



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

Final Audit Report

Subject:

Audit of the Federal Employees Health Benefits Program Operations at UPMC Health Plan

Report No. 1C-8W-00-11-007

Date: July 27, 2011

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Office of the
Inspector General

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

AUDIT REPORT

**Federal Employees Health Benefits Program
Community-Rated Health Maintenance Organization
UPMC Health Plan
Contract Number 2856 - Plan Code 8W
Pittsburgh, Pennsylvania**

Report No. 1C-8W-00-11-007

Date: 7/27/11

A handwritten signature in black ink, appearing to read "Michael R. Esser", written over a horizontal line.

Michael R. Esser
Assistant Inspector General
for Audits



UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

Office of the
Inspector General

EXECUTIVE SUMMARY

**Federal Employees Health Benefits Program
Community-Rated Health Maintenance Organization
UPMC Health Plan
Contract Number 2856 - Plan Code 8W
Pittsburgh, Pennsylvania**

Report No. 1C-8W-00-11-007

Date: 7/27/11

The Office of the Inspector General performed an audit of the Federal Employees Health Benefits Program (FEHBP) operations at UPMC Health Plan (Plan). The audit covered contract years 2007 through 2010 and was conducted at the Plan's office in Pittsburgh, Pennsylvania. Additional field work was performed at our office in Cranberry Township, Pennsylvania. We found that the FEHBP rates were developed in accordance with the applicable laws, regulations, and the Office of Personnel Management's rating instructions for the years audited.

However, during our review of the Plan's FEHBP claims data, we found that the Plan had i) paid for non-covered benefits; ii) inappropriately unbundled claims for billing; and, iii) inadequately monitored coordination of benefits for enrollees with Medicare coverage. The monetary impact of these findings was not significant enough to question the costs; however, they represent procedural issues we believe need to be addressed by the Plan.

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I. INTRODUCTION AND BACKGROUND

Introduction

We completed an audit of the Federal Employees Health Benefits Program (FEHBP) operations at UPMC Health Plan (Plan). The audit covered contract years 2007 through 2010 and was conducted at the Plan’s office in Pittsburgh, Pennsylvania. The audit was conducted pursuant to the provisions of Contract CS 2856; 5 U.S.C. Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. 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.

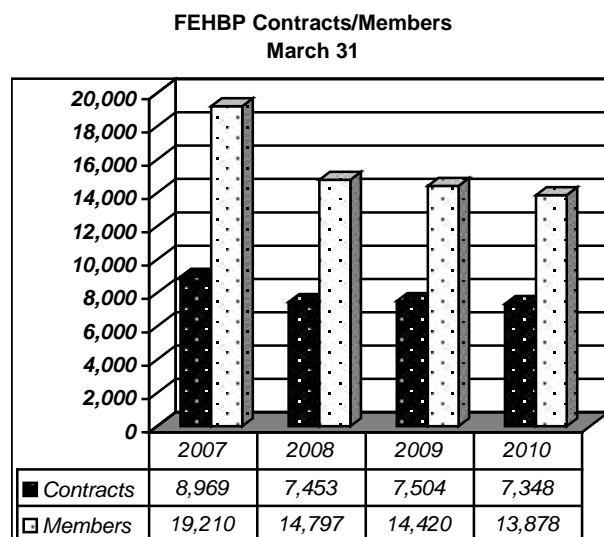
Background

The FEHBP was established by the Federal Employees Health Benefits 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. The FEHBP is administered by OPM’s Healthcare and Insurance Office. The provisions of the Federal Employees Health Benefits Act are implemented by OPM through regulations codified in Chapter 1, Part 890 of Title 5, CFR. Health insurance coverage is provided through contracts with health insurance carriers who provide service benefits, indemnity benefits, or comprehensive medical services.

Community-rated carriers participating in the FEHBP are subject to various federal, state and local laws, regulations, and ordinances. While most carriers are subject to state jurisdiction, many are further subject to the Health Maintenance Organization Act of 1973 (Public Law 93-222), as amended (i.e., many community-rated carriers are federally qualified). In addition, participation in the FEHBP subjects the carriers to the Federal Employees Health Benefits Act and implementing regulations promulgated by OPM.

