



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

Final Audit Report

Subject:

AUDIT OF BLUECROSS BLUESHIELD OF NORTH CAROLINA DURHAM, NORTH CAROLINA

Report No. 1A-10-33-11-023

Date: January 25, 2012

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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
Service Benefit Plan Contract CS 1039
BlueCross BlueShield Association
Plan Code 10

BlueCross BlueShield of North Carolina
Plan Code 310
Durham, North Carolina

REPORT NO. 1A-10-33-11-023

DATE: 01/25/12

A handwritten signature in black ink, appearing to read "Michael R. Esser".

Michael R. Esser
Assistant Inspector General
for Audits



UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

Office of the
Inspector General

EXECUTIVE SUMMARY

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Durham, North Carolina

REPORT NO. 1A-10-33-11-023 DATE: 01/25/12

This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at BlueCross BlueShield of North Carolina (Plan), in Durham, North Carolina, questions \$477,872 in health benefit charges. The BlueCross BlueShield Association (Association) agreed **(A)** with these questioned charges.

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covered claim payments from January 1, 2008 through December 31, 2010 as reported in the Annual Accounting Statements.

The questioned health benefit charges are summarized as follows:

- **Modifier 62 and 66 Review (A)** **\$213,476**

The Plan incorrectly paid 138 multiple surgeon claim lines, resulting in net overcharges of \$213,476 to the FEHBP. Specifically, the Plan overpaid 126 claim lines by \$222,518 and underpaid 12 claim lines by \$9,042.

- **Omnibus Budget Reconciliation Act of 1990 Review (A)** **\$151,035**

The Plan incorrectly paid five claims that were priced under the Omnibus Budget Reconciliation Act of 1990 pricing guidelines, resulting in net overcharges of \$151,035 to the FEHBP. Specifically, the Plan overpaid four claims by \$153,973 and underpaid one claim by \$2,938.

- **Omnibus Budget Reconciliations Act of 1993 Review (A)** **\$97,315**

The Plan incorrectly paid 161 claims that were priced under the Omnibus Budget Reconciliation Act of 1993 pricing guidelines, resulting in net overcharges of \$97,315 to the FEHBP. Specifically, the Plan overpaid 144 claims by \$106,285 and underpaid 17 claims by \$8,970.

- **System and Discount Review (A)** **\$18,980**

Based on our review of a judgmental sample of 100 claims, we determined that the Plan incorrectly paid 9 claims, resulting in overcharges of \$18,980 to the FEHBP.

- **Non-Participating Professional Provider Claims (A)** **(\$105)**

During our review of claims submitted by non-participating professional providers, we determined that the Plan incorrectly paid three claims, resulting in net undercharges of \$105 to the FEHBP. Specifically, the Plan overpaid one claim by \$798 and underpaid two claims by \$903.

- **Continuous Stay Claims (A)** **(\$2,829)**

During our review of continuous stay claims, we determined that the Plan incorrectly paid six claims, resulting in net undercharges of \$2,829 to the FEHBP. Specifically, the Plan overpaid three claims by \$20,476 and underpaid three claims by \$23,305.

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I. INTRODUCTION AND BACKGROUND

INTRODUCTION

This final audit report details the results from our limited scope audit of the Federal Employees Health Benefits Program (FEHBP) operations at BlueCross BlueShield of North Carolina (Plan), located in Durham, North Carolina.

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 Healthcare and Insurance Office 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 BlueCross and BlueShield 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 BlueCross and BlueShield plans throughout the United States to process the health benefit claims of its federal subscribers. The Plan is one of approximately 63 local BlueCross and BlueShield plans participating in the FEHBP.

The Association has established a Federal Employee Program (FEP¹) 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 BlueCross BlueShield, 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 Association and Plan management. Also, management of the 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.

All findings from our previous audit of the Plan (Report No. 1A-10-33-06-037, dated August 28, 2007) for contract years 2002 through 2004 have been satisfactorily resolved.

The results of this audit were provided to the Plan in written audit inquiries; were discussed with Plan and/or Association officials throughout the audit and at an exit conference; and were presented in detail in a draft report, dated June 30, 2011. The Association's comments offered in response to the draft report were considered in preparing our final report and are included as an Appendix to this report. Also, additional documentation provided by the Association and Plan on various dates through October 27, 2011 was considered in preparing our final report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The objectives of our audit were to determine whether the Plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the contract. Specifically, our objectives were to determine whether the Plan complied with contract provisions relative to health benefit payments.

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 objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We reviewed the BlueCross and BlueShield FEHBP Annual Accounting Statements as they pertain to Plan code 310 for contract years 2008 through 2010. During this period, the Plan paid approximately \$1.5 billion in health benefit charges (See Schedule A). Specifically, we reviewed approximately \$15.7 million in claim payments from January 1, 2008 through December 31, 2010 for proper adjudication.

