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

Final Audit Report

Subject:

AUDIT ON GLOBAL COORDINATION OF BENEFITS FOR BLUECROSS AND BLUESHIELD PLANS

Report No. 1A-99-00-13-032

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 Coordination of Benefits
BlueCross and BlueShield Plans

REPORT NO. 1A-99-00-13-032 DATE: 11/22/13

Michael R. Esser
Assistant Inspector General
for Audits

--CAUTION--

EXECUTIVE SUMMARY

Federal Employees Health Benefits Program
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REPORT NO. 1A-99-00-13-032 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 $7,797,641 in health benefit charges. The BlueCross BlueShield Association (Association) and/or BCBS plans agreed with $3,057,218 and disagreed with $4,740,423 of the questioned charges. Regarding the contested charges, even though the Association and/or BCBS plans disagree with our questioning of these charges in this report, they in fact agree that the charges were not properly coordinated with Medicare and resulted in overcharges to the FEHBP.[1]

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covered health benefit payments from April 1, 2012 through January 31, 2013 as reported in the plans' Annual Accounting Statements. Specifically, we identified claims incurred on or after March 15, 2012 that were reimbursed from April 1, 2012 through January 31, 2013 and potentially not coordinated with Medicare. We determined that the BCBS plans did not properly coordinate 16,406 claim line payments with Medicare as required by the FEHBP contract. As a result, the FEHBP was overcharged $7,717,615 for these claim line payments. When we notified the Association of the COB errors on March 1, 2013, these claims were within the Medicare timely filing requirement and could be filed with Medicare for coordination of benefits. Based

[1] Most of the contested amount represents coordination of benefit (COB) errors where the BCBS plans initiated recovery efforts on or after our audit notification date (i.e., February 1, 2013) but before receiving our audit request (i.e., sample of potential COB errors) on March 1, 2013, and also completed the recovery process and adjusted or voided the claims by the audit request due date (i.e., May 31, 2013). However, since the recoveries for these COB errors were initiated on or after our audit notification date, we are continuing to question these overpayments in the final report.

on this, since the BCBS plans are required to initiate recovery efforts immediately for the actual COB errors, our expectation is for the plans to recover and return all of the actual COB errors to the FEHBP. A portion of the questioned amount may be determined to be not paid in error during the audit resolution phase.

Additionally, we identified 260 claim line payments that were not COB errors but contained other claim payment errors, resulting in overcharges of $80,026 to the FEHBP. In total, we determined that the BCBS plans incorrectly paid 16,666 claim lines, resulting in overcharges of $7,797,641 to the FEHBP.

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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 BCBS, 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 coordination of benefits audit of all BCBS plans (Report No. 1A-99-00-12-029, dated March 20, 2013) for claims reimbursed from June 1, 2011 through March 31, 2012 are in the process of being resolved.

Our preliminary results of the potential coordination of benefit errors were presented in detail in a draft report, dated March 1, 2013, and discussed with Association and BCBS plan officials during the entrance conference on March 11, 2013. 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 October 15, 2013 was considered in preparing our final report.

II. OBJECTIVE, SCOPE, AND METHODOLOGY

OBJECTIVE

The objective of this audit was to determine whether the BCBS plans complied with contract provisions relative to coordination of benefits with Medicare.

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 health benefit payments from April 1, 2012 through January 31, 2013 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 claims incurred on or after March 15, 2012 that were reimbursed from April 1, 2012 through January 31, 2013 and potentially not coordinated with Medicare. Based on our claim error reports, we identified 538,671 claim lines, totaling $58,784,918 in payments, that potentially were not coordinated with Medicare. From this universe, we selected and reviewed 67,455 claim lines, totaling $24,359,022 in payments, for coordination of benefits with Medicare. When we notified the Association of these potential errors on March 1, 2013, the claims were within the Medicare timely filing requirement and could be filed with Medicare for coordination of benefits.[2]

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 coordination of benefits. 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 coordination of benefits with Medicare. Exceptions noted in the areas reviewed are set forth in detail in the "Audit Finding and Recommendations" section of this 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] Starting in 2010, claims with incurred dates of service on or after January 1, 2010 that are received by Medicare more than one calendar year after the date of service could be denied by Medicare as being past the timely filing requirement.

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 potential COB errors. 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 objective.

The audit was performed at our offices in Washington, D.C. and Cranberry Township, Pennsylvania from March 2013 through September 2013.

METHODOLOGY

To test each BCBS plan's compliance with the FEHBP health benefit provisions related to coordination of benefits with Medicare, we selected a judgmental sample of potential uncoordinated claim lines that were identified in a computer search. Specifically, we selected for review 67,455 claim lines, totaling $24,359,022 in payments, from a universe of 538,671 claim lines, totaling $58,784,918 in payments, that potentially were not coordinated with Medicare (See Schedule A for our sample selection methodology).

