Department of Health, Social Services & Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

To the Chief Executive and Director of Finance of each
Health and Social Services Board
Central Services Agency
Ophthalmic Adviser of each
Health and Social Services Board

**Circular HSS(F) 43/2001**

Date: 19 November 2001

Dear Sir/Madam

**GUIDANCE TO BOARDS AND THE CENTRAL SERVICES AGENCY ON THE POST PAYMENT VERIFICATION OF CLAIMS FROM OPHTHALMIC PRACTITIONERS AND SUPPLIERS**

## Introduction

1. Post-payment checks of General Ophthalmic Services (GOS) claims have been employed for many years. There is now, however, a need to build on these arrangements and introduce a more systematic analysis of claims and inspection of records held by practices to gain assurance as to the validity of claims submitted. **Undertaking post-payment verification does not imply lack of trust in ophthalmic practitioners/suppliers but is a normal requirement to make available evidence of service provision to support financial reimbursement.**

2. The new arrangements for post-payment checks should be implemented immediately and will apply to all ophthalmic practitioners/suppliers.

3. This guidance has been drawn up in consultation with Boards, the Central Services Agency (CSA), the Negotiating Committee for Northern Ireland Ophthalmic Opticians and the BMA(NI). There are references throughout to Boards/CSA. The guidance is phrased in this way in acknowledgement that the CSA processes payments to practitioners/suppliers on behalf of Boards, with whom practitioners are in contract. Boards, in implementing this guidance, should consult with their Local Ophthalmic Committees (LOCs) on local arrangements. Boards may forge close links with their LOCs and may use those links to consider developments and disputes.

## Reasons for Post-Payment Checks

4. It is important to identify the reasons for the post-payment checks, which are:

   i. to gain assurance that the claims being submitted are proper and in accordance with the Statement of Fees; and

ii. to help decide whether fraudulent claims are being submitted.

5. The latter reason will apply normally only where there is evidence of unexpected or abnormal trends in claims by a practitioner/supplier for which a full explanation is required, or where specific information warrants a detailed investigation.

6. Boards/CSA have a duty to make sure that the payments made are valid. It would clearly be inappropriate for payments to be made where there are doubts about the validity of claims. These doubts might arise out of the claims themselves or where Boards/CSA remain dissatisfied with the outcome of enquiries into previous claims.

**Access to Records**

7. There are several post-payment checks open to Boards/CSA that do not require access to records held by the practice (and these are referred to in paragraph 14). However, it will be necessary for Board staff to access such records as part of the post-payment verification of claims. On occasion they will wish to check claims made against information that is only available from patients' optical records or from other material held by the practice and relevant to the claim. In undertaking these checks, Boards will be confirming that information which they already have is supported by patients' and practice records including appointment diaries (or equivalent documents showing a record of patients attending the practice on any given date for General Ophthalmic Services), copy of orders for individual patients' lenses or internal documents providing similar information.

8. Proper safeguards must be observed about confidentiality and Boards will wish to address these safeguards in the local protocols they establish (see paragraph 10 and also Annex A). Boards/CSA should ensure that procedures are consistent with the guidance "*the Protection and Use of Patient and Client Information"* issued by the Department in June 1999.

**Roles of Boards, Auditors, the CSA and the Counter Fraud Unit**

9. It is important that the respective roles of the main parties involved are understood clearly:

i. **Boards** have the prime responsibility for the post-payment verification process and for ensuring that they have sufficient information to demonstrate their accountability for the use of public funds;

ii. **Internal audit** is an independent appraisal service established by a Board for the review of the internal controls within the organisation. They should be consulted about the implementation of the post-payment verification process and be asked to make recommendations on the standards of internal control to be applied. However, they should not normally have an operational responsibility for the inspections themselves;

iii. **External audit** is responsible for providing an opinion on whether the accounts present fairly the financial affairs and whether there are

arrangements in place for the proper use of resources and safeguards against fraud and corruption;

iv. **The Central Services Agency** acts on behalf of the 4 Boards in processing ophthalmic payments claimed by practitioners and suppliers. However, Boards have the prime responsibility for the post-payment verification process and it is for the Board to advise the CSA what management information is to be provided;

v. **The Counter Fraud Unit** will undertake investigations into cases of potential or actual fraud involving practitioners, either jointly with Boards or on their behalf. The Unit will also be responsible for the detection and pursuit of fraudulent claims to exemption from/remission of FHS charges.