In planning and conducting our audit, we obtained an understanding of the Plan's internal control structure to help determine the nature, timing, and extent of our auditing procedures. This was determined to be the most effective approach to select areas of audit. For those areas selected, we primarily relied on substantive tests of transactions and not tests of controls. Based on our testing, we did not identify any significant matters involving the Plan's internal control structure and its operation. However, since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on the Plan's system of internal controls taken as a whole.

We also conducted tests to determine whether the Plan had complied with the contract, the applicable procurement regulations (i.e., Federal Acquisition Regulations and Federal Employees Health Benefits Acquisition Regulations, as appropriate), and the laws and regulations governing the FEHBP. The results of our tests indicate that, with respect to the items tested, the Plan did not comply with all provisions of the contract and federal procurement regulations. Exceptions noted in the areas reviewed are set forth in detail in the "Audit Findings and Recommendations" section of this audit report. With respect to the items not tested, nothing came to our attention that caused us to believe that the Plan 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, the Plan, and the Centers for Medicare and Medicaid Services (CMS). 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 objectives.

The audit was performed at the Plan's office in Durham, North Carolina from March 21 through March 25, 2011. Audit fieldwork was also performed at our office in Cranberry Township, Pennsylvania through June 30, 2011.

METHODOLOGY

We obtained an understanding of the internal controls over the Plan's claims processing system by inquiry of Plan officials.

To test the Plan's compliance with the FEHBP health benefit provisions, we selected and reviewed samples of 829 claims.² We used the FEHBP contract, the Service Benefit Plan brochure, the Plan's provider agreements, and the Association's FEP administrative manual to determine the allowability of benefit payments. The results of these samples were not projected to the universe of claims.

² See the audit findings for "Modifier 62 and 66 Review" (A1), "Omnibus Budget Reconciliation Act of 1990 Review" (A2), "Omnibus Budget Reconciliation Act of 1993 Review" (A3), "System and Discount Review" (A4), "Non-Participating Professional Provider Claims" (A5), and "Continuous Stay Claims" (A6) on pages 5 through 16 for specific details of our sample selection methodologies.

III. AUDIT FINDINGS AND RECOMMENDATIONS

HEALTH BENEFIT CHARGES

1. Modifier 62 and 66 Review

\$213,476

The Plan incorrectly paid 138 multiple surgeon claim lines, resulting in net overcharges of \$213,476 to the FEHBP. Specifically, the Plan overpaid 126 claim lines by \$222,518 and underpaid 12 claim lines by \$9,042.

Contract CS 1039, 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.” 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 the period January 1, 2008 through December 31, 2010, we identified 149 multiple surgeon claim groups, totaling \$202,787 in potential “estimated” overpayments, that contained at least one claim line with co-surgeon procedure modifier “62” or surgical team procedure modifier “66”. From this universe, we selected and reviewed a judgmental sample of 17 groups (representing 34 claim lines), totaling \$82,528 in potential overpayments, for the purpose of determining if these claim lines were correctly priced and paid by the Plan. Our sample included all groups with potential overpayments of \$2,500 or more.

Based on our review, we determined that 25 claim lines were paid incorrectly, resulting in overcharges of \$81,128 to the FEHBP. These claim payment errors resulted from the following reasons:

- The Plan priced 14 claim lines without applying the co-surgeon reimbursement rate to the procedure fee schedule amounts, resulting in overcharges of \$40,880 to the FEHBP.
- The Plan paid 10 claim lines even though the procedures were not medically necessary or the surgical assistants were not required for the surgeries, resulting in overcharges of \$37,303 to the FEHBP. These claim lines were not deferred for medical review prior to payment.
- In one instance, the Plan’s claims processing system did not defer a claim line as a duplicate billing, resulting in an overcharge of \$2,945 to the FEHBP.

Since most of the claim lines in our sample (claim lines in 14 of the 17 groups) were paid incorrectly, we requested that the Plan review the remaining 132 groups (representing 201 claim lines) in the universe, and determine if those claim lines were paid correctly. After reviewing the Plan’s response to our expanded sample, we determined that 113 additional claim lines were paid incorrectly, resulting in net overcharges of \$132,348 to the FEHBP.

Specifically, 101 claim lines were overpaid by \$141,390 and 12 claim lines were underpaid by \$9,042. These claim payment errors resulted from the following reasons:

- The Plan paid 97 claim lines even though the procedures were not medically necessary or the surgical assistants were not required for the surgeries, resulting in net overcharges of \$130,596 to the FEHBP. Specifically, the Plan overpaid 92 claim lines by \$135,238 and underpaid 5 claim lines by \$4,642. These claim lines were not deferred for medical review prior to payment.
- The Plan priced 16 claim lines without applying the co-surgeon reimbursement rate to the procedure fee schedule amounts, resulting in net overcharges of \$1,752 to the FEHBP. Specifically, the Plan overpaid nine claim lines by \$6,152 and underpaid seven claim lines by \$4,400.

