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

Final Audit Report

Subject:

AUDIT ON GLOBAL CLAIMS WHERE AMOUNTS PAID EXCEEDED COVERED CHARGES FOR BLUECROSS AND BLUESHIELD PLANS

Report No. 1A-99-00-13-003

Date: November 22, 2013

--CAUTION--

AUDIT REPORT

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

Global Claims where Amounts Paid Exceeded Covered Charges
BlueCross and BlueShield Plans

REPORT NO. 1A-99-00-13-003 DATE: 11/22/13

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Assistant Inspector General
for Audits

--CAUTION--

EXECUTIVE SUMMARY

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BlueCross and BlueShield Plans

REPORT NO. 1A-99-00-13-003 DATE: 11/22/13

This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at all BlueCross and BlueShield (BCBS) plans questions $4,077,968 in health benefit charges. The BlueCross BlueShield Association (Association) and/or BCBS plans agreed with $2,090,681 and disagreed with $1,987,287 of the questioned charges. For substantially all of the contested charges, while the Association and/or BCBS plans disagree with our questioning of these charges, the Association and/or plans in fact agree that these were actual overcharges to the FEHBP, and as a result, the plans have initiated recovery efforts for these overpayments.

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covered health benefit payments from February 1, 2010 through July 31, 2012 as reported in the plans' Annual Accounting Statements. Specifically, we performed a computer search on the BCBS claims database, using our SAS data warehouse function, to identify facility claims that were reimbursed during this period where the amounts paid exceeded covered charges (also referred to as potential overpayments or variances). We selected for review all inpatient facility claims that were reimbursed during this period where the amounts paid exceeded covered charges by $10,000 or more. Additionally, we selected for review all outpatient facility claims where the amounts paid exceeded covered charges by $4,000 or more. Our sample included 5,341 facility claims, totaling $105,407,606 in potential overpayments, for 52 of the 64 BCBS plans. Based on our review of this sample, we determined that the BCBS plans incorrectly paid 217 claims, resulting in net overcharges of $4,077,968 to the FEHBP. Specifically, the BCBS plans overpaid 195 claims by $4,422,397 and underpaid 22 claims by $344,429.

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I. INTRODUCTION AND BACKGROUND

INTRODUCTION

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

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

BACKGROUND

The FEHBP was established by the Federal Employees Health Benefits (FEHB) Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for federal employees, annuitants, and dependents. OPM's 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 BCBS plans, has entered into a Government-wide Service Benefit Plan contract (CS 1039) with OPM to provide a health benefit plan authorized by the FEHB Act. The Association delegates authority to participating local BCBS plans throughout the United States to process the health benefit claims of its federal subscribers. There are approximately 64 local BCBS plans participating in the FEHBP.

The Association has established a Federal Employee Program (FEP[1]) Director's Office in Washington, D.C. to provide centralized management for the Service Benefit Plan. The FEP Director's Office coordinates the administration of the contract with the Association, member BCBS 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 management for the Association and each BCBS plan. Also, management of each BCBS plan is responsible for establishing and maintaining a system of internal controls.

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

Findings from our previous global audit of claims where amounts paid exceeded covered charges (Report No. 1A-99-00-10-030, dated January 11, 2011), covering inpatient facility claims reimbursed from January 1, 2008 through January 31, 2010 for all BCBS plans, have been satisfactorily resolved.

Our sample selections, instructions, and preliminary results for this audit were presented in a draft report, dated September 28, 2012, and discussed in detail with Association and BCBS plan officials during the entrance conference on October 18, 2012. The Association's comments offered in response to the draft report were considered in preparing our final report and are included as the Appendix to this report. Also, additional documentation provided by the Association and BCBS plans on various dates through September 27, 2013 was considered in preparing our final report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The objectives of our audit were to determine whether the BCBS plans 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 BCBS plans complied with contract provisions relative to claims where the amounts paid exceeded covered charges.

SCOPE

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

The audit covered claim payments from February 1, 2010 through July 31, 2012 as reported in the plans' Annual Accounting Statements. Using our SAS data warehouse function, we performed a computer search on the BCBS claims database to identify inpatient and outpatient facility claims during this period where the amounts paid exceeded covered charges. Based on this computer search, we identified 150,221 facility claims for this period where the amounts paid exceeded covered charges by a total of $221,799,437 (also referred to as potential overpayments or variances).[2] From this universe, we selected and reviewed a judgmental sample of 3,542 inpatient facility claims, totaling $89,907,050 in potential overpayments, where the amounts paid exceeded covered charges by $10,000 or more. Additionally, we selected and reviewed a judgmental sample of 1,799 outpatient facility claims, totaling $15,500,556 in potential overpayments, where the amounts paid exceeded covered charges by $4,000 or more. In total, our sample selections included 5,341 facility claims, totaling $105,407,606 in potential overpayments, for 52 of the 64 BCBS plans.

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

We also conducted tests to determine whether the BCBS plans had complied with the contract and the laws and regulations governing the FEHBP as they relate to claim payments where the amounts paid exceeded covered charges. The results of our tests indicate that, with respect to the items tested, the BCBS plans did not fully comply with the provisions of the contract relative to claim payments where the amounts paid exceeded covered charges. Exceptions noted in the areas reviewed are set forth in detail in the "Audit Finding and Recommendations" section of this audit report. With respect to the items not tested, nothing came to our attention that caused

[2] This universe included 33,963 inpatient facility claims and 116,258 outpatient facility claims, totaling $170,294,031 and $51,505,406 in potential overpayments, respectively.

us to believe that the BCBS plans had not complied, in all material respects, with those provisions.

In conducting our audit, we relied to varying degrees on computer-generated data provided by the FEP Operations Center and the BCBS plans. 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 facility claims where the amounts paid exceeded covered charges. 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 some of the data generated by the BCBS plans' local claims systems. 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 our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida from September 2012 through May 2013.