**Pre-requisites for Introducing Post-Payment Checks**

10. As a minimum these include:

i. **commitment from Boards/CSA** to implement the new procedures immediately. A key step in implementation will be consultation with Local Optical Committees;

ii. **a management information system** which will enable the Boards/CSA to monitor the pattern of claims from practitioners/suppliers. The importance of such a system should not be underestimated because the sheer number of claims from practitioners/suppliers means that it would be impractical to check every claim. Instead it will be necessary to target inspection resources to areas of greatest risk;

iii. **staff with the skills to interpret the output from the management information system.** Because of the many differences between practitioners/suppliers and their patient base within a Board's area, local factors need to be taken into account when interpreting the output. It follows that what is a reasonable level of activity in one place is not necessarily so in another. Any comparison between practitioners/suppliers needs to take into account these local factors and it may be appropriate to seek the views of the Board's Ophthalmic/Optometry Adviser when interpreting the data; and

iv. **a written local protocol drawn up in consultation with the Local Optical Committee** on such issues of detail as how the inspection process will be carried out, what will be done, who will be involved, and what reports will be produced. A model protocol is appended to this guidance at Annex A. Boards may wish to use this as a guide in determining their own local arrangements.

**Post-payment Checking**

11. Boards/CSA should ensure that their management information systems are producing details to identify the patterns and trends in claims from practitioners/suppliers. The following performance indicators, produced on a

monthly or year to date basis, may be useful for the purposes of measuring a practitioner's or establishment's claims against the locality, Board or Northern Ireland average:

(a) average cost of vouchers reimbursed;
(b) percentage of tints prescribed per voucher;
(c) percentage of second pairs per voucher;
(d) percentage of small frame supplements per voucher;
(e) percentage of complex lenses per voucher;
(f) percentage of prisms per voucher;
(g) percentage of bi-focals or multi focals per voucher;
(h) percentage of replacements to total repairs and replacements;
(i) percentage of domiciliary visits per practitioner/practice;
(j) total GOS remuneration;
(k) conversion rate of sight tests to vouchers;
(l) repeat activity.

12. The statistical information may prompt, and will be useful when undertaking, factual enquiries within the Board/CSA or with others (including patients and the practitioner/supplier) into the reasons for any unusual levels of claims. **There may be readily ascertainable explanations for changes in the level or pattern of claims.** This sort of information will influence the extent and nature of subsequent enquiries.

13. The information from the management information system should be used along with the accumulated knowledge of the Board/CSA to help the Board decide on the areas or practices that require greater scrutiny.

14. Boards/CSA will have a range of actions from which to select in deciding how to conduct post-payment checks. These include:

i. taking account of information already held within the Board/CSA;

ii. writing to patients seeking their confirmation of facts claimed by the practitioner/supplier. This needs to be handled sensitively, and letters to patients should make it clear that the enquiry is a routine one and is not to be taken as implying concerns about the honesty of the practitioner/supplier. Sample letters are appended at Annex C. The format of the letters are for guidance only and may be adapted by Boards in consultation with the Local Optical Committee to suit particular circumstances;

iii. making a direct approach to the practice to ask for its comments on the information generated by the management information system;

iv. carrying out a visit to the practice to discuss its claims, inspect patient records and examine the supporting systems and procedures within the practice; and

v. checking clinics to inspect patients' spectacles, confirm relevant details about attendance(s) and treatment provided and, where possible, gain confirmation of facts claimed by the practitioner/supplier.

15. Whilst visits to practices will not, therefore, be the sole means for Boards to satisfy themselves about the validity of claims, such visits are an important aspect of the post-payment verification procedure. A programme of visits should be devised with the aim of visiting every practice at least once every three years. It may prove necessary for visits to some practices to be more frequent. The management information system may start to show unusual claims, which should prompt the Board to seek further clarification, and may well result in a visit to the practice sooner than would otherwise have been the case.

