

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**THE PASSAMAQUODDY TRIBE'S  
PLEASANT POINT HEALTH CENTER  
NEEDS TO IMPROVE ITS  
MEDICAL-REFERRAL PROCESS**

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## Why OIG Did This Review

Longstanding challenges, including insufficient oversight and limited access to specialists, likely impact the quality of healthcare services provided to American Indians and Alaskan Natives. In certain cases, the Federal government permits Tribes to administer their own healthcare programs through Federally Qualified Health Centers (FQHC), which receive Federal funding but limited Federal oversight in recognition of the independent nation status of the Tribes. In 2017, our office conducted a review of direct-care services provided at the Passamaquoddy Tribe's Pleasant Point Health Center (PPHC) that identified health and safety issues affecting quality of care. This review extends this work to evaluate the medical-referral process for specialty healthcare provided at facilities external to PPHC.

Our objective was to determine whether the Passamaquoddy Tribe at Pleasant Point met Federal requirements for medical referrals processed at PPHC.

## How OIG Did This Review

We reviewed the scope of services identified in the Indian Health Service's (IHS's) contracts with the Passamaquoddy Tribe at Pleasant Point, requirements for Medicare FQHC, and Tribal requirements for calendar years 2014 through 2016 and compared services that were required to be provided to actual services rendered at PPHC.

## The Passamaquoddy Tribe's Pleasant Point Health Center Needs To Improve Its Medical-Referral Process

### What OIG Found

The Passamaquoddy Tribe at Pleasant Point did not always meet Federal requirements for medical referrals. Specifically, we found that PPHC did not utilize a Managed Care Committee (MCC), comprised of the required medical and administrative staff, to review medical referrals on a weekly basis. In addition, PPHC did not always maintain accurate and complete documentation of medical referrals.

PPHC did not follow IHS policies and procedures to utilize an MCC to review medical referrals on a weekly basis and maintain accurate and complete documentation of medical referrals because the Passamaquoddy Tribe at Pleasant Point's health director did not provide adequate supervision of the administrative staff and the referral process, and PPHC did not implement safeguards to prevent the loss of referral data. As a result, there was an increased risk that patients did not receive critical health services for time-sensitive medical conditions and clinical providers did not always have accurate or complete medical documentation to assess and prioritize patients' clinical treatment progress.

### What OIG Recommends

We recommend that the Passamaquoddy Tribe at Pleasant Point (1) reestablish an MCC, comprised of the required medical and administrative staff, to review medical referrals on a weekly basis in accordance with Federal requirements and (2) implement policies and procedures to maintain complete and accurate documentation of medical referrals.

The Passamaquoddy Tribe at Pleasant Point concurred with our recommendations and described actions it has taken or planned to take to address them. For example, PPHC has reestablished the MCC, comprised of medical and administrative professionals, to meet and review referrals on a weekly basis to ensure that medical referrals are processed in a timely manner.

**TABLE OF CONTENTS**

INTRODUCTION.....1

    Why We Did This Review .....1

    Objective .....1

    Background .....1

        Purchased/Referred Care Program.....2

        Referred Care at Tribal Medicare Federally Qualified Health Centers.....2

        Referred Medical Care for Pleasant Point Passamaquoddy Tribe.....3

        Systems and Process for Referred Care.....3

    How We Conducted This Review .....5

FINDINGS.....5

    PPHC Did Not Utilize a Managed Care Committee To Review Medical Referrals .....6

    PPHC Did Not Always Maintain Accurate Medical Referral Documentation .....7

        Medical Priority Level Codes .....8

        Referral Status.....8

    PPHC Had Missing Medical Referrals.....9

RECOMMENDATIONS ..... 10

THE PASSMAQUODDY TRIBE AT PLEASANT POINT COMMENTS..... 10

APPENDICES:

    A: Audit Scope and Methodology ..... 11

    B: Statistical Sampling Methodologies and Results ..... 12

    C: Sample Results and Statistical Estimates ..... 14

    D: Indian Health Services Medical Priority Level Codes for Medical Referrals..... 15

    E: The Passamaquoddy Tribe at Pleasant Point Comments ..... 17

## INTRODUCTION

### WHY WE DID THIS REVIEW

American Indians and Alaskan Natives experience higher mortality rates than all other races in the United States in specific categories such as diabetes, drug- and alcohol-induced deaths, chronic liver disease, assault, homicide, and suicide. The Office of Inspector General (OIG) has identified longstanding challenges, including insufficient oversight and limited access to specialists that likely impact the quality of healthcare services provided to American Indians and Alaskan Natives. Tribes may operate their own clinics with Indian Health Service (IHS) funds. Tribal clinics also may enroll as Medicare Federally Qualified Health Centers (FQHCs). In 2017, our office conducted a review of direct-care services provided at the Passamaquoddy Tribe's Pleasant Point Health Center (PPHC) that identified health and safety issues affecting the quality of care.<sup>1</sup> In this review, we evaluate the medical referrals process for specialty healthcare provided at facilities external to PPHC.