METHODOLOGY

To test each BCBS plan's compliance with the FEHBP health benefit provisions related to claims where the amounts paid exceed covered charges, we selected for review all inpatient facility claims where the amounts paid exceeded covered charges by $10,000 or more that were identified in a computer search. Additionally, we selected for review all outpatient facility claims where the amounts paid exceeded covered charges by $4,000 or more. Specifically, we selected for review a sample of 5,341 facility claims, totaling $105,407,606 in potential overpayments (out of 150,221 facility claims, totaling $221,799,437 in potential overpayments). Our sample included 3,542 inpatient facility claims, totaling $89,907,050 in potential overpayments (out of 33,963 inpatient facility claims, totaling $170,294,031 in potential overpayments). Our sample also included 1,799 outpatient facility claims, totaling $15,500,556 in potential overpayments (out of 116,258 outpatient facility claims, totaling $51,505,406 in potential overpayments). (See Schedule A for a summary of the sample selections of inpatient and outpatient facility claims by BCBS plan)

The sample selections were submitted to each applicable BCBS plan for their review and response. We then conducted a limited review of the plans' "paid incorrectly" responses and an expanded review of the plans' "paid correctly" responses, including the supporting documentation, to verify the accuracy and completeness of the plans' responses, determine if the claims were paid correctly, and/or calculate the appropriate questioned amounts for all claim payment errors. For each BCBS plan, we also reviewed the facility contracts for a sample of providers (a maximum of 10 providers for each plan) with the highest claims utilization to determine if the applicable claims in our sample were priced correctly based on the providers' contract terms.[3] Additionally, we verified on a limited test basis if the plans had initiated recovery efforts, adjusted or voided the claims, and/or completed the recovery process by the audit request due date (i.e., January 18, 2013) for claim payment errors in our sample. As part of our audit, we also reviewed the status of corrective actions that have been or are in the process of

[3] In total for all BCBS plans, we reviewed the facility contracts for 335 providers (from a total of 784 providers), that were reimbursed for claims in our sample.

being implemented by the Association, FEP Operations Center and/or BCBS plans, as a result of our previous global audit, to reduce claim payment errors related to claims where the amounts paid exceeded covered charges. We did not project the sample results to the universe of claims where the amounts paid exceed covered charges.

The determination of the questioned amount is based on the FEHBP contract, the 2010 through 2012 Service Benefit Plan brochures, and the Association's FEP Administrative Manual.

III. AUDIT FINDING AND RECOMMENDATIONS

Claims where Amounts Paid Exceeded Covered Charges **$4,077,968**

During our audit of facility claims where the amounts paid exceeded covered charges, we determined that the BCBS plans incorrectly paid 217 claims, resulting in net overcharges of $4,077,968 to the FEHBP. Specifically, the BCBS plans overpaid 195 claims by $4,422,397 and underpaid 22 claims by $344,429.

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

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

Section 6(h) of the FEHBP Act provides rates should reasonably and equitably reflect the cost of benefits provided.

For the period February 1, 2010 through July 31, 2012, we identified 150,221 facility claims where the amounts paid exceeded covered charges by a total of $221,799,437 (potential overpayments). This universe included 33,963 inpatient facility claims and 116,258 outpatient facility claims, totaling $170,294,031 and $51,505,406 in potential overpayments, respectively. From this universe, we selected and reviewed a judgmental sample of 3,542 inpatient facility claims, totaling $89,907,050 in potential overpayments, where the amounts paid exceeded covered charges by $10,000 or more. Additionally, we selected and reviewed a judgmental sample of 1,799 outpatient facility claims, totaling $15,500,556 in potential overpayments, where the amounts paid exceeded covered charges by $4,000 or more. In total, our sample selections included 5,341 facility claims, totaling $105,407,606 in potential overpayments, for 52 of the 64 BCBS plans. We determined if the claims in our sample were correctly priced and paid by the BCBS plans.

Our sample included 217 claim payment errors by 41 BCBS plans, resulting in net overcharges of $4,077,968 to the FEHBP.[4] Specifically, these BCBS plans overpaid 195 claims by $4,422,397 and underpaid 22 claims by $344,429 (See Schedule B for a summary of the claim payment errors by BCBS plan).

[4] In addition, there were 18 claim payment errors, totaling $440,727 in overpayments, that were identified by the BCBS plans before our audit notification date (i.e., August 1, 2012) and adjusted and returned to the FEHBP by the audit request due date (i.e., January 18, 2013). Since these overpayments were already identified by the BCBS plans before our audit notification date and adjusted and returned to the FEHBP by the audit request due date, we did not question these overpayments in the final report.

Our audit disclosed the following for these claim payment errors:

- The BCBS plans incorrectly paid 141 claims due to manual processing errors, such as incorrect coding, overriding system edits, and using incorrect allowances. Consequently, the BCBS plans overpaid 124 claims by $2,788,732 and underpaid 17 claims by $309,755, resulting in net overcharges of $2,478,977 to the FEHBP.

- The BCBS plans incorrectly paid 11 claims due to provider billing errors, resulting in net overcharges of $566,301 to the FEHBP. Specifically, the BCBS plans overpaid nine claims by $566,875 and underpaid two claims by $574.

- For 13 claims, the paid amounts were higher in the FEP Direct Claims System than in the plans' local claims systems. As a result, the paid amounts for these claims are overstated in the FEP Direct Claims System by $339,133. Consequently, the health benefit payments for these BCBS plans were overstated in the applicable Annual Accounting Statements (AAS). Since claims expense is considered when developing premium rates, overstating the claims expense in the AAS may increase future rates.

- The BCBS plans did not properly coordinate six claims with Medicare or the patient's primary insurance carrier, resulting in overcharges of $311,127 to the FEHBP.

