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

Final Audit Report

Subject:

AUDIT OF
BLUECROSS BLUESHIELD OF LOUISIANA
BATON ROUGE, LOUISIANA

Report No. 1A-10-07-13-005

Date: December 19, 2013

AUDIT REPORT

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

BlueCross BlueShield of Louisiana
Plan Codes 170/670
Baton Rouge, Louisiana

REPORT NO. 1A-10-07-13-005 DATE: 12/19/13

Michael R. Esser
Assistant Inspector General
for Audits

--CAUTION--

EXECUTIVE SUMMARY

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

BlueCross BlueShield of Louisiana
Plan Codes 170/670
Baton Rouge, Louisiana

REPORT NO. 1A-10-07-13-005 DATE: 12/19/13

This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at BlueCross BlueShield of Louisiana (Plan), in Baton Rouge, Louisiana, questions $454,085 in health benefit charges. The BlueCross BlueShield Association agreed (***A***) with these questioned charges.

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covers claim payments from January 1, 2010 through November 30, 2012 as reported in the Annual Accounting Statements.

The questioned health benefit charges are summarized as follows:

- **Non-Participating Provider Claims *(A)*** **$208,745**

  During our review of claims submitted by non-participating providers, we determined that the Plan incorrectly paid 25 claims, resulting in overcharges of $208,745 to the FEHBP. Specifically, the Plan overpaid 10 professional claims by $116,258, 13 basic coverage claims by $77,226, and 2 inpatient claims by $15,261.

- **System and Discount Review *(A)*** **$166,667**

  Based on our review of a judgmental sample of 150 claims, we determined that the Plan incorrectly paid 7 claims, resulting in net overcharges of $166,667 to the FEHBP. Specifically, the Plan overpaid six claims by $167,167 and underpaid one claim by $500.

- **Durable Medical Equipment Claims *(A)*** **$51,782**

  Based on our review of a judgmental sample of 50 durable medical equipment claims, we determined that the Plan incorrectly paid 3 claims, resulting in net overcharges of $51,782 to the FEHBP. Specifically, the Plan overpaid two claims by $53,305 and underpaid one claim by $1,523.

- **Duplicate Payments – Professional/Facility Claims *(A)*** **$26,891**

  The Plan incorrectly paid 35 professional claims, resulting in overcharges of $26,891 to the FEHBP. These claims were included in payment groups that contained one facility claim and one or more possible duplicate professional claims.

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 BlueCross BlueShield of Louisiana (Plan). The Plan is located in Baton Rouge, Louisiana.

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 64 local BlueCross and BlueShield 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 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 prior audit of the Plan (Report No. 1A-10-07-07-016, dated January 18, 2008), which included claim payments from 2003 through September 30, 2006, 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 21, 2013. 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.

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 codes 170 and 670 for contract years 2010 through 2012. During this period, the Plan paid approximately $703 million in health benefit charges (See Figure 1 and Schedule A). In total, we reviewed approximately $9.5 million in claim payments made from January 1, 2010 through November 30, 2012 for proper adjudication.

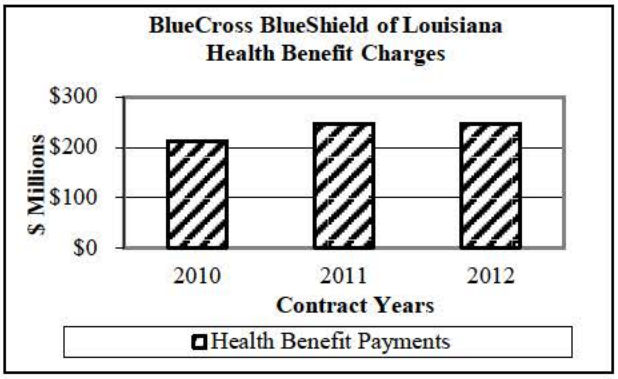

Figure 1 – Health Benefit Charges

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 operations. 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 and the applicable laws and regulations governing the FEHBP as they relate to claim payments. The results of our tests indicate that, with respect to the items tested, the Plan did not fully comply with the provisions of the contract relative to claim payments. 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, and the Plan. Through audits and a reconciliation process, we have verified the reliability of the BCBS claims data in our data warehouse, which was used to identify the universe of claims for each type of review. The BCBS claims data is provided to us on a monthly basis by the FEP Operations Center, and after a series of internal steps, uploaded into our data warehouse. However, due to time constraints, we did not verify the reliability of the data generated by the Plan's local claims system. 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 Baton Rouge, Louisiana from April 16, 2013 through April 24, 2013. Audit fieldwork was also performed at our offices in Washington, D.C. and Cranberry Township, Pennsylvania through June 5, 2013.