### OBJECTIVE

Our objective was to determine whether the Passamaquoddy Tribe at Pleasant Point met Federal requirements for medical referrals processed at PPHC.

### BACKGROUND

Within the U.S. Department of Health and Human Services, IHS's mission is to partner with American Indians and Alaskan Natives to elevate their physical, mental, social, and spiritual health to the highest level. The goal of the IHS is to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to all of the approximately 2.2 million people of the 573 federally-recognized Tribes.

In 1975, Congress recognized the importance of Tribal decision making in Tribal affairs and the nation-to-nation relationship between the United States and Tribes through the passage of the Indian Self-Determination and Education Assistance Act (ISDEAA) (Public Law 93-638). Under Title I of the ISDEAA, federally-recognized Tribes can enter into Self-Determination contracts to administer their own healthcare programs and services that IHS would otherwise provide. The contracts may cover a definite or indefinite term and the amount of funding is negotiated each year in annual funding agreements. The Self-Determination Contract sets the general terms of the arrangement, such as what programs that tribe will assume. The annual funding agreement sets out the funding IHS will award the Tribe.

In its self-determination contract, awarded on January 31, 2011, for an indefinite term, the Passamaquoddy Tribe agreed to follow IHS policies and procedures for Contract Health

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<sup>1</sup> *The Passamaquoddy Tribe's Pleasant Point Health Center Did Not Always Meet Federal and Tribal Health and Safety Requirements* (A-01-17-01500). Available online at <https://oig.hhs.gov/oas/reports/region1/11701500.pdf>.

Services. These include using a Managed Care Committee (MCC) to review referrals and using the IHS medical priority level code definitions when referring health services.

### **Purchased/Referred Care Program**

In January 2014, the Consolidated Appropriations Act of 2014 renamed the Contract Health Services program to the Purchased/Referred Care (PRC) program.<sup>2</sup> All policies and practices remain the same.

The PRC program is integral to providing comprehensive healthcare services to American Indians and Alaska Natives (AI/AN). The IHS health system delivers care through direct-care services provided in IHS, Tribal, and urban (I/T/U) health facilities (e.g., hospitals and clinics) and through PRC services provided by non-IHS providers. The general purpose of PRC is for IHS and Tribal facilities to purchase services from private healthcare providers in situations in which (1) no IHS or Tribal direct-care facility exists; (2) the existing direct-care element is incapable of providing required emergency or specialty care; (3) utilization in the direct-care element exceeds existing staffing; and (4) supplementation of alternate resources (e.g., Medicare, Medicaid, or private insurance) is required to provide comprehensive healthcare to eligible AI/AN.

The combination of an increasing AI/AN population, limited funding, medical inflation, and limited competitive pricing and options requires strict adherence to program guidelines to ensure the most effective use of PRC resources. These guidelines apply to qualifying factors such as medical priority levels of care and eligibility requirements that are more stringent than those for IHS direct care.

### **Referred Care at Tribal Medicare Federally Qualified Health Centers**

While most FQHCs are outpatient primary care facilities that provide care to primarily low-income individuals and receive grants under section 330 of the Public Health Service Act, Tribal health centers funded by IHS may apply to become Medicare FQHCs. For the purposes of Medicare Part B, the Social Security Act considers an FQHC to be (1) a 330 grantee, (2) a facility that meets the requirements of a 330 grantee, (3) an entity that was treated as a federally funded health center for the purposes of Medicare part B as of January 1, 1990, or (4) a facility operated by a Tribe, Tribal organization, or urban Indian organization receiving IHS funding.<sup>3</sup> PPHC is a Tribal health center that is funded by IHS and therefore meets the last of these criteria.

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<sup>2</sup> Indian Health Service, "Purchased/Referred Care History." Available online at <https://www.ihs.gov/prc/history/>. Accessed on January 9, 2019.

<sup>3</sup> Section 1861(aa)(4) of the Social Security Act.

By obtaining certification from the Centers for Medicare & Medicaid Services (CMS) as a Medicare FQHC, a clinic will be deemed to meet the standards for certification under Medicaid (42 CFR § 491.3). Tribally-operated health centers may receive reimbursement for health services provided to qualifying individuals.

CMS certifies tribally-operated health centers as Medicare FQHCs based on the Tribe's written self-attestation that the health center will comply with specific health and safety requirements. CMS performs monitoring site visits at these health centers only when it receives a patient complaint and limits its investigation to address the specific grievance.

PPHC funds the purchased and referred health services through its Title I contract and annual funding agreement with IHS and reimbursements from Federal programs such as Medicaid and Medicare.