- CareFirst BCBS (CareFirst) incorrectly paid 21 claims due to 2 local claims system processing errors, resulting in overcharges of $255,701 to the FEHBP. Specifically, CareFirst's local claims processing system ("FEP Thin") did not defer 19 outpatient facility claims for review that contained non-covered services, resulting in overcharges of $232,484 to the FEHBP ("System Error #1"). Additionally, CareFirst's "FEP Thin" incorrectly calculated two outpatient facility claims due to the incorrect bundling of multiple pricing methods, resulting in overcharges of $23,217 to the FEHBP ("System Error #2").

  According to CareFirst, these system errors started in June 2010, when CareFirst switched to a new claims system ("FEP Thin"). CareFirst states that "System Error #1" was identified in February 2012 and corrective actions were implemented in April 2012 to fix this "FEP Thin" system error. CareFirst also states that "System Error #2" was identified in March 2012 and corrective actions were implemented in September 2012 to fix this "FEP Thin" system error. Although corrective actions were implemented to fix these "FEP Thin" system errors, CareFirst did not identify, review and/or adjust the claims that were potentially affected by these errors and/or initiate recoveries for the actual overpayments until after the start of our audit. (Note: For the overpayments in our sample due to these system errors, we noted that CareFirst adjusted or voided the applicable claims in the FEP Direct Claims System and/or initiated overpayment recoveries after receiving our audit request (i.e., sample of facility claims) on September 28, 2012.)

  Due to the possible significant impact of these system errors, we requested CareFirst to identify and/or review all FEP claims that were potentially processed and paid incorrectly because of "System Error #1" from June 2010 through April 2012 and "System Error #2" from June 2010 through September 2012. In July 2013, CareFirst informed us that

approximately 80,500 claims were potentially affected by these system errors (5,000 claims for "System Error #1" and 75,500 claims for "System Error #2"). CareFirst is in the process of identifying and reviewing the impact of these potential claim payment errors as well as initiating recoveries for the overpayments that are considered collectible. After completing our review of CareFirst's analysis of these potential claim payment errors, we will issue a supplemental final report if there were significant overcharges to the FEHBP as a result of these system errors.

- For seven of the claim payment errors, the BCBS plans did not correctly load the contract rates into their local claims systems. Consequently, these BCBS plans overpaid four claims by $92,340 and underpaid three claims by $34,100, resulting in net overcharges of $58,240 to the FEHBP.

- The BCBS plans inadvertently paid two claims twice, resulting in duplicate charges of $46,091 to the FEHBP.

- The FEP Operation's Center incorrectly applied the subscriber liability amounts for 16 claims, resulting in overcharges of $22,398 to the FEHBP.

Of the $4,077,968 in net overcharges to the FEHBP:

- $2,429,814 (60 percent) represents 179 claim payment errors that were identified as a result of our audit. Specifically, the BCBS plans overpaid 157 of these claims by $2,774,243 and underpaid 22 of these claims by $344,429. We noted that the BCBS plans initiated corrective actions for these claim payment errors after receiving our audit request (i.e., sample of facility claims) on September 28, 2012.

- $862,656 (21 percent) represents 21 claim overpayments where the BCBS plans initiated recovery efforts on or after our audit notification date (i.e., August 1, 2012) but before receiving our audit request (i.e., September 28, 2012), and also completed the recovery process and adjusted or voided these claims by the audit request due date (i.e., January 18, 2013). However, since the recoveries for these overpayments were initiated on or after our audit notification date, we are continuing to question these claim payment errors.

- $785,498 (19 percent) represents 17 claim overpayments where the BCBS plans initiated recovery efforts before receiving our audit request (i.e., September 28, 2012) but had not recovered the overpayments and/or adjusted or voided the claims by the audit request due date (i.e., January 18, 2013). Since these overpayments had not been recovered and returned to the FEHBP by the audit request due date, we are continuing to question these claim payment errors.

Association's Response:

The Association agrees with $882,034 of the net questioned charges. The Association states that the BCBS plans have recovered and returned $699,109 of the overpayments to the FEHBP as of February 1, 2013. To the extent that claim payment 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 BCBS plans are unable to recover are allowable charges to the FEHBP as long as the plans demonstrate due diligence in the recovery of these overpayments. As good faith erroneous payments, lost investment income is not applicable to the claim payment errors identified in this finding.

Regarding the contested claim payment errors, the Association states the following:

- The majority of the claims were paid correctly according to the BCBS plans' pricing methodologies.
- The remaining claims were initially paid incorrectly but the BCBS plans are in the process of or have resolved recovery of the overpayment amounts.

The Association states, "In order to prevent these types of overpayments from occurring, BCBSA implemented the System Wide Claims Review (SWCR) process which includes APG [amounts paid greater than covered charges] claims. As part of this process, we monitored Plan review of the claims and we re-audited a sample of claims as part of our Control Performance Review (CPR) process to ensure that the claims were evaluated correctly. In October 2012, the Association transitioned the SWCR process to an on-line claims monitoring tool that includes inpatient APG claims. We continue to monitor the application to ensure that these claims are being worked and paid correctly. We currently do not include outpatient APG claims in the AMT [Claims Audit Monitoring Tool] . . . We will evaluate inclusion of outpatient APG claims in our processes as well as continue to evaluate additional opportunities to improve the prevention and detection of both inpatient and outpatient APG claim overpayments."

In addition, the Association states that "the main reasons for the overpayments were caused by Processor Coding Errors. Further analysis identified that processor insufficient investigation of FEP Deferrals was also a cause of errors. In order to prevent these error causes, we will perform the following by June 30, 2013:

Examiner Coding Errors - FEP will request that the Plans use these confirmed payment errors as training tools in any re-fresher and new claims examiner training sessions with instructions on how to re-check the payment amounts for DRG, Per Diem and Per Case types of reimbursements.

Insufficient Investigation of FEP Deferrals - A number of the confirmed overpayments had deferred by FEP requesting that the Plans verify that the payments were correct because of the payment amount (High Dollar Edit). Due to the sign-off process that these deferrals require other characteristics of the payments were not properly investigated. FEP will look to expand this edit to include verification of APG amount, if the reimbursement type is DRG or a Per Case Rate. A team of experts from the various departments within FEP will conduct an assessment of the existing edits that impact these payment types to determine what if any changes can be made to identify the types of confirmed payment errors identified in this audit in an effort to correct on a pre-payment basis."