The sample selections were submitted to each applicable BCBS plan for their review and response. We then conducted a limited review of the plans' agreed responses and an expanded review of the plans' disagreed responses to determine the appropriate questioned amount. We also 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., May 31, 2013) for the claim payment errors in our sample. Additionally, we reviewed the status of corrective actions that have been or are in the process of being implemented by the Association, FEP Operations Center and/or BCBS plans, as a result of our previous global audits, to reduce potential coordination of benefit errors. We did not project the sample results to the universe of potentially uncoordinated claim lines.

The determination of the questioned amount is based on the FEHBP contract, the 2012 and 2013 Service Benefit Plan brochures, the Association's FEP Administrative Manual, and various manuals and other documents available from the Center for Medicare and Medicaid Services that explain Medicare benefits.

III. AUDIT FINDING AND RECOMMENDATIONS

Coordination of Benefits with Medicare Review **$7,797,641**

The BCBS plans incorrectly paid 16,666 claim lines, resulting in overcharges of $7,797,641 to the FEHBP. Specifically, the BCBS plans did not properly coordinate 16,406 claim line payments, totaling $8,640,313, with Medicare as required by the FEHBP contract. As a result, the FEHBP paid as the primary insurer for these claims when Medicare was the primary insurer. Therefore, we estimate that the FEHBP was overcharged by $7,717,615 for these 16,406 claim lines. The remaining 260 claim line payments were not coordination of benefit (COB) errors but contained other claim payment errors, resulting in overcharges of $80,026 to the FEHBP.

The 2012 BlueCross and BlueShield Service Benefit Plan brochure, page 124, Primary Payer Chart, illustrates when Medicare is the primary payer. In addition, page 26 of that brochure states, "We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), regardless of whether Medicare pays."

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 . . . ."

Regarding reportable monetary findings, Contract CS 1039, Part III, section 3.16(b) states, "Claim payment findings (i.e., claim overpayments) in the scope of an OIG audit are reportable as questioned charges unless the Carrier provides documentation supporting that these findings were already identified (i.e., documentation that the plan initiated recovery efforts) prior to audit notification and corrected (i.e., claims were adjusted and/or voided and overpayments were recovered and returned to the FEHBP) by the original due date of the . . . response."

For claims incurred on or after March 15, 2012 that were reimbursed from April 1, 2012 through January 31, 2013, we performed a computer search and identified 538,671 claim lines, totaling $58,784,918 in payments, that potentially were not coordinated with Medicare. From this universe, we selected for review a sample of 67,455 claim lines, totaling $24,359,022 in payments, to determine whether the BCBS plans complied with the contract provisions relative to COB with Medicare. When we submitted our sample of potential COB errors to the Association on March 1, 2013, the claims were within the Medicare timely filing requirement and could be filed with Medicare for coordination of benefits. Based on this, since the BCBS plans are required to initiate recovery efforts immediately for the actual COB errors, our

expectation is for the plans to recover and return all of the actual COB errors to the FEHBP. A portion of the questioned amount may be determined to be not paid in error during the audit resolution phase.

Generally, Medicare Part A pays all covered costs for inpatient care in hospitals, skilled nursing facilities, and hospice care, except for deductibles and coinsurance. For each Medicare Benefit Period, there is a one-time deductible, followed by a daily copayment beginning with the 61st day. Beginning with the 91st day of the Medicare Benefit Period, Medicare Part A benefits may be exhausted, depending on whether the patient elects to use their Lifetime Reserve Days. For the uncoordinated Medicare Part A claims, we estimate that the FEHBP was overcharged for the total claim payment amounts. When applicable, we reduced the questioned amount by the Medicare deductible and/or Medicare copayment.

Medicare Part B pays 80 percent of most outpatient charges and professional claims after the calendar year deductible has been met. Also, Medicare Part B pays 80 percent of inpatient facility charges for ancillary services such as medical supplies, diagnostic tests, and clinical laboratory services. Based on our experience, ancillary items account for approximately 30 percent of the total inpatient claim payment. Therefore, we estimate that the FEHBP was overcharged 25 percent for these inpatient claim lines (0.30 x 0.80 = 0.24 ~ 25 percent).

We separated the uncoordinated claims into the following six categories based on the clinical setting and whether Medicare Part A or B should have been the primary payer.

- Categories A and B consist of inpatient claims that should have been coordinated with Medicare Part A. In a small number of instances where the BCBS plans indicated that Medicare Part A benefits were exhausted, we reviewed the claims to determine whether there were any inpatient services that were payable by Medicare Part B. For these claim lines, we only questioned the services covered by Medicare Part B.

- Categories C and D include inpatient claims with ancillary items that should have been coordinated with Medicare Part B. When we could not reasonably determine the actual overcharge for the ancillary items, we questioned 25 percent of the amount paid for these inpatient claim lines. In a small number of instances where the BCBS plans indicated that members had Medicare Part B only and priced the claims according to the Omnibus Budget Reconciliation Act of 1990 pricing guidelines, we reviewed the claims to determine whether there were any inpatient services that were payable by Medicare Part B.

- Categories E and F include outpatient and professional claims where Medicare Part B should have been the primary payer. When we could not reasonably determine the actual overcharge for a claim line, we questioned 80 percent of the amount paid for the claim lines.