The FEHBP should pay a market price rate, which is defined as the best rate offered to either of the two groups closest in size to the FEHBP. In contracting with community-rated carriers, OPM relies on carrier compliance with appropriate laws and regulations and, consequently, does not negotiate base rates. OPM negotiations relate primarily to the level of coverage and other unique features of the FEHBP.

The chart to the right shows the number of FEHBP contracts and members reported by the Plan as of March 31 for each contract year audited.



The Plan has participated in the FEHBP since 2000 and provides health benefits to FEHBP members in Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, Warren, Washington, and Westmoreland counties in Pennsylvania.

The last audit of the Plan was conducted in 2007 and covered contract years 2005 and 2006. That audit questioned \$5,413,611 for defective pricing and lost investment income. All issues related to that audit have been resolved.

The preliminary results of this audit were discussed with Plan officials at an exit conference and in subsequent correspondence. A draft report was also provided to the Plan for review and comment. The Plan's comments were considered in the preparation of this report and are included, as appropriate, as the Appendix.

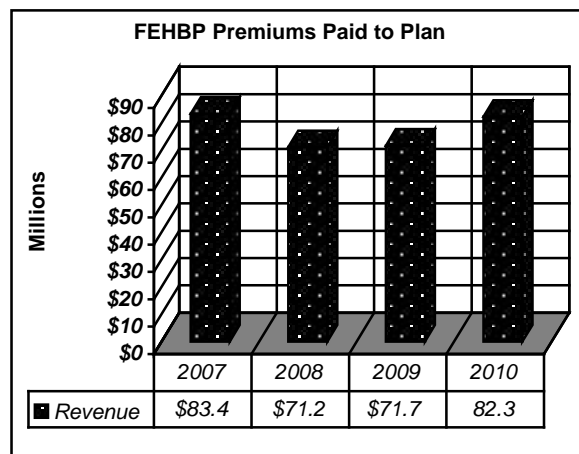
II. OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The primary objectives of the audit were to verify that the Plan offered market price rates to the FEHBP and to verify that the loadings to the FEHBP rates were reasonable and equitable. Additional tests were performed to determine whether the Plan was in compliance with the provisions of the laws and regulations governing the FEHBP.

Scope

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.



This performance audit covered contract years 2007 through 2010. For contract years 2007 through 2010, the FEHBP paid approximately \$308.6 million in premiums to the Plan. The premiums paid for each contract year audited are shown on the chart above.

OIG audits of community-rated carriers are designed to test carrier compliance with the FEHBP contract, applicable laws and regulations, and OPM rate instructions. These audits are also designed to provide reasonable assurance of detecting errors, irregularities, and illegal acts.

We obtained an understanding of the Plan's internal control structure, but we did not use this information to determine the nature, timing, and extent of our audit procedures. However, the audit included such tests of the Plan's rating system and such other auditing procedures considered necessary under the circumstances. Our review of internal controls was limited to the procedures the Plan has in place to ensure that:

- The appropriate similarly sized subscriber groups (SSSG) were selected;
- the rates charged to the FEHBP were the market price rates (i.e., equivalent to the best rate offered to the SSSGs); and
- the loadings to the FEHBP rates were reasonable and equitable.

In conducting the audit, we relied to varying degrees on computer-generated billing, enrollment, and claims data provided by the Plan. We did not verify the reliability of the data generated by

the various information systems involved. However, nothing came to our attention during our audit testing utilizing the computer-generated data to cause us to doubt its reliability. We believe that the available data was sufficient to achieve our audit objectives. Except as noted above, the audit was conducted in accordance with generally accepted government auditing standards, issued by the Comptroller General of the United States.

The audit fieldwork was performed at the Plan's office in Pittsburgh, Pennsylvania, during December 2010. Additional audit work was completed at our offices in Cranberry Township, Pennsylvania.