OIG Comments:

After reviewing the Association's response and additional documentation provided by the BCBS plans, we determined that 41 BCBS plans incorrectly paid 217 claims, resulting in net overcharges of $4,077,968 to the FEHBP. If the BCBS plans identified the claim payment errors and initiated recovery efforts before our audit notification date (i.e., August 1, 2012) and completed the recovery process (i.e., adjusted or voided the claims and recovered and returned the overpayments to the FEHBP) by the audit request due date (i.e., January 18, 2013), we did not question these claim payment errors in the final report. Based on the Association's response and the BCBS plans' additional documentation, we determined that the Association and/or plans agree with $2,090,681 and disagree with $1,987,287 of these net questioned overcharges. Although the Association only agrees with $882,034 of these net questioned overcharges in its response, the BCBS plans' documentation supports concurrence with $2,090,681.

Based on the Association's response and/or the BCBS plans' documentation, the contested amount of $1,987,287 represents the following items:

- $862,656 of the contested amount represents 21 claim overpayments where the BCBS plans initiated recovery efforts on or after our audit notification date (i.e., August 1, 2012) but before receiving our audit request (i.e., September 28, 2012), and also completed the recovery process and adjusted or voided the claims by the audit request due date (i.e., January 18, 2013). However, since the recoveries for these overpayments were initiated on or after our audit notification date, we are continuing to question this amount in the final report.

- $682,871 of the contested amount represents nine claim overpayments where the BCBS plans initiated recovery efforts before receiving our audit request (i.e., September 28, 2012) but had not recovered the overpayments and/or adjusted or voided the claims by the audit request due date (i.e., January 18, 2013). Since these overpayments had not been recovered and returned to the FEHBP by the audit request due date, we are continuing to question this amount in the final report.

- $339,133 of the contested amount represents 13 claims that Independence BC and the BCBS plans of Arizona, Kentucky, New Jersey, and New Mexico state were charged correctly to the FEHBP. Although these plans made the correct payments to the providers, the paid amounts for these claims were higher in the FEP Direct Claims System than in the plans' local claims systems. As a result, the health benefit payments for these plans were overstated in the applicable AAS's. Since claims expense is considered when developing premium rates, overstating the claims expense in the AAS may increase future rates.

- $102,627 of the contested amount represents eight claim overpayments that the BCBS plans agree were paid incorrectly. However, since all recovery efforts have been exhausted, the plans state that these claim overpayments are uncollectible. The plans did not provide sufficient documentation to support that all recovery efforts have been exhausted. Therefore, we are continuing to question this amount in the final report.

Recommendation 1

We recommend that the contracting officer disallow $4,422,397 for claim overcharges and verify that the BCBS plans return all amounts recovered to the FEHBP.

Recommendation 2

We recommend that the contracting officer allow the BCBS plans to charge the FEHBP $344,429 if additional payments are made to the providers to correct the underpayments. However, before making any additional payment(s) to a provider, the contracting officer should require the BCBS plan to first recover any questioned overpayment(s) for that provider.

Recommendation 3

We recommend that the contracting officer instruct the Association to have the FEP Operation's Center develop an edit in the FEP Direct Claims System that defers a claim when the BCBS plan's allowed amount exceeds the claim covered charges (such as by $10,000 or more for an inpatient facility claim and $4,000 or more for an outpatient facility claim) and requires the plan to perform an additional review before payment of the claim. The contracting officer should also require the Association to provide evidence or supporting documentation ensuring that this system edit has been implemented.

Recommendation 4

Although the Association has developed a corrective action plan to reduce claim payment errors where the amounts paid exceeded covered charges, we recommend that the contracting officer instruct the Association to provide evidence or supporting documentation ensuring that all BCBS plans are following the corrective action plan. Also, we recommend that the contracting officer verify that the additional corrective actions included in the Association's draft report response are being implemented.

Recommendation 5

For the claim payment errors where the provider contract rates were loaded incorrectly into the BCBS plans' local claims systems, we recommend that the contracting officer require the Association to provide evidence or supporting documentation ensuring that these plans have implemented controls for properly updating their local claims systems with the provider contract rates. We noted these exceptions with BC of California and the BCBS plans of Maine, Massachusetts, and Western New York.

Recommendation 6

Due to amount paid variances that were identified between the plans' local claims systems and the FEP Direct Claims System for Independence BC and the BCBS plans of Arizona, Kentucky, New Jersey and New Mexico, we recommend that the contracting officer require the Association to provide evidence or supporting documentation ensuring that all BCBS plans are performing regular reconciliations between their local claim systems and the FEP Direct Claims System. Additionally, the BCBS plans with the questioned variances should adjust the applicable claims in the FEP Direct Claims System to reflect the actual amounts paid to the providers.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

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GLOBAL AUDIT OF CLAIMS WHERE AMOUNTS PAID EXCEEDED COVERED CHARGES
BLUECROSS AND BLUESHIELD PLANS