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 501 claims.[2] We used the FEHBP contract, the 2010 through 2012 Service Benefit Plan brochures, 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 "Non-Participating Provider Claims" (1), "System and Discount Review" (2), "Durable Medical Equipment Claims" (3), and "Duplicate Payments – Professional/Facility Claims" (4) on pages 5 through 11 for specific details of our sample selection methodologies.

III. AUDIT FINDINGS AND RECOMMENDATIONS

HEALTH BENEFIT CHARGES

1. Non-Participating Provider Claims $208,745

During our review of claims submitted by non-participating (non-par) providers, we determined that the Plan incorrectly paid 25 claims, resulting in overcharges of $208,745 to the FEHBP.

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." In addition, 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 . . . ."

The 2012 BlueCross and BlueShield Service Benefit Plan brochure, page 132, states, "Non-participating providers – We have no agreements with these providers to limit what they can bill you for their services. This means that using Non-participating providers could result in your having to pay significantly greater amounts for the services you receive."

For the period January 1, 2010 through November 30, 2012, we performed a computer search to identify inpatient, outpatient, and professional claims that were submitted by non-par providers. In total, we identified 140,754 non-par provider claims (representing 463,358 claim lines), totaling $15,265,823 in payments that met this search criteria. From this universe, we selected and reviewed a judgmental sample of 150 claims (representing 1,608 claim lines), totaling $3,367,899 in payments, to determine if these claims were correctly priced by the FEP Operations Center and/or paid by the Plan.[3]

Our sample selections are summarized as follows:

- From a population of 173 non-par inpatient claims (representing 2,094 claim lines, totaling $1,540,405 in payments), we selected and reviewed a judgmental sample of 75 claims (representing 1,236 claim lines), totaling $1,187,581 in payments. The sample selections included the 75 highest paid claims in this population.

- From a population of 324 non-par outpatient claims (representing 371 claim lines, totaling $626,664 in payments), we did not select a sample of claims since the total payment amounts were considered immaterial.

- From a population of 140,257 non-par professional claims (representing 460,893 claim lines, totaling $13,098,754 in payments), we selected and reviewed a judgmental sample of 75 claims (representing 372 claim lines), totaling $2,180,318 in payments. The sample selections included the 75 highest paid claims in this population.

[3] The non-par provider claims are generally priced by the FEP Operations Center and then paid by the Plan.

After reviewing our initial sample of 150 non-par provider claims, we expanded our testing to also include all non-par provider claims with amounts paid of $2,500 or more that were processed for members with basic coverage only. This expanded sample included an additional 63 claims, totaling $485,259 in payments, from the universe.

In total, we determined that 25 of the non-par claims in our initial and expanded samples were paid incorrectly, resulting in overcharges of $208,745 to the FEHBP. Specifically, the Plan overpaid 10 professional claims by $116,258, 13 basic coverage claims by $77,226, and 2 inpatient claims by $15,261. These claim payment errors resulted from the following:

- The Plan applied the non-par "balance relief" incorrectly when pricing nine professional claims, resulting in overcharges of $114,003 to the FEHBP.

- The Plan inadvertently included non-covered services when pricing four claims, resulting in overcharges of $62,284 to the FEHBP. Specifically, the Plan overpaid three basic coverage claims by $53,084 and one inpatient facility claim by $9,200. In each instance, the Plan did not have proper authorization for the medical necessity of the claim, which made the claim charges unallowable (non-covered services).

- The Plan priced six basic coverage claims using incorrect allowed amounts, resulting in overcharges of $20,831 to the FEHBP.

- The FEP Operations Center did not properly coordinate two claims with the members' additional insurance when pricing the claims. Consequently, the Plan overpaid one inpatient facility claim by $6,061 and one professional claim by $2,255, resulting in overcharges of $8,316 to the FEHBP.