### **Referred Medical Care for Pleasant Point Passamaquoddy Tribe**

The Passamaquoddy Tribe resides on two separate reservations in Maine: Indian Township and Pleasant Point. Each reservation has its own distinct Tribal government consisting of a chief, a vice chief, and a Tribal council who are elected for varying terms by Tribe members who live on or near their respective reservation. Each Tribal government separately contracts with IHS under Title I of the ISDEAA to operate a health center located on its reservation. The Passamaquoddy Tribe at Pleasant Point has a total population of approximately 2,200. For calendar year (CY) 2014 through 2016, the PPHC PRC expenditures from all sources averaged \$1,059,000 per year.

In January 2014, the Pleasant Point Passamaquoddy Tribe requested technical assistance and advice from the IHS Area Office in Nashville, Tennessee,<sup>4</sup> to improve PPHC and its healthcare delivery system. In its March 2014 response to the Tribe, IHS reported that PPHC had experienced difficulties in the transition from paper to electronic health records (EHRs), with the extended length of referral times and with some patients not receiving referred services. IHS recommended that PRC be one of the first process improvement projects for the clinic. Since February 2018, the Tribe has sought technical assistance from IHS regarding improvements to the PRC processes at PPHC.

### **Systems and Process for Referred Care**

PPHC uses the Resource and Patient Management System Electronic Health Record (RPMS EHR) to manage PRC. RPMS EHR helps providers manage all aspects of patient care electronically, by providing a full range of functions for data retrieval and capture to support patient review, encounter, and followup.

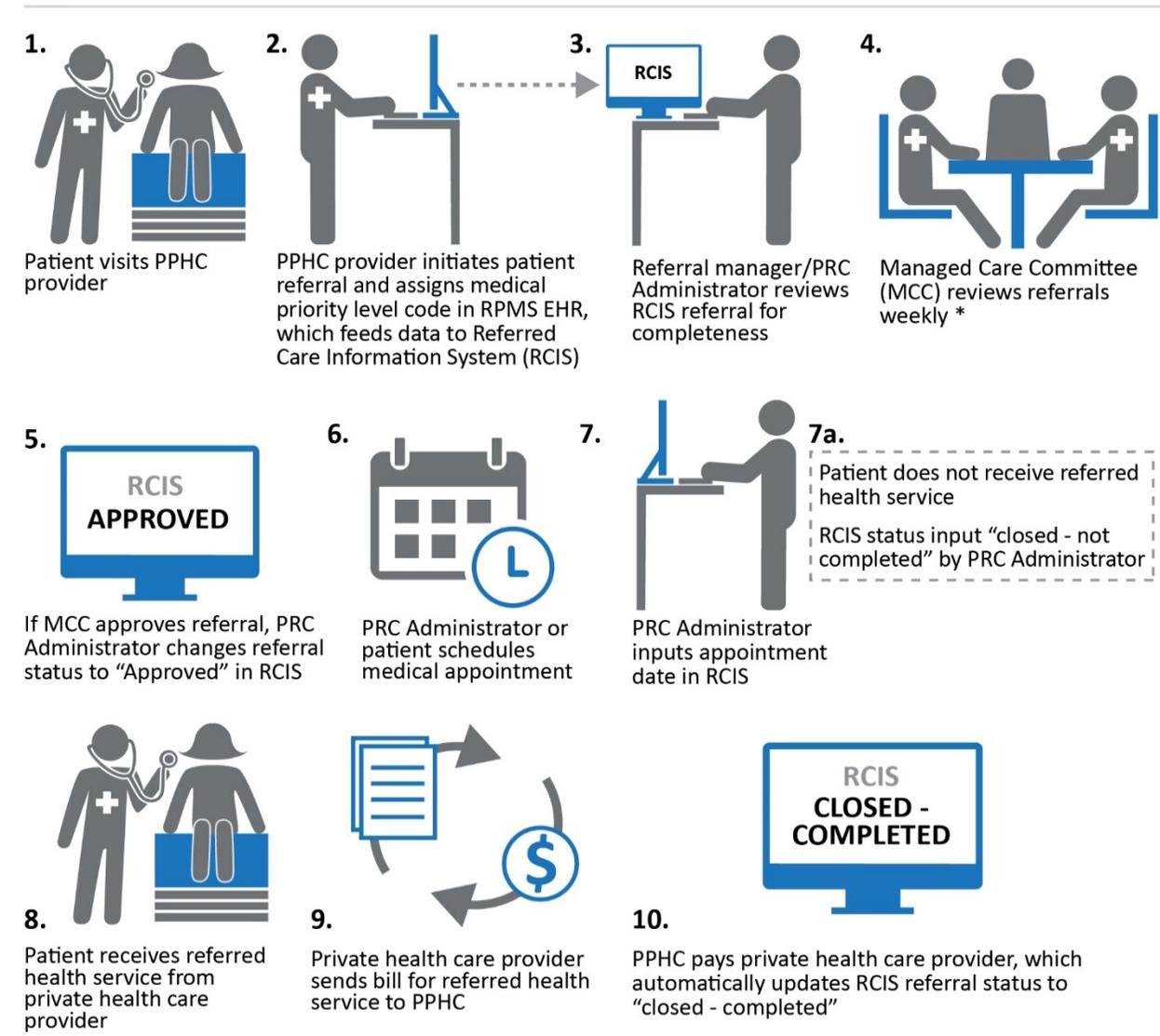
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<sup>4</sup> IHS is organized into 12 Area offices which provide funding and technical assistance to tribes with Self-Determination Contracts within designated Areas. The Passamaquoddy Tribe in Maine receives funding and technical assistance support from the IHS Area Office in Nashville, Tennessee.