SUMMARY OF SAMPLE SELECTIONS BY PLAN

			SAMPLE - INPATIENT FACILITY CLAIMS Variances of $10,000 or More				SAMPLE - OUTPATIENT FACILITY CLAIMS Variances of $4,000 or More				TOTAL
Site Number	Plan Name	State	Claims	Total Covered Charges	Total Amounts Paid	Potential Overcharges (Variances)	Claims	Total Covered Charges	Total Amounts Paid	Potential Overcharges (Variances)	Potential Overcharges (Variances)
003	BlueCross BlueShield of New Mexico (HCSC)	NM	22	$154,471	$494,092	$339,621	0	$0	$0	$0	$339,621
005	WellPoint BlueCross BlueShield of Georgia	GA	41	$1,749,509	$2,557,710	$808,201	4	$11,754	$47,893	$36,139	$844,340
006	CareFirst BlueCross BlueShield (Maryland Service Area)	MD	2	$19,782	$47,137	$27,356	7	$13,358	$164,431	$151,073	$178,429
007	BlueCross BlueShield of Louisiana	LA	4	$101,444	$400,200	$298,756	4	$109,601	$174,875	$65,274	$364,030
009	BlueCross BlueShield of Alabama	AL	120	$3,747,066	$6,738,962	$2,991,897	0	$0	$0	$0	$2,991,897
010	BlueCross of Idaho Health Service	ID	50	$1,340,386	$2,159,445	$819,059	19	$172,994	$308,398	$135,404	$954,463
011	BlueCross BlueShield of Massachusetts	MA	583	$21,124,897	$37,593,388	$16,468,491	1	$10,595	$15,048	$4,453	$16,472,944
012	BlueCross BlueShield of Western New York	NY	60	$1,111,795	$2,646,945	$1,535,150	3	$18,095	$32,578	$14,484	$1,549,633
013	Highmark BlueCross BlueShield	PA	13	$228,229	$649,465	$421,236	0	$0	$0	$0	$421,236
015	BlueCross BlueShield of Tennessee	TN	55	$1,500,506	$2,520,206	$1,019,701	8	$126,244	$181,590	$55,346	$1,075,047
016	BlueCross BlueShield of Wyoming	WY	40	$779,609	$1,532,325	$752,717	0	$0	$0	$0	$752,717
017	BlueCross BlueShield of Illinois (HCSC)	IL	0	$0	$0	$0	0	$0	$0	$0	$0
021	WellPoint BlueCross BlueShield of Ohio	OH	80	$861,668	$2,282,753	$1,421,085	26	$200,210	$461,515	$261,305	$1,682,390
024	BlueCross BlueShield of South Carolina	SC	0	$0	$0	$0	0	$0	$0	$0	$0
027	WellPoint BlueCross BlueShield of New Hampshire	NH	29	$1,390,952	$1,920,733	$529,781	22	$97,791	$216,583	$118,792	$648,573
028	BlueCross BlueShield of Vermont	VT	19	$193,723	$470,045	$276,322	0	$0	$0	$0	$276,322
029	BlueCross BlueShield of Texas (HCSC)	TX	37	$1,585,686	$2,400,080	$814,395	13	$193,534	$333,227	$139,693	$954,087
030	WellPoint BlueCross BlueShield of Colorado	CO	5	$162,129	$240,315	$78,186	3	$46,925	$83,508	$36,583	$114,770
031	Wellmark BlueCross BlueShield of Iowa	IA	64	$1,834,116	$3,341,068	$1,506,953	320	$1,886,420	$4,872,213	$2,985,793	$4,492,746
032	BlueCross BlueShield of Michigan	MI	0	$0	$0	$0	0	$0	$0	$0	$0
033	BlueCross BlueShield of North Carolina	NC	190	$5,294,611	$8,964,104	$3,669,493	7	$17,440	$80,854	$63,414	$3,732,906
034	BlueCross BlueShield of North Dakota	ND	20	$387,133	$739,839	$352,706	0	$0	$0	$0	$352,706
036	Capital BlueCross	PA	67	$1,949,967	$3,662,223	$1,712,256	36	$227,531	$415,043	$187,512	$1,899,769
037	BlueCross BlueShield of Montana	MT	0	$0	$0	$0	0	$0	$0	$0	$0
038	BlueCross BlueShield of Hawaii	HI	15	$417,130	$751,285	$334,155	0	$0	$0	$0	$334,155
039	WellPoint BlueCross BlueShield of Indiana	IN	123	$2,369,621	$4,773,128	$2,403,507	19	$112,974	$225,700	$112,726	$2,516,234
040	BlueCross BlueShield of Mississippi	MS	0	$0	$0	$0	0	$0	$0	$0	$0
041	Florida Blue	FL	64	$2,093,670	$4,069,808	$1,976,138	23	$156,468	$349,035	$192,567	$2,168,706
042	BlueCross BlueShield of Kansas City (Missouri)	MO	0	$0	$0	$0	0	$0	$0	$0	$0
043	Regence BlueShield of Idaho	ID	0	$0	$0	$0	0	$0	$0	$0	$0
044	BlueCross BlueShield of Arkansas	AR	1	$45,153	$122,782	$77,629	0	$0	$0	$0	$77,629
045	WellPoint BlueCross BlueShield of Kentucky	KY	8	$156,084	$295,108	$139,023	1	$3,792	$12,690	$8,898	$147,922
047	WellPoint BlueCross BlueShield United of Wisconsin	WI	6	$162,158	$287,529	$125,371	0	$0	$0	$0	$125,371
048	Empire BlueCross BlueShield (WellPoint)	NY	266	$14,499,596	$23,731,575	$9,231,979	74	$403,611	$918,912	$515,301	$9,747,279
049	Horizon BlueCross BlueShield of New Jersey	NJ	14	$397,934	$600,937	$203,003	9	$113,269	$166,772	$53,503	$256,506
050	WellPoint BlueCross BlueShield of Connecticut	CT	40	$1,242,290	$2,203,500	$961,209	26	$286,174	$563,242	$277,068	$1,238,277
052	Wellpoint BlueCross of California	CA	39	$3,369,890	$4,774,798	$1,404,908	10	$70,803	$179,494	$108,691	$1,513,599

