in the CNMI (Commonwealth Register Volume 21 Number 07, Pages 16860 - 16870). The regulations require all physical therapists and physical therapist assistants practicing in the CNMI to be duly licensed by the MPLB.

Among other things, the new regulations provide that applicants for licensure as a physical therapist must possess the following qualifications: (1) must be a graduate of a program accredited by the American Physical Therapy Association or the Canadian Physiotherapy Association leading to a degree in physical therapy, (2) have completed the application for licensure in the CNMI, (3) have successfully passed the Physical Therapy Licensing Examination in the United States or Canada, and (4) possess a valid license in a state of the United States or a province of Canada. Also, any person educated, trained, and licensed in a jurisdiction outside the United States or Canada must have successfully completed the Physical Therapy Licensing Examination in the United States or Canada, and hold a current license to practice physical therapy in a state of the United States or a province of Canada, in order to obtain a license in the CNMI.

The regulations also define physical therapy as the care and services provided by or under the direction and supervision of a licensed physical therapist, and physical therapist as a person who has met all the conditions of the regulations for licensure and is licensed in the CNMI to practice physical therapy.

Objectives, Scope, and Methodology

The objectives of our audit and investigation were to (1) determine whether GHLIB paid Megaplus for fraudulent health insurance claims of physical therapy services, (2) establish the amounts and circumstances which allowed the payment of any fraudulent claims, and (3) determine the adequacy of existing internal controls over the processing and payment of health insurance claims for physical therapy services.

The scope of our audit included all health insurance payments to Megaplus covering the period June 1993 to December 1999. To accomplish our objectives, we examined health insurance payments and supporting claim documents. We also engaged the services of a licensed physical therapist to assist us in evaluating physical therapy services performed by Megaplus. In addition, we reviewed applicable laws, regulations, and operating procedures related to the processing and payment of health insurance claims. We also interviewed knowledgeable officials and employees of GHLIB, CNMI Department of Finance, Office of Personnel Management, Commonwealth Health Center, Pacific Medical Center, Saipan Health Clinic, Tinian Health Center and Rota Health Center. However, the scope of our audit was limited because the GHLIB health insurance payment records were incomplete.

We performed our audit and investigation at the offices of the GHLIB and the CNMI Department of Finance on Saipan from April 1996 to June 1997 and from January to July 2000. The audit was made, where applicable, in accordance with the Government Auditing Standards issued by the Comptroller General of the United States. Accordingly, we included such tests of records and such other audit procedures as were considered necessary under the circumstances.

As part of our audit, we evaluated GHLIB's internal controls over the processing and payment of health insurance claims. We found major internal control weaknesses in these areas. These internal control weaknesses are discussed in the Findings and Recommendations section of this report. Our recommendations, if implemented, should improve the internal controls in these areas.

Prior Audit Coverage

During the past five years, OPA issued one audit report concerning GHIP. The report entitled "Audit of CNMI Group Health Insurance Program," issued on May 31, 1995, concluded mainly that health insurance contributions and deductibles were not sufficient to cover the cost of operations, and that a large backlog of unprocessed claims was outstanding. The report, however, did not include any specific finding regarding health insurance payments to Megaplus.

In addition, an independent public accounting firm issued an audit report on the Northern Mariana Islands Government Health and Life Insurance Trust Fund for each of fiscal years 1997, 1998 and 1999. The reports included a finding regarding the lack of utilization reviews. Utilization review is a standard procedure employed by an entity paying medical claims. It involves the review of each health insurance claim to determine if proper procedures were performed and if proper medications were prescribed. This finding was also noted during our audit.

Findings and Recommendations

Megaplus Was Paid for Fraudulent Health Insurance Claims

GHLIB Incurred losses amounting to $313,516 in fraudulent claims. At least $548,744 in unsupported claims was also improperly paid to Megaplus.

GHLIB should ensure that only valid health insurance claims are paid. Our audit and investigation showed, however, that GHLIB paid Megaplus for fraudulent health insurance claims of physical therapy services. The fraudulent claims were supported by falsified doctors' prescriptions or referral forms. The results of a prior audit and investigation also showed that Megaplus was "padding" health insurance claims by billing unperformed and unnecessary treatments. In addition, Megaplus was also paid for claims without the required doctors' prescriptions or referral forms. This condition occurred because Megaplus officials engaged in an illegal scheme to obtain undeserved health insurance payments from GHLIB. The scheme was not detected by GHLIB employees primarily because of insufficient training and experience in reviewing health insurance claims. As a result, GHLIB incurred losses amounting to $313,516 in fraudulent claims. At least $548,744 in unsupported claims was also improperly paid to Megaplus.