From these six categories, we selected for review a sample of claim lines that potentially were not coordinated with Medicare (See Schedule A for our sample selection methodology). Based on our review, we determined that 60 of the 62 BCBS plan sites did not properly coordinate claim charges with Medicare. Specifically, we identified 16,406 claim lines, totaling $8,640,313 in payments, where the FEHBP paid as the primary insurer when Medicare was the primary

insurer. We estimate that the FEHBP was overcharged $7,717,615 for these claim line payments.[3]

The following table details the six categories of questioned COB claim lines:

Category	Claim Lines	Amount Paid	Amount Questioned
Category A: Medicare Part A Primary for Inpatient (I/P) Facility	238	$3,694,202	$3,589,299
Category B: Medicare Part A Primary for Skilled Nursing/Home Health Care (HHC)/ Hospice Care	3,674	$796,552	$767,602
Category C: Medicare Part B Primary for Certain I/P Facility Charges	39	$394,757	$179,907
Category D: Medicare Part B Primary for Skilled Nursing/HHC/Hospice Care	19	$104,279	$27,166
Category E: Medicare Part B Primary for Outpatient (O/P) Facility and Professional	9,538	$2,204,731	$1,955,510
Category F: Medicare Part B Primary for O/P Facility and Professional (Participation Code F)	2,898	$1,445,792	$1,198,131
Total	16,406	$8,640,313	$7,717,615

Our audit disclosed the following for the COB errors:

- For 10,555 (64 percent) of the claim lines questioned, the BCBS plans incorrectly paid these claims due to retroactive adjustments. Specifically, there was no special information present in the FEP Direct Claims System to identify Medicare as the primary payer when the claims were paid. However, when the Medicare information was subsequently added to the FEP Direct Claims System, the BCBS plans did not review and/or adjust the patient's prior claim(s) back to the Medicare effective dates. As a result, we estimate that the FEHBP was overcharged $5,107,203 for these COB errors.

- For 2,428 (15 percent) of the claim lines questioned, the BCBS plans incorrectly paid these claims due to systematic processing errors. Specifically, the claims were not deferred on the FEP Direct Claims System for Medicare COB review by the processors. We noted that most of these questioned claim lines were for HHC services that were not properly coordinated with Medicare. As a result, the FEHBP was overcharged $883,578 for these COB errors.

[3] In addition, there were 4,455 claim lines, totaling $2,577,240 in COB overpayments, that were identified by the BCBS plans before our audit notification date (i.e., February 1, 2013) and adjusted and returned to the FEHBP by the audit request due date (i.e., May 31, 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.

- For 2,221 (14 percent) of the claim lines questioned, the BCBS plans incorrectly paid these claims due to manual processing errors. In most cases, there was special information present in the FEP Direct Claims System to identify Medicare as the primary payer when these claims were paid. However, an incorrect Medicare Payment Disposition Code was used to override the FEP Direct Claims System's deferral of these claims. The Medicare Payment Disposition Code identifies Medicare's responsibility for payment on each charge line of a claim. According to the FEP Administrative Manual, the completion of this field is required on all claims for patients who are age 65 or older. We found that codes D, E, F, G and N were incorrectly used. An incorrect entry in this field causes the claim line to be excluded from coordination of benefits with Medicare. As a result, we estimate that the FEHBP was overcharged $1,448,961 for these COB errors.

- For 1,202 (7 percent) of the claim lines questioned, the BCBS plans incorrectly paid these claims due to provider billing errors. As a result, we estimate that the FEHBP was overcharged $277,873 for these COB errors.

Of the $7,717,615 in questioned COB errors:

- $3,641,502 (47 percent) represents 8,351 claim line overpayments that were identified as a result of our audit. We noted that the BCBS plans initiated recovery efforts for these overpayments after receiving our audit request (i.e., sample of potential COB errors) on March 1, 2013.

- $2,831,236 (37 percent) represents 5,395 claim line overpayments where the BCBS plans initiated recovery efforts on or after our audit notification date (i.e., February 1, 2013) but before receiving our audit request (i.e., March 1, 2013), and also completed the recovery process and adjusted the claims by the audit request due date (i.e., May 31, 2013). However, since the recoveries for these overpayments were initiated on or after our audit notification date, we are continuing to question these COB errors.

- $1,244,877 (16 percent) represents 2,660 claim line overpayments where the BCBS plans initiated recovery efforts before receiving our audit request (i.e., March 1, 2013) but had not recovered the overpayments and adjusted the claims by the audit request due date (i.e., May 31, 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 COB errors.

Additionally, we identified 260 claim line payments that were not COB errors but contained other claim payment errors, resulting in overcharges of $80,026 to the FEHBP. These claim payment errors resulted from the following:

- The BCBS plans paid 255 claim lines using the incorrect procedure allowances or pricing methods when pricing these claim lines, resulting in overcharges of $64,474 to the FEHBP.