GLOBAL AUDIT OF CLAIMS WHERE AMOUNTS PAID EXCEEDED COVERED CHARGES
BLUECROSS AND BLUESHIELD PLANS

SUMMARY OF SAMPLE SELECTIONS BY PLAN

			SAMPLE - INPATIENT FACILITY CLAIMS Variances of $10,000 or More				SAMPLE - OUTPATIENT FACILITY CLAIMS Variances of $4,000 or More				TOTAL
Site Number	Plan Name	State	Claims	Total Covered Charges	Total Amounts Paid	Potential Overcharges (Variances)	Claims	Total Covered Charges	Total Amounts Paid	Potential Overcharges (Variances)	Potential Overcharges (Variances)
053	BlueCross BlueShield of Nebraska	NE	1	$212,159	$277,545	$65,386	0	$0	$0	$0	$65,386
054	Mountain State BlueCross BlueShield	WV	100	$2,408,147	$4,459,717	$2,051,569	768	$4,411,968	$10,997,516	$6,585,548	$8,637,117
055	Independence BlueCross	PA	24	$946,388	$1,411,723	$465,335	62	$1,462,169	$2,186,963	$724,794	$1,190,129
056	BlueCross BlueShield of Arizona	AZ	107	$2,396,393	$6,278,652	$3,882,259	0	$0	$0	$0	$3,882,259
058	Regence BlueCross BlueShield of Oregon	OR	111	$3,201,353	$7,935,665	$4,734,312	20	$216,645	$423,974	$207,329	$4,941,640
059	WellPoint BlueCross BlueShield of Maine	ME	45	$705,767	$1,552,433	$846,666	22	$426,237	$670,389	$244,152	$1,090,818
060	BlueCross BlueShield of Rhode Island	RI	23	$530,242	$898,907	$368,665	9	$44,366	$94,400	$50,033	$418,698
061	WellPoint BlueCross BlueShield of Nevada	NV	6	$1,061,705	$1,547,333	$485,628	0	$0	$0	$0	$485,628
062	WellPoint BlueCross Blue Shield of Virginia	VA	406	$13,111,630	$21,359,475	$8,247,844	6	$4,850	$59,051	$54,201	$8,302,046
064	Excellus BlueCross BlueShield of the Rochester Area	NY	14	$475,731	$891,914	$416,183	16	$90,951	$222,978	$132,027	$548,210
066	Regence BlueCross BlueShield of Utah	UT	2	$34,163	$118,105	$83,943	0	$0	$0	$0	$83,943
067	BlueShield of California	CA	0	$0	$0	$0	0	$0	$0	$0	$0
068	Triple-S Salud, Inc. of Puerto Rico	PR	1	$897	$32,208	$31,311	1	$4,582	$17,925	$13,343	$44,653
069	Regence BlueShield of Washington	WA	0	$0	$0	$0	0	$0	$0	$0	$0
070	BlueCross BlueShield of Alaska	AK	1	$70,547	$211,132	$140,585	0	$0	$0	$0	$140,585
074	Wellmark BlueCross BlueShield of South Dakota	SD	0	$0	$0	$0	0	$0	$0	$0	$0
075	Premera BlueCross	WA	0	$0	$0	$0	2	$71,638	$97,624	$25,986	$25,986
076	WellPoint BlueCross BlueShield of Missouri	MO	4	$381,750	$435,352	$53,602	1	$285	$6,709	$6,424	$60,026
078	BlueCross BlueShield of Minnesota	MN	2	$1,078	$25,496	$24,418	1	$1,566	$6,130	$4,564	$28,982
079	Excellus BlueCross BlueShield of Central New York	NY	20	$772,714	$1,365,767	$593,053	9	$59,431	$152,385	$92,954	$686,008
082	BlueCross BlueShield of Kansas	KS	0	$0	$0	$0	0	$0	$0	$0	$0
083	BlueCross BlueShield of Oklahoma (HCSC)	OK	68	$1,381,007	$2,559,132	$1,178,125	29	$167,173	$357,514	$190,341	$1,368,466
084	Excellus BlueCross BlueShield of Utica-Watertown	NY	7	$101,756	$202,350	$100,594	133	$835,155	$1,737,742	$902,587	$1,003,181
085	CareFirst BlueCross BlueShield (DC Service Area)	DC	508	$17,357,817	$30,488,831	$13,131,014	84	$673,755	$1,405,896	$732,141	$13,863,155
088	BlueCross of Northeastern Pennsylvania	PA	13	$176,872	$447,542	$270,670	1	$217	$10,330	$10,114	$280,784
089	BlueCross BlueShield of Delaware	DE	0	$0	$0	$0	0	$0	$0	$0	$0
092	Carefirst BlueCross BlueShield (Overseas)	DC	2	$11,354	$46,960	$35,606	0	$0	$0	$0	$35,606
	Totals		**3,542**	**$115,610,674**	**$205,517,724**	**$89,907,050**	**1,799**	**$12,750,570**	**$28,251,126**	**$15,500,556**	**$105,407,606**

