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

Final Audit Report

Subject:

AUDIT ON GLOBAL CONTINUOUS STAY CLAIMS FOR BLUECROSS AND BLUESHIELD PLANS

Report No. 1A-99-00-13-004

Date: August 20, 2013

--CAUTION--

AUDIT REPORT

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

Global Continuous Stay Claims
BlueCross and BlueShield Plans

REPORT NO. 1A-99-00-13-004 DATE: August 20, 2013

Michael R. Esser
Assistant Inspector General
for Audits

--CAUTION--

EXECUTIVE SUMMARY

Federal Employees Health Benefits Program
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REPORT NO. 1A-99-00-13-004 DATE: August 20, 2013

This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at all BlueCross and BlueShield (BCBS) plans questions $6,259,347 in health benefit charges. The BlueCross BlueShield Association (Association) and/or BCBS plans agreed with $3,436,554 and disagreed with $2,822,793 of the questioned charges.

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covered health benefit payments from January 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 continuous stay claims that were paid from January 1, 2010 through July 31, 2012. Continuous stay claims are two or more inpatient facility claims with consecutive dates of service that were billed by a provider for a patient with one length of stay. We selected for review a sample of 8,054 continuous stay claim groups (representing 21,446 claims), totaling $945,117,644 in payments. Our sample included all groups with cumulative claim payment amounts of $35,000 or more. Based on our review of this sample, we determined that the BCBS plans incorrectly paid 630 continuous stay claims, resulting in net overcharges of $5,982,167 to the FEHBP. We also identified 29 additional claim payment errors, totaling $277,180 in overcharges to the FEHBP, as a result of an expanded review of continuous stay claims for BCBS of Nebraska. In total, we determined that the BCBS plans overpaid 512 claims by $9,713,652 and underpaid 147 claims by $3,454,305, resulting in net overcharges of $6,259,347 to the FEHBP for these 659 claim payment errors.

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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.

This is our first global audit of continuous stay claims for the BCBS plans. Our sample selections and instructions 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 July 9, 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 continuous stay claim payments. Continuous stay claims are two or more inpatient facility claims with consecutive dates of service that were billed by a provider for a patient with one length of stay.

SCOPE

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

The audit covered claim payments from January 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 continuous stay claims that were paid from January 1, 2010 through July 31, 2012. Based on this computer search, we identified 57,140 continuous stay claim groups (representing 126,476 claims), totaling approximately $1.3 billion in payments.[2] From this universe, we selected and reviewed a judgmental sample of 8,054 groups (representing 21,446 claims), totaling $945,117,644 in payments. Our sample included all groups with cumulative claim payment amounts of $35,000 or more for 59 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 continuous stay claim payments. 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 continuous stay claim payments. 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 us to believe that the BCBS plans had not complied, in all material respects, with those provisions.

[2] This universe excludes continuous stay claim groups for BCBS plans that were already audited during this period.

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 continuous stay claim groups. 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 SAS 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 October 2012 through June 2013.

METHODOLOGY

To test each BCBS plan's compliance with the FEHBP health benefit provisions related to continuous stay claims, we selected for review all continuous stay groups with cumulative claim payment amounts of $35,000 or more that were identified in a computer search. Specifically, we selected for review a sample of 8,054 continuous stay claims groups, representing 21,446 claims, totaling $945,117,644 in payments (out of 57,140 groups, representing 126,476 claims, totaling approximately $1.3 billion in payments). Each of these groups contained two or more inpatient facility claims with consecutive dates of service that were billed by a provider for a patient with one length of stay. (See Schedule A for a summary of the universe and sample selections of continuous stay claim groups 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 continuous stay claims were paid correctly, and/or calculate the appropriate questioned amounts for the claim payment errors. For each BCBS plan, we also reviewed the inpatient facility contracts for a sample of providers (a maximum of five providers for each plan) with the highest claims utilization to determine if the applicable continuous stay 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. We did not project the sample results to the universe of continuous stay claims.

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.

[3] In total for all BCBS plans, we reviewed the inpatient facility contracts for 290 providers (from a total of 1,581 providers) that were reimbursed for continuous stay claims in our sample.

III. AUDIT FINDING AND RECOMMENDATIONS

Continuous Stay Claim Payment Errors **$6,259,347**

During our audit of continuous stay claims, we determined that the BCBS plans incorrectly paid 659 continuous stay claims (630 from our initial sample and an additional 29 from an expanded review), resulting in net overcharges of $6,259,347 to the FEHBP. Specifically, the BCBS plans overpaid 512 claims by $9,713,652 and underpaid 147 claims by $3,454,305. Continuous stay claims are two or more inpatient facility claims with consecutive dates of service that were billed by a provider for a patient with one length of stay.

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 . . . [redacted] 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 FEHB Act provides that rates should reasonably and equitably reflect the cost of the benefits provided.

For the period January 1, 2010 through July 31, 2012, we identified 57,140 continuous stay claim groups (representing 126,476 claims), totaling approximately $1.3 billion in payments.[4] From this universe, we selected and reviewed a judgmental sample of 8,054 continuous stay claim groups (representing 21,446 claims), totaling $945,117,644 in payments, to determine if these claims were correctly priced and paid by the BCBS plans. Our sample included all groups with cumulative claim payment amounts of $35,000 or more for 59 of the 64 BCBS plans.

Our initial sample included 630 continuous stay claim payment errors, resulting in net overcharges of $5,982,167 to the FEHBP. Specifically, the BCBS plans overpaid 483 claims by $9,436,472 and underpaid 147 claims by $3,454,305.[5]

[4] This universe excludes continuous stay claim groups for BCBS plans that were already audited during this period.

