U.S. OFFICE OF PERSONNEL MANAGEMENT
OFFICE OF THE INSPECTOR GENERAL
OFFICE OF AUDITS

Final Audit Report

Subject:

AUDIT ON GLOBAL COORDINATION OF BENEFITS FOR BLUECROSS AND BLUESHIELD PLANS CONTRACT YEAR 2007

Report No. 1A-99-00-09-011

Date: July 20, 2009

--CAUTION--

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

Office of the
Inspector General

AUDIT REPORT

Federal Employees Health Benefits Program
Service Benefit Plan Contract CS 1039
BlueCross BlueShield Association
Plan Code 10

Global Coordination of Benefits
BlueCross and BlueShield Plans

REPORT NO. 1A-99-00-09-011 DATE: July 20, 2009

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UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

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Inspector General

EXECUTIVE SUMMARY

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This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at all BlueCross and BlueShield (BCBS) plans questions $4,387,806 in health benefit charges. The BlueCross BlueShield Association (Association) and/or BCBS plans agreed with $2,536,354 and disagreed with $1,851,452 of the questioned charges.

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covered health benefit payments for contract year 2007 as reported in the Annual Accounting Statement. Specifically, we reviewed claims incurred from October 1, 2006 through December 31, 2007 that were reimbursed in 2007 and potentially not coordinated with Medicare. We determined that the BCBS plans did not properly coordinate 12,751 claim line payments with Medicare as required by the FEHBP contract. As a result, the FEHBP was overcharged $4,387,806. When we notified the Association of these errors on October 1, 2008, the claims were within the Medicare timely filing requirement and could be filed with Medicare for coordination of benefits.

CONTENTS

I. INTRODUCTION AND BACKGROUND

INTRODUCTION

This final audit report details the findings, conclusions, and recommendations resulting from our limited scope audit of the Federal Employees Health Benefits Program (FEHBP) operations at all BlueCross and BlueShield (BCBS) plans.

The audit was performed by the Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as established by the Inspector General Act of 1978, as amended.

BACKGROUND

The FEHBP was established by the Federal Employees Health Benefits (FEHB) Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for federal employees, annuitants, and dependents. OPM's Center for Retirement and Insurance Services has overall responsibility for administration of the FEHBP. The provisions of the FEHB Act are implemented by OPM through regulations, which are codified in Title 5, Chapter 1, Part 890 of the Code of Federal Regulations (CFR). Health insurance coverage is made available through contracts with various health insurance carriers.

The BlueCross BlueShield Association (Association), on behalf of participating BCBS plans, has entered into a Government-wide Service Benefit Plan contract (CS 1039) with OPM to provide a health benefit plan authorized by the FEHB Act. The Association delegates authority to participating local BCBS plans throughout the United States to process the health benefit claims of its federal subscribers. There are approximately 63 local BCBS plans participating in the FEHBP.

The Association has established a Federal Employee Program (FEP[1]) Director's Office in Washington, D.C. to provide centralized management for the Service Benefit Plan. The FEP Director's Office coordinates the administration of the contract with the Association, member BlueCross and BlueShield plans, and OPM.

The Association has also established an FEP Operations Center. The activities of the FEP Operations Center are performed by CareFirst BCBS, located in Washington, D.C. These activities include acting as fiscal intermediary between the Association and member plans, verifying subscriber eligibility, approving or disapproving the reimbursement of local plan payments of FEHBP claims (using computerized system edits), maintaining a history file of all FEHBP claims, and maintaining an accounting of all program funds.

Compliance with laws and regulations applicable to the FEHBP is the responsibility of the management for the Association and each BCBS plan. Also, management of each BCBS plan is responsible for establishing and maintaining a system of internal controls.

[1] Throughout this report, when we refer to "FEP" we are referring to the Service Benefit Plan lines of business at the Plan. When we refer to the "FEHBP" we are referring to the program that provides health benefits to federal employees.

Findings from our previous global coordination of benefits audit of all BCBS plans (Report No. 1A-99-00-08-007, dated June 25, 2008) for contract year 2006 are in the process of being resolved.

Our preliminary results of the potential errors were presented in detail in a draft report, dated October 1, 2008. The Association's comments offered in response to the draft report were considered in preparing our final report and are included as the Appendix to this report. Also, additional documentation provided by the Association and BCBS plans was considered in preparing our final report.

II. OBJECTIVE, SCOPE, AND METHODOLOGY

OBJECTIVE

The objective of this audit was to determine whether the BCBS plans complied with contract provisions relative to coordination of benefits with Medicare.

SCOPE

We conducted our limited scope performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient and appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

The audit covered health benefit payments for contract year 2007 as reported in the BlueCross and BlueShield FEHBP Annual Accounting Statement. Specifically, we reviewed claims incurred from October 1, 2006 through December 31, 2007 that were reimbursed in 2007 and potentially not coordinated with Medicare. Based on our claim error reports, we identified 927,387 claim lines, totaling $85,666,214 in payments, that potentially were not coordinated with Medicare. From this universe, we selected and reviewed 58,276 claim lines, totaling $32,646,080 in payments, for coordination of benefits with Medicare. When we notified the Association of these potential errors, the claims were within the Medicare timely filing requirement and could be filed with Medicare for coordination of benefits.