The RPMS EHR feeds data into the Referred Care Information System (RCIS). RCIS automates the clinical and administrative management of PRC and tracks all referred care, including referrals to internal providers, other IHS facilities, and outside contracted providers.

Medical providers and PRC administrators use important information in RCIS such as medical priority level codes and the referral status to prioritize, process, and track the status of the referred health services. See Figure 1 for the medical-referral process.

**Figure 1: The Medical-Referral Process**



\* If MCC denies referral, PRC Administrator informs patient

## HOW WE CONDUCTED THIS REVIEW

We reviewed the medical-referral process at PPHC for the period CY 2014 through 2016. We analyzed a statistical sample of 30 medical referrals initiated during CY 2014 through 2016 to test the accuracy of referral documentation and identify sample processing times for the period. In addition, we interviewed PPHC staff, reviewed referral documentation made by providers, and assessed the timeliness and issues related to medical referrals made by PPHC providers.

We conducted this performance audit 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.

## FINDINGS

The Passamaquoddy Tribe at Pleasant Point did not always meet Federal requirements for processing medical referrals at PPHC for CYs 2014 through 2016. Specifically, we found the following:

- PPHC did not utilize an MCC, comprised of the required medical and administrative professionals, to review medical referrals on a weekly basis.
- PPHC did not always maintain accurate documentation to facilitate the processing of medical referrals. On the basis of our sample, we estimated that 2,284 of 2,635 (87 percent) of medical referrals in the RCIS had inaccurate documentation of medical priority level codes or referral status.<sup>5</sup>
- PPHC had 746 (16 percent) missing referrals from the RCIS.

PPHC did not follow IHS policies and procedures to utilize an MCC to review medical referrals on a weekly basis and maintain accurate and complete documentation of medical referrals because the Passamaquoddy Tribe at Pleasant Point's health director did not provide adequate supervision of the administrative staff and the referral process. As a result, there was an increased risk that patients did not receive critical health services for time-sensitive medical conditions and clinical providers did not always have accurate or complete medical documentation to assess and prioritize patients' clinical treatment progress.

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<sup>5</sup> These totals do not represent all records but only those in which the date of service was populated.

## PPHC DID NOT UTILIZE A MANAGED CARE COMMITTEE TO REVIEW MEDICAL REFERRALS

In its Self-Determination Contract (Contract)<sup>6</sup> with IHS, the Passamaquoddy Tribe at Pleasant Point agreed to follow the Contract Health Services<sup>7</sup> policies and procedures in the *Indian Health Services Manual* (IHS Manual), which requires the utilization of an MCC to review referrals.

The IHS Manual states that the purpose of managed care is to promote access to needed healthcare at the most affordable cost, maximize utilization of resources and alternate resources, and support greater continuity of care. In its Contract with IHS, PPHC agreed to follow IHS policies and procedures (as outlined in the IHS Manual, part 2, § 3.21) for medical referrals, which include the following:

- an MCC must review contract health services (CHSs) referrals or emergency cases;
- members of the MCC should include the clinical director, director of nursing, or clinical manager (or other primary care provider), utilization review nurse (if available), administrative officer, and the CHS specialist; and
- meetings of the MCC must be held at least once a week to determine the appropriateness of referral requests for expenditure of CHS funds.

During the period of our review, PPHC did not utilize an MCC, comprised of the required medical and administrative staff, to review referrals or emergency cases on a weekly basis.<sup>8</sup> Specifically, none of the 3,956 medical referrals were reviewed by an MCC. We also noted that PPHC did not utilize an MCC to review and monitor medical referrals for CY 2017.

PPHC did not utilize an MCC to review referrals because the health director did not provide the necessary supervision<sup>9</sup> to ensure this committee was actively in place and that it would review medical referrals in accordance with the IHS contract. Because PPHC did not utilize an MCC, PPHC patients may not have received timely referrals for medical care; in some cases, patients did not receive any referred medical service. In our random sample of 30 medical referrals, it

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<sup>6</sup> The parties to this contract agreed the effective date of this contract was January 1, 2011 and will continue until terminated.

<sup>7</sup> Renamed Purchased/Referred Care in 2014. The *Indian Health Manual* has not yet been updated to reflect this change.