16. For a routine visit the aim is to gain assurance that the system for claiming fees is operating properly. The most cost-effective way of doing this will be to gain an understanding of how the practice prepares claims, the information sources used and the records kept. A sample of claims paid should then be traced back to the underlying records to prove their validity. The sample size will be a matter for each Board to determine locally after discussions with their internal and external auditors. The records inspected will depend upon the information kept at the practice but, in accordance with paragraph 6 of the Terms of Service for Ophthalmic Practitioners, there should be a proper record in respect of all patients to whom general ophthalmic services are provided. The details need to be discussed and a written protocol drawn up in consultation with the LOC before any inspections begin. The use of standard programmes and documentation for the work to be done by visiting staff will help in making the process as efficient as possible and assist in assessing the quality of the work done.

17. The level of resources to be devoted to the monitoring and verification process needs careful consideration. The resources will include the cost of developing (or, if necessary, purchasing) the management information system, the costs of implementing the system and getting it to produce the necessary monitoring data, and the staff engaged on managing and undertaking the visits. The number and mix of staff engaged on visits should be determined by the outcome of the assessment process outlined above. Board management will need to ensure that such staff are appropriately trained, work under clear lines of accountability and report their findings to the practice and the Board.

**Output from the Post Payment Checking Process**

18. There will be several possible products:

i. information identifying over-claims which should lead to repayment by the practice or under-claims which should lead to amended claims being submitted for payment;

ii. information for the internal and external auditors to assist in their work;

iii. aggregated information in anonymised form that can be regularly shared with practitioners/suppliers to enable them to assess where they stand in relation to the Board/Northern Ireland average and to other practices;

iv. in the case of a visit, a report setting out the results of the visit and providing advice where necessary on changes to improve the practice's systems and administration; these reports should be shared in draft form with the practice and finalised in the light of the comments received;

v. a periodic summary report for the Chief Executive/General Manager or the Director of Finance of the Board stating whether the claims paid were valid and commenting on the practice's claims systems.

**Fraudulent Claims**

19. Any indication of possible fraudulent claims must be investigated fully until the suspicions are either confirmed, or allayed. Each case will be different but experience has shown that the key to a successful investigation is a carefully thought out fraud response plan which covers arrangements for:

i. liaison with internal and external auditors, the Counter Fraud Unit, the police, and the Department;

ii. training for staff; in particular ensuring that investigating staff, where it is not the police, have adequate knowledge of the procedures for collecting evidence under the Police and Criminal Evidence (Northern Ireland) Order 1989;

iii. investigating the suspected fraud which will involve:

- collaboration with the Counter Fraud Unit;
- contacting the internal/external auditor and police;
- assigning responsibility for investigation to a specific person;
- preparing a background and objectives statement;
- considering likely outcome with the police;
- agreeing terms of reference, scope, and key dates;
- identifying staff resources and responsibilities;
- estimating and monitoring costs of investigations;
- maintaining regular contact with senior managers and police;
- identifying lessons learned and action required;

iv. reporting fraud;

v. recovery of losses;

vi. procedures for preparing and preserving evidence and managing public relations; and

vii. prosecution and disciplinary action against the perpetrators.

20. It is important that these issues are discussed with all the interested parties so that a general consensus is reached on the Board's approach to fraud investigation. Making these arrangements should not be left until the Board is faced with investigating an actual case of fraud.

**Conclusion**

21. A summary of the key steps which Boards/CSA need to take to prepare for and conduct post-payment checks is included as Annex B.

**Action**

22. Health and Social Services Boards and the Central Services Agency are asked to implement immediately the new arrangements for post-payment checks for all ophthalmic practitioners/suppliers. Boards, in implementing this guidance, should consult with their Local Ophthalmic Committees (LOCs) on local arrangements.

Yours faithfully

**ANDREW HAMILTON**
**Director of Financial Management**

**ANNEX A**

# MODEL LOCAL PROTOCOL COVERING POST-PAYMENT VERIFICATION OF CLAIMS

## PURPOSE

1. The Guidance to Boards and the Central Services Agency on the Post-Payment Verification of Claims issued on 19 November 2001 (HSS (F) 43/2001) sets out the principles governing post-payment checks of claims from ophthalmic practitioners/suppliers, and provides for the inspection of practice records as part of the verification process. The guidance provides that each Board should set out detailed local arrangements in the form of a protocol on which the LOC should be consulted.