Only Valid Health Insurance Claims Should Be Paid

GHLIB is responsible for paying health insurance claims of medical care providers who provide medical services to patients enrolled under GHIP. Medical services covered by GHIP include outpatient services rendered by health care professionals. In the GHIP Manual (Article 4.03, c.2), physical therapy is classified as an outpatient service provided by a licensed physical therapist or licensed chiropractor for the administration of physical therapy in accordance with a referral and specific instructions by a doctor of medicine as to treatment type and duration. This means that a health insurance claim for physical therapy services should be supported by a valid doctor's prescription or referral form. This requirement helps to prevent possible health care fraud and abuse by ensuring that only valid claims are paid by GHLIB.

In the United States, many health insurance agencies employ a standard procedure called "utilization review" to help address health care fraud. This procedure involves the review of each health insurance claim by a person with sufficient training and experience in the medical field to determine if proper procedures were performed and if proper medications were prescribed. Utilization reviews are essential in controlling health insurance costs and in detecting false claims arising from unnecessary or inappropriate procedures and medications.

Strict federal laws are also in place to address health care fraud and abuse. For example, the submission of false claims by medical care providers by itself is

considered a violation of federal law[1]. The operator of a health insurance fraud scheme does not need to actually obtain payment on the false claim to be guilty of a crime - submitting the fraudulent claim is enough to risk prosecution.

Megaplus Submitted Fraudulent Health Insurance Claims

During our audit and investigation conducted from January to July 2000, we found that Megaplus submitted health insurance claims to GHLIB supported by false documents. From June 1993 to December 1999, GHLIB paid Megaplus a total of $1,418,771. Of this amount, $313,516 or about 22% was supported by falsified doctors' prescriptions or referral forms.

The audit and investigation was initiated by a complaint that OPA received from a confidential informant on or about January 2000. The complaint alleged that Megaplus was providing unnecessary physical therapy services to patients and was billing both local and federal agencies (i.e., GHLIB and Medicare). A follow up investigation by OPA auditors disclosed evidence that Megaplus may have been altering prescriptions to support health insurance claims submitted to GHLIB for payment. The case was subsequently referred to the OPA-FBI joint task force because of possible federal law violations. The FBI led the investigation of the case with OPA auditors and investigators providing audit and investigative assistance.

During the course of the audit and investigation, we found that Megaplus officials employed their illegal scheme in a variety of ways such as the following:

- Patient referral forms were altered to increase the number of times or duration of physical therapy services. For example, Megaplus inserted "3x wk x 8-10 mos" in one patient's referral form prepared by a doctor from the Commonwealth Health Center (CHC) to make it appear that the doctor prescribed physical therapy three times a week for 8 to 10 months. The referring doctor denied prescribing any duration for the treatment. Furthermore, CHC's Director of Physical Therapy explained that it would be highly unusual to prescribe a treatment of more than one month at a time given the nature of this patient's condition. Usually, the patient's progress is evaluated monthly before any extension of treatment is prescribed.

- Prescription forms were duplicated and different patient names were inserted to make it appear that a doctor had prescribed physical therapy services. Other times, the date of the prescription was altered to make it appear that a treatment extension was granted. For example, the original patient name on a CHC prescription form was "whited out" using correction liquid or tape. The

[1] United States Code Title 18 Chapter 63 Section 1347 states that "Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice - (1) to defraud any health care benefit program; or (2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program, in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 10 years, or both."

prescription form was then photocopied five times and the names of five other patients were separately inserted. Further investigation showed that some of the other patients were never seen by the prescribing physician.

- The nature of the doctor's prescription was changed to reflect physical therapy services although none was actually required. For example, a CHC prescription was changed from a request for "hospital bed" to "therapy 3x 16 months." The physician who wrote the prescription advised us that the form had been altered, and showed us a copy of the original prescription form.

- The doctor's signature on the prescription form was forged. For example, a CHC doctor advised us that he did not write a particular prescription and that his apparent signature appearing on the form was a forgery. During the investigation, we also found "blank" CHC prescription forms bearing the signatures of a CHC doctor with no other information present (i.e., date, patient name, nature of condition, and treatment).

The audit and investigation revealed many instances and different versions of the above scheme. Also, many of the duplicated and "whited out" forms were subsequently found at the residence of Megaplus officials (during the execution of a federal search warrant conducted by the FBI).

Megaplus Submitted Padded Claims to Obtain Undeserved Payments

The results of a prior audit and investigation conducted from April 1996 to July 1997, showed that Megaplus had been previously cheating the CNMI Government by submitting "padded" health insurance claims. Megaplus padded the claims by billing unperformed and unnecessary treatments. Patients were being asked to sign blank forms which were later filled in by Megaplus with false treatment information. The forms were then used to support large billings to GHLIB.