<sup>8</sup> PPHC staff indicated that PPHC did not hold MCC meetings during the period of our review; however, the staff said PPHC held MCC meetings in CY 2013.

<sup>9</sup> The description of the PPHC health director position states that the health director's duties include (1) participating in contract negotiations between the Tribal government and IHS, (2) maintaining compliance standards as outlined in grants and contracts, and (3) ensuring that patient referrals to outside providers are processed in a timely manner.

took PPHC, on average, approximately 3 months to schedule a referral and PPHC patients did not receive the medical care until approximately 4 months, on average, after a referral was created by the provider.

For example, a medical provider ordered a referral for a PPHC patient who had a concerning growth. The patient did not receive the referred medical care. Six months later, a different physician identified the concerning growth and performed a biopsy, which identified that the patient had a type of malignant cancer. Once identified, the patient underwent a surgical intervention to address the serious medical concern. Without regular, timely review of referrals by PPHC clinical and administrative staff, critical patient health issues may remain untreated for extended time periods, allowing harmful disease progression.

### **PPHC DID NOT ALWAYS MAINTAIN ACCURATE MEDICAL REFERRAL DOCUMENTATION**

Federal regulations state that a designated member of the professional staff is responsible for maintaining medical records and for ensuring that the records are completely and accurately documented, readily accessible, and systematically organized (42 CFR § 491.10(a)(2)).

RCIS information fields, such as medical priority level codes and referral status, provide important information for system users in the processing of the medical referrals at PPHC. When ordering medical referrals for purchased health services, the providers assign a medical priority level code to the service that classifies the referred service in RCIS using IHS standardized definitions based on the relative urgency and significance of the needed medical care. For instance, medical priority level code one identifies emergent or acutely urgent diagnostic or therapeutic services that are necessary to prevent the immediate death or serious impairment of the health of the individual. In another example, medical priority level code two identifies preventive services including sophisticated diagnostic procedures and care primarily intended for symptomatic relief or chronic maintenance. IHS has five defined medical priority level codes of care. See Appendix D for these codes.

In RCIS, referral status indicates the processing standing of the referral and can also identify whether the health service was received. Referral status fields include:

- **Active:** When a medical provider initiates a referral, it automatically becomes “active” in RCIS.
- **Approved:** Once reviewed by appropriate staff that it satisfies the health center’s required criteria for a referred service, PRC administrator inputs the referral status as “approved” in the RCIS system.
- **Closed-Completed:** Once the health service has been received, and the bill paid, the referral status in RCIS automatically updates to “closed-completed.”

- Closed-Not Completed: If a health service is denied or is not received, the PRC administrator changes the referral status in RCIS to “closed-not completed.” Once the referral is identified as “closed-not completed,” it cannot be reopened in RCIS, so the medical provider will need to create a new referral if the health service is still needed.

On the basis of our sample results, we estimated that PPHC did not maintain accurate documentation of approximately 87 percent of all referrals. Of the 30 medical referrals in our sample, 26 contained at least 1 medical documentation error for medical priority level codes or referral status as follows:

- 14 referrals had an incorrect medical priority level code and
- 23 referrals had an incorrect referrals status.

### **Medical Priority Level Codes**

In its Self Determination Contract with IHS, effective January 1, 2011, the Passamaquoddy Tribe at Pleasant Point agreed to use the IHS Medical Priority Level Codes to prioritize its PRC Services.

Of the 30 sample referrals, 14 referrals had incorrect medical priority level codes for the referred medical service. For example, five referrals for medical priority level code two “preventative diagnostic tests,” such as colonoscopies or mammograms, were incorrectly reported as medical priority level code one “urgent care services.” Ninety percent of the referrals in the sample were classified as medical priority level one code for “urgent care.” (See Appendix D for the medical priority level codes.)<sup>10</sup>

Incorrect medical priority level codes were used because the referral system had a default setting for referrals using medical level priority code one. Also, the medical providers did not have adequate training on the medical priority level code descriptions. Patients with preventative care (medical priority level two codes) were categorized the same as urgent care (medical priority level one codes), overstating the number of urgent care referrals. As a result, patients faced an increased risk that the most serious and urgent medical cases would not be identified and treated in a timely manner.

### **Referral Status**

Of the 30 sample referrals, 23 had an incorrect referral status (22 of the sample items had a referral status of “closed-not completed” even though the services were rendered, and 1 service had a status of “closed-completed” when the service was not rendered). A PRC administrator closed a significant number of medical referrals using a software function and

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<sup>10</sup> In its Title I contract with IHS, the Passamaquoddy Tribe at Pleasant Point agreed to use the IHS prioritization definitions to classify its referred medical services. These codes and their definitions appear in Appendix D.

identified the health services in RCIS as “not completed” even though numerous services were actually rendered. In RCIS, 96.5 percent of the total sample of medical referrals (3,816 of the 3,956 medical referrals) had a referral status of “closed-not completed.” For example, a patient with a cardiac disorder received the health service even though the referral was listed as “closed-not completed” in RCIS with no explanation of the reason the service was listed as not completed.