- In one instance, a member's enrollment data records, which identified the patient's eligibility status in the FEP Direct System, were incorrect when the Plan paid a basic coverage claim. However, after receiving the patients' updated enrollment data records, the Plan did not review and/or adjust this basic coverage claim. As a result, the Plan inappropriately charged the FEHBP $3,011 for this claim that was incurred after the patient's termination date of coverage.

- The FEP Operations Center did not properly calculate the copayment amounts for three basic coverage claims. As a result, the Plan overpaid these claims by $300.

Association's Response:

The Association states, "The Plan agrees that 19 claim payments totaling $206,490 were paid incorrectly . . . The Plan has initiated overpayment recovery efforts for the confirmed overpayments. As of August 21, 2013, the Plan has recovered and returned $59,660 to the FEP Program. In addition, the Plan has established $66,211 in offsets of future member payable claims on FEP Direct because the refund letters did not result in the recovery of these overpayments. The remaining $80,619 balance is still in recovery. The Plan continues to show due diligence in its recovery efforts."

To the extent that errors did occur, the Association also states that these payments were good faith erroneous benefit payments and fall within the context of CS 1039, Part II, section 2.3(g). Any payments the Plan is unable to recover are allowable charges to the FEHBP as long as the Plan demonstrates due diligence in the collection of these overpayments. As good faith erroneous payments, lost investment income does not apply to the claim payment errors identified in this finding.

In addition, the Association states that the Plan has implemented corrective actions to minimize these types of claim payment errors in the future.

OIG Comments:

Based on our review of the Association's response and additional documentation, we revised the amount questioned from the draft report to $208,745 for this finding. Although the Association only agrees with $206,490 in its written response, the Association's additional documentation supports concurrence with the revised questioned charges of $208,745.

Recommendation 1

We recommend that the contracting officer disallow $208,745 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 2

We recommend that the contracting officer require the Association to provide evidence or documentation supporting 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.

2. System and Discount Review $166,667

The Plan incorrectly paid seven claims, resulting in net overcharges of $166,667 to the FEHBP. Specifically, the Plan overpaid six claims by $167,167 and underpaid one claim by $500.

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 incurred and reimbursed from July 1, 2011 through November 30, 2012 (excluding Omnibus Budget Reconciliation Act of 1990, Omnibus Budget Reconciliation Act of 1993, and case management claims), we identified 2,629,320 claim lines, totaling $289,826,071 in payments, where the FEHBP paid as the primary insurer. From this universe, we selected and reviewed a judgmental sample of 150 claims (representing 1,699 claim lines), totaling $5,387,293 in payments, for the purpose of determining if the Plan adjudicated these claims properly and/or priced them according to the

provider contract rates.[4] As part of our review, we also selected 30 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 seven claim payment errors, resulting in net overcharges of $166,667 to the FEHBP. Specifically, the Plan overpaid six claims by $167,167 and underpaid one claim by $500. These claim payment errors resulted from the following:

- The Plan paid five claims using the incorrect pricing allowances, resulting in overcharges of $115,388 to the FEHBP.

- In one instance, the Plan inadvertently included a non-covered service when pricing the claim, resulting in an overcharge of $51,779 to the FEHBP.

- In one instance, the Plan inadvertently applied a pre-certification penalty when pricing the claim, resulting in an undercharge of $500 to the FEHBP.

Association's Response:

The Association agrees with this finding. The Association states that the Plan has initiated recoveries of the overpayments. As of August 21, 2013, the Plan had recovered and returned $100,196 of the overpayments to the FEHBP. In the FEP Direct System, the Plan has also set-up $66,471 in offsets of future member payable claims because the refund letters did not result in recoveries of these overpayments. To the extent that errors did occur, the Association also states that these payments were good faith erroneous benefit payments and fall within the context of CS 1039, Part II, section 2.3(g). Any payments the Plan is unable to recover are allowable charges to the FEHBP as long as the Plan demonstrates due diligence in the collection of these overpayments. As good faith erroneous payments, lost investment income does not apply to the claim payment errors identified in this finding.

In addition, the Association states that the Plan has implemented corrective actions to minimize these types of claim payment errors in the future.

Recommendation 3

We recommend that the contracting officer disallow $167,167 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 4

We recommend that the contracting officer allow the Plan to charge the FEHBP $500 if an additional payment is made to the provider to correct the underpayment error.

[4] 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.