2. This document sets out the local protocol agreed by the [name] Board following consultation with the [name] Local Optical Committee. It details the arrangements for access by Board staff to records, including patient records where necessary, in order to verify that the claims made are correct and in accordance with the Statement of Fees. It should be read in conjunction with the main guidance referred to above. The spirit of the protocol is "working together" in a professional manner. It is not about creating unnecessary additional administrative procedures.

## PRACTICE VISITS ARRANGEMENTS

3. Visits to practices will be made by prior appointment, and timed so as to minimise the inconvenience to ophthalmic practitioners/suppliers and their staff. Prior to the visit, Board personnel will select a sample of claims made by the practice during the preceding months. Normally practices will be advised of the details of the claims selected for checking at the commencement of the visit.

4. The sample sizes may be influenced by the claims pattern shown on the Board's/CSA's monitoring records and responses from the practice or patients to enquiries by the Board/CSA seeking confirmation of services provided. The Board will make a judgement about the reliance that can be placed on responses from patients. The level of reliability may vary substantially between areas and this in turn may have an impact on the sample sizes of claims to be verified at practices.

5. Routine verification visits to practices may take place every three years. If the practice has more than one outlet, the verification process may include visits to all sites.

6. Additional visits from the Board may be needed where a higher level of claims or a substantial change in claims rates is evident from the Board's management information system, or where routine enquiries made by the Board/CSA do not provide satisfactory evidence of service provision.

7. The composition of the team is at the discretion of the Board who should take into account any possible local sensitivities in regard to the personnel involved. The

Board will ensure that those who are involved in the post-payment checks, including those who visit practices, are aware of the need to respect patient confidentiality and it will take appropriate steps to see that such confidentiality is not breached (see also paragraph 13 of this protocol). Procedures will be consistent with the guidelines: *"The Protection and Use of Patient and Client Information",* issued by the Department. Whenever possible, advance notice will be given to the practice of the names of those who will be visiting.

8. Members of the practice staff need to be available to help the Board team. The ophthalmic practitioner's/supplier's presence during the verification process is at his/her discretion and he/she may invite any other person, such as a LOC representative.

**AUDIT PROCESS**

9. Routine visits will involve Board staff looking at:

   i. Systems and procedures within the practice for submitting each type of claim and for ensuring claims conform with the Statement of Fees;

   ii. How the practice prepares the claims for submission and who is involved;

   iii. Patient clinical records maintained by the practice to provide evidence of services provided to patients. In accordance with good practice and paragraph 6 of their terms of service, ophthalmic practitioners must keep a proper record in respect of each patient to whom he provides GOS and these should be retained for a period of seven years;

   iv. Additional information sources such as (a) day books and/or appointment diaries or (b) copy orders for wholesalers for individual patient's lenses (or in the case of an in-house production, the internal documents outlining the frame, dioptre powers, data and patient's name); and

   v. Practice protocols aimed at "maximising" the occurrence of particular services provided to patients.

10. The purpose of the review of the practice's internal control systems is to gain assurance that:

   i. There are adequate procedures for recording services provided by the practice to patients;

   ii. There is a satisfactory understanding and application of the provisions set out in the Statement of Fees in respect of each claim type; and

   iii. Systems exist to prevent and correct errors and omissions, as far as possible, in the claims submitted and payments made.

11. At the start of the visit, Board staff will submit to the practice's representative details of the sample claims they wish to inspect. The Board team will seek evidence from the practice's records of the service having been provided. Acceptable evidence might include:

    i. Patient's attendance confirmed from the reception records; or

    ii. Entries in patients' records such as patient's details; details and date of service provided; and name of person who provided service;

    iii. Prescribing records;

    iv. Orders to suppliers/optical laboratories.

12. The Board team will expect to obtain 100 per cent verification of service provision on the sample check of practice records.

13. Where access by authorised Board staff to patient records for the purpose of verifying claims is considered necessary, it will be sought on the clear understanding that proper safeguards are observed about accessing confidential patient information. Practice staff may facilitate the verification process by extracting the relevant records for Board staff. The information supplied should be sufficiently comprehensive to identify the nature of the service provided and other basic information supporting the particular claim under examination

14. Where the optical records are computerised, the practice staff should produce relevant information on the computer screen. There will normally be no need to produce the records in a printed format. However, printed information will be required if any follow up investigation is necessary.