[5] In addition, there were 40 claim payment errors, totaling $298,772 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.

These claim payment errors resulted from the following:

- The BCBS plans incorrectly paid 453 claims due to manual processing errors, such as incorrect coding, overriding system edits, and using incorrect allowances. Consequently, the BCBS plans overpaid 336 claims by $5,647,877 and underpaid 117 claims by $2,568,902, resulting in net overcharges of $3,078,975 to the FEHBP.

- The BCBS plans incorrectly paid 98 claims due to provider billing errors, resulting in net overcharges of $1,271,254 to the FEHBP. Specifically, the BCBS plans overpaid 77 claims by $1,976,826 and underpaid 21 claims by $705,572.

- The BCBS plans did not provide documentation to support the pricing and payment amounts for 35 claims, resulting in unsupported charges (overcharges) of $1,068,205 to the FEHBP. (Note: On multiple occasions during the audit, we requested BlueCross (BC) of California and the BCBS plans of Minnesota, Mississippi, Missouri, Montana, North Carolina, Texas, and Virginia to provide support for the pricing and payment amounts of these potential questionable claims. However, these plans did not provide the requested documentation.)

- The BCBS plans did not properly coordinate 13 claims with Medicare or the patient's primary insurance carrier, resulting in net overcharges of $379,708 to the FEHBP. Specifically, the BCBS plans overpaid 12 claims by $381,957 and underpaid 1 claim by $2,249.

- For seven 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 $135,692. 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 inadvertently paid six claims twice, resulting in duplicate charges of $89,962 to the FEHBP.

- BCBS of Nebraska incorrectly paid three claims, resulting in overcharges of $21,814 to the FEHBP, due to the plan's local claims system ("CoreLink") incorrectly calculating the claim payment amounts when the patient transferred from one facility to another. Specifically, these overpayments were due to the plan's "CoreLink" using too many days when calculating the claim payment amounts and/or not applying the lesser of logic when the allowed amounts exceeded the covered charges. Since this is a local system processing error, we expanded our review of this claim payment error for BCBS of Nebraska (see below).

- For 15 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 seven claims by $114,139 and underpaid eight claims by $177,582, resulting in net undercharges of $63,443 to the FEHBP.

We expanded our review of the "CoreLink" system processing error for BCBS of Nebraska. Specifically, we requested this plan to identify all claims paid during the period January 1, 2010 through December 31, 2012, where patients transferred from one facility to another and the claim payment amounts were incorrectly calculated and paid. As a result of our expanded review, we identified 29 additional claim payment errors, totaling $277,180 in overcharges to the FEHBP. According to BCBS of Nebraska, corrective actions were implemented in May 2013 to fix this "CoreLink" system processing error.

In total, we determined that 51 BCBS plans incorrectly paid 659 claims, resulting in net overcharges of $6,259,347 to the FEHBP. Of these, the BCBS plans overpaid 512 claims by $9,713,652 and underpaid 147 claims by $3,454,305 (See Schedule B for a summary of the claim payment errors by BCBS plan).

Of the $6,259,347 in net overcharges to the FEHBP:

- $5,062,218 (81 percent) represents 597 claim payment errors that were identified as a result of our audit. Specifically, the BCBS plans overpaid 450 of these claims by $8,516,523 and underpaid 147 of these claims by $3,454,305. We noted that the BCBS plans initiated corrective actions for these claim payment errors after receiving our audit request (i.e., sample of continuous stay claims) on September 28, 2012.

- $720,451 (11 percent) represents 29 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.

- $476,678 (8 percent) represents 33 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.

In addition to the questioned charges, we identified the following procedural issues requiring corrective action by the Association and/or FEP Operations Center:

For 1,197 continuous stay claims, we identified that the FEP Direct Claims System (FEP Direct) potentially applied multiple inpatient admission copayments incorrectly, instead of only one admission copayment, for a patient's entire length of stay. As a result, 999 members were potentially overcharged $383,086 for copayments. Specifically, 271 members with Basic Option coverage were potentially overcharged $181,160 and 728 members with Standard Option coverage were potentially overcharged $201,926. On average, we determined that each of these members with Basic Option coverage was potentially overcharged by $668 and each of these members with Standard Option coverage was potentially overcharged by $277. Since the

providers collect the members' copayment amounts, we could not determine the actual amounts billed by the providers and paid by the members for these claims. Therefore, we only estimated the potential impact of these copayment calculation errors to the members. Additionally, these copayment calculation errors could result in potential undercharges of $383,086 to the FEHBP.

The 2012 BlueCross and BlueShield Service Benefit Plan brochure, page 69, states that the member's liability to a preferred provider for unlimited days is "$750 per admission copayment" for Basic Option coverage and "$150 per day copayment up to $250 per admission" for Standard Option coverage.[6] Additionally, page 128 of this brochure defines an admission as, "the period from entry (admission) as an inpatient into a hospital (or other covered facility) until discharge."

For the continuous stay claims in our sample, we noted that FEP Direct calculated the member's liability by using the following claim data fields: incurred date, discharge date, bill type, and patient transfer status. However, FEP Direct did not properly recognize continuous stay claims that were processed out of sequential order and/or for in-house transfers to a different level of care with no gaps in service dates. Specifically, we identified 508 claims, totaling $159,411 in potential overpayments by members, for continuous stay claims that were processed out of sequential order. We also identified 689 claims, totaling $223,675 in potential overpayments by members, for continuous stay claims where the patient transferred to a different level of care within the same facility and without gaps in service dates.