We did not consider each BCBS plan's internal control structure in planning and conducting our auditing procedures. Our audit approach consisted mainly of substantive tests of transactions and not tests of controls. Therefore, we do not express an opinion on each BCBS plan's system of internal controls taken as a whole.

We also conducted tests to determine whether the BCBS plans had complied with the contract and the laws and regulations governing the FEHBP as they relate to coordination of benefits. The results of our tests indicate that, with respect to the items tested, the BCBS plans did not fully comply with the provisions of the contract relative to coordination of benefits with Medicare. Exceptions noted in the areas reviewed are set forth in detail in the "Audit Finding and Recommendations" section of this report. With respect to the items not tested, nothing came to our attention that caused us to believe that the BCBS plans had not complied, in all material respects, with those provisions.

In conducting our audit, we relied to varying degrees on computer-generated data provided by the FEP Director's Office, the FEP Operations Center, and the BCBS plans. Due to time constraints, we did not verify the reliability of the data generated by the various information systems involved. However, while utilizing the computer-generated data during our audit testing, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objective.

The audit was performed at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida from February 2009 through May 2009.

METHODOLOGY

To test each BCBS plan's compliance with the FEHBP health benefit provisions related to coordination of benefits with Medicare, we selected a judgmental sample of potential uncoordinated claim lines that were identified in a computer search. Specifically, we selected for review 58,276 claim lines, totaling $32,646,080 in payments, from a universe of 927,387 claim lines, totaling $85,666,214 in payments, that potentially were not coordinated with Medicare (See Schedule A for our sample selection methodology).

The claim samples were submitted to each applicable BCBS plan for their review and response. For each plan, we then conducted a limited review of their agreed responses and an expanded review of their disagreed responses to determine the appropriate questioned amount. We did not project the sample results to the universe.

The determination of the questioned amount is based on the FEHBP contract, the Service Benefit Plan brochure, the Association's FEP administrative manual, and various manuals and other documents available from the Center for Medicare and Medicaid Services that describe Medicare benefits.

III. AUDIT FINDING AND RECOMMENDATIONS

Coordination of Benefits with Medicare **$4,387,806**

The BCBS plans did not properly coordinate 12,751 claim line payments, totaling $5,612,369, with Medicare as required by the FEHBP contract. As a result, the FEHBP paid as the primary insurer for these claims when Medicare was the primary insurer. Therefore, we estimate that the FEHBP was overcharged by $4,387,806 for these claim lines.

The 2007 Blue Cross and Blue Shield Service Benefit Plan brochure, page 103, Primary Payer Chart, illustrates when Medicare is the primary payer. In addition, page 25 of that brochure states, "We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), regardless of whether Medicare pays."

Contract CS 1039, Part II, section 2.6 states, "(a) The Carrier shall coordinate the payment of benefits under this contract with the payment of benefits under Medicare . . . (b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary carrier . . . ." Also, Part III, section 3.2 (b)(1) states, "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable . . . [and] on request, document and make available accounting support for the cost to justify that the cost is actual, reasonable and necessary; and (ii) determine the cost in accordance with: (A) the terms of this contract . . . ."

In addition, Contract CS 1039, Part II, section 2.3(g) states, "If the Carrier or OPM determines that a Member's claim has been paid in error for any reason . . . the Carrier shall make a prompt and diligent effort to recover the erroneous payment . . . ."

For claims incurred from October 1, 2006 through December 31, 2007 and reimbursed in 2007, we performed a computer search and identified 927,387 claim lines, totaling $85,666,214 in payments that potentially were not coordinated with Medicare. From this universe, we selected for review a sample of 58,276 claim lines, totaling $32,646,080 in payments, to determine whether the BCBS plans complied with the contract provisions relative to coordination of benefits (COB) with Medicare. When we submitted our sample of potential COB errors to the Association on October 1, 2008, the claims were within the Medicare timely filing requirement and could be filed with Medicare for coordination of benefits.

Generally, Medicare Part A covers 100 percent of inpatient care in hospitals, skilled nursing facilities and hospice care. For each Medicare Benefit Period, there is a one-time deductible, followed by a daily copayment beginning with the 61st day. Beginning with the 91st day of the Medicare Benefit Period, Medicare Part A benefits may be exhausted, depending on whether the patient elects to use their Lifetime Reserve Days. For the uncoordinated Medicare Part A claims, we estimate that the FEHBP was overcharged for the total claim payment amounts. When applicable, we reduced the questioned amount by the Medicare deductible and/or Medicare copayment.