The prior audit and investigation was initiated by OPA on or about April 1996 based on information provided by the former Director of Labor. The Director provided OPA with a statement from a GHIP member claiming that she was made to sign blank receipts after receiving physical therapy treatments from Megaplus. According to her, she was referred by a fellow teacher (not a doctor) to Megaplus for treatment of her back pains. She was told by Megaplus that 80% of the treatment costs would be covered by government insurance and that the 20% patient share would be waived. She stated that when she asked Megaplus how much the treatment costs were, she was told that they were minimal. However, when she subsequently inquired from GHLIB, she learned that at least $13,000 had been paid to Megaplus for the months of January to March 1995 alone, and that Megaplus was charging $480 to $500 per session. She also stated that she referred many teachers to Megaplus for physical therapy services.

The above information suggested that Megaplus may have been padding claims through the use of the blank receipts signed by patients. The blank receipts were actually "Treatment Forms" showing what services were rendered by Megaplus. The forms were used by Megaplus as invoices to bill GHLIB. Since the patients signed the forms in blank, Megaplus could easily insert or charge numerous items without the knowledge of the patient. OPA conducted an investigation and concluded that Megaplus was involved in a pattern of padding claims to receive unearned payments from GHLIB. Among other things, the investigation showed the following:

- Many patients confirmed that Megaplus was asking them to sign blank treatment forms. Several patients had been undergoing physical therapy treatments without being seen by physicians. Most treatments were ongoing and continued for more than one year, which was highly unusual according to the CHC Physical Therapy Director.

- A licensed and experienced physical therapist engaged by OPA to review Megaplus billings reported that many treatments being billed were not even applicable to the patient's conditions. For example, a female patient was supposedly being treated for back pains caused by a vasectomy (a birth control procedure that can be performed only on males). In many cases, patients were initially evaluated for a specific problem and then during each session, additional treatments were supposedly performed which were unrelated to the patient's condition. The therapist also reported that the billings showed that many patients were being treated with excessive procedures which are physically impossible to perform at one time. The therapist concluded that there appears to be consistent "padding" of claims by the billing of excessive and unnecessary physical therapy services.

- Former Megaplus employees (physical therapists) claimed that they were asked by Megaplus officials to perform additional, but unnecessary treatments to patients in order to increase billings to GHLIB. OPA also found evidence that Megaplus charged patients with government insurance at a rate of about $200 to $400 per session. Other patients in the private sector were being charged only $20 per session. It was apparent that Megaplus was charging excessive rates if patients had government insurance since GHLIB picked up the tab and not the patients.

On June 3, 1997, OPA referred the results of the investigation to the Attorney General's Office (AGO) for local prosecution. On August 22, 2000, however, AGO informed OPA that it no longer intended to take further action.

Megaplus Improperly Paid for Unsupported Claims

Our audit and investigation also showed that Megaplus was paid for claims without the necessary doctor's prescriptions or referral forms. As part of our work, we reviewed all health insurance payments to Megaplus from the start of the payments

in June 1993 until December 1999 when GHLIB stopped its payments. Apart from the falsified claims, we found that Megaplus was paid at least $548,744 in unsupported claims. This represents about 39 percent of the $1,418,771 in total claims paid to Megaplus during the period.

As provided under the GHIP manual, health insurance claims for physical therapy services should be supported by a doctor's prescription or referral form. Our review also showed that at least two documents were submitted by medical providers to support their health insurance claims. These included (1) health insurance claim forms or treatment invoices showing the date of service, type of treatment (in codes), amounts billed, and doctor's name among others, and (2) valid doctors' prescriptions or referral forms certifying medical necessity.

Our audit showed, however, that the GHLIB claims examiner/health insurance adjuster concentrated more on determining eligibility of patients for insurance coverage (i.e., whether the patient was currently enrolled under GHIP or not). Also, only the health insurance claim form was subjected to detailed review. For example, information from the form was recorded in the computer (e.g., service dates, benefit codes, charge per unit, total charges, etc...). The computer checked the information against prerecorded data and rejected any incorrect information. The related doctor's prescription or referral form was not scrutinized for validity or compared at all with the services performed as reflected in the health insurance claim form. Therefore, it was possible that claims were processed even without these important documents.

To address this problem, GHLIB recently required all medical care providers, effective March 16, 2000, to ensure that all health insurance claim forms are signed by a physician or authorized representative, and that each claim for physical therapy is duly supported by a doctor's prescription or referral form. In addition, physical therapy treatments in excess of ten sessions are required to be justified accordingly.