These medical referrals had an incorrect referral status because of (1) inadequate supervision of PPHC’s PRC administrative staff to ensure referrals were properly closed and accurately documented and (2) a lack of policies and procedures for closing and documenting medical referral status. Because referral status for health services was inaccurate, RCIS did not reliably identify whether patients received referred health services, which put patients at an increased risk of not receiving critical medical services or not receiving them on a timely basis.

### **PPHC HAD MISSING MEDICAL REFERRALS**

The health center must provide safeguards to prevent the loss, destruction, or unauthorized use of record information (42 CFR § 491.10(b)(1)).

We identified several days with a high number of missing referrals in RCIS and compared RCIS referrals reported to actual medical records to identify (1) what patients and health services were associated with the missing referral and (2) whether the patients actually received the health service for the missing referral.

PPHC had 746 (16 percent) referrals missing from the RCIS, with a significant number removed by a single PRC administrator who misused system privileges to delete referrals. Specifically, the PRC administrator was granted system privileges to remove duplicate referrals<sup>11</sup> but in the process also deleted actual medical referrals ordered by clinical providers.

Patients with missing referrals had an increased risk of not receiving critical care or of receiving delayed care for serious medical conditions. For example, we identified the following three patients with missing referrals:

- a patient with congestive heart failure, who had two missing referrals, did not receive a referred consult to a cardiologist for nearly 4 months;
- a patient did not receive a magnetic resonance imaging to evaluate a potential head trauma; and

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<sup>11</sup> In the referral creation process, medical providers are sometimes interrupted while creating a referral, resulting in multiple data entry sessions. Inadvertently, this process may result in the creation of a second, or “duplicate,” referral by the provider. After identifying that the PRC administrator had deleted referrals, PPHC MMIS staff removed the staff member’s system privilege to delete referrals.

- a patient did not receive a referred consult for treatment of a serious respiratory condition.

These missing referrals occurred because PPHC did not have adequate safeguards to prevent the loss of medical referrals in the RCIS; specifically, PPHC had insufficient oversight and reporting to identify that referrals were missing from the RCIS.

## **RECOMMENDATIONS**

We recommend that the Passamaquoddy Tribe at Pleasant Point:

- reestablish the practice of conducting MCC meetings that are comprised of the required medical and administrative staff to review referrals on a weekly basis in accordance with Federal requirements;
- develop and implement policies and procedures to ensure accurate documentation of medical referrals, including:
  - eliminate the system default settings for referral medical priority level codes,
  - ensure provider training and proper use of the correct medical priority level code definitions,
  - ensure supervision of PRC administrative staff so that referrals are properly closed, accurately documented, and closed individually, and
  - identify process requirements for closing referrals and documenting the reasons that referrals were not completed; and
- institute safeguards to prevent the loss of medical referrals from RCIS, including the implementation of a tracking, reporting, and review process that ensures that the RCIS accounts for all medical referrals created.

## **THE PASSAMQUODDY TRIBE AT PLEASANT POINT COMMENTS**

In written comments on our draft report, the Passamaquoddy Tribe at Pleasant concurred with our recommendations and described the actions it has taken or planned to take to address them. For example, PPHC has reestablished the MCC, comprised of medical and administrative professionals, to meet and review referrals on a weekly basis to ensure medical referrals are processed in a timely manner. Additionally, PPHC has updated its policies and procedures to ensure maintenance of accurate referral documentation and to institute safeguards to prevent the loss, destruction, or unauthorized use of medical record information. The Passamaquoddy Tribe at Pleasant Point's comments are included in their entirety in Appendix E.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

We reviewed PPHC's operations relative to Federal requirements for medical referrals for CY 2014 through 2016. We limited our review of internal controls to those applicable to the delivery of referred healthcare; we did not review the purchase orders related to referred care.

We conducted our fieldwork at the Pleasant Point Reservation and PPHC located in Sipayik, Maine, from September 2017 through October 2018.

### SCOPE

To accomplish our objectives, we:

- reviewed applicable Federal requirements for medical referrals;
- interviewed PPHC staff to understand the medical referrals process;
- obtained an understanding of the RPMS EHR and RCIS, including system privileges assigned to users of the RCIS;
- analyzed a statistical sample of 30 medical referrals initiated during CYs 2014 through 2016 to test the accuracy of referral documentation;
- identified and researched a selection of missing referrals to identify health services delayed or not completed, including:
  - conducted a nonstatistical sample (specifically, we selected 1 day per year with a high number of missing referrals and researched referred services for patients treated on those days) and
  - compared missing referral records to available physical and electronic health records;
- summarized the results of our review; and
- discussed audit results with the Tribal chief and the interim health director.