Methodology

We examined the Plan's federal rate submissions and related documents as a basis for validating the market price rates. Further, we examined claim payments to verify that the cost data used to develop the FEHBP rates was accurate, complete, and valid. In addition, we examined the rate development documentation and billings to other groups, such as the SSSGs, to determine if the market price was actually charged to the FEHBP. Finally, we used the contract, the Federal Employees Health Benefits Acquisition Regulations (FEHBAR), and OPM's Rate Instructions to Community-Rated Carriers to determine the propriety of the FEHBP premiums and the reasonableness and acceptability of the Plan's rating system.

To gain an understanding of the internal controls in the Plan's rating system, we reviewed the Plan's rating system's policies and procedures, interviewed appropriate Plan officials, and performed other auditing procedures necessary to meet our audit objectives.

To test the Plan's compliance with the FEHBP health benefit provisions, we selected and reviewed a judgmental sample of claims for contract years 2007 through 2010. First, we determined the birth year required for Medicare eligibility. Next, we ran queries on the actual experience claim lines for each contract year and isolated the claims by the members' date of birth. Then, we selected claims from the results based upon a dollar value equal to or greater than \$15,000. As a result, this audit included a sample for 2007 contract year of 13 claims from 573,826 claim lines, a sample for 2008 of 15 claims from 591,113 claim lines, a sample for 2009 of 10 claims from 598,141 claim lines, and a sample for 2010 of 12 claims from 543,930 claim lines. The results from the various samples were not projected.

III. AUDIT FINDINGS AND RECOMMENDATIONS

Premium Rate Review

Our audit showed that the Plan's rating of the FEHBP was in accordance with the applicable laws, regulations, and the OPM rating instructions to carriers for contract years 2007 through 2010.

Claims Review

Plans participating in the FEHBP are required to provide back-up copies of claims databases for audit purposes. We reviewed the Plan's FEHBP claims data for contract years 2007 through 2010. We ran queries and reviewed a sample of claims related to hospital, physician, out-of-area, prescription drugs, injectible drugs, and large claims cost. We also reviewed the Plan's FEHBP claims database for evidence of payment of non-covered benefits, for evidence of incorrect unbundling of claims, and for evidence of coordination of benefits monitoring. We found the following in our review:

1. Payment of Non-Covered Services

The FEHBP benefit brochures for 2007 through 2010 state that elective abortions and biofeedback claims are not covered benefits. Our review of the FEHBP claims determined that non-covered elective abortion and biofeedback claims were paid for contract years 2007 through 2010. The amount of the non-covered claims was not significant enough to affect the final 2007 through 2010 audited rates. However, the Plan's claim monitoring system should be more effective in identifying and removing non-covered claims before any payment is made. The Plan stated that it reconfigured its claims adjudication system to catch the elective abortion claims in November 2009 and that it is in the process of reconfiguring for the biofeedback claims.

Plan's Comments (See Appendix):

The Plan states that it has configured its claims processing system to deny elective abortion and biofeedback claims.

OIG's Response to the Plan's Comments:

We acknowledge the Plan's stated implementation of corrective action and will determine if the changes have been adequately implemented during our next audit of the Plan.

Recommendation 1

The Plan has implemented corrective actions to address the finding. No further action is needed at this time.

2. Incorrect Unbundling of Claims

Medical services provided to patients are identified by Current Procedural Terminology (CPT) codes. When claims are electronically submitted for payment they will contain CPT codes associated with the services being billed. In most cases, services are billed as individual line items. However, some services are combined, or bundled, into a single CPT code. This is done to recognize the fact that some services, such as blood panels, can be done at the same time, and the cost of billing them separately does not accurately reflect the actual effort it took to provide the services. For these services, the providers are to submit claims under the bundled CPT code. Our review of the FEHBP claims data found that claims were inappropriately unbundled in contract years 2007 and 2008 for CPT code 80069 (Renal Function Panel) and CPT code 80051 (Electrolyte Panel). There were no results for contract years 2009 and 2010. The Plan explained that it went through system updates in October 2009 for Medicare products and April 2008 for commercial products to capture instances of unbundling, and to reimburse based upon the lab panels and/or deny when billed inappropriately. All claims in question occurred before the Plan's system updates and we did not find any inappropriately unbundled claims after 2008. The claims totals in question for 2007 and 2008 were not significant enough to affect the final 2007 and 2008 premiums. However, the Plan should continue to take the necessary precautions to verify claims are bundled appropriately.