During our review of the documentation requirements for claims processing, we also noted that GHLIB operated without the benefit of written guidelines. For example, there were no specific documentation requirements to justify claims for patients who had been undergoing extended medical treatments. At the very least, progress or periodic evaluation reports from a physician should be required to be submitted before such claims are processed. More importantly, written guidelines are necessary to aid in the performance of procedures by employees, establish uniformity and consistency in applying procedures, and to assist in the orientation and training of new personnel.

Megaplus Officials Engaged in Illegal Scheme

Our audit and investigation showed that Megaplus officials engaged in an illegal scheme to obtain undeserved payments from GHLIB. They employed this scheme by (1) submitting claims supported by falsified doctors' prescriptions and referrals, and (2) padding claims with unperformed and unnecessary treatments. Furthermore,

they exploited GHLIB's lax procedures by submitting claims with incomplete supporting documents.

The scheme was not detected by GHLIB employees primarily because of insufficient training and experience in reviewing health insurance claims. GHLIB does not conduct a utilization review of claims to determine if proper procedures were performed and the proper medications were prescribed. This normally requires the services of a person with sufficient training and experience in the medical field. No GHLIB employee, however, meets these requirements.

As a result, GHLIB incurred losses amounting to $313,516 in fraudulent claims. At least $548,744 in unsupported claims was also improperly paid to Megaplus. Overall, total false and unsupported claims paid to Megaplus amounted to at least $862,260.

The FBI-OPA joint task force investigations eventually led to the arrest of two Megaplus officials on March 28, 2000. The two officials were charged with federal violations for health care fraud. They subsequently entered into plea agreements and were sentenced on July 25, 2000, receiving jail terms of up to four years. They were also required to reimburse GHLIB more than $700,000. This amount was the estimated amount of false and unsupported claims initially determined and provided by OPA to the FBI on May 9, 2000.

Request for Proposal for Utilization Review Services

To address current problems and eliminate abuses by medical care providers, GHLIB solicited requests for proposals (RFP) for utilization review services. GHLIB, through the Northern Mariana Islands Retirement Fund (NMIRF), advertised the RFP on two separate occasions, with the latest advertisement dated June 2, 2000. As of the date of this report, however, no contract for utilization review services has been entered into by NMIRF.

Internal Control Matters

As part of our audit, we evaluated GHLIB's internal controls over the processing and payment of health insurance claims. We found major internal control weaknesses in these areas as follows:

Qualification Requirements for Claims Examiner Not Adequate

The claims examiner is primarily responsible for reviewing health insurance claims and processing them for payment. The position, however, does not require training and experience in the medical field as a qualification requirement. Consequently, the claims examiner had insufficient knowledge to determine if proper medical procedures were performed and if proper medications were prescribed. As a result, GHLIB was not able to detect health care fraud and abuses.

Disbursement Vouchers and Supporting Documents Are Not Voided Upon Payment

During our examination of documents evidencing the payment of health insurance claims, we noted that the supporting documents (e.g., disbursement vouchers, health insurance claim forms, treatment invoices, doctor's prescriptions and referrals) were not marked paid or otherwise voided. To prevent the reuse of original documents and possible duplication of payments, GHLIB should void all documents upon completion of check processing. This can be accomplished by stamping "PAID" on the face of the documents.

Incompatible Functions of Accountant and Claims Examiner

Signed checks for health insurance claims are returned to the accountant who prepared the checks. The checks are then forwarded by the accountant to the claims examiner who posts the payment information in the computer. After this procedure, the checks are given to the administrative assistant for distribution. To improve internal controls, signed checks should be given directly to the administrative assistant who has no access to accounting and payment records. As an alternative, the checks could be mailed directly to the vendor or payee.

Missing and Incomplete Claim Documents

The scope of our audit was limited because a large number of claim documents were either missing or incomplete. Of the $1,418,771 total claims paid to Megaplus, we were not able to examine claims amounting to $492,514, or about 35 percent of the total paid claims. The absence of essential documents means that there is no assurance that all false and unsupported claims were detected by our audit, and also indicates the lack of proper recordkeeping and maintenance procedures.

Conclusion and Recommendations

GHLIB should ensure that health insurance claims submitted by medical care providers are valid and properly authorized before payments are made. In view of the actual and potentially huge losses from false and unsupported claims, steps should be undertaken immediately to prevent and detect fraud and abuse by medical care providers. Accordingly, we recommend that the Administrator:

1. Expedite the hiring of a utilization review specialist either on a contract or employment basis. The utilization review specialist should be well qualified and experienced in reviewing of health insurance claims, and should be at least a health care professional, preferably a duly licensed nurse or physician.

2. Instruct the GHLIB Manager to prepare written guidelines for the review and processing of claims. The guidelines should include specific documentation requirements to justify claims for patients who have been undergoing extended medical treatments.