- According to the Association, 508 of these copayment calculation errors occurred because FEP Direct did not properly recognize the continuous stay claims that were processed out of sequential order. However, the Association states that these copayment calculation errors were identified by the BCBS plans prior to the audit, and the FEP Operations Center has already developed two corrective action initiatives, one for the Basic Option coverage and another for the Standard Option coverage. Specifically, the copayment calculation error for the Basic Option coverage was identified in October 2008 and the FEP Direct modifications were implemented in April 2012. The copayment calculation error for the Standard Option coverage was identified in November 2012 and the FEP Direct modifications are scheduled to be implemented in September 2013. The Association also states that when these copayment calculation errors were initially identified, the Association instructed the BCBS plans to manually calculate the members' copayment amounts for these continuous stay claims until the FEP Direct modifications are implemented. Even though the BCBS plans have procedures to manually calculate admission copayments for continuous stay claims that are processed out of sequential order (according to the Association), we identified 508 claims in our sample where FEP Direct and/or the BCBS plans incorrectly processed the members' copayments because the claims were out of sequential order. Additionally, the Association has not instructed the BCBS plans to determine the impact on members affected by this copayment calculation error to ensure that these members are refunded for overpayments.

- For the 689 claims where members were potentially charged extra inpatient admission copayments for transferring to a different level of care within the same facility, the Association and/or BCBS plans did not provide sufficient documentation to support that

[6] Since our sample included claims with multiple incurred dates of service, we determined the member's copayment amount by using the applicable Service Benefit Plan brochure service year.

these were not actually continuous stay claims. As a result, the members were potentially overcharged for re-admission copayments. Since these potential copayment errors were identified as a result of this audit, the Association is continuing to research this issue.

For these procedural issues, we estimate that 999 members potentially paid unnecessary copayments of $383,086 for 1,197 continuous stay claims in our sample.

Association's Response:

The Association agrees with $1,363,732 of the questioned charges. The Association states that the BCBS plans have recovered and returned $964,081 of the confirmed 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.

Regarding corrective actions, the Association states, "In order to prevent these types of overpayments from occurring, as of January 1, 2013 we began including these types of claim payments in our online claims monitoring tool. Thus far, the majority of the overpayments were caused by one of the following reasons:

- Examiner Coding Errors;
- Provider Billing Errors; and
- Insufficient Investigation of FEP Deferrals.

Examiner Coding Errors: FEP has requested that coding instructions for claims where the patient is still confined to the hospital be one of the topics for training during the 2013 Micro Regional Meetings conducted by the FEP Operations Center . . . In addition, FEP will request that the Plans use these confirmed payment errors as training tools in any re-fresher and new claims examiner training sessions. We expect this to be completed by 3rd quarter 2013.

Provider Billing Errors: For a number of the confirmed overpayments, the providers submitted the charges on a UB04 claim form with type of bill 111 which means that the charges on the claim covered from admission to discharge. FEP is investigating the feasibility of developing an edit that would defer claims when the type of billing is '111' and the patient status is 30 (patient is confined in hospital). The instructions to the Plans would be to return the claim to the

provider with instructions to change the type of bill if the patient is still confined in the hospital. We will complete the feasibility review by 3rd quarter 2013.

Insufficient Investigation of FEP Deferrals: A number of the confirmed overpayments deferred requesting that the Plans verify that the payments were correct because of the payment amount (High Dollar Edit). FEP will look to expand this edit to include verification of Continuous Stay Claims, if the reimbursement type is DRG or a Per Case Rate by 3rd quarter 2013."

OIG Comments:

After reviewing the Association's draft report response and additional documentation provided by the BCBS plans, we determined that 51 BCBS plans incorrectly paid 659 continuous stay claims, resulting in net overcharges of $6,259,347 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 $3,436,554 and disagree with $2,822,793 of these net questioned overcharges. Although the Association only agrees with $1,363,732 of these net questioned overcharges in its response, the BCBS plans' documentation supports concurrence with $3,436,554.

Based on the Association's response and/or the BCBS plans' documentation, the contested amount of $2,822,793 represents the following items:

- $1,068,205 of the contested amount represents 35 claims that the BCBS plans state were charged correctly to the FEHBP. However, the plans did not provide sufficient documentation to support that these claims were paid correctly. (Note: On multiple occasions during the audit, we requested BC of California and the BCBS plans of Minnesota, Mississippi, Missouri, Montana, North Carolina, Texas, and Virginia to provide support for the pricing and payment amounts of these potential questionable claims. However, these plans did not provide the requested documentation.)

- $476,678 of the contested amount represents 33 claim overpayments where the BCBS plans initiated recovery efforts on or after our audit notification date (i.e., August 1, 2013) 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.

- $421,767 of the contested amount represents 44 claim overpayments that the BCBS plans agree were paid incorrectly. However, due to overpayment recovery time limitations with providers, the plans state that these overpayments are uncollectible. Since these

overpayments were identified as a result of our audit, we are continuing to question this amount in the final report. If the plans had timely identified these overpayments prior to our audit, the plans' recovery efforts would have been within the applicable time limitations, and therefore, the overpayments would have been recoverable. Additionally, the FEHBP should not be expected to cover these claim overpayments because of provider refund issues.

- $411,563 of the contested amount represents 18 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.

- $308,888 of the contested amount represents 11 claim overpayments that the BCBS plans agree were paid incorrectly. However, since all recovery efforts have been exhausted, the plans state that these claim payments 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.