Association's Response:

In response to the amount questioned in the draft report for the initial sample, the Association agrees with \$81,823 of the questioned overpayments. The Association states that the Plan has initiated recoveries for the confirmed overpayments. As of August 15, 2011, the Plan has recovered and returned \$55,270 of the confirmed overpayments to the FEHBP for the initial sample.

Regarding the expanded sample, the Association agrees with \$141,390 of the questioned overpayments and \$9,041 of the questioned underpayments. The Association states that the Plan has initiated recoveries for the confirmed overpayments and will issue additional payments for the confirmed underpayments. As of August 30, 2011, the Plan has recovered and returned \$77,489 of the confirmed overpayments to the FEHBP for the expanded sample.

The Association states, "These overpayments were the result of claim examiners' manual processing errors in that the examiners did not send the claims to medical Review . . . The following steps have been taken to address and decrease the number of claims payment errors of this nature in the future:

- The Plan has created a cross-functional team to review the current Standard Operating Procedure (SOP) for the processing of these claims. Revisions have been made to the SOP to ensure that it provides a comprehensive end-to-end perspective process flow with clear and concise instructions.
- The Plan will create a new edit in its local system to auto defer all claims with modifiers 62 & 66 to Medical Review. This process will allow the pre-payment review to determine the medical appropriateness of the services and promote the accuracy of the payment. . . .

- The processing of these claims will now be handled by the Operations Specialists. This change will limit the processing of these claims to a small population of experienced staff in an effort to reduce overpayments.
- The Plan will also provide . . . training to a targeted selection of team members to ensure they are aware of the requirements for reviewing and processing of these claims.”

OIG Comments:

Based on our review of the Association’s response and additional documentation provided by the Association and Plan, we revised the amount questioned from the draft report to \$213,476. The Association’s response and/or additional documentation support concurrence with our revised questioned amount.

Recommendation 1

We recommend that the contracting officer disallow \$222,518 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 2

We recommend that the contracting officer allow the Plan to charge the FEHBP \$9,042 if additional payments are made to the providers to correct the underpayment errors. However, before making any additional payment(s) to a provider, the contracting officer should require the Plan to first recover any questioned overpayment(s) for that provider.

Recommendation 3

We recommend that the contracting officer have the Association verify that the Plan’s corrective steps for improving the prevention of these types of claim payment errors are being implemented. These corrective steps are included in the Association’s response to the draft report.

2. Omnibus Budget Reconciliation Act of 1990 Review \$151,035

The Plan incorrectly paid five claims that were priced under the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) pricing guidelines, resulting in net overcharges of \$151,035 to the FEHBP. Specifically, the Plan overpaid four claims by \$153,973 and underpaid one claim by \$2,938.

As previously cited from CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments.

OBRA 90 limits the benefit payments for certain inpatient hospital services provided to annuitants age 65 or older who are not covered under Medicare Part A. The FEHBP fee-for-service plans are required to limit the claim payment to the amount equivalent to the Medicare Part A payment.

For the period May 1, 2009 through December 31, 2010, we identified 607 claims, totaling \$6,557,469 in payments, that were subject to OBRA 90 pricing guidelines. From this universe, we selected and reviewed a judgmental sample of 57 claims, totaling \$2,103,253 in payments, to determine if these claims were correctly priced by the FEP Operations Center and paid by the Plan. Our sample included all OBRA 90 claims with amounts paid of \$17,500 or more.

Using a program developed by CMS to price OBRA 90 claims, we recalculated the claim payment amounts for the claims in our samples that were subject to and/or processed as OBRA 90. Based on our review, we determined that five claims were paid incorrectly, resulting in net overcharges of \$151,035 to the FEHBP. Specifically, the Plan overpaid four claims by \$153,973 and underpaid one claim by \$2,938.

These claim payment errors resulted from the following:

- The FEP Operations Center priced two claims using the incorrect Medicare diagnosis related grouping (DRG) codes, resulting in overcharges of \$127,687 to the FEHBP. In each instance, the FEP Operations Center determined the DRG code without applying the “present on admission” indicators.
- The FEP Operations Center priced two claims prior to updating the OBRA 90 pricing software with the most current version. Consequently, the Plan overpaid one claim by \$20,416 and underpaid one claim by \$2,938, resulting in net overcharges of \$17,478 to the FEHBP.
- In one instance, the FEP Operations Center priced a claim using the incorrect allowable amounts, resulting in an overcharge of \$5,870 to the FEHBP.

Association’s Response:

The Association agrees with this finding. The Association states that the Plan has initiated recovery efforts for the overpayments and issued an additional payment to correct the underpayment error.

The Association states that these pricing errors were due to manual processing issues. The Association states that the Plan will take corrective action to improve the accuracy of claims data submitted to the FEP Operations Center for OBRA 90 pricing. In addition, the FEP Director’s Office has taken corrective action to improve the pricing accuracy of OBRA 90 claims.