- The BCBS plans paid five claim lines using incorrect Omnibus Budget Reconciliation Act of 1990 or 1993 pricing amounts, resulting in overcharges of $15,552 to the FEHBP.

Of this $80,026 in questioned claim payment errors (non-COB errors):

- $57,563 (72 percent) represents 250 claim line overpayments that were identified as a result of our audit. We noted that the BCBS plans initiated recovery efforts for these overpayments after receiving our audit request (i.e., sample of potential COB errors) on March 1, 2013.

- $13,483 (17 percent) represents 7 claim line overpayments where the BCBS plans initiated recovery efforts on or after our audit notification date (i.e., February 1, 2013) but before receiving our audit request (i.e., March 1, 2013), and also completed the recovery process and adjusted or voided the claims by the audit request due date (i.e., May 31, 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.

- $8,980 (11 percent) represents 3 claim line overpayments where the BCBS plans initiated recovery efforts before receiving our audit request (i.e., March 1, 2013) but had not recovered the overpayments and adjusted or voided the claims by the audit request due date (i.e., May 31, 2013). Since the overpayment 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:

In response to the draft report, the Association states, "After reviewing the OIG listing of potentially uncoordinated Medicare COB claims . . . We agree that $2,650,791 of the questioned amount was paid in error and the error was not identified by the start of the audit."

The Association disagrees with $17,610,616 of the questioned charges in the draft report. For this contested amount, the Association states that "the BCBS Association identified the following:

- $10,508,680 in claims that were paid correctly;
- $2,285,875 in claims that were initially paid incorrectly but the error was identified and corrected before the Audit Notification date and overpayment was recovered and returned before the response was due to OPM;
- $2,696,620 in claims that were initially paid incorrectly but recovery was initiated on or after the Audit Notification date but before receiving the OIG sample and the overpayment was recovered and returned before the response was due to OPM; and
- $2,119,441 that was initially paid incorrectly but recovery was initiated before receiving the OIG sample, however overpayment was not recovered and returned before the response was due to OPM."

Regarding corrective actions, the Association states, "The Association's Action Plan includes oversight and governance procedures to assure all BCBS Plans are following the corrective action plans. In addition, to reduce the number and frequency of uncoordinated Medicare claims, BCBSA has implemented the following corrective actions which are currently in process or under review:

- Provided additional Plan guidance on mapping data from Medicare crossover claims to the correct Medicare Payment Disposition code.
- The FEP claims system will be modified by December 31, 2013 to include the Medicare Payment Disposition code from Medicare denials. In conjunction with this change, the system will be modified to defer claims for additional Plan review for certain Medicare denial reason codes . . .

To ensure that Plans review all claims incurred back to the Medicare effective date:

- FEP updated the Plan Administrative Manual to instruct the Plans on what to do with the Retroactive Enrollment Report.
- As part of the FEP Control Performance Review, FEP reviews Plan's procedures for reviewing retroactive enrollment reports as well as tests transactions to ensure that all claims are reviewed back to the Medicare effective dates."

OIG Comments:

After reviewing the Association's response and additional documentation provided by the BCBS plans, we revised the questioned charges in our draft report from $20,261,409 to $7,797,641. If the BCBS plans identified the claim payment errors and initiated recovery efforts before our audit notification date (i.e., February 1, 2013) 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., May 31, 2013), we did not question these claim payment errors (approximately $2.6 million in COB overpayments) in the final report. Additionally, after reviewing the BCBS plans' supporting documentation, we also concluded that approximately $10 million in potential COB overpayments from the draft report were not claim payment errors.

Based on the Association's response and the BCBS plans' additional documentation, we determined that the Association and/or plans agree with $3,057,218 and disagree with $4,740,423 of the revised questioned charges. Although the Association only agrees with $2,650,791 in its response, the BCBS plans' documentation supports concurrence with $3,057,218. It should be noted that while the Association and/or BCBS plans disagree with our questioning of $4,740,423 in this report, they do not disagree that these charges were not properly coordinated with Medicare and resulted in overcharges to the FEHBP.

Based on the Association's response and/or the BCBS plans' documentation, the contested amount of $4,740,423 represents the following items:

- $2,844,719 ($2,831,236 for COB errors plus $13,483 for non-COB errors) of the contested amount represents claim overpayments where the BCBS plans initiated recovery efforts on or after our audit notification date (i.e., February 1, 2013) but before receiving our audit request (i.e., March 1, 2013), and also completed the recovery process and adjusted or voided the claims by the audit request due date (i.e., May 31, 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.

- $1,253,857 ($1,244,877 for COB errors plus $8,980 for non-COB errors) of the contested amount represents claim overpayments where the BCBS plans initiated recovery efforts before receiving our audit request (i.e., March 1, 2013) but had not recovered the overpayments and/or adjusted or voided the claims by the audit request due date (i.e., May 31, 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.

- $641,847 of the contested amount represents claim lines that the BCBS plans agree were COB errors. 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.