Medicare Part B pays 80 percent of most outpatient charges and professional claims after the calendar year deductible has been met. Also, Medicare Part B covers a portion of inpatient facility charges for ancillary services such as medical supplies, diagnostic tests, and clinical laboratory services. Based on our experience, ancillary items account for approximately 30 percent of the total inpatient claim payment. Therefore, we estimate that the FEHBP was overcharged 25 percent for these inpatient claim lines (0.30 x 0.80 = 0.24 ~ 25 percent).

We separated the uncoordinated claims into the following six categories based on the clinical setting and whether Medicare Part A or B should have been the primary payer.

- Categories A and B consist of inpatient claims that should have been coordinated with Medicare Part A. In a small number of instances where the BCBS plans indicated that Medicare Part A benefits were exhausted, we reviewed the claims to determine whether there were any inpatient services that were payable by Medicare Part B. For these claim lines, we only questioned the services covered by Medicare Part B.

- Categories C and D include inpatient claims with ancillary items that should have been coordinated with Medicare Part B. When we could not reasonably determine the actual overcharge for a claim line, we questioned 25 percent of the amount paid for these inpatient claim lines. In a small number of instances where the BCBS plans indicated that members had Medicare Part B only and priced the claims according to the Omnibus Budget Reconciliation Act of 1990 pricing guidelines, we reviewed the claims to determine whether there were any inpatient services that were payable by Medicare Part B.

- Categories E and F include outpatient and professional claims where Medicare Part B should have been the primary payer. When we could not reasonably determine the actual overcharge for a claim line, we questioned 80 percent of the amount paid for these claim lines.

From these six categories, we selected for review a sample of claims lines that potentially were not coordinated with Medicare (See Schedule A for our sample selection methodology). Based on our review, we identified 12,751 claim lines, totaling $5,612,369 in payments, where the FEHBP paid as the primary insurer when Medicare was the primary insurer. We estimate that the FEHBP was overcharged $4,387,806 for these claim line payments.[2]

[2] In addition, there were 23,104 claim lines, totaling $10,645,349 in payments, with COB errors that were identified by the BCBS plans before the start of our audit (i.e., October 1, 2008) and adjusted on or before the Association's response due date (i.e., January 16, 2009) to the draft report. Since these COB errors were identified by the BCBS plans before the start of our audit and adjusted by the Association's response due date to the draft report, we did not question these COB errors in the final report.

The following table details the six categories of questioned uncoordinated claim lines:

Category	Claim Lines	Amount Paid	Amount Questioned
Category A: Medicare Part A Primary for Inpatient (I/P) Facility	138	$1,596,151	$1,596,151
Category B: Medicare Part A Primary for Skilled Nursing/Home Health Care (HHC)/ Hospice Care	1,620	$428,033	$428,033
Category C: Medicare Part B Primary for Certain I/P Facility Charges	87	$689,282	$191,225
Category D: Medicare Part B Primary for Skilled Nursing/HHC/Hospice Care	114	$285,168	$71,301
Category E: Medicare Part B Primary for Outpatient (O/P) Facility and Professional	10,327	$2,105,354	$1,694,408
Category F: Medicare Part B Primary for O/P Facility and Professional (Participation Code F)	465	$508,381	$406,688
Total	12,751	$5,612,369	$4,387,806

Our audit disclosed the following for the COB errors:

- For 10,333 (81 percent) of the claim lines questioned, there was no special information on the FEP national claims system to identify Medicare as the primary payer when the claims were paid. However, when the Medicare information was subsequently added to the FEP national claims system, the BCBS plans did not review and/or adjust the patient's prior claims back to the Medicare effective dates.

- For 2,418 (19 percent) of the claim lines questioned, there was special information present on the FEP national claims system to identify Medicare as the primary payer when the claims were paid. An incorrect Medicare Payment Disposition Code was used for 66 percent of these claims. The Medicare Payment Disposition Code identifies Medicare's responsibility for payment on each charge line of a claim. Per the FEP Administrative Manual, the completion of this field is required on all claims for patients who are age 65 or older. We found that codes E, F, and N were incorrectly used. An incorrect entry in this field causes the claim line to be excluded from coordination of benefits with Medicare.

Of the $4,387,806 in questioned charges, $1,606,490 (37 percent) were identified by the BCBS plans before the start of our audit (i.e., October 1, 2008). However, since the BCBS plans had not completed the recovery process and/or adjusted these claims by the Association's response due date (i.e., January 16, 2009) to the draft report, we are continuing to question these COB errors. The remaining questioned charges of $2,781,316 (63 percent) were identified as a result of our audit.

Association's Response:

In response to the draft audit report, the Association states, "After reviewing the OIG Draft Audit Report and listing of potentially uncoordinated Medicare COB claims . . . we identified $2,526,632 in claim payments that were not coordinated with Medicare after the initial claim payment, and subsequently became claim payment errors . . . Recovery has been initiated on these overpayments and the Plans will continue to pursue these overpayments . . .