3. Adopt measures to improve internal controls over the processing and payment of health insurance claims as follows: (a) qualification requirements for the position of claims examiner should be improved by requiring sufficient training and experience in the medical field, (b) supporting claim documents should be marked paid after completion of check processing to prevent duplicate payments, (c) for proper segregation of duties, signed checks for distribution to vendors should be mailed directly or distributed by the administrative assistant without being returned to persons who have access to accounting and payment records, and (d) written filing procedures should be prepared to control and monitor the locations of accounting records and claim documents.

Northern Mariana Islands Retirement Fund Response

The Deputy Administrator responded that the NMIRF Board endorses prompt resolution and implementation of OPA recommendations. According to the Deputy Administrator, the following actions were taken to address our recommendations; (1) a firm has been selected to perform utilization reviews, but NMIRF is presently awaiting funding from the CNMI Legislature before executing the contract, (2) a qualified utilization review specialist will be hired by NMIRF and a job vacancy announcement for this position has already been advertised, and (3) written operating procedures for processing of medical claims have been drafted to address inadequacies of existing practices. The Administrator is currently reviewing the draft procedures and would appreciate OPA's comments or additional recommendations.

OPA Comments

Based on the Deputy Administrator's response, we consider Recommendations 1 and 2 as resolved, and Recommendation 3 as open. The additional information or actions required to consider Recommendations 1, 2, and 3 closed are presented in Appendix B.

Recommendation 1 is considered resolved pending further actions. The NMIRF has undertaken two separate plans of action to address Recommendation 1. These plans are (1) contracting with a utilization review firm, and (2) hiring a utilization review specialist. In a subsequent discussion with the Deputy Administrator, we found out that the plan for contracting with a utilization review firm will transfer generally all functions concerning medical claims processing to the firm. However, this plan is tentative and cannot be immediately implemented at the present time. We, therefore, suggest that NMIRF pursue the hiring of the utilization review specialist instead of contracting with the firm. NMIRF should also consider advertising outside the CNMI, including the U.S. mainland, to attract qualified applicants and immediately fill the position. To close this recommendation, NMIRF should provide sufficient documentation to OPA evidencing that a utilization review specialist has been hired.

We also consider Recommendation 2 as resolved pending further actions. The NMIRF should include in the written operating procedures the following: (1) submission of original referral letters from a doctor of medicine, (2) submission of health insurance claim forms duly signed by patients, and (3) submission of periodic treatment and evaluation reports by physicians to justify extended medical treatment. In addition, NMIRF should prepare a documentation checklist form to ensure that all requirements are completed before claims are processed. To close this recommendation, NMIRF should provide a copy of the final approved version of the written operating procedures to OPA.

Recommendation 3 is considered open because the Deputy Administrator's response did not contain any specific plan of action to address this recommendation.

Appendix A
Page 1 of 7

Northern Mariana Islands
RETIREMENT FUND
"Investing For The Future Financial Security Of Our Members"

1980

December 18, 2000

Mr. Mike Sablan
Acting Public Auditor
Office of the Public Auditor
Commonwealth of the Northern Marianas
2nd Floor, J.E. Tenorio Building
Gualo Rai, Saipan

Re: Response to Draft Letter Report on Audit and Investigation of GHLITF payments to Mega Plus Int'l. CNMI, Inc.; your letter dated November 16, 2000

Dear Mr. Sablan:

On behalf of the Board of Trustees, we extend our warmest congratulations on your recent appointment to serve as the CNMI Public Auditor. We wish you a speedy confirmation!

We have completed our review of your letter and the accompanying draft audit report. In addition, we have discussed in detail your findings and recommendations with the Board of Trustees during its meeting held on November 30, 2000. Your findings and recommendations are acknowledged and we certainly do not refute any of the specifics. As a result of the audit, the Board endorses prompt resolution and implementation of your recommendations as follows:

1. A Utilization Reviewer firm has been selected to review and process medical claims billed to GHLITF including claims from the medical referral. Before executing the service contract, however, adequate funding must be available which the GHLITF presently do not have. As you are well aware, the Board of Trustees has formally requested and is presently awaiting funding from the CNMI Legislature to meet the financial requirements of the Utilization Reviewer selected by the Board.

2. Hiring of a qualified individual possessing the training and experience in the medical and or nursing field such as a registered nurse, physician assistant, etc. A job vacancy announcement for the position of "Utilization Review Specialist" has since been announced. A copy of the newspaper advertisement is attached for your information.