15. The Board team may wish to discuss with the practice its recent claims record as well as any recent changes and, if appropriate, seek reasons for the level of service being above or below the local average.

**VISIT OUTCOMES**

16. The practice or a person nominated by the practice will normally be informed of the early conclusions arising at the end of the visit. Board staff will inform the practice of any observations and advice about its systems and procedures, and the level of services being provided, based on their knowledge and experience. In this way the practice has an opportunity to benefit directly from the visit. Subsequent to each visit, the practice will be provided with a written report and given an opportunity to comment on the findings before they are formally considered by the Board.

17. Follow up visits may be required to verify changes to a practice's procedures where recommendations have been made by the Board and accepted. Where the Board team finds discrepancies or claims that cannot be verified owing to lack of evidence, then additional records will normally be examined in order to ascertain the extent of the problem and the underlying reasons.

18. Where it is ascertained that some claims have been submitted incorrectly or there are doubts about their validity, then certain actions will be taken by the Board, which may include:

- Extending the sample of claims;
- The practice will be required to undertake to improve its systems so as to prevent any repetition of the errors in future. Where there is evidence of underclaiming, the practice will be given a reasonable opportunity to submit amended claims for the Board's/CSA's consideration;
- Where Board staff are dissatisfied with the evidence or the explanations given in respect of errors found, the matter will then be referred to other parties, for example, the Director of Dental and Optical Services or internal auditors, for comments and further enquiries. The Board should also extend its enquiries with patients if it is appropriate to the type of claim under review;
- The Board will report its findings, along with any recommendations, back to the practice;
- If the Board becomes aware of the possibility of fraud, then it should consult the Counter Fraud Unit, the police and the external auditor. By agreement with the Police, the Board may then collect additional evidence from the practice by invoking the rules under the Police and Criminal Evidence (Northern Ireland) Order 1989.

**CO-OPERATION OF PRACTITIONERS/SUPPLIERS**

19. Routine visits are to be seen as fact-finding and should not in any way be threatening to the practice or undertaken in an atmosphere of mistrust. It is in the interests of practitioners/suppliers to co-operate fully with this protocol which is designed to create understanding and trust between the two parties and to allow the visits to be informative for both parties.

20. The Board will make available to all practices summarised information about claims profiles for all its practices for each of the main types of claims.

21. If a practice refuses to co-operate with the Board by, for example, not allowing reasonable access to records within the terms of this protocol, the Board should contact the Local Optical Committee and seek its assistance in resolving the problem as quickly and amicably as possible. The Board reserves the right to take such further action as it deems necessary, including in extreme cases the suspension of further payment of claims to the practitioner/supplier concerned until the matter is resolved.

**ANNUAL REPORT**

22. An annual summary of claims investigated may be prepared on an anonymised basis and may be made available to the LOC.

**OPERATION OF THIS PROTOCOL**

23. Questions about the interpretation or application of this protocol should be directed in the first instance to **[name and job title].**

**[name]** Health and Social Services Board

Date

**ANNEX B**

**CHECKLIST OF ACTIONS FOR BOARDS ON THE POST-PAYMENT VERIFICATION OF CLAIMS FROM OPHTHALMIC PRACTITIONERS/SUPPLIERS**

| | Key Issue | Responsible person/Target Date |
|---|---|---|
| 1. | Commitment from the Board to immediately commence procedures to implement guidance. | |
| 2. | Management information system to monitor claims from ophthalmic practitioners/suppliers, agreed with the CSA. | |
| 3. | Staff trained to be able to interpret comparative data. | |
| 4. | Written local protocol drawn up in consultation with the LOC. | |
| 5. | Draw up a programme of visits to practices. | |
| 6. | Draw up standard work programmes and documentation for visits in consultation with LOC. | |
| 7. | Determine staff resources to carry out inspections. | |
| 8. | Determine format of reports to CEO/DoF/Practice/DHSSPS/CSA. | |
| 9. | Devise fraud response plan. | |

**SPECIMENT FORMS**

_____

_____

_____

_____

_____

Dear Sir/Madam

The _____ Health and Social Services Board/The Central Services Agency is responsible for the reimbursement of the cost of NHS Vouchers to Optometrists/Suppliers. We must also ensure that claims are being made appropriately and that the best value for money is achieved for the services being provided to patients.