Number of BCBS Plans in Sample = 52

GLOBAL AUDIT OF CLAIMS WHERE AMOUNTS PAID EXCEEDED COVERED CHARGES
BLUECROSS AND BLUESHIELD PLANS

SUMMARY OF QUESTIONED CHARGES BY PLAN

Site Number	Plan Name	State	Inpatient Facility Claims	Inpatient Facility Questioned Charges	Outpatient Facility Claims	Outpatient Facility Questioned Charges	Total Questioned Claims	Total Questioned Questioned Charges	Plan Agrees	Plan Disagrees
003	BlueCross BlueShield of New Mexico (HCSC)	NM	4	$129,225	0	$0	4	$129,225	$22,672	$106,553
005	WellPoint BlueCross BlueShield of Georgia	GA	4	$395	1	$6,754	5	$7,148	$395	$6,754
006	CareFirst BlueCross BlueShield (Maryland Service Area)	MD	0	$0	7	$163,833	7	$163,833	$63,533	$100,300
007	BlueCross BlueShield of Louisiana	LA	1	($3,665)	1	($173)	2	($3,838)	($3,838)	$0
009	BlueCross BlueShield of Alabama	AL	1	$7,897	0	$0	1	$7,897	$0	$7,897
010	BlueCross of Idaho Health Service	ID	0	$0	3	($6,855)	3	($6,855)	($6,855)	$0
011	BlueCross BlueShield of Massachusetts	MA	10	$206,327	0	$0	10	$206,327	$134,024	$72,303
012	BlueCross BlueShield of Western New York	NY	2	($13,234)	0	$0	2	($13,234)	($13,234)	$0
013	Highmark BlueCross BlueShield	PA	0	$0	0	$0	0	$0	$0	$0
015	BlueCross BlueShield of Tennessee	TN	0	$0	7	$50,364	7	$50,364	$50,364	$0
016	BlueCross BlueShield of Wyoming	WY	2	$12,022	0	$0	2	$12,022	$12,022	$0
017	BlueCross BlueShield of Illinois (HCSC)	IL	0	$0	0	$0	0	$0	$0	$0
021	WellPoint BlueCross BlueShield of Ohio	OH	5	$51,837	2	$22,086	7	$73,923	$69,367	$4,556
024	BlueCross BlueShield of South Carolina	SC	0	$0	0	$0	0	$0	$0	$0
027	WellPoint BlueCross BlueShield of New Hampshire	NH	0	$0	0	$0	0	$0	$0	$0
028	BlueCross BlueShield of Vermont	VT	1	$15,250	0	$0	1	$15,250	$15,250	$0
029	BlueCross BlueShield of Texas (HCSC)	TX	0	$0	10	$260,425	10	$260,425	$246,047	$14,379
030	WellPoint BlueCross BlueShield of Colorado	CO	0	$0	0	$0	0	$0	$0	$0
031	Wellmark BlueCross BlueShield of Iowa	IA	0	$0	3	$12,522	3	$12,522	$12,522	$0
032	BlueCross BlueShield of Michigan	MI	0	$0	0	$0	0	$0	$0	$0
033	BlueCross BlueShield of North Carolina	NC	10	$167,699	6	$22,422	16	$190,121	$190,121	$0
034	BlueCross BlueShield of North Dakota	ND	1	$17,286	0	$0	1	$17,286	$0	$17,286
036	Capital BlueCross	PA	0	$0	15	$5,309	15	$5,309	$5,309	$0
037	BlueCross BlueShield of Montana	MT	0	$0	0	$0	0	$0	$0	$0
038	BlueCross BlueShield of Hawaii	HI	1	$18,775	0	$0	1	$18,775	$0	$18,775
039	WellPoint BlueCross BlueShield of Indiana	IN	1	$25,114	0	$0	1	$25,114	$25,114	$0
040	BlueCross BlueShield of Mississippi	MS	0	$0	0	$0	0	$0	$0	$0
041	BlueCross BlueShield of Florida	FL	3	$286,308	7	$117,456	10	$403,764	$117,456	$286,308
042	BlueCross BlueShield of Kansas City (Missouri)	MO	0	$0	0	$0	0	$0	$0	$0
043	Regence BlueShield of Idaho	ID	0	$0	0	$0	0	$0	$0	$0
044	BlueCross BlueShield of Arkansas	AR	0	$0	0	$0	0	$0	$0	$0
045	WellPoint BlueCross BlueShield of Kentucky	KY	0	$0	1	$12,690	1	$12,690	$0	$12,690
047	WellPoint BlueCross BlueShield United of Wisconsin	WI	0	$0	0	$0	0	$0	$0	$0
048	Empire BlueCross BlueShield (WellPoint)	NY	2	$65,666	4	$23,915	6	$89,581	$64,927	$24,654
049	Horizon BlueCross BlueShield of New Jersey	NJ	1	$18,510	1	$14,017	2	$32,527	$0	$32,527
050	WellPoint BlueCross BlueShield of Connecticut	CT	1	($3,951)	0	$0	1	($3,951)	($3,951)	$0

GLOBAL AUDIT OF CLAIMS WHERE AMOUNTS PAID EXCEEDED COVERED CHARGES
BLUECROSS AND BLUESHIELD PLANS

SUMMARY OF QUESTIONED CHARGES BY PLAN

Site Number	Plan Name	State	Inpatient Facility Claims	Inpatient Facility Questioned Charges	Outpatient Facility Claims	Outpatient Facility Questioned Charges	Total Questioned Claims	Total Questioned Questioned Charges	Plan Agrees	Plan Disagrees
052	Wellpoint BlueCross of California	CA	0	$0	2	$27,371	2	$27,371	$21,692	$5,679
053	BlueCross BlueShield of Nebraska	NE	0	$0	0	$0	0	$0	$0	$0
054	Mountain State BlueCross BlueShield	WV	0	$0	0	$0	0	$0	$0	$0
055	Independence BlueCross	PA	3	$122,924	10	$162,801	13	$285,726	$1,097	$284,629
056	BlueCross BlueShield of Arizona	AZ	1	$29,311	0	$0	1	$29,311	$0	$29,311
058	Regence BlueCross BlueShield of Oregon	OR	22	$716,942	1	$5,048	23	$721,990	$127,007	$594,983
059	WellPoint BlueCross BlueShield of Maine	ME	1	$29,615	0	$0	1	$29,615	$29,615	$0
060	BlueCross BlueShield of Rhode Island	RI	2	$3,142	3	$12,674	5	$15,816	$15,816	$0
061	WellPoint BlueCross BlueShield of Nevada	NV	0	$0	0	$0	0	$0	$0	$0
062	WellPoint BlueCross Blue Shield of Virginia	VA	3	$425,801	1	$23,358	4	$449,159	$433,260	$15,900
064	Excellus BlueCross BlueShield of the Rochester Area	NY	1	$28,895	0	$0	1	$28,895	$0	$28,895
066	Regence BlueCross BlueShield of Utah	UT	0	$0	0	$0	0	$0	$0	$0
067	BlueShield of California	CA	0	$0	0	$0	0	$0	$0	$0
068	Triple-S Salud, Inc. of Puerto Rico	PR	1	$26,910	1	$10,633	2	$37,543	$10,633	$26,910
069	Regence BlueShield of Washington	WA	0	$0	0	$0	0	$0	$0	$0
070	BlueCross BlueShield of Alaska	AK	1	$210,000	0	$0	1	$210,000	$0	$210,000
074	Wellmark BlueCross BlueShield of South Dakota	SD	0	$0	0	$0	0	$0	$0	$0
075	Premera BlueCross	WA	0	$0	1	$14,713	1	$14,713	$14,713	$0
076	WellPoint BlueCross BlueShield of Missouri	MO	0	$0	1	$6,618	1	$6,618	$6,618	$0
078	BlueCross BlueShield of Minnesota	MN	0	$0	0	$0	0	$0	$0	$0
079	Excellus BlueCross BlueShield of Central New York	NY	1	$1,478	0	$0	1	$1,478	$0	$1,478
082	BlueCross BlueShield of Kansas	KS	0	$0	0	$0	0	$0	$0	$0
083	BlueCross BlueShield of Oklahoma (HCSC)	OK	2	$62,159	1	$6,861	3	$69,019	$69,019	$0
084	Excellus BlueCross BlueShield of Utica-Watertown	NY	0	$0	3	$1,351	3	$1,351	$1,351	$0
085	CareFirst BlueCross BlueShield (DC Service Area)	DC	4	$29,153	31	$375,312	35	$404,466	$358,616	$45,850
088	BlueCross of Northeastern Pennsylvania	PA	0	$0	0	$0	0	$0	$0	$0
089	BlueCross BlueShield of Delaware	DE	0	$0	0	$0	0	$0	$0	$0
092	Carefirst BlueCross BlueShield (Overseas)	DC	2	$38,672	0	$0	2	$38,672	$0	$38,672
TOTALS			**94**	**$2,726,462**	**123**	**$1,351,506**	**217**	**$4,077,968**	**$2,090,681**	**$1,987,287**