OIG Comments:

Based on our review of the Association’s response and additional documentation, we revised the amount questioned from the draft report to \$151,035. The Association’s response and/or additional documentation support concurrence with our revised questioned amount.

Recommendation 4

We recommend that the contracting officer disallow \$153,973 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 5

We recommend that the contracting officer allow the Plan to charge the FEHBP \$2,938 for the additional payment made to the provider to correct the underpayment error. However, before allowing this additional payment to the provider, the contracting officer should require the Plan to first recover any questioned overpayment(s) for that provider.

Recommendation 6

We recommend that the contracting officer have the Association verify that the Plan and FEP Director’s Office have implemented the corrective actions that are included in the Association’s response to the draft report.

3. Omnibus Budget Reconciliation Act of 1993 Review \$97,315

The Plan incorrectly paid 161 claims that were priced under the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) pricing guidelines, resulting in net overcharges of \$97,315 to the FEHBP. Specifically, the Plan overpaid 144 claims by \$106,285 and underpaid 17 claims by \$8,970.

As previously cited from CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments.

OBRA 93 limits the benefit payments for certain physician services provided to annuitants age 65 or older who are not covered under Medicare Part B. The FEHBP fee-for-service plans are required to limit the claim payment to the lesser of the amount equivalent to the Medicare Part B payment or billed charges.

For the period January 1, 2008 through December 31, 2010, we identified 11,567 claims (35,318 claim lines), totaling \$2,027,885 in payments, that were subject to OBRA 93 pricing guidelines. From this universe, we selected and reviewed a judgmental sample of 298 claims (393 claim lines), totaling \$332,236 in payments, to determine if these claims

were correctly priced by the FEP Operations Center and paid by the Plan. Our sample included all claims with amounts paid of \$4,000 or more, as well as all claim line payments greater than \$350 that were processed with an “OFMA” override code or a procedure containing two or more modifiers.

Using a program developed by CMS to price OBRA 93 claims, we recalculated the claim payment amounts for the claims in our sample that were subject to and/or processed as OBRA 93. Based on our review, we determined that 161 claims were paid incorrectly, resulting in net overcharges of \$97,315 to the FEHBP. Specifically, the Plan overpaid 144 claims by \$106,285 and underpaid 17 claims by \$8,970.

These claim payment errors resulted from the following:

- The FEP Operations Center did not price 136 claims according to OBRA 93 pricing guidelines, resulting in net overcharges of \$85,391 to the FEHBP. Specifically, the Plan overpaid 123 claims by \$92,241 and underpaid 13 claims by \$6,850. These errors resulted from the FEP national claims system, by design, automatically generating an “OFMA” override code when the system did not receive a timely response (i.e., within 15 days) from Palmetto (an OBRA 93 pricing vendor). Consequently, the FEP Operations Center used the allowable charge (covered charge minus preferred provider allowance/participating savings amount) instead of the Medicare allowance to calculate the claim line payments.
- The Plan incorrectly paid 10 surgery claims due to Palmetto not recognizing the multiple or bilateral procedures and erroneously calculating these payments. Consequently, the Plan overpaid nine claims by \$8,018 and underpaid one claim by \$218, resulting in net overcharges of \$7,800 to the FEHBP.
- The Plan incorrectly paid eight claims due to Palmetto not recognizing the second and third procedure modifiers and erroneously calculating the payments, resulting in overcharges of \$3,053 to the FEHBP.
- The Plan paid six claims using the incorrect local procedure allowances, pricing methods, or modifier reimbursement percentages, resulting in net overcharges of \$1,305 to the FEHBP. Specifically, the Plan overpaid four claims by \$2,973 and underpaid two claims by \$1,668.
- In one instance, the Plan paid a claim using the incorrect Medicare pricing allowance, resulting in an undercharge of \$234 to the FEHBP.

Association’s Response:

The Association agrees with this finding. The Association states that the Plan has initiated refunds for the confirmed overpayments and issued additional payments to the providers for the confirmed underpayments. As of August 15, 2011, the Plan has recovered and returned \$31,224 to the FEHBP.

To improve the pricing accuracy of OBRA 93 claims, the Association states that “the FEP Director's Office has taken the following action:

- The FEP Director's Office is currently working with Palmetto to ensure that all applicable FEP claims are priced in accordance with Medicare pricing requirements.
- Established a chain of communication between the FEP Operations Center and Palmetto in an effort to improve the pricing process.
- Started including claims that were not OBRA '93 priced (Claims with the information Code OFMA) in the quarterly System-Wide Claims Review process. . . .
- Conducted Plan trainings on how OBRA '93 claims should be . . . coded and submitted to the Operations Center. . . .
- FEP is currently evaluating its OBRA '93 system edits to determine whether there are changes that can be made to further promote the accuracy of the claims selection that are sent to Palmetto for pricing. System enhancements in FEPEXpress are scheduled to be implemented with the 2011 System Release 4 that will have an effective date of January 1, 2012.”