Recommendation 1

We recommend that the contracting officer disallow $7,717,615 for the uncoordinated claim payments and verify that the BCBS plans return all amounts recovered to the FEHBP (See Schedule B for a summary of these questioned uncoordinated claim payments by BCBS plan).

Recommendation 2

Although the Association has developed a corrective action plan to reduce COB findings, 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. We also recommend that the contracting officer ensure that the Association's additional corrective actions for improving the prevention and detection of uncoordinated claim payments are being implemented. These additional corrective actions are included in the Association's response to the draft report.

Recommendation 3

Since the highest percentage of the COB errors resulted from retroactive adjustments, we recommend that the contracting officer require the Association to provide evidence or supporting documentation ensuring that all BCBS plans are using the daily retroactive enrollment reports and reviewing all claims incurred back to the Medicare effective dates when the other party liability information is updated in the FEP Direct Claims System. When Medicare eligibility is subsequently reported, the plans are expected to immediately determine if previously paid claims are affected and, if so, to initiate the recovery process within 30 days.

Recommendation 4

Due to the significant number of retroactive COB adjustments, we recommend that the contracting officer require the Association to provide evidence or supporting documentation ensuring that the FEP Operations Center continues to utilize the Medicare Data Exchange Agreement that requires a quarterly exchange of enrollment data between Medicare and the FEHBP. We also recommend that the contracting officer require the Association to provide evidence or supporting documentation ensuring that the enrollment data provided by Medicare is updated in a timely manner in the FEP Direct Claims System.

Recommendation 5

Due to the significant number of manual processing errors, we recommend that the contracting officer require the Association to provide evidence or supporting documentation after the FEP Operations Center includes the field(s) in the FEP Direct Claims System to collect Remittance Advice Remark Codes (RARC) and Claim Adjustment Reason Codes (CARC) from the BCBS plans. These Medicare generated codes (RARC and CARC) provide the reason Medicare denied a claim payment. The Association should also have the FEP Operations Center and BCBS plans utilize the RARC and CARC field(s) when implementing the Medicare Disposition Code corrective actions. (Note: Based on the Association's draft report response, the FEP Direct Claims System will be modified to include the Medicare Disposition Code for Medicare denials.)

Recommendation 6

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 continues to allow claims (such as home health care claims) that require Medicare COB to bypass COB edits. After identifying the reason(s) why, the FEP Operations Center should implement corrective edits in the system. The contracting officer should also require the Association to provide evidence or supporting documentation ensuring that the applicable corrective edits have been implemented.

Recommendation 7

We recommend that the contracting officer disallow $80,026 for the non-COB claim payment errors and verify that the BCBS plans return all amounts recovered to the FEHBP (See Schedule B for a summary of these questioned non-COB claim payment errors by BCBS plan).

IV. MAJOR CONTRIBUTORS TO THIS REPORT

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SCHEDULE A

V. SCHEDULES

Coordination of Benefits with Medicare
BlueCross and BlueShield Plans
Claims Reimbursed from April 1, 2012 through January 31, 2013

UNIVERSE AND SAMPLE OF POTENTIALLY UNCOORDINATED CLAIM LINES

	UNIVERSE				SAMPLE						
CATEGORY	**Number of Claims**	**Number of Claim Lines**	**Number of Patients**	**COB Universe Total Payments**	**Sample Selection Methodology**	**Number of Claims**	**Number of Claim Lines**	**Number of Patients**	**Amounts Paid**	**Estimated Overcharge Percentage**	**Potential Overcharge**
Category A: Medicare Part A Primary for I/P Facility	512	515	397	$6,488,518	all patients selected	512	515	397	$6,488,518	100%	$6,488,518
Category B: Medicare Part A Primary for Skilled Nursing/HHC/Hospice Care	4,102	14,291	1,338	$2,632,955	patients with cumulative claims of $1,000 or more	2,565	10,380	504	$2,318,488	100%	$2,318,488
Category C: Medicare Part B Primary for Certain I/P Facility Charges	82	82	59	$1,544,510	all patients selected	82	82	59	$1,544,511	25%	$386,128
Category D: Medicare Part B Primary for Skilled Nursing/HHC/Hospice Care	88	161	52	$267,012	patients with cumulative claims of $2,500 or more	46	46	31	$250,417	25%	$62,604
Category E: Medicare Part B Primary for Outpatient Facility and Professional	12,300	22,281	3,217	$5,326,037	patients with cumulative claims of $1,000 or more	7,446	15,069	817	$4,595,052	80%	$3,676,042
Category F: Medicare Part B Primary for Outpatient Facility and Professional (Participation Code F)	319,178	501,341	157,657	$42,525,886	patients with cumulative claims of $3,500 or more	15,297	41,363	1,107	$9,162,036	80%	$7,329,629
Totals	**336,262**	**538,671**		**$58,784,918**		**25,948**	**67,455**		**$24,359,022**		**$20,261,409**

Coordination of Benefits with Medicare
BlueCross and BlueShield Plans
Claims Reimbursed from April 1, 2012 through January 31, 2013