Plan's Comments (See Appendix):

The Plan states that on April 20, 2008, and October 4, 2009, updated versions of [REDACTED] were implemented in the claim processing system. These versions include lab panel bundling logic. Prior to this, the logic did not meet standards, was outdated and was removed in order to prevent inappropriate claim denials.

In addition, the Plan states that [REDACTED] is a new code-editing product provided by [REDACTED]. The Plan has targeted to replace [REDACTED] with [REDACTED] in January 2012. [REDACTED] includes identical lab panel bundling logic; however, the application is more flexible and is capable of capturing the coding/bundling scenarios identified during this audit.

OIG's Response to the Plan's Comments:

We acknowledge the Plan's stated intention to implement corrective action and will determine if the changes have been adequately implemented during our next audit of the Plan.

Recommendation 2

The Plan has taken steps to address the finding, and has stated their intention to implement additional steps to fully resolve the finding. We recommend that the contracting officer require the Plan to continue to take the necessary precautions to verify that the claims are being bundled appropriately.

3. Coordination of Benefits

When enrollees of the Plan have other insurance coverage, the Plan is responsible for coordination of benefits. Coordination of benefits involves identifying the other insurance coverage, making a determination as to who is the primary payer of benefits versus the secondary payer, and making sure the claims are paid accordingly. One of the most frequent instances of other insurance coverage is when an enrollee is covered by Medicare. We tested a sample number of claims for FEHBP enrollees who were also enrolled in Medicare to determine if the Plan had identified Medicare as the primary payer and correctly coordinated the payment of benefits for these enrollees.

To test the Plan's compliance with the FEHBP health benefit provisions, we selected and reviewed a judgmental sample of claims for contract years 2007 through 2010. First, we determined the birth year required for Medicare eligibility. Next, we ran queries on the actual experience claim lines for each contract year and isolated the claims by the members' date of birth. Then, we selected claims from the results based upon a dollar value equal to or greater than \$15,000. As a result, this audit included a sample for the 2007 contract year of 13 claims from 573,826 claim lines; a sample for 2008 of 15 claims from 591,113 claim lines; a sample for 2009 of 10 claims from 598,141 claim lines; and a sample for 2010 of 12 claims from 543,930 claim lines. The results from the various samples were not projected to the entire population.

From the 2007 sample selection, 7 of the 13 identified medical claims, amounting to \$180,792, were not coordinated. Instead of the Centers for Medicare and Medicaid Services (CMS) paying primary, the Plan paid primary, and the claims were never adjusted. As a result, the uncoordinated claims totals were removed from the rate development in 2007. The claims totals were not significant enough to affect the 2007 premium. However, the Plan should make the appropriate adjustments to properly coordinate these claims.

From the 2008 sample selection, 11 of the 15 identified medical claims, amounting to \$278,248, were not coordinated. Again, the Plan paid as primary when CMS should have been the primary payer and the claims were never adjusted. As a result, the uncoordinated claims were removed from the rate development in 2008. The claims totals were not significant enough to affect the 2008 premium. However, the Plan should make the appropriate adjustments to properly coordinate these claims.

From the 2009 sample selection, 7 of the 10 identified medical claims, amounting to \$165,127, were not coordinated. As a result, the Plan paid the claims as the primary payer

and never coordinated the claims with CMS. We removed the uncoordinated claims from the rate development in 2009. While the claims totals were not significant enough to affect the 2009 premium, the Plan should make the appropriate adjustments to properly coordinate these claims.