We conducted this performance audit 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.

## **APPENDIX B: STATISTICAL SAMPLING METHODOLOGIES AND RESULTS**

### **PPHC PURCHASED AND REFERRED CARE**

#### **Target Population**

The population consisted of medical referrals with an expected begin date of service scheduled in CY 2014 through 2017.

#### **Sampling Frame**

PPHC provided a file that contained a total of 3,956 medical patient referrals that were made during CY 2014 through 2016. We removed 1,321 patient referrals that did not have a date in the expected begin date of service (DOS) field, which left us with 2,635 medical referrals for patients with a date in the expected begin DOS. Since the 1,321 referrals did not have a scheduled appointment date, the time to schedule was not measurable.

#### **Sample Unit**

The sample unit was a medical referral with a value in the expected begin DOS field.

#### **Sample Design**

We used a simple random sample.

#### **Sample Size**

We selected a sample of 30 medical referrals.

#### **Source of Random Numbers**

We used the Office of Inspector General, Office of Audit Services (OIG/OAS), statistical software to generate the random numbers.

#### **Method of Selecting Sample Items**

We consecutively numbered the lines in the sampling frame from 1 to 2,635. After generating the random numbers, we selected the corresponding frame items for our sample.

#### **Estimation Methodology**

Using the OIG/OAS attributes appraisal module in the RAT-STATS statistical software package, we estimated the number of referrals that were inaccurately documented. For the sampled

items, we calculated the time it takes from referral date creation to actual service date during CY 2014 through 2016.

## APPENDIX C: SAMPLE RESULTS AND STATISTICAL ESTIMATES

### Sample Results

Frame Size	Sample Size	Number of Medical Referrals with Accuracy Errors
2,635	30	26

### Statistical Estimates

*(Limits Calculated at the 90-Percent Confidence Level)*

Estimate Descriptions	Lower Limit	Point Estimate	Upper Limit
Percentage of medical referrals with accuracy errors out of all referrals with values in the expected begin DOS field	72%	87%	95%
Number of medical referrals with accuracy errors out of all referrals with values in the expected begin DOS field	1,901	2,284	2,510

## APPENDIX D: INDIAN HEALTH SERVICE MEDICAL PRIORITY LEVEL CODES FOR MEDICAL REFERRALS

**Medical Priority Level Code I—Emergent or Acutely Urgent Care Services** are diagnostic or therapeutic services that are necessary to prevent the immediate death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual necessitate the use of the most accessible healthcare available and capable of furnishing such services. Diagnosis and treatment of injuries or medical conditions that if left untreated, would result in uncertain but potentially grave outcomes.

**Medical Priority Level Code II—Preventive Services** are distinguished from emergency care, sophisticated diagnostic procedures, treatment of acute conditions, and care primarily intended for symptomatic relief or chronic maintenance. Most services listed as Medical Priority Level Code II are available at IHS direct care facilities. If no direct-care capabilities are available at the IHS or Tribal direct-care facility, preventative services can be purchased using CHS funds

**Medical Priority Level Code III—Primary and Secondary Care Services** include inpatient and outpatient care services. The inpatient and outpatient services involve the treatment of prevalent illnesses or conditions that have a significant impact on morbidity and mortality. This involves treatment for conditions that may be delayed without progressive loss of function or risk of life, limb, or senses. It also includes services that may not be available at many IHS facilities or may require specialty consultation.

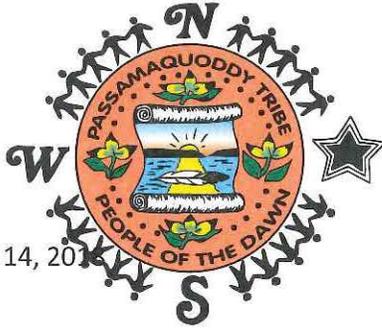
**Medical Priority Level Code IV—Chronic Tertiary and Extended Care Services** are services that (1) are not essential for initial/emergent diagnosis or therapy, (2) have less impact on mortality than morbidity, or (3) are high cost, are elective, and often require tertiary care facilities. These services are not readily available from direct care IHS facilities.

**Medical Priority Level Code V—Excluded Services** includes cosmetic procedures and experimental and other procedures excluded from authorization for CHS payment. The list of Medical Priority Level V-Excluded Services is based upon CMS's Medicare National Coverage Determinations Manual.

- **Cosmetic Procedures:** The fiscal intermediary (FI) will not pay a claim for a potentially cosmetic procedure listed in Medical Priority Level V—Excluded Services, unless the Area CMO approval is obtained. This may be granted if one of the listed procedures, normally considered cosmetic, is necessary for proper mechanical function or psychological reasons.
- **Experimental and other Excluded Procedures:** Payment for the excluded procedures listed in Medical Priority Level V—Excluded Services will not be paid by the FI, unless a formal exception has been granted by the IHS CMO.