As part of our routine verification procedures, we write to a sample of patients to request confirmation that services claimed for by the practitioner or supplier have been provided in accordance with the current regulations.

I would be grateful if you would kindly complete the attached questionnaire and return it to me in the pre-paid envelope provided. A parent, guardian or other responsible person should complete and sign the form on behalf of a child under the age of 16 and for other persons unable to do so for themselves.

**I should stress that this is a routine enquiry** and your Ophthalmic Practice is aware that this approach may be made to you. Thank you for your co-operation.

Yours faithfully

Enc

To: _____ Health and Social Services Board/Central Services Agency.

I confirm that I have received the following within the last 6 months (please tick whichever boxes apply. If one of the categories applies more than once, please enter the number of times in the box, eg if you have received two pairs of Reading Glasses enter "2" in the box).

- ☐ Free NHS Sight Test (please give approximate date of test if known _____).
- ☐ Reading glasses
- ☐ Distance vision glasses
- ☐ Bi-focal/multi-focal glasses
- ☐ Contact lenses
- ☐ A tint was supplied
- ☐ No charge was made
- ☐ I cannot confirm that I have received any of the above services.

Comments _____

Signed _____ Name _____

Date _____ Address _____

_____

_____

Date:

Dear Sir/Madam

The _____ Health and Social Services Board/The Central Services Agency is responsible for the reimbursement of the cost of NHS Vouchers to Optometrists/suppliers. We must also ensure that claims are being made appropriately and that the best value for money is achieved for the services being provided to patients.

As part of our routine verification procedures we write to a sample of patients to request confirmation that services claimed for by the Optometrist/supplier have been provided in accordance with the current regulations.

I would be grateful if you would kindly complete the tear-off slip at the foot of this letter and return it to me in the pre-paid envelope provided. A parent, guardian or other responsible person should complete and sign the form on behalf of a child under the age of 16 and for other persons unable to do so for themselves.

**I should stress that this is a routine enquiry** and your Ophthalmic Practice is aware that this approach may be made to you. Thank you for your co-operation.

Yours faithfully

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To: _____ Health and Social Services Board/Central Services Agency

I have received the following repairs or replacements within the last 6 months through the NHS Voucher Scheme. (Please tick whichever boxes apply. If one of the categories applies more than once, please enter the number of times in the box, eg if you have had two Whole Frames repaired, enter "2" in the repair box).

| | **Repair** | **Replacement** |
|---|---|---|
| Whole Frame | ☐ | ☐ |
| Front of Frame | ☐ | ☐ |
| Side of Frame | ☐ | ☐ |
| Both Lenses | ☐ | ☐ |
| Right Lens | ☐ | ☐ |
| Left Lens | ☐ | ☐ |
| Extras: Tinted Lenses | ☐ | ☐ |
| I cannot confirm that I have received any of the above services. | ☐ | ☐ |

Comments _____

Signed _____ Name _____

Date: _____ Address _____

_____

**ANNEX C**

Dear Dr

The Patient named below has applied for a NHS Sight Test on the grounds that he/she suffers from Diabetes/Glaucoma.

As part of the Board's/Central Services Agency's routine monitoring arrangements, I would be grateful if you would verify the condition suffered by the patient, by completing the slip below and return it to me at the above address.

I confirm that the patient has consented to this check being carried out on his/her condition by signing the GOS1 Application for NHS Sight Test form, a copy of which is enclosed for your information.

I thank you for your assistance and look forward to hearing from you shortly.

Yours sincerely

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To: _____ Health and Social Services Board/Central Services Agency

Patient's Name _____

Patient's Address _____

_____

_____

I can confirm the following:

(✓)

☐ This patient suffers from diabetes

☐ This patient suffers from glaucoma

☐ I cannot confirm that this patient suffers from either of the above conditions.

Signed _____ GP Code _____

Date _____