- $135,692 of the contested amount represents seven claims that BC of Northeastern Pennsylvania, Empire BCBS, and Independence BC 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 FEP Direct 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.

Regarding the procedural issues for the copayment calculation errors, we developed these issues while reviewing the BCBS plans' responses to our sample selections and after receiving the Association's response to the draft report. However, we had numerous discussions with the Association while developing these procedural issues. The Association and/or FEP Operations Center are continuing to research these procedural issues.

Recommendation 1

We recommend that the contracting officer disallow $9,713,652 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 $3,454,305 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

Although the Association has developed a corrective action plan to reduce continuous stay claim payment errors, 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 4

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; the BCBS plans of Florida, Georgia, Kentucky, and Oklahoma; and Empire BCBS.

Recommendation 5

Due to paid amount variances that were identified between the plans' local claims systems and the FEP Direct Claims System for the BC of Northeastern Pennsylvania, Empire BCBS, and Independence BC plans, 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 FEP Direct to reflect the actual amounts paid to the providers.

Recommendation 6

Due to the significant number of copayment calculation errors, we recommend that the contracting officer require the Association to have the FEP Operations Center identify the reason(s) why the FEP Direct Claims System is incorrectly calculating the members' copayments for continuous stay claims. After identifying the reason(s) why, the FEP Operations Center should implement corrective edits in the FEP Direct Claims System.

In addition to implementing corrective edits, we recommend that the contracting officer require the Association to have the FEP Operations Center perform an analysis to identify all continuous stay claims potentially impacted by the copayment calculation errors, and then determine if FEP members are due refunds and/or if providers are due additional payments as a result of any copayment calculation errors. The results of this analysis should be provided to the contracting officer.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Experience-Rated Audits Group

[redacted], Lead Auditor

[redacted], Auditor

[redacted], Auditor

[redacted], Chief [redacted]

Information Systems Audits Group

[redacted], Senior Information Technology Specialist

[redacted], Senior Information Technology Specialist

GLOBAL CONTINUOUS STAY CLAIMS
BLUECROSS AND BLUESHIELD PLANS

UNIVERSE AND SAMPLE OF CONTINUOUS STAY CLAIM GROUPS BY PLAN

			UNIVERSE				SAMPLE		
Site Number	Plan Name	State	Claim Groups	Claims	Amounts Paid	Period Subject to Audit	Claim Groups	Claims	Amounts Paid
003	BlueCross BlueShield of New Mexico (HCSC)	NM	369	815	$ 5,984,904	January 1, 2010 through July 31, 2012	40	104	$ 3,422,562
005	WellPoint BlueCross BlueShield of Georgia	GA	1,101	2,442	$ 52,203,196	January 1, 2010 through July 31, 2012	329	787	$ 43,197,745
006	CareFirst BlueCross BlueShield (Maryland Service Area)	MD	3,264	7,352	$ 75,751,819	January 1, 2010 through July 31, 2012	526	1,322	$ 56,184,566
007	BlueCross BlueShield of Louisiana	LA	722	1,613	$ 15,710,738	January 1, 2010 through July 31, 2012	98	234	$ 10,586,212
009	BlueCross BlueShield of Alabama	AL	1,362	3,009	$ 38,731,039	January 1, 2010 through July 31, 2012	291	820	$ 31,759,337
010	BlueCross of Idaho Health Service	ID	215	444	$ 1,319,724	January 1, 2010 through July 31, 2012	10	23	$ 620,524