To the extent that claim payment errors did occur or were not identified, these payments were good faith erroneous benefit payments and fall within the context of CS 1039, Section 2.3(g). Any benefit payments the Plans are unable to recover are allowable charges to the Program. In addition, as good faith erroneous payments, lost investment income does not apply to the payments identified in the finding.

Our analysis of payment errors indicated the following:

- Claims were processed incorrectly because the claims examiner failed to use the Medicare Explanation of Benefits (MEOB) to process the claim. This resulted in claims being paid as 'not covered by Medicare' when the MEOB indicated that Medicare made a payment on the claim.

- Refunds were not initiated on claims that were provided to the Plan on either the retroactive enrollment report or the FEP Director's Office COB Self Assessment report. In some cases, recovery could not be initiated because when retroactive enrollment reports were received, the claim was already outside the Plan's provider contract time limit to recover the claims.

In order to continue to improve the FEP Program's Medicare COB processing, FEP will continue with our current COB Action Plan, with modification as necessary . . . ."

Regarding the contested amount, the Association states that "the claims were paid correctly as discussed below:

- Claims totaling $1,870,617 are contested because recovery had been initiated in accordance with CS1039, 2.3 (g) but not completed or were uncollectible at the time the Draft Audit Report response was provided. The majority of these claims were also paid correctly based upon the Medicare information that was on file at the time of initial payment. Also, at the time of our response to the Draft Report, some claims have already been determined to be uncollectible after recovery was initiated, four letters were sent to the provider and no response from the provider was received. . . .

- Claims . . . are contested for 'other' reasons, including but not limited to the fact that Medicare was not primary on the incurred date . . .

Documentation to support the contested amounts has been provided. Documentation to support initiation of overpayment recovery before the audit has also been provided."

OIG Comments:

After reviewing the Association's response and additional documentation provided by the BCBS plans, we revised the questioned charges from our draft report to $4,387,806. Based on the Association's response and the BCBS plans' additional documentation, we determined that the Association and/or plans agree with $2,536,354 and disagree with $1,851,452.

Although the Association only agrees with $2,526,632 in its response, the BCBS plans' documentation supports concurrence with $2,536,354. For these uncontested COB errors, we disagree with the Association's comments that the payments were good faith erroneous benefit payments. When the Medicare information was subsequently added to the claims system, the BCBS plans did not review and/or adjust the patients' prior claims back to the Medicare effective dates. Since the BCBS plans did not take the proper action to immediately correct the overpayments, we do not believe the BCBS plans acted in good faith to recover these overpayments.

Based on the Association's response and/or the BCBS plans' documentation, $1,606,490 of the contested amount represents 6,866 COB errors where recovery efforts were initiated by the plans before the audit started. However, the BCBS plans had not recovered these overpayments and adjusted the claims by the Association's response due date to the draft report. Since these overpayments had not been recovered and returned to the FEHBP by the Association's response due date, we are continuing to question this amount in the final report.

For the remaining contested amount of $244,962 (three COB errors), the BCBS of Texas plan disagrees that the claims should have been coordinated with Medicare because in each instance the patient's Medicare coverage became effective during the inpatient stay. Since Medicare is the primary insurer for health benefit costs incurred on and after the Medicare effective date, even when the effective date occurs during an inpatient stay, we are continuing to question this amount in the final report. In each instance, the FEHBP should have paid as the primary insurer for the patient's inpatient costs incurred before the Medicare effective date, and then Medicare should have paid as the primary insurer for the costs incurred on or after the Medicare effective date.

Recommendation 1

We recommend that the contracting officer disallow $4,387,806 for uncoordinated claim payments and verify that the BCBS plans return all amounts recovered to the FEHBP.

Recommendation 2

Although the Association has developed a corrective action plan to reduce COB findings, we recommend that the contracting officer instruct the Association to ensure that all BCBS plans are following the corrective action plan.

Recommendation 3

We recommend that the contracting officer require the Association to ensure that the BCBS plans have procedures in place to review all claims incurred back to the Medicare effective dates when updated, other party liability information is added to the FEP national claims system. When Medicare eligibility is subsequently reported, the plans are expected to immediately determine if already paid claims are affected and, if so, to initiate the recovery process within 30 days.