3. Durable Medical Equipment Claims $51,782

During our review of durable medical equipment (DME) claims, we determined that the Plan incorrectly paid three claims, resulting in net overcharges of $51,782 to the FEHBP. Specifically, the Plan overpaid two DME claims by $53,305 and underpaid one DME claim by $1,523.

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.

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 . . . ."

For the period January 1, 2011 through November 30, 2012, we identified 174,666 DME claim lines, totaling $11,748,429 in payments. From this universe, we selected and reviewed a judgmental sample of 50 claims (representing 362 claim lines), totaling $534,682 in payments, to determine if these claims were correctly priced and paid by the Plan. Our sample included all claims with amounts paid of $500 or more.

Based on our review, we determined that three of the DME claims in our sample were paid incorrectly, resulting in net overcharges of $51,782 to the FEHBP. Specifically, the Plan overpaid two claims by $53,305 and underpaid one claim by $1,523. These claim payment errors resulted from the following:

- In one instance, the Plan paid a claim using the incorrect provider identification number and fee schedule pricing allowance, resulting in an overcharge of $41,487 to the FEHBP.

- In one instance, the Plan incorrectly priced each claim line separately for a claim, when the claim lines should have been grouped and paid under the first claim line. As a result, the Plan overpaid the claim by $11,818.

- In one instance, the Plan did not properly coordinate a claim with Medicare, resulting in an undercharge of $1,523 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 $53,305 to the FEHBP, as well as issued a payment of $1,523 to the applicable provider to correct the underpayment error.

Recommendation 5

We recommend that the contracting officer disallow $53,305 for claim overcharges and verify that the Plan has returned these overcharges to the FEHBP.

Recommendation 6

We recommend that the contracting officer allow the Plan to charge the FEHBP $1,523 for the underpayment error.

4. Duplicate Payments – Professional/Facility Claims $26,891

The Plan incorrectly paid 35 professional claims, resulting in overcharges of $26,891 to the FEHBP. These claims were included in payment groups that contained one facility claim and one or more possible duplicate professional claims.

As previously cited from CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. Also, the Plan must coordinate the payment of benefits under this contract with the payment of benefits under Medicare. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments.

Section 6(h) of the FEHB Act provides that rates should reasonably and equitably reflect the costs of benefits provided.

We performed computer searches on the BCBS claims database, using our SAS data warehouse function, to identify potential duplicate professional claims that were paid by the Plan from January 1, 2010 through November 30, 2012.

- Using our "duplicate professional and inpatient match" search criteria, we identified 592 potential duplicate payment groups containing two or more claims, where one claim was the original inpatient facility claim and the other(s) were possible duplicate professional claims. These potential duplicate groups included 1,571 claim lines, totaling $59,705 in payments. Due to the immaterial payment amounts, we did not select a sample of these groups to review.

- Using our "duplicate professional and outpatient match" search criteria, we identified 26,791 potential duplicate payment groups containing two or more claims, where one claim was the original outpatient facility claim and the other(s) were possible duplicate professional claims. These potential duplicate groups included 57,631 claim lines, totaling $2,205,631 in payments. From this universe, we selected and reviewed a judgmental sample of 151 groups (representing 454 claim lines), totaling $223,992 in payments. Our sample included all groups with potential duplicate payments of $100 or more.

Based on our review, we identified 35 professional claim payment errors, resulting in overcharges of $26,891 to the FEHBP. These claim payment errors occurred due to the following reasons:

- Due to various provider billing errors, the Plan inadvertently paid 31 duplicate claims, resulting in overcharges of $23,788 to the FEHBP.

- In two instances, the Plan incorrectly used override codes when processing the claims, resulting in duplicate charges of $1,902 to the FEHBP.

- In one instance, the Plan did not properly coordinate a claim with Medicare, resulting in an overcharge of $1,131 to the FEHBP (a non-duplicate claim payment error).

- In one instance, although the provider submitted a revised claim with a modifier on the duplicate procedure code, the Plan did not correctly adjust the claim in the local claims system, resulting in an overcharge of $70 to the FEHBP.

Association's Response:

The Association agrees with this finding. The Association states that the Plan has initiated recoveries of the overpayments. As of August 21, 2013, the Plan has recovered and returned $15,305 of the overpayments to the FEHBP. To the extent that errors did occur, the Association also states that these payments were good faith erroneous benefit payments and fall within the context of CS 1039, Part II, section 2.3(g). Any payments the Plan is unable to recover are allowable charges to the FEHBP as long as the Plan demonstrates due diligence in the collection of these overpayments. As good faith erroneous payments, lost investment income does not apply to the claim payment errors identified in this finding.