011	BlueCross BlueShield of Massachusetts	MA	1,613	3,499	$ 18,722,491	January 1, 2010 through July 31, 2012	159	428	$ 10,668,217
012	BlueCross BlueShield of Western New York	NY	118	260	$ 1,821,758	January 1, 2010 through July 31, 2012	13	32	$ 1,312,051
013	Highmark BlueCross BlueShield	PA	1,089	2,455	$ 8,814,310	January 1, 2010 through July 31, 2012	36	100	$ 3,758,733
015	BlueCross BlueShield of Tennessee	TN	913	1,892	$ 16,003,217	January 1, 2010 through July 31, 2012	119	260	$ 10,916,729
016	BlueCross BlueShield of Wyoming	WY	148	449	$ 2,636,831	January 1, 2010 through July 31, 2012	22	115	$ 1,411,430
017	BlueCross BlueShield of Illinois (HCSC)	IL	2,715	6,204	$ 72,805,639	January 1, 2010 through July 31, 2012	491	1,281	$ 50,778,552
021	WellPoint BlueCross BlueShield (Ohio)	OH	3,019	6,632	$ 62,388,630	January 1, 2010 through July 31, 2012	285	755	$ 45,250,344
024	BlueCross BlueShield of South Carolina	SC	271	566	$ 7,117,956	January 1, 2010 through July 31, 2012	67	142	$ 4,777,641
027	WellPoint BlueCross BlueShield of New Hampshire	NH	502	1,053	$ 8,643,812	January 1, 2010 through July 31, 2012	59	131	$ 6,269,554
028	BlueCross BlueShield of Vermont	VT	94	201	$ 1,240,645	January 1, 2010 through July 31, 2012	7	15	$ 681,719
029	BlueCross BlueShield of Texas (HCSC)	TX	4,455	9,971	$ 141,522,460	January 1, 2010 through July 31, 2012	839	2,238	$ 107,777,105
030	WellPoint BlueCross BlueShield of Colorado	CO	1,274	2,916	$ 36,007,039	January 1, 2010 through July 31, 2012	185	588	$ 28,850,612
031	Wellmark BlueCross BlueShield of Iowa	IA	493	1,051	$ 5,610,133	January 1, 2010 through July 31, 2012	38	107	$ 3,002,184
032	BlueCross BlueShield of Michigan	MI	946	2,008	$ 9,966,711	January 1, 2010 through July 31, 2012	79	179	$ 5,171,797
033	BlueCross BlueShield of North Carolina	NC	780	1,638	$ 15,002,484	January 1, 2011 through July 31, 2012	120	273	$ 11,491,600
034	BlueCross BlueShield of North Dakota	ND	219	563	$ 2,816,466	January 1, 2010 through July 31, 2012	18	92	$ 1,581,156
036	Capital BlueCross	PA	635	1,291	$ 4,804,252	January 1, 2010 through July 31, 2012	33	69	$ 2,210,566
037	BlueCross BlueShield of Montana	MT	354	1,069	$ 8,515,796	January 1, 2010 through July 31, 2012	76	445	$ 6,326,619
038	BlueCross BlueShield of Hawaii	HI	30	67	$ 1,095,962	January 1, 2010 through July 31, 2012	10	23	$ 941,553
039	WellPoint BlueCross BlueShield of Indiana	IN	1,383	3,015	$ 32,105,587	January 1, 2010 through July 31, 2012	180	449	$ 24,690,795
040	BlueCross BlueShield of Mississippi	MS	586	1,246	$ 5,669,575	January 1, 2010 through July 31, 2012	41	91	$ 3,619,443
041	Florida Blue	FL	1,120	2,398	$ 20,008,661	October 1, 2011 through July 31, 2012	98	218	$ 13,587,949
042	BlueCross BlueShield of Kansas City	MO	581	1,285	$ 8,806,078	January 1, 2010 through July 31, 2012	73	179	$ 6,011,567
043	Regence BlueShield of Idaho	ID	0	0	$ -	January 1, 2010 through July 31, 2012	0	0	$ -
044	BlueCross BlueShield of Arkansas	AR	680	1,569	$ 8,883,868	January 1, 2010 through July 31, 2012	63	242	$ 5,489,729
045	WellPoint BlueCross BlueShield of Kentucky	KY	1,199	2,601	$ 21,619,174	January 1, 2010 through July 31, 2012	125	338	$ 14,291,699
047	WellPoint BlueCross BlueShield United of Wisconsin	WI	780	1,709	$ 21,243,906	January 1, 2010 through July 31, 2012	126	325	$ 17,406,309
048	Empire BlueCross BlueShield (WellPoint)	NY	904	1,950	$ 22,978,582	January 1, 2010 through July 31, 2012	160	380	$ 17,725,190
049	Horizon BlueCross BlueShield of New Jersey	NJ	680	1,438	$ 8,398,415	January 1, 2011 through July 31, 2012	51	137	$ 4,688,673
050	WellPoint BlueCross BlueShield of Connecticut	CT	666	1,412	$ 14,464,180	January 1, 2010 through July 31, 2012	85	206	$ 10,417,160
052	WellPoint BlueCross of California	CA	2,920	6,500	$ 153,376,453	January 1, 2010 through July 31, 2012	771	2,030	$ 141,206,256