Recommendation 4

We recommend that the contracting officer require the Association to revise and correct the procedures regarding the input of Medicare Payment Disposition Codes. We also recommend that the software used for handling claims received electronically be reviewed to verify that it creates the appropriate value for Medicare Payment Disposition Codes. These corrective actions should ensure that the FEP system will utilize the special information when it is present to properly coordinate these claims.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

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SCHEDULE A

V. SCHEDULES

Coordination of Benefits with Medicare
BlueCross and BlueShield Plans
Claims Reimbursed in 2007

UNIVERSE AND SAMPLE OF POTENTIALLY UNCOORDINATED CLAIM LINES

	UNIVERSE				SAMPLE				
CATEGORY	Number of Claims	Number of Claim Lines	Number of Patients	Total Payments	Sample Selection Methodology	Number of Claims	Number of Claim Lines	Number of Patients	Amounts Paid
Category A: Medicare Part A Primary for Inpatient Facility	737	741	582	$8,788,288	patients with cumulative claims of $500 or more	726	730	571	$8,785,317
Category B: Medicare Part A Primary for Skilled Nursing/Home Health Care/Hospice Care	3,433	12,478	1,261	$2,617,207	patients with cumulative claims of $2,500 or more	935	4,535	170	$1,900,896
Category C: Medicare Part B Primary for Certain Inpatient Facility Charges	291	291	246	$2,655,689	patients with cumulative claims of $2,500 or more	278	278	233	$2,635,016
Category D: Medicare Part B Primary for Skilled Nursing/Home Health Care/Hospice Care	237	464	161	$764,952	patients with cumulative claims of $2,500 or more	162	320	97	$699,341
Category E: Medicare Part B Primary for Outpatient Facility and Professional	26,603	54,683	5,843	$9,841,495	patients with cumulative claims of $1,000 or more	16,310	38,705	1,475	$8,713,682
Category F: Medicare Part B Primary for Outpatient Facility and Professional (Participation Code F)	520,167	858,730	208,631	$60,998,583	patients with cumulative claims of $10,000 or more	5,898	13,708	348	$9,911,828
Total	**551,468**	**927,387**	**216,724**	**$ 85,666,214**		**24,309**	**58,276**	**2,894**	**$ 32,646,080**

Coordination of Benefits with Medicare
BlueCross and BlueShield Plans
Claims Reimbursed in 2007

SUMMARY OF QUESTIONED CHARGES

			COB Category A		COB Category B		COB Category C		COB Category D		COB Category E		COB Category F		ALL COB Categories	
Plan Site #	Plan State	Plan Name	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned
003	NM	BCBS of New Mexico	1	$ 3,348	0	$ -	0	$ -	0	$ -	14	$ 2,952	0	$ -	15	$ 6,300
005	GA	WellPoint BCBS of Georgia	18	$ 225,545	12	$ 28,528	1	$ 666	0	$ -	938	$ 254,248	0	$ -	969	$ 508,987
006	MD	CareFirst BCBS	0	$ -	0	$ -	4	$ 10,025	0	$ -	218	$ 36,196	2	$ 9,715	224	$ 55,936
007	LA	BCBS of Louisiana	4	$ 27,507	0	$ -	1	$ 5,248	0	$ -	21	$ 3,304	9	$ 1,394	35	$ 37,453
009	AL	BCBS of Alabama	1	$ 18,800	0	$ -	0	$ -	0	$ -	410	$ 77,911	0	$ -	411	$ 96,711
010	ID	BC of Idaho Health Service	0	$ -	0	$ -	0	$ -	0	$ -	1	$ 79	0	$ -	1	$ 79
011	MA	BCBS of Massachusetts	0	$ -	8	$ 648	1	$ 113	0	$ -	5	$ 1,679	0	$ -	14	$ 2,440
012	NY	BCBS of Western New York	2	$ 23,653	0	$ -	0	$ -	0	$ -	2	$ 83	0	$ -	4	$ 23,736
013	PA	Highmark BCBS	1	$ 4,321	55	$ 10,078	9	$ 13,136	0	$ -	107	$ 72,254	4	$ 256	176	$ 100,045
015	TN	BCBS of Tennessee	4	$ 23,746	0	$ -	0	$ -	0	$ -	17	$ 3,694	0	$ -	21	$ 27,440
016	WY	BCBS of Wyoming	0	$ -	0	$ -	0	$ -	0	$ -	38	$ 6,574	0	$ -	38	$ 6,574
017	IL	BCBS of Illinois	1	$ 8,669	98	$ 13,128	4	$ 4,166	0	$ -	444	$ 72,255	27	$ 21,720	574	$ 119,938
021	OH	Ohio WellPoint BCBS	7	$ 60,124	111	$ 41,418	5	$ 10,816	24	$ 29,084	127	$ 20,861	13	$ 10,200	287	$ 172,503
024	SC	BCBS of South Carolina	0	$ -	0	$ -	0	$ -	0	$ -	15	$ 2,639	0	$ -	15	$ 2,639
027	NH	New Hampshire WellPoint BCBS	0	$ -	0	$ -	0	$ -	2	$ 2,943	0	$ -	0	$ -	2	$ 2,943
028	VT	BCBS of Vermont	0	$ -	0	$ -	0	$ -	0	$ -	1	$ 68	0	$ -	1	$ 68
029	TX	BCBS of Texas	13	$ 309,638	313	$ 46,121	5	$ 7,790	0	$ -	3027	$ 362,442	93	$ 72,362	3,451	$ 798,353
030	CO	Colorado WellPoint BCBS	2	$ 21,227	0	$ -	0	$ -	0	$ -	134	$ 39,144	7	$ 4,242	143	$ 64,613
031	IA	Wellmark BCBS of Iowa	3	$ 12,883	97	$ 34,331	0	$ -	0	$ -	0	$ -	0	$ -	100	$ 47,214
032	MI	BCBS of Michigan	3	$ 25,441	45	$ 8,359	5	$ 14,033	0	$ -	0	$ -	2	$ 58	55	$ 47,891
033	NC	BCBS of North Carolina	12	$ 115,630	101	$ 8,901	4	$ 22,557	0	$ -	459	$ 52,156	0	$ -	576	$ 199,244
034	ND	BCBS of North Dakota	1	$ 18,285	0	$ -	0	$ -	0	$ -	13	$ 615	0	$ -	14	$ 18,900
036	PA	Capital BC	0	$ -	26	$ 2,608	1	$ 1,008	0	$ -	14	$ 2,364	0	$ -	41	$ 5,980
037	MT	BCBS of Montana	0	$ -	126	$ 32,427	0	$ -	0	$ -	0	$ -	0	$ -	126	$ 32,427
038	HI	BCBS of Hawaii	0	$ -	6	$ 24,221	0	$ -	0	$ -	0	$ -	0	$ -	6	$ 24,221
039	IN	Indiana WellPoint BCBS	2	$ 11,662	0	$ -	6	$ 7,716	1	$ 1,050	84	$ 3,072	13	$ 3,578	106	$ 27,078
040	MS	BCBS of Mississippi	3	$ 10,841	4	$ 360	1	$ 2,698	0	$ -	83	$ 7,998	0	$ -	91	$ 21,897