The Association states that the Plan has implemented corrective actions to reduce these types of claim payment errors in the future. In addition, the Association states that the FEP Director's Office will be adding monthly duplicate listings to the FEP Direct System's "Claims Audit Monitoring Tool" later this year.

Recommendation 7

We recommend that the contracting officer disallow $26,891 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Experience-Rated Audits Group

[redacted], Auditor-In-Charge

[redacted], Auditor

[redacted], Chief [redacted]

Information Systems Audits Group

[redacted], Senior Information Technology Specialist

[redacted], Senior Information Technology Specialist

V. SCHEDULE A

BLUECROSS BLUESHIELD OF LOUISIANA
BATON ROUGE, LOUISIANA

HEALTH BENEFIT CHARGES AND AMOUNTS QUESTIONED

HEALTH BENEFIT CHARGES	2010	2011	2012	TOTAL
HEALTH BENEFIT CHARGES				
PLAN CODE 170:				
CLAIM PAYMENTS	$121,018,071	$147,103,311	$148,570,896	$416,692,278
MISCELLANEOUS PAYMENTS AND CREDITS*	73,125	(44,364)	(547,081)	(518,320)
PLAN CODE 670:				
CLAIM PAYMENTS	90,654,953	98,496,314	97,964,089	287,115,356
MISCELLANEOUS PAYMENTS AND CREDITS*	0	0	0	0
TOTAL	$211,746,149	$245,555,261	$245,987,904	$703,289,314

AMOUNTS QUESTIONED	2010	2011	2012	TOTAL
1. NON-PARTICIPATING PROVIDER CLAIMS	$8,428	$98,495	$101,822	$208,745
2. SYSTEM AND DISCOUNT REVIEW	0	42,069	124,598	166,667
3. DURABLE MEDICAL EQUIPMENT CLAIMS	0	(1,523)	53,305	51,782
4. DUPLICATE PAYMENTS - PROFESSIONAL/FACILITY CLAIMS	3,708	8,359	14,824	26,891
TOTAL QUESTIONED CHARGES	$12,136	$147,400	$294,549	$454,085

*** We did not review the miscellaneous payments and credits on this audit.**

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
Phone # 202.942.1000
Fax 202.942.1125

September 6, 2013

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

Reference: **OPM DRAFT AUDIT REPORT**
Blue Cross and Blue Shield of Louisiana
Audit Report Number 1A-10-07-13-005
(Dated June 21, 2013 and Received June 24, 2013)

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 Blue Cross and Blue Shield of Louisiana. Our comments concerning the findings in this report are as follows:

HEALTH BENEFIT CHARGES

1. Non-Participating Provider Claims $239,616

The Plan agrees that 19 claim payments totaling $206,490 were paid incorrectly. These errors resulted in nine facility and ten professional claims overpayments. The Plan has initiated overpayment recovery efforts for the confirmed overpayments. As of August 21, 2013, the Plan has recovered and returned $59,660 to the FEP Program. In addition, the Plan has established $66,211 in offsets of future member payable claims on FEP Direct because the refund letters sent did not result in the recovery of these overpayments. The remaining $80,619 balance is still in recovery. The Plan continues to show due diligence in its recovery efforts.

The Plan contests that $33,126 for samples # 62 & 63 were overpaid. These claims were determined to be paid correctly.

These overpayments were caused by the manual submission of the Plan Allowance/FEP Non-Par Per Diem used by the Operations Center to calculation the Non-Par Allowances and determine the FEP Payable Amounts.

The Plan has taken the following actions to minimize these types of errors in the future:

- Conduct period coding training for the claims processors.

- Include any errors identified during the quality review process, internal and external audits and confirmed errors from quarterly performance reporting in the periodic coding training sessions.

- The confirmed errors in this report were also used as training tools during recent re-fresher training sessions for the claims staff held on August 19 and August 20, 2013. In addition, the Plan will use its quality process to continue to monitor the accuracy of these types of claims. Attached is support documenting the re-fresher training that was conducted.