QUESTIONED CHARGES BY PLAN

			COB Category A		COB Category B		COB Category C		COB Category D		COB Category E		COB Category F		Total COB Errors		Non-COB Errors		TOTAL QUESTIONED	
Plan Site Number	Plan State	Plan Name	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned
003	NM	BlueCross BlueShield of New Mexico (HCSC)	0	$0	27	$2,449	0	$0	0	$0	50	$5,337	5	$1,342	82	$9,128	0	$0	82	$9,128
005	GA	WellPoint BlueCross BlueShield of Georgia	8	$224,370	106	$18,887	1	$3,326	0	$0	951	$156,881	377	$187,057	1443	$590,520	5	$2,244	1448	$592,764
006	MD	CareFirst BlueCross BlueShield (Maryland Service Area)	11	$71,621	360	$87,061	2	$34,730	0	$0	445	$60,260	68	$49,791	886	$303,462	0	$0	886	$303,462
007	LA	BlueCross BlueShield of Louisiana	0	$0	170	$24,993	16	$46,206	0	$0	33	$11,191	76	$36,056	295	$118,445	2	$10,020	297	$128,465
009	AL	BlueCross BlueShield of Alabama	13	$218,527	0	$0	2	$2,075	0	$0	306	$35,917	13	$10,410	334	$266,929	0	$0	334	$266,929
010	ID	BlueCross of Idaho Health Service	1	$4,850	0	$0	0	$0	0	$0	71	$14,158	0	$0	72	$19,008	0	$0	72	$19,008
011	MA	BlueCross BlueShield of Massachusetts	2	$23,993	49	$5,986	5	$64,646	0	$0	113	$14,437	101	$11,129	270	$120,191	0	$0	270	$120,191
012	NY	BlueCross BlueShield of Western New York	1	$8,607	0	$0	0	$0	0	$0	0	$0	0	$0	1	$8,607	0	$0	1	$8,607
013	PA	Highmark BlueCross BlueShield	0	$0	0	$0	0	$0	0	$0	218	$30,164	0	$0	218	$30,164	4	$452	222	$30,616
015	TN	BlueCross BlueShield of Tennessee	7	$64,720	36	$4,973	0	$0	0	$0	547	$120,909	57	$48,872	647	$239,474	2	$896	649	$240,370
016	WY	BlueCross BlueShield of Wyoming	0	$0	43	$10,483	0	$0	0	$0	0	$0	0	$0	43	$10,483	0	$0	43	$10,483
017	IL	BlueCross BlueShield of Illinois (HCSC)	10	$127,381	20	$3,432	0	$0	0	$0	365	$67,857	74	$18,729	469	$217,399	2	$1,133	471	$218,532
021	OH	WellPoint BlueCross BlueShield of Ohio	10	$134,372	220	$49,874	0	$0	7	$5,255	133	$13,014	62	$10,654	432	$213,169	0	$0	432	$213,169
024	SC	BlueCross BlueShield of South Carolina	1	$28,279	59	$5,272	0	$0	0	$0	231	$103,075	19	$31,749	310	$168,375	0	$0	310	$168,375
027	NH	WellPoint BlueCross BlueShield of New Hampshire	1	$18,697	46	$4,651	0	$0	0	$0	35	$6,732	15	$2,338	97	$32,418	1	$978	98	$33,396
028	VT	BlueCross BlueShield of Vermont	0	$0	0	$0	0	$0	0	$0	9	$446	0	$0	9	$446	0	$0	9	$446
029	TX	BlueCross BlueShield of Texas (HCSC)	28	$315,460	183	$15,678	4	$7,688	0	$0	1056	$205,061	112	$32,842	1383	$576,728	199	$43,383	1582	$620,112
030	CO	WellPoint BlueCross BlueShield of Colorado	2	$57,974	46	$17,429	0	$0	9	$7,974	52	$4,372	8	$9,549	117	$97,299	0	$0	117	$97,299
031	IA	Wellmark BlueCross BlueShield of Iowa	2	$14,617	17	$50,629	1	$12,139	1	$5,177	229	$62,692	18	$6,589	268	$151,843	0	$0	268	$151,843
032	MI	BlueCross BlueShield of Michigan	1	$12,707	74	$8,080	0	$0	0	$0	83	$13,740	83	$53,326	241	$87,853	0	$0	241	$87,853
033	NC	BlueCross BlueShield of North Carolina	8	$309,678	248	$26,063	3	$4,279	0	$0	306	$68,803	95	$66,026	660	$474,849	10	$4,987	670	$479,837