Number of BCBS Plans in Sample = 52

Number of BCBS Plans with Claim Payment Errors = 41

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

Federal Employee Program
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February 4, 2013

[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**
Global Audit on Claims Where Amounts Paid Exceeded Covered Charges
Audit Report #1A-99-00-13-003
(Report dated and received 09/28/2012)

Dear [redacted]:

This is in response to the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report concerning the Global Audit on Claims Where Amounts Paid Exceeded Covered Charges for claims paid from February 1, 2010 through July 31, 2012, with potential overpayments totaling $105,407,606 in both inpatient and outpatient facility claims. Our comments concerning the findings in this report are as follows:

The OPM OIG auditors recommended that the Association and/or BCBS Plans review the sample of 5,341 inpatient and outpatient facility claims, totaling potential overpayments of $105,407,606, to determine whether the claims were paid properly. For all claim payment errors, the BCBS plans should initiate recovery efforts immediately as required by the FEHBP contract, and return all amounts recovered to the FEHBP.

BCBSA Response:

After reviewing the listings of Amount Paid Exceeded Covered Charges (APG) potential overpayments totaling $105,407,606, the Association does not contest 185 overpayments totaling $1,213,578 and 27 underpayments totaling $331,544, for a net overpayment amount of $882,034. As of February 1, 2013, the Plans have

recovered and returned $699,109 to the Program of the identified overpayments. See Attachment A (Inpatient) and C (Outpatient) for a listing of contested and uncontested amounts per Plan and Schedule B (Inpatient) and Schedule D (Outpatient) for a listing of the reasons the claims were paid incorrectly.

To the extent that claim payment errors did occur or were not identified, these payments were good faith erroneous benefit payments and fall within the context of CS 1039, Section 2.3 (g). Any benefit payments the Plans are unable to recover are allowable charges to the Program as long as the Plan is able to demonstrate due diligence in collection of the overpayments. In addition, as good faith erroneous payments, lost investment income is not applicable to these confirmed overpayments.

We contest the remaining 5,220 claims totaling $104,198,160 in potential claim payment errors (support provided) for the following reasons:

- $102,850,243 in potential claim payment errors were paid correctly according to the Plan's pricing methodology;
- $1,347,917 in claims that were initially paid incorrectly but the Plan is in the process of or has resolved recovery of the overpayment amount.

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

In order to prevent these types of overpayments from occurring, BCBSA implemented the System Wide Claims Review (SWCR) process which includes APG claims. As part of this process, we monitored Plan review of the claims and we re-audited a sample of claims as part of our Control Performance Review (CPR) process to ensure that the claims were evaluated correctly. In October 2012, the Association transitioned the SWCR process to an on-line claims monitoring tool that includes inpatient APG claims. We continue to monitor the application to ensure that these claims are being worked and paid correctly. We currently do not include out-patient APG claims in the AMT. These types of errors represented .49% of the identified errors. We will evaluate inclusion of outpatient APG claims in our processes as well as continue to evaluate additional opportunities to improve the prevention and detection of both inpatient and outpatient APG claim overpayments.

Based upon Attachment B, the main reasons for the overpayments were caused by Processor Coding Errors. Further analysis identified that processor insufficient

investigation of FEP Deferrals was also a cause of errors. In order to prevent these error causes, we will perform the following by June 30, 2013:

Examiner Coding Errors - FEP will request that the Plans use these confirmed payment errors as training tools in any re-fresher and new claims examiner training sessions with instructions on how to re-check the payment amounts for DRG, Per Diem and Per Case types of reimbursements.

Insufficient Investigation of FEP Deferrals - A number of the confirmed overpayments had deferred by FEP requesting that the Plans verify that the payments were correct because of the payment amount (High Dollar Edit). Due to the sign-off process that these deferrals require other characteristics of the payments were not properly investigated. FEP will look to expand this edit to include verification of APG amount, if the reimbursement type is DRG or a Per Case Rate. A team of experts from the various departments within FEP will conduct an assessment of the existing edits that impact these payment types to determine what if any changes can be made to identify the types of confirmed payment errors identified in this audit in an effort to correct on a pre-payment basis.

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

Sincerely,

[redacted]
Director, FEP Program Assurance

Attachments

cc: [redacted]