Coordination of Benefits with Medicare
BlueCross and BlueShield Plans
Claims Reimbursed in 2007

SUMMARY OF QUESTIONED CHARGES

			COB Category A		COB Category B		COB Category C		COB Category D		COB Category E		COB Category F		ALL COB Categories	
Plan Site #	Plan State	Plan Name	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned
041	FL	BCBS of Florida	6	$ 73,045	0	$ -	1	$ 9,025	0	$ -	199	$ 15,373	21	$ 48,090	227	$ 145,533
042	MO	BCBS of Kansas City	0	$ -	0	$ -	0	$ -	2	$ 3,494	20	$ 1,475	0	$ -	22	$ 4,969
043	ID	Regence BS of Idaho	0	$ -	0	$ -	0	$ -	0	$ -	1	$ 79	0	$ -	1	$ 79
044	AR	Arkansas BCBS	3	$ 31,526	0	$ -	0	$ -	28	$ 766	190	$ 12,674	20	$ 4,262	241	$ 49,228
045	KY	Kentucky WellPoint BCBS	0	$ -	61	$ 16,905	3	$ 18,885	2	$ 3,207	15	$ 411	2	$ 3,896	83	$ 43,304
047	WI	WellPoint BCBS United of Wisconsin	2	$ 21,796	0	$ -	1	$ 2,518	2	$ 9	386	$ 61,341	16	$ 28,031	407	$ 113,695
048	NY	Empire BCBS	8	$ 63,707	61	$ 7,023	3	$ 5,483	0	$ -	673	$ 74,651	40	$ 25,409	785	$ 176,273
049	NJ	Horizon BCBS of New Jersey	0	$ -	63	$ 2,944	4	$ 6,973	0	$ -	97	$ 46,524	1	$ 40,858	165	$ 97,299
050	CT	Connecticut WellPoint BCBS	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -
052	CA	WellPoint BC of California	11	$ 116,571	103	$ 15,948	4	$ 11,616	1	$ 1,800	159	$ 60,852	0	$ -	278	$ 206,787
053	NE	BCBS of Nebraska	1	$ 564	0	$ -	1	$ 176	0	$ -	48	$ 22,469	0	$ -	50	$ 23,209
054	WV	Mountain State BCBS	1	$ 37,196	60	$ 7,861	1	$ 811	0	$ -	4	$ 3,254	0	$ -	66	$ 49,122
055	PA	Independence BC	0	$ -	0	$ -	1	$ 1,571	5	$ 3,848	0	$ -	0	$ -	6	$ 5,419
056	AZ	BCBS of Arizona	2	$ 9,924	0	$ -	0	$ -	0	$ -	367	$ 80,914	24	$ 14,121	393	$ 104,959
058	OR	Regence BCBS of Oregon	1	$ 1,265	25	$ 4,654	2	$ 3,313	27	$ 5,626	0	$ -	24	$ 24,181	79	$ 39,039
059	ME	Maine WellPoint BCBS	0	$ -	67	$ 3,566	1	$ 1,001	2	$ 975	0	$ -	0	$ -	70	$ 5,542
060	RI	BCBS of Rhode Island	1	$ 3,241	0	$ -	0	$ -	0	$ -	42	$ 3,259	0	$ -	43	$ 6,500
061	NV	Nevada WellPoint BCBS	1	$ 35,483	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	1	$ 35,483
062	VA	Virginia WellPoint BCBS	4	$ 11,986	3	$ 16,783	1	$ 1,775	9	$ 9,424	16	$ 943	68	$ 5,594	101	$ 46,505
066	UT	Regence BCBS of Utah	1	$ 23,840	7	$ 2,936	0	$ -	3	$ 2,913	4	$ 1,467	31	$ 7,817	46	$ 38,973
067	CA	BS of California	0	$ -	0	$ -	0	$ -	0	$ -	953	$ 52,849	0	$ -	953	$ 52,849
069	WA	Regence BS of Washington	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -
070	AK	BCBS of Alaska	1	$ 992	0	$ -	0	$ -	0	$ -	32	$ 3,272	29	$ 42,774	62	$ 47,038
074	SD	Wellmark BCBS of South Dakota	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -
075	WA	Premera BC	1	$ 21,149	3	$ 17,600	0	$ -	0	$ -	30	$ 4,053	3	$ 9,216	37	$ 52,018
076	MO	WellPoint BCBS of Missouri	8	$ 89,147	16	$ 19,495	12	$ 19,034	1	$ 1,727	413	$ 131,409	5	$ 27,020	455	$ 287,832
078	MN	BCBS of Minnesota	1	$ 8,719	0	$ -	0	$ -	0	$ -	36	$ 17,895	0	$ -	37	$ 26,614
079	NY	BCBS of Central NY	1	$ 91,905	0	$ -	0	$ -	0	$ -	3	$ 691	0	$ -	4	$ 92,596