OIG Comments:

Based on our review of the Association’s response and additional documentation, we revised the amount questioned from the draft report to \$97,315. The Association’s response and/or additional documentation support concurrence with our revised questioned amount.

Recommendation 7

We recommend that the contracting officer disallow \$106,285 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 8

We recommend that the contracting officer allow the Plan to charge the FEHBP \$8,970 for additional payments made to the providers to correct the underpayment errors. However, before allowing any additional payment(s) to a provider, the contracting officer should require the Plan to first recover any questioned overpayment(s) for that provider.

Recommendation 9

We recommend that the contracting officer have the Association verify that the proposed corrective actions for improving the pricing accuracy of OBRA 93 claims are being implemented by the FEP Director's Office. These corrective actions are included in the Association's response to the draft report.

4. System and Discount Review **\$18,980**

The Plan incorrectly paid nine claims, resulting in overcharges of \$18,980 to the FEHBP.

As previously cited from CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments.

For health benefit claims reimbursed during the period January 1, 2010 through December 31, 2010 (excluding OBRA 90, OBRA 93, and case management claims), we identified 5,270,572 claim lines, totaling \$481,373,382 in payments, where the FEHBP paid as the primary insurer. From this universe, we selected and reviewed a judgmental sample of 100 claims (representing 1,010 claim lines), totaling \$2,661,337 in payments, to determine if the Plan adjudicated these claims properly and/or priced them according to the provider contract rates.³ As part of our review, we also selected 25 participating and preferred providers, which were associated with the highest reimbursed claims in our sample, for the purpose of verifying if these providers' contract rates were accurately and timely updated in the Plan's local network pricing system.

Our review identified nine claim payment errors, resulting in overcharges of \$18,980 to the FEHBP. These claim payment errors resulted from the following:

- The Plan incorrectly paid four claims containing multiple procedures or procedures performed by co-surgeons, resulting in overcharges of \$10,096 to the FEHBP. In each instance, the Plan did not apply the correct reimbursement percentage to the procedure's fee schedule amount.

³ We selected our sample from an OIG-generated "Place of Service Report" (SAS application) that stratified the claims by place of service (POS), such as provider's office and payment category, such as \$50 to \$99.99. We judgmentally determined the number of sample items to select from each POS stratum based on the stratum's total claim dollars paid.

- The Plan incorrectly paid three claims due to manual pricing errors, resulting in overcharges of \$4,092 to the FEHBP.
- In one instance, the Plan paid a claim using the incorrect pricing method and allowance for hearing aids, resulting in an overcharge of \$3,004 to the FEHBP.
- In one instance, the claims processor did not defer the claim for a medical necessity review, resulting in an overcharge of \$1,788 to the FEHBP. This claim should have been denied for payment because the procedure was not medically necessary.

Association’s Response:

The Association agrees with this finding. The Association states that the Plan has recovered and returned the questioned overpayments of \$18,980 to the FEHBP.

The Association states, “These overpayments were caused by manual pricing errors. The Plan has taken the following actions to minimize these types of errors in the future:

- A report noting the nature of the errors identified in this finding was sent to all Team Leads and Management in the FEP Department to review with the claims examiners.
- Coaching clinics were conducted by the Team Leads with each of the Claims Professionals that had an error identified in the report.
- These confirmed errors will also be used as training tools during future refresher training for the claims staff.”

Recommendation 10

We recommend that the contracting officer disallow \$18,980 for claim overcharges and verify that these funds were returned to the FEHBP.

Recommendation 11

We recommend that the contracting officer have the Association verify that the Plan’s corrective actions to minimize these types of claim payment errors in the future are being implemented. These corrective actions are included in the Association’s response to the draft report.

5. Non-Participating Professional Provider Claims (\$105)

During our review of claims submitted by non-participating professional providers, we determined that the Plan incorrectly paid three claims, resulting in net undercharges of \$105 to the FEHBP. Specifically, the Plan overpaid one claim by \$798 and underpaid two claims by \$903.

As previously cited from CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments.

The 2009 BlueCross and BlueShield Service Benefit Plan brochure, page 123, states, “Non-participating providers – We have no agreements with these providers. We determine our allowance as follows . . . For physicians and other covered health care professionals that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is equal to the greater of 1) the Medicare participating fee schedule amount for the service or supply in the geographic area in which it was performed or obtained (or 60% of the billed charge if there is no equivalent Medicare fee schedule amount) or 2) 100% of the 2009 Usual, Customary, and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained.”

For the period January 1, 2008 through December 31, 2010, we identified 910,829 claim lines (representing 392,887 claims), totaling \$25,512,971 in payments, submitted by non-participating professional providers. From this universe, we selected and reviewed a judgmental sample of 139 claim lines (representing 25 claims), totaling \$367,921 in payments, to determine if these claim lines were correctly priced by the FEP Operations Center and paid by the Plan. Our sample included the 10 highest dollar claims that were not submitted by emergency transport providers, as well as an additional 15 randomly selected claims.