- **Payment for Direct Services:** Examples of direct care services that cannot be reimbursed with CHS funds are on-call hours, after hours or weekend pay, holiday coverage (e.g., for x-ray, laboratory, or pharmacy).

APPENDIX E: THE PASSAMAQUODDY TRIBE AT PLEASANT POINT COMMENTS



*Pleasant Point Reservation*

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March 14, 2019

David Lamir  
Regional Inspector General  
For Audit Services  
Office of Audit Services, Region 1  
15 Sudbury Street, Room 2425  
Boston, MA 02203

RE: A-01-17-01503

Dear Mr. Lamir

Please consider this letter the official response to letter dated February 12, 2019 regarding draft report number A-01-17-01503 entitled *The Passamaquoddy Tribe's Pleasant Point Health Center Needs to Improve Its Medical-Referral Process*.

The Pleasant Point Tribal Government concurs with each of the findings listed in the draft report and has implemented several corrective actions prior to receiving this report. A description of corrective action, taken or planned, is provided below:

**FINDING: PPHC DID NOT UTILIZE A MANAGED CARE COMMITTEE TO REVIEW MEDICAL REFERRALS**

**CORRECTIVE ACTION:** As indicated in our Self-Determination Contract, PPHC will follow the Indian Health Service (IHS) policies and procedures for contract health services, now called Purchase and Referred Care, that are applicable to tribal operated health programs. Specifically, PPHC has re-established the Managed Care Committee (MCC), to review referrals, any emergency care, and monitor spending. The MCC is comprised of PRC Staff, Referral Specialist, Medical Provider(s), Health Director and/or Assistant Health Director. The MCC is scheduled to meet weekly to ensure that referrals are processed in a timely manner. It is important to note that there are some instances where an outside provider may require that appointments be made directly through the patient being referred. This can sometimes delay the referral being finalized even after the MCC has reviewed/approved the service. During these instances, the Referral Specialist attempts to stay in close contact with the patient in order to capture any appointments that may be scheduled so they can be noted in the referral system as appropriate.

The lack of supervision by the PPHC Health Director to ensure the MCC was actively in place will be addressed in accordance with the Pleasant Point Tribal Government (PPTG) Personnel Policies.

**FINDING: PPHC DID NOT ALWAYS MAINTAIN ACCURATE MEDICAL REFERRAL DOCUMENTATION**

**CORRECTIVE ACTION: Medical Priority Level Codes** -The Referred Care Information System (RCIS) has several features that had not been maximized until 2018. This included the Medical Priority Level codes for each referred service. Prior to 2018, the RCIS system parameters were set to automatically enter a Priority 1 as the default service level. This parameter was changed in 2018 to require the provider to enter the appropriate medical priority level when ordering a referred service. Orientation for new providers includes a review of the Medical Priority Levels and is reinforced during the MCC meetings.

**Referral Status** – Accurate referral status and documentation is a key component to quality health care. Policies and procedures outlining the correct process to close referrals have been developed and implemented. In addition, the option to close referrals in large batches, or by fiscal year has been removed from the RCIS Menu of PRC Staff. All referrals must be closed individually and marked with the appropriate status. PRC Staff are required to provide a reason for any referral that they want to mark “closed-not complete”.

The inadequate supervision of PPHC’s PRC Administrative Staff to ensure referrals were properly closed and accurately documented will be addressed in accordance with the PPTG Personnel Policies.

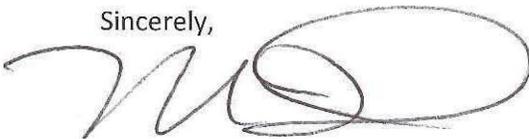
**FINDING: PPHC HAD MISSING REFERRALS**

**CORRECTIVE ACTION:** PPHC has instituted additional safeguards to prevent the loss, destruction or unauthorized use of record information. The RCIS function to delete referrals has been removed from all PRC staff. Current Policy and procedures regarding PRC prohibits the deletion of any referral. In the event a referral is found to be a duplicate, the referral is appropriately noted as such in the RCIS and marked “Closed-Not Complete”. New and existing PRC Staff are closely supervised to ensure compliance with these additional safeguards. PPHC administration have been working collaboratively with the IHS NAO Office Consultants to ensure that PRC staff are appropriately trained and correct PRC processes are in place. The Information Systems Manager has developed a monitoring and tracking process to ensure that the RCIS accounts for all medical referrals created.

**Summary**

The Passamaquoddy Tribe at Pleasant Point is appreciative of OIG’s commitment to the quality of care provided to the Passamaquoddy people. We are committed to improving the health care delivery system at Pleasant Point and will continue our efforts to realign health care operations in order to address any deficiencies and prevent any further occurrence.

Sincerely,



Marla Dana, Tribal Chief



Elizabeth Dana, Vice Chief