From the 2010 sample selection, all of the identified medical claims were coordinated or adjusted for coordination.

Plan's Comments (See Appendix):

The Plan states that currently a monthly report is extracted from its data warehouse of members turning age 65 and other Medicare coverage for these individuals is researched. By prospectively identifying other coverage, coordination of benefits is processed accurately.

In 2010, new logic for the COB overpayment report was implemented. The report identifies claims that were paid as primary and subsequent COB was identified. This report has created an effective tool for reporting claim overpayments.

OIG's Response to the Plan's Comments:

We acknowledge the Plan's stated implementation of corrective action and will determine if the changes have been adequately implemented during our next audit of the Plan.

Recommendation 3

The Plan has implemented actions to correctly monitor coordination of benefits. No further action is needed regarding this issue. However, we recommend that the contracting officer require the Plan to make the appropriate adjustments for the uncoordinated claims we identified in 2007, 2008 and 2009.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Community-Rated Audits Group

██████████, Auditor-In-Charge

██████████, Lead Auditor

██████████, Lead Auditor


██████████, Chief

██████████, Senior Team Leader

UPMC HEALTH PLAN

P.O. Box 296
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May 17, 2011

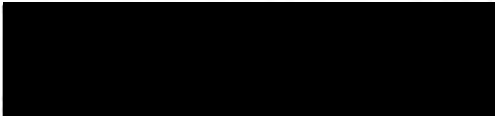

Chief, Community-Rated Audits Group
U.S. Office of Personnel Management
Office of the Inspector General
1900 E Street, NW
Room 6400
Washington, DC 20415-1100

Dear 

Enclosed is the official UPMC Health Plan response to the Federal Employees Health Benefits Program (FEHBP) Operations audit draft.

As requested, a hard copy of the entire draft report, with audit responses is enclosed as well as the same information on CD.

Please contact me if you have questions or require additional information.


Vice President
UPMC Insurance Division
Quality Audit, Fraud & Abuse Department

UPMC HEALTH PLAN

P.O. Box 296
Pittsburgh, PA 1523

UPMC Health Plan Audit Response – May 17, 2011

Recommendation 1

We recommend that the contracting officer require the Plan ensure that its claims system is effectively monitoring all claims to identify non-covered benefits. In particular, we recommend that the Plan's claim system tracks all elective abortion and biofeedback claims so these claims are rejected as a non-covered benefit.

UPMC Health Plan Response:

Configuration for denial of elective abortion was completed (retro to plan's effective date) to systematically deny elective abortions by diagnosis code.

Configuration for denial of biofeedback was completed (retro to plan's effective date) to systematically deny biofeedback services.

Recommendation 2

We recommend that the contracting officer require the Plan to continue to take the necessary precautions to verify that the claims are bundled appropriately.

UPMC Health Plan Response:

On 4/20/2008 an updated version of [REDACTED] was implemented in UPMC Health Plan's claim processing system. This version includes lab panel bundling logic. Prior to this, the logic did not meet standards and was removed in order to prevent inappropriate claim denials.

On 10/4/2009 an updated version of [REDACTED] was implemented in [REDACTED]. This version included lab panel bundling logic. Prior to this, the Medicare version was outdated and was to be removed for compliance reasons.

[REDACTED] is a new code-editing product provided by [REDACTED]. It is targeted to replace [REDACTED] in January 2012. It includes identical lab panel bundling logic; however the application is more flexible and is capable of capturing the coding/bundling scenarios identified during this audit.

Recommendation 3

We recommend that the contracting officer require the Plan take the necessary steps to make sure coordination of benefits is performed in a timely and effective manner in its system.

UPMC Health Plan Response:

Currently a monthly report is extracted from the Health Plan's data warehouse of members turning age 65 and other Medicare coverage for these individuals is researched. By prospectively identifying other coverage coordination of benefits is processed accurately.

In 2010, new logic for the COB overpayment report was implemented. The report identifies claims that were paid as primary and subsequent COB was identified. This report has created an effective tool for reporting claim overpayments.