Based on our review, we determined that three of these claims were paid incorrectly, resulting in net undercharges of \$105 to the FEHBP. Specifically, the Plan overpaid one claim by \$798 and underpaid two claims by \$903. In each instance, the FEP Operations Center priced the claim with the incorrect UCR or Medicare fee schedule amount.

Association’s Response:

The Association agrees with this finding. The Association states that the Plan has initiated recovery for the overpayment and issued additional payments to correct the underpayments.

The Association states that these claim payment errors were the result of manual pricing errors. To minimize these types of errors in the future, the Plan has implemented corrective actions.

Recommendation 12

We recommend that the contracting officer disallow \$798 for a claim overcharge and verify that the Plan returns the amount recovered to the FEHBP.

Recommendation 13

We recommend that the contracting officer allow the Plan to charge the FEHBP \$903 for additional payments made to the providers to correct the underpayment errors. However, before allowing any additional payment(s) to a provider, the contracting officer should require the Plan to first recover any questioned overpayment(s) for that provider.

6. Continuous Stay Claims (\$2,829)

During our review of continuous stay claims, we determined that the Plan incorrectly paid six claims, resulting in net undercharges of \$2,829 to the FEHBP. Specifically, the Plan overpaid three claims by \$20,476 and underpaid three claims by \$23,305.

As previously cited from CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments.

For the period January 1, 2008 through December 31, 2010, we identified 1,149 continuous stay claim groups (representing 2,392 claims), totaling \$17,425,802 in payments. From this universe, we selected and reviewed a judgmental sample of 68 continuous stay claim groups (representing 165 claims), totaling \$9,862,335 in payments, to determine if these claims were correctly priced and paid by the Plan. Our sample included groups with cumulative claim payment amounts of \$50,000 or more. The majority of these claim groups contained claims with consecutive dates of service.

Our review identified six claim payment errors, resulting in net undercharges of \$2,829 to the FEHBP. Specifically, three claims were overpaid by \$20,476 and three claims were underpaid by \$23,305.

These claim payment errors resulted from the following:

- The Plan paid three claims using incorrect allowable amounts, resulting in net overcharges of \$10,001 to the FEHBP. Specifically, the Plan overpaid two claims by \$11,090 and underpaid one claim by \$1,089.
- In one instance, the Plan paid a claim using the incorrect pricing method, resulting in an overcharge of \$9,386 to the FEHBP.
- The Plan priced two claims using the incorrect DRG codes, resulting in undercharges of \$22,216 to the FEHBP.

Association's Response:

The Association agrees with this finding. The Association states that the Plan has recovered and returned the overpayments of \$20,476 to the FEHBP. The Plan has also issued additional payments of \$23,305 to the providers for the underpayments.

The Association states that these claim payment errors were caused by manual coding errors. To minimize these types of errors in the future, the Plan has implemented corrective actions.

Recommendation 14

We recommend that the contracting officer disallow \$20,476 for claim overcharges and verify that these funds were returned to the FEHBP.

Recommendation 15

We recommend that the contracting officer allow the Plan to charge the FEHBP \$23,305 for additional payments made to the providers to correct the underpayment errors. However, before allowing any additional payment(s) to a provider, the contracting officer should require the Plan to first recover any questioned overpayment(s) for that provider.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Experience-Rated Audits Group

██████████, Lead Auditor

██████████, Auditor

██████████, Chief ██████████

Community-Rated Audits Group

██████████, Chief

Information Systems Audits Group

██████████, Senior Information Technology Specialist

██████████ Senior Information Technology Specialist

V. SCHEDULE A

**BLUECROSS BLUESHIELD OF NORTH CAROLINA
DURHAM, NORTH CAROLINA**

HEALTH BENEFIT CHARGES AND AMOUNTS QUESTIONED

HEALTH BENEFIT CHARGES	2008	2009	2010	TOTAL
CLAIM PAYMENTS	\$476,651,459	\$500,971,454	\$514,587,699	\$1,492,210,612
MISCELLANEOUS PAYMENTS*	696,103	783,045	1,468,412	2,947,560
TOTAL HEALTH BENEFIT CHARGES	\$477,347,562	\$501,754,499	\$516,056,111	\$1,495,158,172
A	2008	2009	2010	TOTAL
M				
1. MODIFIER 62 AND 66 REVIEW	\$84,706	\$50,633	\$78,137	\$213,476
2. OMNIBUS BUDGET RECONCILIATION ACT OF 1990 REVIEW	0	127,686	23,349	151,035
3. OMNIBUS BUDGET RECONCILIATION ACT OF 1993 REVIEW	2,747	63,370	31,198	97,315
4. SYSTEM AND DISCOUNT REVIEW	0	0	18,980	18,980
5. NON-PARTICIPATING PROFESSIONAL PROVIDER CLAIMS	(448)	0	343	(105)
6. CONTINUOUS STAY CLAIMS	2,072	8,296	(13,197)	(2,829)
TOTAL QUESTIONED CHARGES	\$89,077	\$249,985	\$138,810	\$477,872

* We did not audit the miscellaneous payments.