Coordination of Benefits with Medicare
BlueCross and BlueShield Plans
Claims Reimbursed in 2007

SUMMARY OF QUESTIONED CHARGES

			COB Category A		COB Category B		COB Category C		COB Category D		COB Category E		COB Category F		ALL COB Categories	
Plan Site #	Plan State	Plan Name	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned
082	KS	BCBS of Kansas	0	$ -	0	$ -	0	$ -	0	$ -	1	$ 230	2	$ 228	3	$ 458
083	OK	BCBS of Oklahoma	3	$ 12,505	25	$ 8,876	2	$ 2,706	0	$ -	191	$ 55,408	8	$ 848	229	$ 80,343
084	NY	BCBS of Utica-Watertown	0	$ -	27	$ 3,082	0	$ -	0	$ -	1	$ 102	0	$ -	28	$ 3,184
085	DC	CareFirst BCBS	3	$ 20,270	97	$ 49,232	3	$ 6,366	5	$ 4,435	272	$ 20,127	1	$ 818	381	$ 101,248
088	PA	BC of Northeastern Pennsylvania	0	$ -	0	$ -	0	$ -	0	$ -	1	$ 30	0	$ -	1	$ 30
089	DE	BCBS of Delaware	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -
092	DC	CareFirst BCBS (Overseas)	0	$ -	0	$ -	0	$ -	0	$ -	1	$ 68	0	$ -	1	$ 68
		Totals	**138**	**$ 1,596,151**	**1,620**	**$ 428,033**	**87**	**$ 191,225**	**114**	**$ 71,301**	**10,327**	**$ 1,694,408**	**465**	**$ 406,688**	**12,751**	**$ 4,387,806**

APPENDIX

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

February 3, 2009

[redacted], Group Chief
Experience-Rated Audits Group
Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, Room 6400
Washington, DC 20415-1100

Reference: **OPM DRAFT AUDIT REPORT**
Tier VIII Global Coordination of Benefits
Audit Report #1A-99-00-09-011
(Report dated and received 10/1/08)

Dear [redacted]:

This is in response to the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report concerning the Global Coordination of Benefits Audit for claims paid in 2007. Our comments concerning the findings in the report are as follows:

AI1. Coordination of Benefits with Medicare
Questioned Amount - $26,408,610

The OPM OIG submitted their sample of potential COB errors to the BCBS Association on October 1, 2008. The BCBS Association and/or BCBS plans were requested to review these potential COB errors and provide responses by January 16, 2009. For claims incurred from October 1, 2006 through December 31, 2007 and reimbursed in 2007, OPM OIG identified 58,276 claim lines totaling $26,408,610 in potential uncoordinated claims.

Blue Cross Blue Shield Association Preliminary Response:

After reviewing the OIG Draft Audit Report and listing of potentially uncoordinated Medicare COB claims totaling $26,408,610, we identified $2,526,632 in claim payments that were not coordinated with Medicare after the initial claim payment, and subsequently became claim payment errors (or 10 % of the amount identified as potential COB errors). Recovery has been initiated on these overpayments and the Plans will continue to pursue these overpayments as required by CS 1039, Section 2.3 (g)(i).

To the extent that claim payment errors did occur or were not identified, these payments were good faith erroneous benefit payments and fall within the context of CS 1039, Section 2.3 (g). Any benefit payments the Plans are unable to recover are allowable charges to the Program. In addition, as good faith erroneous payments, lost investment income does not apply to the payments identified in the finding.