034	ND	BlueCross BlueShield of North Dakota	0	$0	19	$4,468	0	$0	0	$0	14	$2,650	38	$5,444	71	$12,563	0	$0	71	$12,563
036	PA	Capital BlueCross	2	$11,985	39	$4,164	0	$0	0	$0	36	$16,500	14	$7,317	91	$39,966	0	$0	91	$39,966
037	MT	BlueCross BlueShield of Montana	0	$0	0	$0	0	$0	0	$0	24	$2,166	0	$0	24	$2,166	0	$0	24	$2,166
038	HI	BlueCross BlueShield of Hawaii	0	$0	0	$0	0	$0	0	$0	0	$0	1	$132	1	$132	0	$0	1	$132
039	IN	WellPoint BlueCross BlueShield of Indiana	1	$4,501	92	$14,395	0	$0	0	$0	166	$15,317	14	$4,498	273	$38,712	0	$0	273	$38,712
040	MS	BlueCross BlueShield of Mississippi	2	$16,415	123	$13,915	0	$0	0	$0	24	$15,195	36	$17,311	185	$62,837	0	$0	185	$62,837
041	FL	BlueCross BlueShield of Florida	8	$226,791	168	$54,548	0	$0	0	$0	336	$96,521	304	$279,116	816	$656,977	19	$2,507	835	$659,484
042	MO	BlueCross BlueShield of Kansas City (Missouri)	0	$0	0	$0	0	$0	0	$0	22	$6,018	5	$4,245	27	$10,263	0	$0	27	$10,263
043	ID	Regence BlueShield of Idaho	0	$0	0	$0	0	$0	0	$0	16	$1,570	0	$0	16	$1,570	0	$0	16	$1,570
044	AR	BlueCross BlueShield of Arkansas	2	$23,546	14	$2,179	0	$0	0	$0	54	$4,810	0	$0	70	$30,536	0	$0	70	$30,536
045	KY	WellPoint BlueCross BlueShield of Kentucky	2	$9,041	80	$6,790	0	$0	0	$0	47	$42,449	40	$16,827	169	$75,107	0	$0	169	$75,107
047	WI	WellPoint BlueCross BlueShield United of Wisconsin	5	$112,048	48	$10,826	0	$0	0	$0	168	$56,807	18	$12,188	239	$191,869	0	$0	239	$191,869
048	NY	Empire BlueCross BlueShield (WellPoint)	10	$129,069	8	$1,045	1	$1,153	1	$2,160	435	$66,953	382	$29,916	837	$230,295	0	$0	837	$230,295
049	NJ	Horizon BlueCross BlueShield of New Jersey	3	$16,522	0	$0	0	$0	0	$0	204	$41,768	8	$7,574	215	$65,864	2	$4,760	217	$70,624
050	CT	WellPoint BlueCross BlueShield of Connecticut	3	$25,303	59	$5,054	0	$0	0	$0	46	$8,771	0	$0	108	$39,129	0	$0	108	$39,129
052	CA	WellPoint BlueCross of California	12	$98,288	174	$28,449	0	$0	0	$0	133	$66,574	80	$30,413	399	$223,723	0	$0	399	$223,723
053	NE	BlueCross BlueShield of Nebraska	1	$87,668	6	$1,096	0	$0	0	$0	56	$10,206	0	$0	63	$98,969	0	$0	63	$98,969
054	WV	Mountain State BlueCross BlueShield	0	$0	0	$0	0	$0	0	$0	2	$144	1	$299	3	$444	0	$0	3	$444
055	PA	Independence BlueCross	2	$35,360	13	$1,691	0	$0	0	$0	6	$6,401	0	$0	21	$43,451	0	$0	21	$43,451
056	AZ	BlueCross BlueShield of Arizona	0	$0	139	$15,747	0	$0	0	$0	584	$60,582	2	$11,929	725	$88,258	0	$0	725	$88,258
058	OR	Regence BlueCross BlueShield of Oregon	2	$33,299	9	$1,392	0	$0	0	$0	98	$14,538	13	$2,295	122	$51,524	4	$3,416	126	$54,939
059	ME	WellPoint BlueCross BlueShield of Maine	0	$0	59	$7,456	1	$767	1	$6,600	10	$597	70	$10,334	141	$25,754	0	$0	141	$25,754
060	RI	BlueCross BlueShield of Rhode Island	0	$0	77	$16,132	0	$0	0	$0	4	$5,091	0	$0	81	$21,223	7	$1,052	88	$22,275
061	NV	Wellpoint BlueCross BlueShield of Nevada	1	$3,937	31	$3,075	0	$0	0	$0	17	$3,173	19	$10,007	68	$20,192	0	$0	68	$20,192