**BlueCross BlueShield
Association**

An Association of Independent
Blue Cross and Blue Shield Plans

Federal Employee Program
1310 G Street, N.W.
Washington, D.C. 20005
202.942.1000
Fax 202.942.1125

September 19, 2011

[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**
BlueCross BlueShield of North Carolina
Audit Report Number 1A-10-33-11-023
(Dated June 30, 2011 and Received June 30, 2011)

Dear [REDACTED]

This is our response to the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report covering the Federal Employees' Health Benefits Program (FEHBP) for BlueCross BlueShield of North Carolina. Our comments concerning the findings in this report are as follows:

A. HEALTH BENEFIT CHARGES

1. **Modifier 62 and 66 Review** **\$215,111**

The Plan disagrees that \$13,030 in claims payments were incorrectly paid on the original listing. However, the Plan does agree that claims totaling \$81,823 may have been paid incorrectly. The Plan has initiated recovery efforts on all of the confirmed overpayments. As of August 15, 2011, the Plan has recovered and returned \$55,270 to the Program for this listing and will continue to show due diligence in its recovery efforts.

For the expanded listing, the Draft Audit Report indicated an estimated amount of \$120,000. However, after the Plan completed its review of this listing, it was determined that the actual amount for the expanded listing is a net value of \$240,517. The following is the categorization of the questioned claims on this listing:

- A total of \$108,168 in claim payments were determined to be paid correctly after review by the Plan's medical staff;
- Claims totaling \$141,390 were confirmed as overpayments; and
- Underpayments in the amount of 9,041 were also confirmed.

The Plan has initiated recoveries on the confirmed overpayments and will issue the additional payments for the confirmed underpayments. As of August 30, 2011, the Plan has collected and returned to the Program a total of \$77,489.29 of the confirmed overpayments on the expanded listing. The Plan will continue its due diligence in this recovery effort.

These overpayments were the result of claim examiners' manual processing errors in that the examiners did not send the claims to medical Review to determine. The following steps have been taken to address and decrease the number of claims payment errors of this nature in the future:

- The Plan has created a cross-functional team to review the current Standard Operating Procedure (SOP) for the processing of these claims. Revisions have been made to the SOP to ensure that it provides a comprehensive end-to-end perspective process flow with clear and concise instructions.
- The Plan will create a new edit in its local system to auto defer all claims with modifiers 62 & 66 to Medical Review. This process will allow the pre-payment review to determine the medical appropriateness of the services and promote the accuracy of the payment. This system edits will be in place by December 31, 2011.
- The processing of these claims will now be handled by the Operations Specialists. This change will limit the processing of these claims to a small population of experience staff in an effort to reduce overpayments.
- The Plan will also provide re-fresher training to a targeted selection of team members to ensure they are aware of the requirements for reviewing and processing of these claims.

2. Omnibus Budget Reconciliation Act of 1990 Review

\$180,987

The Plan disagrees that Sample # 15 for services rendered in the long term rehab portion of Kindred Hospital for \$28,527 should have been subject to OBRA '90 pricing. Long term facilities are not subject to OBRA '90 pricing limitation. For Sample #45, the FEP Mainframe OBRA '90 Pricer generated a different pricing of \$58,316 for this claim. As a result, the Plan disagrees with \$1,424 of the question amount. The overpayment amount for this claim is \$107,784.

However, the Plan does agree that \$153,972 in claims payments were not issued in accordance to the OBRA '90 requirements. Recovery efforts have been initiated for these confirmed overpayments. For Sample # 89 with the \$2,938 underpayment, the Plan has now been corrected the claim on the FEP System and this additional payment was issued to the provider.

The Plan indicated that these pricing errors were due to manual processing issues. The Plan will take the following action to improve the accuracy of claims data submitted to the FEP Operations Center for OBRA '90 pricing:

- o A report noting the nature of these errors identified in this finding was sent to all Team Leads and Management in the FEP Department to be used as training tools for the claim examiners.
- o Coaching clinics will be conducted by the Team Leads with the applicable Claims Staff that had an error identified in the report.
- o These confirmed errors will also be used during future re-fresher training for the claims staff.
- o In addition, the Plan will continue to randomly audit Claims Professionals monthly to ensure compliance with the processing guidelines.

To continue to enhance OBRA '90 claims pricing accuracy the FEP Director's Office has taken the following action:

- o Includes all claims that were not OBRA '90 priced in the quarterly System-Wide Claims Review process.
- o Conducts Plan training on how OBRA '90 claims should be submitted to the Operations Center for adjudication. Training was completed at the 2009 Micro Regional Meetings (training sessions conducted by the Operations Center with small groups of Plans in three different locations throughout the country), the FEP Annual Operations and FEP Information System Meetings held during 2009. Additional training is targeted for 2010 that include meetings, correspondence and Webinar Sessions.