Our analysis of payment errors indicated the following:

- Claims were processed incorrectly because the claims examiner failed to use the Medicare Explanation of Benefits (MEOB) to process the claim. This resulted in claims being paid as "not covered by Medicare" when the MEOB indicated that Medicare made a payment on the claim.

- Refunds were not initiated on claims that were provided to the Plan on either the retroactive enrollment report or the FEP Director's Office COB Self Assessment report. In some cases, recovery could not be initiated because when retroactive enrollment reports were received, the claim was already outside the Plan's provider contract time limit to recover the claims.

In order to continue to improve the FEP Program's Medicare COB processing, FEP will continue with our current COB Action Plan, with modification as necessary, to include the following:

- Monitoring of Medicare COB activity via the new on-line processing application that requires all Plans to update their COB Self Assessment reports directly on the FEP Claims system. This will allow easier monitoring of Plan's COB activities by the FEP Director's Office as well as Plan Management and Audit staff.
- Modification of the FEP Administrative Manual to provide better guidance on when the Medicare Participation "F" code should be used as well as when certain home health, skilled nursing and hospice claims should be coordinated.
- Evaluation of the feasibility of implementing a deferral for inpatient facility Medicare Part A claims over a certain dollar threshold that are coordinated with a Medicare Participation code "F" – not covered by Medicare. If implemented, the deferral will require Plan Claims Management to approve processing of the claim.
- Provide Plan training as necessary.

With respect to the remaining $23,882,355, our review indicated that the claims were paid correctly as discussed below:

- Claims totaling $1,870,617 are contested because recovery had been initiated in accordance with CS1039, 2.3 (g) but not completed or were uncollectible at the time the Draft Audit Report response was provided. The majority of these claims were also paid correctly based upon the Medicare information that was on file at the time of initial payment. Also, at the time of our response to the Draft Report, some claims have already been determined to be uncollectible after recovery was initiated, four letters were sent to the provider and no response from the provider was received.
- Claims totaling $9,740,892 are contested because the claims were adjusted before the response to the Draft Audit Report was submitted. Approximately $4,300,000 of the amount adjusted was adjusted before July 31, 2008, with many having been adjusted in first quarter 2008. The majority of these claims were paid correctly based upon the Medicare information that was on file at the time of initial payment. Recovery was initiated and the claims were subsequently adjusted and funds returned to the Program once the claim errors were identified through retroactive enrollment notices or the FEP Director's Office COB Self Assessment Reports.
- Claims totaling $942,926 did not require coordination because the Medicare benefits were exhausted at the time of payment or Medicare was secondary.
- Claims totaling $7,688,635 are contested because the services were not covered by Medicare.
- Claims totaling $3,164,276 are contested for "other" reasons, including but not limited to the fact that Medicare was not primary on the incurred date, only the deductible or coinsurance was paid for a VA, Indian Health or DOD facility, or the claim was coordinated correctly.
- Claims totaling $475,009 are contested because the services were provided by a non Medicare approved provider.

Our evaluation of claims that were contested because services were not covered noted the following:

- Non-covered drug claims were incorrectly included in the audit sample. Medicare Part B only covers the following: drug infusions, antigens, osteoporosis drugs, drugs for end stage renal disease, blood clotting factors, inject able drugs, immunosuppressive drugs, oral cancer drugs and oral anti-nausea drugs. Also, these drugs are only covered under certain circumstances. None of the drugs included in the COB Tier 8 audit were in the category of drugs that Medicare Part B covers. Supporting documentation has been provided.

- The audit sample included nursing services, speech therapy, physical medicine therapy, physical therapy, and durable medical equipment

claims that are only covered by Medicare Part B when the services are provided by a Medicare approved provider, when the services are approved by the members' physician in advance, when the service is provided in the appropriate setting (i.e., home), or if determined to be medically necessary. Also, in the case of some services, such as physical or speech therapy, service limits apply.

Because the drug name, the physician authorization, determination of medical necessity or whether or not the member has reached the Medicare limit maximum is not included on the FEP Claims system, it cannot be automatically assumed that the claims were paid incorrectly.

Documentation to support the contested amounts has been provided. Documentation to support initiation of overpayment recovery before the audit has also been provided. In addition, we have attached a schedule listed as Attachment A that shows the amount questioned, contested, reason contested and amount recovered by each Plan location. The Plans will continue to pursue the remaining amounts as required by CS 1039, Section 2.3 (g)(l). Any benefit payments the Plan is unable to recover are allowable charges to the Program. In addition, as good faith erroneous payments, lost investment income does not apply to the payments identified in the finding.

We appreciate the opportunity to provide our response to this Draft Audit Report and would request that our comments be included in their entirety as part of the Final Audit Report.

Sincerely,

[redacted]

Director
Program Assurance

Attachment

cc: [redacted]