GLOBAL CONTINUOUS STAY CLAIMS
BLUECROSS AND BLUESHIELD PLANS

UNIVERSE AND SAMPLE OF CONTINUOUS STAY CLAIM GROUPS BY PLAN

			UNIVERSE				SAMPLE		
Site Number	Plan Name	State	Claim Groups	Claims	Amounts Paid	Period Subject to Audit	Claim Groups	Claims	Amounts Paid
053	BlueCross BlueShield of Nebraska	NE	180	385	$ 3,081,164	January 1, 2010 through July 31, 2012	25	59	$ 1,610,018
054	Mountain State BlueCross BlueShield	WV	499	1,144	$ 8,283,891	January 1, 2010 through July 31, 2012	54	140	$ 4,961,662
055	Independence BlueCross	PA	1,175	2,471	$ 22,830,489	January 1, 2010 through July 31, 2012	169	380	$ 14,564,372
056	BlueCross BlueShield of Arizona	AZ	712	1,604	$ 12,855,800	January 1, 2010 through July 31, 2012	86	223	$ 7,798,327
058	Regence BlueCross BlueShield of Oregon	OR	736	1,976	$ 16,518,842	January 1, 2010 through July 31, 2012	129	432	$ 11,293,110
059	WellPoint BlueCross BlueShield of Maine	ME	440	921	$ 5,375,755	January 1, 2010 through July 31, 2012	36	76	$ 3,122,510
060	BlueCross BlueShield of Rhode Island	RI	289	614	$ 2,668,278	January 1, 2010 through July 31, 2012	14	33	$ 839,166
061	WellPoint BlueCross BlueShield of Nevada	NV	338	739	$ 6,646,579	January 1, 2010 through July 31, 2012	39	105	$ 4,128,355
062	WellPoint BlueCross Blue Shield of Virginia	VA	2,918	6,152	$ 28,579,937	January 1, 2010 through July 31, 2012	140	318	$ 15,557,709
064	Excellus BlueCross BlueShield of the Rochester Area	NY	67	153	$ 1,228,393	January 1, 2010 through July 31, 2012	6	23	$ 804,665
066	Regence BlueCross BlueShield of Utah	UT	950	2,103	$ 18,893,896	January 1, 2010 through July 31, 2012	141	373	$ 13,827,521
067	BlueShield of California	CA	0	0	$ -	January 1, 2010 through July 31, 2012	0	0	$ -
068	Triple-S Salud, Inc	PR	9	18	$ 63,189	January 1, 2010 through July 31, 2012	0	0	$ -
069	Regence BlueShield of Washington	WA	0	0	$ -	January 1, 2010 through July 31, 2012	0	0	$ -
070	BlueCross BlueShield of Alaska	AK	105	270	$ 7,451,636	January 1, 2010 through July 31, 2012	53	163	$ 6,810,145
074	Wellmark BlueCross BlueShield of South Dakota	SD	0	0	$ -	January 1, 2010 through July 31, 2012	0	0	$ -
075	Premera BlueCross	WA	1,172	2,461	$ 18,369,784	January 1, 2010 through July 31, 2012	111	258	$ 12,562,940
076	WellPoint BlueCross BlueShield of Missouri	MO	950	2,104	$ 19,214,025	January 1, 2010 through July 31, 2012	117	332	$ 13,828,293
078	BlueCross BlueShield of Minnesota	MN	870	2,198	$ 37,622,492	January 1, 2010 through July 31, 2012	216	663	$ 30,539,306
079	Excellus BlueCross BlueShield of Central New York	NY	55	115	$ 1,016,774	January 1, 2010 through July 31, 2012	9	21	$ 577,631
082	BlueCross BlueShield of Kansas	KS	571	1,179	$ 3,442,814	January 1, 2010 through July 31, 2012	27	55	$ 1,929,629
083	BlueCross BlueShield of Oklahoma (HCSC)	OK	1,293	2,784	$ 31,389,050	January 1, 2010 through July 31, 2012	272	645	$ 21,104,740
084	Excellus BlueCross BlueShield of Utica-Watertown	NY	33	70	$ 556,755	January 1, 2010 through July 31, 2012	4	10	$ 421,609
085	CareFirst BlueCross BlueShield (DC Service Area)	DC	4,376	9,583	$ 83,484,063	January 1, 2010 through July 31, 2012	505	1,437	$ 49,328,661
088	BlueCross of Northeastern Pennsylvania	PA	502	1,195	$ 2,945,226	January 1, 2010 through July 31, 2012	16	49	$ 864,168
089	BlueCross BlueShield of Delaware	DE	263	560	$ 8,216,609	January 1, 2010 through July 31, 2012	54	116	$ 7,031,938
092	CareFirst BlueCross BlueShield (Overseas)	DC	437	1,094	$ 17,587,340	January 1, 2010 through July 31, 2012	108	377	$ 13,527,293
Totals			**57,140**	**126,476**	**$ 1,291,115,270**		**8,054**	**21,446**	**$ 945,117,644**