3. Drafted specific guidelines, forms and procedures in the processing of medical claims addressing in particular the concerns and inadequacies of the existing practices. The proposed guidelines and procedures entail specific documentation requirements to facilitate services and payments of claims and refunds. The

P.O. Box 501247 C.K., Saipan, MP 96950 | Tel: (670) 664-3863 | Fax: (670) 664-8080
Internet: http://www.saipan.com/gov/branches/retire/index.htm E-mail: nmi.retirement@saipan.com

Appendix A
Page 2 of 7

Administrator is currently reviewing the draft procedures and will provide you a copy of the procedures when completed and approved. In the meantime, we ask for your comments or additional recommendations on the proposed draft.

In the draft audit report, it is mentioned the court order stipulated Mega Plus is required to make restitution to the Government Health and Life Insurance Trust Fund. In this regard, we would like to be provided with additional information such as the following:

1. A copy of the Court Order or Case No.
2. Listing of Assets of Mega Plus that is the subject of the restitution. This should include cash, if any, that may have been seized or in the custody of the Court or enforcement agency. Is there a prospect of the Trust Fund receiving partial restitution soon? If not soon, when may we expect the initial restitution?
3. Which CNMI government office should be responsible to follow up on the progress of the restitution; is it the Office of the Public Auditor, or the Attorney General's Office?
4. Is it possible for our legal counsel or Administrator to be provided copies of all future correspondence regarding this matter?

If you should have any question or require additional information please let us know.

Sincerely,

Fred F. Camacho
Deputy Administrator

Enclosures

Xc: Administrator
BOT
Mgr. GHLITF

GOVERNMENT HEALTH AND LIFFE INSURANCE TRUST FUND MEDICAL CLAIMS INSURANCE OPERATING PROCEDURES

ARITICLE I INTRODUCTION

1.01 **Authority:** Public Law 10-19 enacted on June 21, 1996 established the (GHLITF) Government Health and Life Insurance Trust Fund and transferred the administration of the Government Health and Life Insurance Program including its personnel to the NMI Retirement Fund. The trust fund administers the employees and employer premium contributions from which medical claims and administrative expenses are paid. The statute further authorizes the NMI Retirement Fund to promulgate administrative procedures necessary for the administration of the program.

1.02 **Purpose and Objective:** This operating procedure is established to facilitate the efficient processing of medical claims, refunds and reimbursements. Implementation of this procedure should improve the members' services, safeguard the assets of the trust fund, and provide the ghlitf staff with specific guidelines on the disposition of claims inclusive of processing and filing. It is not, by any means, the final operating document, but rather a basic procedure to be followed pending promulgation of a comprehensive policy and procedure covering every aspect of the benefit plan description.

ARTICLE 2 DEFINITIONS

2.01 Applicability and Reference: Any phrase or terms used throughout this procedure is as defined in the Plan Benefit Document.

ARTICLE 3 MEMBERSHIPS IN THE GHLITF

3.01 **Eligibility:** All employees of the CNMI government and retirees are eligible to apply to enroll in the Government Health Insurance. Only employees, retirees and eligible survivors whose enrollment application are filed and approved are eligible for medical insurance benefits.

3.02 **Enrollment Application Form:** To be eligible for medical coverage, each subscriber must complete and file application form ghlitf 4. The Administrator or his or her designee must approve the enrollment application.

3.03 **Premium- Payroll/Pension Deduction**: Subscribers generally make premium contribution through payroll deduction. It shall be the subscribers' responsibility to ensure that premiums are deducted from the employees' paycheck, or if a retiree or survivor, from retirement or survivor pension.

However, enrollees who have properly executed an automatic payroll or pension deduction should not be denied benefits in the event premium contributions are not timely deducted or transmitted to GHLITF through no fault of the subscriber.

3.04 **Non-payment of Premium**: Medical claim benefits must not be paid unless the subscriber's premium contributions are current. Under extenuating circumstances, the Administrator must be consulted to exercise judicial discretion and determine whether or not payments should be made. Subscribers with premium arrears longer than 60 days should be notified in writing and informed of possible expulsion from the program. Subscribers whose insurance premium remains un-paid for 90 days or longer may be terminated from the program and re-admitted only upon payment of outstanding premium after fulfilling other eligibility criteria.

ARTICLE 4 CLAIMS

4.01 **Claims Processing.**

A. Timely Filing and Forms Required: All medical claims must be filed within one year from date of service rendered. Health Care Providers must complete and file form HCFA 1500. Providers may file claims electronically, provided the hard copies are submitted at the same time. Electronically filed claims must include basic information such as the name of enrollee, name of provider, dates services were rendered, description of illness, injury or services rendered by way of a CPT and CHPT codes, and prescriptions filled, etc. **All claims and accompanying documentations must be retained.**

B. **Claim Examiner Review Procedures:** Claim Examiners should be assigned to process claims from specific Health Care Providers. Claim Examiners must ensure each claim is filed timely, in proper form, and actual services rendered is covered under the Plan Benefit Description and that the charges reflect the services rendered. Once these are ascertained, the Claim Examiner must verify eligibility of the enrollee and then proceed to examine the appropriateness of the services and charges specified in the claim.