- o Modified the FEP Claims System OBRA '90 mainframe software to accept claims for all years that the data is retained by CMS instead of three years after the claims were incurred.
- o In 2011, FEP implemented an edit that will prevent claims from by-passing the OBRA '90 Pricer, regardless of the Process Code used to adjudicate the claims.

3. Omnibus Budget Reconciliation Act of 1993 Review

\$100,932

The Plan disagrees that \$2,349 should have been subject to OBRA '93 pricing because Palmetto, the FEP OBRA '93 Vendor, did not apply Medicare pricing to these claim lines. However, the Plan agrees that claim payments totaling \$107,553 should have been subject to OBRA'93. Refunds have been initiated for the confirmed overpayments. As of August 15, 2011, the Plan has recovered and returned \$31,224 to the Program. Also, the Plan has issued additional payments to the providers for the confirmed \$8,970 in underpayments.

To enhance OBRA '93 claims pricing accuracy the FEP Director's Office has taken the following action:

- o The FEP Director's Office is currently working with Palmetto to ensure that all applicable FEP claims are priced in accordance with Medicare pricing requirements.
- o Established a chain of communication between the FEP Operations Center and Palmetto in an effort to improve the pricing process.
- o Started including claims that were not OBRA '93 priced (Claims with the information Code OFMA) in the quarterly System-Wide Claims Review process. These claims were included on the quarterly report starting during the 4th Quarter 2010 and will continue to be included until it is determined that this is no longer a pricing issue.
- o Conducted Plan trainings on how OBRA '93 claims should be to coded and submitted to the Operations Center. The first training was held at the FEP 2010 System Information Meeting in October 2010. Future trainings will be held via Webinars, and Plan meetings, visits and correspondence.
- o FEP is currently evaluating its OBRA '93 system edits to determine whether there are changes that can be made to further promote the accuracy of the claims selection that are sent to Palmetto for pricing. System enhancements in FEPEXpress are scheduled to be implemented with the 2011 System Release 4 that will have an effective date of January 1, 2012.

- o Started including claims that were not OBRA '93 priced (Claims with the information Code OFMA) in the quarterly System-Wide Claims Review process. These claims were included on the quarterly report starting during the 4th Quarter 2010 and will continue to be included until it is determined that this is no longer a pricing issue.

4. System and Discount Review

\$22,456

The Plan disagrees that claims payments totaling \$3,476 were incorrectly paid. Documentation to support the Plan's position for this finding has been submitted to the auditors for review. However, the Plan does agree that \$18,980 of the questioned claims may have been over paid. These claims payments were caused by manual and local system errors. Recoveries have been initiated on the confirmed overpayments. As of August 15, 2011, the Plan has recovered and returned \$18,980 to the Program.

These overpayments were caused by manual pricing errors. The Plan has taken the following actions to minimize these types of errors in the future:

- o A report noting the nature of the errors identified in this finding was sent to all Team Leads and Management in the FEP Department to review with the claims examiners.
- o Coaching clinics was conducted by the Team Leads with each of Claims Professionals that had an error identified in the report.
- o These confirmed errors will also be used as training tools during future refresher training for the claims staff.

5. Non-Participating Professional Provider Claims

(\$105)

The Plan does not contest that \$798 for one claim payment resulted in an overpayment. Recovery efforts have been initiated to recover this overpayment. Also, the Plan has issued additional payments to providers for the confirmed \$903 underpayments for two claims.

These claim payment errors were caused by manual pricing errors. The Plan has taken the following actions to minimize these types of errors in the future:

- o A report noting the nature of the errors identified in this finding was sent to all Team Leads and Management in the FEP Department to review with the claims examiners.

- o Coaching clinics will be conducted by the Team Leads with each of Claims Professionals that had an error identified in the report.
- o These confirmed errors will also be used as training tools during future re-fresher training for the claims staff.

6. Continuous Stay Claims

(\$2,829)

The Plan agrees with this finding. These payment errors were caused by manual coding errors. As of August 15, 2011, the Plan had recovered and returned to the Program \$20,476 and issued the additional payments to the providers for the confirmed \$23,305 in undercharges.

The Plan will take the following actions to minimize these types of errors in the future:

- o Conducted re-fresher training in those areas where these manual payment errors occurred. Special emphasis was placed on the correct pricing procedures for interim facility billings and the impact on the pricing requirements for the entire admission;
- o Reviewed the current SOP to ensure that the procedures included the conduction of research for the deferrals related to this admission type prior to the completion of the resolution process; and
- o Updated procedures for the manual pricing of these claims.

The FEP Director's Office also includes these claim types in its System-wide Review process.

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


Executive Director
Program Integrity

cc: , FEP
FEP
FEP