GLOBAL CONTINUOUS STAY CLAIMS
BLUECROSS AND BLUESHIELD PLANS

QUESTIONED CHARGES BY PLAN

Site Number	Plan Name	State	Total Questioned Claims	Total Questioned Charges	Amounts Questioned by Year 2009	2010	2011	2012	Plan Agrees	Plan Disagrees
003	BlueCross BlueShield of New Mexico (HCSC)	NM	11	$ 61,345	$ (1,368)	$ 12,205	$ 50,507	$ -	$ 61,345	$ -
005	WellPoint BlueCross BlueShield of Georgia	GA	14	$ (29,658)	$ -	$ (3,595)	$ 23,411	$ (49,474)	$ (74,782)	$ 45,124
006	CareFirst BlueCross BlueShield (Maryland Service Area)	MD	11	$ 66,478	$ -	$ 3,305	$ 3,798	$ 59,374	$ 63,228	$ 3,250
007	BlueCross BlueShield of Louisiana	LA	26	$ (67,507)	$ -	$ 110,414	$ (259,269)	$ 81,349	$ (310,280)	$ 242,774
009	BlueCross BlueShield of Alabama	AL	12	$ 623,144	$ -	$ -	$ 95,165	$ 527,978	$ 623,144	$ -
010	BlueCross of Idaho Health Service	ID	6	$ 188,492	$ -	$ -	$ 188,492	$ -	$ 188,492	$ -
011	BlueCross BlueShield of Massachusetts	MA	21	$ 286,208	$ -	$ 96,401	$ 32,819	$ 156,988	$ 135,152	$ 151,056
012	BlueCross BlueShield of Western New York	NY	0	$ -	$ -	$ -	$ -	$ -	$ -	$ -
013	Highmark BlueCross BlueShield	PA	0	$ -	$ -	$ -	$ -	$ -	$ -	$ -
015	BlueCross BlueShield of Tennessee	TN	0	$ -	$ -	$ -	$ -	$ -	$ -	$ -
016	BlueCross BlueShield of Wyoming	WY	1	$ (1,275)	$ -	$ (1,275)	$ -	$ -	$ (1,275)	$ -
017	BlueCross BlueShield of Illinois (HCSC)	IL	31	$ 323,113	$ 5,102	$ 247,450	$ (14,189)	$ 84,749	$ 323,113	$ -
021	WellPoint BlueCross BlueShield (Ohio)	OH	9	$ 40,093	$ 5,355	$ 40,056	$ (2,426)	$ (2,892)	$ 40,093	$ -
024	BlueCross BlueShield of South Carolina	SC	4	$ 6,207	$ -	$ 20,093	$ (13,886)	$ -	$ 6,207	$ -
027	WellPoint BlueCross BlueShield of New Hampshire	NH	3	$ 8,778	$ 1,613	$ -	$ -	$ 7,165	$ 8,778	$ -
028	BlueCross BlueShield of Vermont	VT	0	$ -	$ -	$ -	$ -	$ -	$ -	$ -
029	BlueCross BlueShield of Texas (HCSC)	TX	106	$ 1,547,990	$ 56,197	$ 571,725	$ 413,179	$ 506,889	$ 1,303,289	$ 244,701
030	WellPoint BlueCross BlueShield of Colorado	CO	24	$ (146,449)	$ (2,970)	$ (2,810)	$ (1,806)	$ (138,862)	$ (148,298)	$ 1,850
031	Wellmark BlueCross BlueShield of Iowa	IA	6	$ 106,325	$ -	$ 534	$ 26,479	$ 79,311	$ 106,325	$ -
032	BlueCross BlueShield of Michigan	MI	0	$ -	$ -	$ -	$ -	$ -	$ -	$ -
033	BlueCross BlueShield of North Carolina	NC	18	$ 536,035	$ -	$ -	$ 380,347	$ 155,688	$ 339,469	$ 196,565
034	BlueCross BlueShield of North Dakota	ND	0	$ -	$ -	$ -	$ -	$ -	$ -	$ -
036	Capital BlueCross	PA	2	$ 25,303	$ -	$ 25,303	$ -	$ -	$ 25,303	$ -
037	BlueCross BlueShield of Montana	MT	17	$ 120,112	$ -	$ 87,577	$ 30,256	$ 2,280	$ 2,280	$ 117,833
038	BlueCross BlueShield of Hawaii	HI	2	$ 9,350	$ -	$ 592	$ 8,758	$ -	$ 9,350	$ -
039	WellPoint BlueCross BlueShield of Indiana	IN	9	$ (12,852)	$ 9,946	$ (15,649)	$ (3,720)	$ (3,429)	$ (34,864)	$ 22,011
040	BlueCross BlueShield of Mississippi	MS	6	$ 104,420	$ 39,459	$ 56,293	$ -	$ 8,668	$ 48,127	$ 56,293
041	Florida Blue	FL	21	$ 513,327	$ -	$ -	$ 128,749	$ 384,578	$ 491,666	$ 21,661
042	BlueCross BlueShield of Kansas City	MO	2	$ 16,456	$ -	$ 16,456	$ -	$ -	$ -	$ 16,456
043	Regence BlueShield of Idaho	ID	0	$ -	$ -	$ -	$ -	$ -	$ -	$ -
044	BlueCross BlueShield of Arkansas	AR	5	$ (1,905)	$ -	$ 145	$ (1,250)	$ (800)	$ (1,905)	$ -
045	WellPoint BlueCross BlueShield of Kentucky	KY	7	$ 49,540	$ 3,596	$ 36,260	$ (937)	$ 10,621	$ 49,540	$ -
047	WellPoint BlueCross BlueShield United of Wisconsin	WI	5	$ 49,028	$ -	$ -	$ (65,169)	$ 114,196	$ 25,336	$ 23,692
048	Empire BlueCross BlueShield (WellPoint)	NY	11	$ 70,045	$ -	$ 141,190	$ 19,325	$ (90,470)	$ (20,375)	$ 90,421
049	Horizon BlueCross BlueShield of New Jersey	NJ	1	$ 2,824	$ -	$ -	$ 2,824	$ -	$ 2,824	$ -
050	WellPoint BlueCross BlueShield of Connecticut	CT	7	$ (61,507)	$ -	$ (10,572)	$ (64,547)	$ 13,612	$ (77,358)	$ 15,851
052	WellPoint BlueCross of California	CA	45	$ 110,090	$ 2,610	$ 8,383	$ 325,967	$ (226,869)	$ (268,021)	$ 378,111
053	BlueCross BlueShield of Nebraska	NE	33	$ 330,445	$ -	$ 74,076	$ 71,417	$ 184,952	$ 249,000	$ 81,445