C. **Computer Entry and Claims Processing Procedure:** Details of the claim are then entered into the system and a computer print out is produced to initiate the payment request. This is accomplished by entering into the system the *provider code number* assigned followed by the assigned *claim batch number*.

D. **Review by Supervisor of Claims and Payment Procedure:** Claim Examiner or clerk prepares a disbursement request form (GHLITF-2)

accompanied by the claim documents, computer printout and other supporting documents and forwards to the Branch Manager for review.

a. Branch Manager reviews individual claims and signs off on disbursement sheet indicating claim (s) and charges are appropriate.
b. After the review by the Branch Manager, payment request and accompanying documents are forwarded to the Accounting Manager (or designee) for certification of availability of funds by affixing her signature provided on the disbursement sheet.
c. After funds are certified available, claims are forwarded to Deputy Administrator or Administrator to authorize issuance of check for payment.
d. Claims are then forwarded to the GHLITF accountant who will prepare payment voucher, a check for the amount requested and initiate the proper accounting entries into the Peachtree accounting system developed for GHLITF.
e. Accountant or Accounting Clerk forwards prepared check to the Administrator for signature.
f. Accountant forwards signed check or checks with claims and supporting documents to the GHLITF Benefits Technician who will stamp "PAID" **each** claim and prepare transmittal letter, envelope, etc. for mailing.
g. Benefits Technician files claims in batches together with copy of check and files to appropriate storage box. Each box should be *accurately labeled* according to the months the checks are issued and series of *check numbers* contained in the box.

E. **Claims Filing Procedure**: All claims and accompanying documentation must be filed and attached to the copy of the check from which it is paid. If paid claims are grouped in batches, each batch should be accurately labeled and the batch box or boxes properly enumerated for easy access and identification.

4.02 **Claims Filing for Reimbursement Received from Members**

A. **Documentations Required**: The *subscriber*, or the subscribers *enrolled spouse* must complete form ghlitf 6 in order to obtain reimbursement. Only original receipts are acceptable for reimbursement. Copies of the Doctor's diagnosis report are also required to support claims for reimbursement.

B. **Timely Filing:** Claims for reimbursement must be submitted to GHLITF within one calendar year following the date on which the medical service was rendered.

C. **Review and Processing Procedure**: The review and processing procedure are the same as that established for private health care providers.

ARTICLE 5 DISPUTED CLAIMS

5.01 Claims received from Health care Providers:

a. Claim Examiner must report to the GHLITF Manager or designee findings inconsistent with the Plan Documents.
b. GHLITF Manager must determine eligibility of the claim and either approve or disapprove the claim.
c. GHLITF Manager must reject and return the claim to the provider with an explanation or reason for denial.

5.02 **Claims received from Subscribers:**

a. Claim Examiner must reject and report claims not covered under the plan to the GHLITF Manager.
b. The Manager must review and make a determination whether to approved or disapproved said claim. If the Managers' decision is to disapprove the claim, claimant should be promptly notified in writing of the disapproval. and the reason for disapproval explained. Also, the claimant must be advised of his/her rights for reconsideration and appeals as enumerated under Article 19.01 of the Benefit Plan.

5.03 **Adjudication Procedures – Health Care Providers and Enrollees:**
It is the responsibility of the GHLITF Manager to adjudicate claims and charges disapproved in whole or in part. The Administrator may employ the assistance of professionals to assist in the adjudication process. Administrator and GHLITF Manager is expected to make reasonable attempt to resolve any disputes to the mutual satisfaction of all parties, however any such decision should not compromise the integrity of the Plan Document.

eland First Minister David Trimble, from left to right, President Clinton, Northern Ireland st Minister Seamus Mallon and British Prime Minister Tony Blair pose on the steps of arliament buiding in Belfast prior to their meeting on Wednesday, Dec. 13. AP

province to around lowest level in three

lams, leader of the Sinn Fein party, still wasn't doing d blamed Blair of ting bias towards t he praised Clinton and said the president had blazed a solid trail for his successor.

"The USA now has a peace policy toward Ireland. I can't see any president abandoning that," said Adams, who was in the audience for Clinton's speech.

A lone heckler, apparently disputing Clinton's comment that violence is on the wane, tried to shout Clinton down. "I'll listen to if you let me finish," Clinton told him, drawing stomps of approval from the crowd. But when the man kept yelling, Clinton told the crowd,

tion for Sinn Fein party - both stipulations of the Good Friday pact.