Accordingly, to the extent that errors did occur, the payments are good faith erroneous benefit payments and fall within the context of CS 1039, section 2.3(g). Any benefit payments the Plan is unable to recover are allowable charges to the Program as long as the Plan is able to demonstrate due diligence in collection of the overpayment. In addition, as good faith erroneous benefit payments the Plan continues to initiate recovery in a timely manner for confirmed overpayments. Because these are good faith erroneous payments, they are not subject to lost investment income.

2. System and Discount Review **$166,667**

The Plan agrees that seven claims totaling $166,667 may have been paid incorrectly. These payment errors consist of six overpayments totaling $167,167 and one underpayment for $500. Refund recovery efforts have been initiated for these confirmed overpayments. As of August 21, 2013, the Plan has collected and returned $100,196 to the FEP Program. In addition, the Plan has established $66,471 in offsets of future member payable claims on FEP Direct because the refund letters sent did not result in the recovery of these overpayments. The Plan continues to show due diligence in its recovery efforts.

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

- These confirmed errors were used as training tools during recent re-fresher training sessions for the claims staff on August 19 and August 20, 2013. In addition, the Plan will use its quality process to continue to monitor the accuracy of these types of claims payments.

- Plan staff also conducts random system reviews to promote the efficiency of the functionality of the system in an effort to reduce the amount of human intervention required for pricing.

Accordingly, to the extent that errors did occur, the payments are good faith erroneous benefit payments and fall within the context of CS 1039, section 2.3(g). Any benefit payments the Plan is unable to recover are allowable charges to the Program as long as the Plan is able to demonstrate due diligence in collection of the overpayment. In addition, as good faith erroneous benefit payments; the Plan continues to initiate recovery in a timely manner for confirmed overpayments. Because these are good faith erroneous payments, they are not subject to lost investment income.

2. Durable Medical Equipment Claims **$51,782**

The Plan agrees that three claims with a net total of $51,782 may have been paid incorrectly. These payment errors resulted in two overpayments totaling $53,305 and one underpayment totaling $1,523. The Plan has taken actions to initiate recovery on these two overpayments and has issued the identified underpayment amount to the provider. As of August 21, 2013, the Plan has collected and returned$53,305 to the FEP Program.

The two overpayments were the result of manual pricing errors. The Plan has implemented additional procedures that would require peer review of any manual priced claims prior to the submission to the FEP Operations Center.

3. Duplicate Payments- Professional/Facility Claims **$26,891**

The Plan agrees that 35 claims from a population of 592 professional claims groupings with a net total of $26,891may have been paid incorrectly. These payment errors were the result of providers submitting multiple billings and examiners overriding the duplicate edits generated by the FEP Operations Center. As of August 21, 2013, the Plan has collected and returned $15,305 to the FEP Program. The Plan continues to show due diligence in its recovery efforts for the remaining $11,586.

The Plan believes that these overpayments occurred because a few select providers submitted multiple billings and processors incorrectly overrode the duplicate edits generated by the FEP Claims System. To reduce future payments of this nature in the future, the Plan has taken the following actions:

- Sent out educational materials to their providers to encourage them not to re-submit billings but to use the Plan's on-line claim status process to determine the adjudication stage of claims prior to the re-submission of previously submitted claims.

- Plan re-fresher training sessions that were conducted that included these error types. The sessions included the actions to be taken to resolve the duplicates which include pulling a copy of the other claims that caused the generation of the duplicate edit and performing a manual comparison review to determine whether the transactions should be paid or rejected.

In addition, the FEP Director's Office will be adding monthly Duplicate Listings to the FEP Claims System on-line Claims Audit Monitoring Tool later this year. We believe that these actions should further reduce the potential for duplicate payments and promote the timely identification and recovery of any overpayment.

Accordingly, to the extent that errors did occur, the payments are good faith erroneous benefit payments and fall within the context of CS 1039, section 2.3(g). Any benefit payments the Plan is unable to recover are allowable charges to the Program as long as the Plan is able to demonstrate due diligence in collection of the overpayment. In addition, as good faith erroneous benefit payments; the Plan continues to initiate recovery in a timely manner for confirmed overpayments. Because these are good faith erroneous payments, they are not subject to lost investment income.

We appreciate the opportunity to provide our response to each of the findings in this report and request that our comments be included in their entirety and are made a part of the Final Audit Report. If you have any questions, please contact me at [redacted] or [redacted] at [redacted].

Sincerely,

[redacted]

Program Assurance

Attachment (1)

cc: [redacted] OPM
OPM
FEP
FEP