GLOBAL CONTINUOUS STAY CLAIMS
BLUECROSS AND BLUESHIELD PLANS

QUESTIONED CHARGES BY PLAN

Site Number	Plan Name	State	Total Questioned Claims	Total Questioned Charges	Amounts Questioned by Year 2009	2010	2011	2012	Plan Agrees	Plan Disagrees
054	Mountain State BlueCross BlueShield	WV	0	$ -	$ -	$ -	$ -	$ -	$ -	$ -
055	Independence BlueCross	PA	13	$ 225,345	$ -	$ 84,700	$ 17,073	$ 123,573	$ 106,661	$ 118,684
056	BlueCross BlueShield of Arizona	AZ	1	$ 4,500	$ -	$ 4,500	$ -	$ -	$ 4,500	$ -
058	Regence BlueCross BlueShield of Oregon	OR	10	$ 128,602	$ 754	$ 12,535	$ 88,700	$ 26,613	$ 122,975	$ 5,627
059	WellPoint BlueCross BlueShield of Maine	ME	7	$ 69,641	$ -	$ 2,435	$ 71,871	$ (4,666)	$ 69,641	$ -
060	BlueCross BlueShield of Rhode Island	RI	4	$ 5,745	$ -	$ (1,796)	$ 9,676	$ (2,136)	$ 5,745	$ -
061	WellPoint BlueCross BlueShield of Nevada	NV	2	$ 47,717	$ -	$ -	$ -	$ 47,717	$ 47,717	$ -
062	WellPoint BlueCross Blue Shield of Virginia	VA	19	$ 499,023	$ 2,533	$ 5,301	$ 379,767	$ 111,422	$ 130,433	$ 368,591
064	Excellus BlueCross BlueShield of the Rochester Area	NY	1	$ 9,026	$ -	$ -	$ 9,026	$ -	$ 9,026	$ -
066	Regence BlueCross BlueShield of Utah	UT	3	$ 4,476	$ -	$ (6,496)	$ 3,511	$ 7,462	$ 4,476	$ -
067	BlueShield of California	CA	0	$ -	$ -	$ -	$ -	$ -	$ -	$ -
068	Triple-S Salud, Inc	PR	0	$ -	$ -	$ -	$ -	$ -	$ -	$ -
069	Regence BlueShield of Washington	WA	0	$ -	$ -	$ -	$ -	$ -	$ -	$ -
070	BlueCross BlueShield of Alaska	AK	7	$ 17,350	$ 17,534	$ -	$ 4,266	$ (4,450)	$ (184)	$ 17,534
074	Wellmark BlueCross BlueShield of South Dakota	SD	0	$ -	$ -	$ -	$ -	$ -	$ -	$ -
075	Premera BlueCross	WA	2	$ (6,556)	$ -	$ (6,556)	$ -	$ -	$ (12,383)	$ 5,827
076	WellPoint BlueCross BlueShield of Missouri	MO	8	$ 260,660	$ -	$ 34,637	$ 192,459	$ 33,564	$ 118,148	$ 142,512
078	BlueCross BlueShield of Minnesota	MN	2	$ 188,902	$ -	$ -	$ -	$ 188,902	$ -	$ 188,902
079	Excellus BlueCross BlueShield of Central New York	NY	2	$ 6,738	$ -	$ -	$ 6,738	$ -	$ 6,738	$ -
082	BlueCross BlueShield of Kansas	KS	0	$ -	$ -	$ -	$ -	$ -	$ -	$ -
083	BlueCross BlueShield of Oklahoma (HCSC)	OK	31	$ 87,803	$ (13,474)	$ 12,263	$ 31,584	$ 57,430	$ (34,732)	$ 122,535
084	Excellus BlueCross BlueShield of Utica-Watertown	NY	1	$ 1,235	$ -	$ -	$ 1,235	$ -	$ 1,235	$ -
085	CareFirst BlueCross BlueShield (DC Service Area)	DC	63	$ (218,100)	$ -	$ 83,945	$ (239,515)	$ (62,530)	$ (318,503)	$ 100,404
088	BlueCross of Northeastern Pennsylvania	PA	1	$ 11,030	$ -	$ 11,030	$ -	$ -	$ -	$ 11,030
089	BlueCross BlueShield of Delaware	DE	1	$ 10,410	$ -	$ -	$ 10,410	$ -	$ 10,410	$ -
092	CareFirst BlueCross BlueShield (Overseas)	DC	5	$ 31,805	$ -	$ -	$ (4,075)	$ 35,880	$ (250)	$ 32,055
TOTALS			**659**	**$ 6,259,347**	**$ 126,886**	**$ 1,751,055**	**$ 1,957,021**	**$ 2,424,385**	**$ 3,436,554**	**$ 2,822,793**

Plan Sites in Sample = 59

Plan Sites with Claim Payment Errors = 51

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

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 Continuous Stay Claims
Audit Report #1A-99-00-13-004
(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 Continuous Stay Claims for claims paid from January 1, 2010 through July 31, 2012. The sample included 8,054 groups with cumulative claim payment amounts of $35,000 or more, representing 21,446 claims, totaling $945,117,644 in payments. Potential overpayments were not estimated in the draft report. 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 21,446 continuous stay claims totaling $945,117,644 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 sample of Continuous Stay claims totaling $945,117,644, the Association does not contest 546 overpayments totaling $5,224,800 and 625 underpayments totaling $3,861,968, for a net overpayment amount of $1,363,732. As of February 1, 2013, the Plans have recovered and returned $964,081 to the

Program for the identified overpayments. See Attachment A for a listing of contested and uncontested amounts per Plan and Schedule B 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 21,020 claims totaling $943,753,912 in potential claim payment errors (support provided) for the following:

- $940,271,539 in potential claim payment errors were paid correctly according to the Plan's pricing methodology;
- $3,482,373 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, as of January 1, 2013 we began including these types of claim payments in our online claims monitoring tool.

Thus far, the majority of the overpayments were caused by one of the following reasons:

- Examiner Coding Errors;
- Provider Billing Errors; and
- Insufficient Investigation of FEP Deferrals.

Examiner Coding Errors: FEP has requested that coding instructions for claims where the patient is still confined to the hospital be one of the topics for training during the 2013 Micro Regional Meetings conducted by the FEP Operations Center for small of groups of Plan held in multiple areas of the country. In addition, FEP will request that the Plans use these confirmed payment errors as training tools in any

re-fresher and new claims examiner training sessions. We expect this to be completed by 3rd quarter 2013.

Provider Billing Errors: For a number of the confirmed overpayments, the providers submitted the charges on a UB04 claim form with type of bill 111 which means that the charges on the claim covered from admission to discharge. FEP is investigating the feasibility of developing an edit that would defer claims when the type of billing is "111" and the patient status is 30 (patient is confined in hospital). The instructions to the Plans would be to return the claim to the provider with instructions to change the type of bill if the patient is still confined in the hospital. We will complete the feasibility review by 3rd quarter 2013.

Insufficient Investigation of FEP Deferrals: A number of the confirmed overpayments deferred requesting that the Plans verify that the payments were correct because of the payment amount (High Dollar Edit). FEP will look to expand this edit to include verification of Continuous Stay Claims, if the reimbursement type is DRG or a Per Case Rate by 3rd quarter 2013.

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]

[redacted]
Director, FEP Program Assurance

Attachments

cc: [redacted]