"The president could use the force of the United States and his office to say to these people that the days of terror are finished," Wilson told reporters.

Clinton later told reporters: "No, we're not soft on" terrorism.

Clinton and Blair each met separately with Trimble; Seamus Mallon, the government's senior Roman Catholic; and the Sinn Fein's Adams.

wave

ved together.
Hamill was only 9
hen Clinton's first
fast thrust her into
it.
ed heartstrings in
she told the world
ddy was killed by
unmen before she
linton was so taken
nde schoolgirl that
her to America to
ite House.
said Wednesday she
sed by her fame but
for Clinton's inter-
ing peace.
ars ago I really
e about the peace
ho killed my daddy
said.

m plan

n, who was sent
the Soviet authori-
rk, won the Nobel
ature in 1970.
syn also reiterated
of Russia's war in
saying the rebels
ed the fighting by
neighboring Rus-
of Dagestan. He
d warnings that
the press was at
sident Vladimir
, saying the me-
o be controlled
owners' financial

Appendix B
Page 1 of 2

STATUS OF RECOMMENDATIONS

Recommendations	Agency to Act	Status	Agency Response/ Additional Information or Action Required
1. The Administrator should expedite the hiring of a utilization review specialist either on a contract or employment basis. The utilization review specialist should be well qualified and experienced in the review of health insurance claims, and should be at least a health care professional, preferably a duly licensed nurse or physician.	NMIRF	Resolved	The Deputy Administrator responded that the NMIRF Board endorses prompt resolution and implementation of OPA recommendations. According to the Deputy Administrator, the following actions were taken to address the recommendation; (1) a firm has been selected to perform utilization reviews, however, NMIRF is presently awaiting funding from the CNMI Legislature before executing the contract, and (2) a qualified utilization review specialist will be hired by NMIRF and a job vacancy announcement for this position has already been advertised. *Further Action Required* The NMIRF has taken two separate plans of action to address Recommendation 1. These plans are (1) contracting with a utilization review firm and (2) hiring of a utilization review specialist. In a subsequent discussion with the Deputy Administrator, we found out that the plan for contracting with a utilization review firm will transfer generally all functions concerning medical claims processing to the firm. However, this plan is tentative and cannot be immediately implemented at the present time. We, therefore, suggest that NMIRF pursue the hiring of the utilization review specialist instead of contracting with the firm. NMIRF should also consider advertising outside the CNMI, including the U.S. mainland to attract qualified applicants and immediately fill the position. **To close this recommendation, NMIRF should provide sufficient documentation to OPA evidencing that a utilization review specialist has been hired.**
2. The Administrator should instruct the GHLIB Manager to prepare written guidelines for the review and processing of claims. The guidelines should include specific documentation requirements to justify claims for patients who have been undergoing extended medical treatments.	NMIRF	Resolved	The Deputy Administrator responded that written operating procedures for processing of medical claims have been drafted to address inadequacies of existing practices. The Administrator is currently reviewing the draft procedures and would appreciate OPA's comments or additional recommendations. *Further Action Required* The NMIRF should include in the written operating procedures the following: (1) submission of original referral letters from a doctor of medicine, (2) submission of health insurance claim forms duly signed by patients, and (3) submission of periodic treatment and evaluation reports by physicians to justify extended medical treatment.

Appendix B
Page 2 of 2

STATUS OF RECOMMENDATIONS

Recommendations	Agency to Act	Status	Agency Response/ Additional Information or Action Required
			In addition, NMIRF should prepare a documentation checklist form to ensure that all requirements are completed before claims are processed. **To close this recommendation, NMIRF should provide a copy of the final approved version of the written operating procedures to OPA.**
3. The Administrator should adopt measures to improve internal controls over the processing and payment of health insurance claims as follows: (a) qualification requirements for the position of claims examiner should be improved by requiring sufficient training and experience in the medical field, (b) supporting claim documents should be marked paid after completion of check processing to prevent duplicate payments, (c) for proper segregation of duties, signed checks for distribution to vendors should be mailed directly or distributed by the administrative assistant without being returned to persons who have access to accounting and payment records, and (d) written filing procedures should be prepared to control and monitor the locations of accounting records and claim documents.	NMIRF	Open	The Deputy Administrator's response did not contain any specific plan of action to address this recommendation. *Further Action Required* NMIRF should implement the recommendation.

Published by Office of the Public Auditor, P.O. Box 501399, Saipan, MP 96950
Telephone No. (670) 234-6481 Fax No. (670) 234-7812
Web Site: http://opacnmi.com E-Mail: mail@opacnmi.com