Coordination of Benefits with Medicare
BlueCross and BlueShield Plans
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QUESTIONED CHARGES BY PLAN

			COB Category A		COB Category B		COB Category C		COB Category D		COB Category E		COB Category F		Total COB Errors		Non-COB Errors		TOTAL QUESTIONED	
Plan Site Number	Plan State	Plan Name	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned
062	VA	WellPoint BlueCross Blue Shield of Virginia	5	$36,260	63	$20,330	0	$0	0	$0	130	$17,831	264	$47,857	462	$122,278	0	$0	462	$122,278
064	NY	Excellus BlueCross BlueShield of the Rochester Area	0	$0	0	$0	0	$0	0	$0	13	$1,234	8	$909	21	$2,143	0	$0	21	$2,143
066	UT	Regence BlueCross BlueShield of Utah	0	$0	142	$12,365	0	$0	0	$0	70	$9,371	51	$9,423	263	$31,159	0	$0	263	$31,159
067	CA	BlueShield of California	0	$0	78	$3,360	0	$0	0	$0	369	$51,277	195	$17,186	642	$71,822	1	$971	643	$72,793
068	PR	Triple-S Salud, Inc. of Puerto Rico	0	$0	0	$0	0	$0	0	$0	1	$1,929	0	$0	1	$1,929	0	$0	1	$1,929
069	WA	Regence BlueShield of Washington	0	$0	0	$0	0	$0	0	$0	46	$4,989	6	$543	52	$5,532	0	$0	52	$5,532
070	AK	BlueCross BlueShield of Alaska	1	$8,299	0	$0	0	$0	0	$0	57	$42,255	2	$3,939	60	$54,493	1	$1,184	61	$55,677
074	SD	Wellmark BlueCross BlueShield of South Dakota	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
075	WA	Premera BlueCross	2	$36,883	1	$2,580	0	$0	0	$0	61	$7,782	23	$6,808	87	$54,054	1	$2,043	88	$56,097
076	MO	WellPoint BlueCross BlueShield of Missouri	3	$43,903	172	$39,440	1	$302	0	$0	29	$7,543	7	$3,552	212	$94,741	0	$0	212	$94,741
078	MN	BlueCross BlueShield of Minnesota	3	$41,533	0	$0	0	$0	0	$0	172	$87,929	4	$10,162	179	$139,623	0	$0	179	$139,623
082	KS	BlueCross BlueShield of Kansas	0	$0	0	$0	0	$0	0	$0	30	$2,294	1	$11,074	31	$13,369	0	$0	31	$13,369
083	OK	BlueCross BlueShield of Oklahoma (HCSC)	14	$158,598	16	$2,401	2	$2,595	0	$0	115	$17,519	37	$10,548	184	$191,661	0	$0	184	$191,661
085	DC	CareFirst BlueCross BlueShield (DC Service Area)	47	$772,611	333	$157,708	0	$0	0	$0	470	$107,098	72	$49,826	922	$1,087,244	0	$0	922	$1,087,244
088	PA	BlueCross of Northeastern Pennsylvania	1	$21,587	7	$1,056	0	$0	0	$0	32	$3,251	0	$0	40	$25,893	0	$0	40	$25,893
089	DE	BlueCross BlueShield of Delaware	0	$0	0	$0	0	$0	0	$0	208	$53,361	0	$0	208	$53,361	0	$0	208	$53,361
092	DC	CareFirst BlueCross BlueShield (Overseas Area)	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
		TOTALS	**238**	**$3,589,299**	**3,674**	**$767,602**	**39**	**$179,907**	**19**	**$27,166**	**9,538**	**$1,955,510**	**2,898**	**$1,198,131**	**16,406**	**$7,717,615**	**260**	**$80,026**	**16,666**	**$7,797,641**

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

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June 23, 2013

[redacted]
Group Chief
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Reference: **OPM DRAFT AUDIT REPORT**
Tier XIII Global Coordination of Benefits
Audit Report #1A-99-00-13-032

Dear [redacted]:

This is in response to the above – referenced U.S. Office of Personnel Management (OPM) Draft Audit Report concerning the Global Coordination of Benefits Audit for claims paid from April 1, 2012 through January 31, 2013. Our comments concerning the findings in the report are as follows:

Recommendation 1 and 3:

Coordination of Benefits with Medicare Questioned Amount **$20,261,409**

The OPM OIG submitted their sample of potential Medicare Coordination of Benefits errors to the Blue Cross Blue Shield Association (BCBS) on March 1, 2013. The BCBS Association and/or the BCBS Plans were requested to review these potential errors and provide responses by May 31, 2013. These listings included claims incurred on or after March 31, 2012 and reimbursed from April 1, 2012 through January 31, 2013. OPM OIG identified 538,671 claim lines, totaling $58,784,918 in payments, which potentially were not coordinated with Medicare. From this universe, OPM OIG selected for review a sample of 67,455 claim lines, totaling $24,359,022 in payments with a potential overpayment of $20,261,409 to the Federal Employee Health Benefit Program (FEHBP).

Furthermore, although the BCBS Association has developed corrective actions to reduce COB findings, OPM OIG recommended that the contracting officer instruct the BCBS Association to ensure that all BCBS Plans are following the corrective action plan. Also, the BCBS Association should continue to identify additional corrective actions to further reduce COB findings.

Blue Cross Blue Shield Association (BCBSA) Response to Recommendation 1, 2 and 3:

After reviewing the OIG listing of potentially uncoordinated Medicare COB claims totaling $20,261,408, the BCBS Association identified the following:

- $10,508,680 in claims that were paid correctly;
- $2,285,875 in claims that were initially paid incorrectly but the error was identified and corrected before the Audit Notification date and overpayment was recovered and returned before the response was due to OPM;
- $2,696,620 in claims that were initially paid incorrectly but recovery was initiated on or after the Audit Notification date but before receiving the OIG sample and the overpayment was recovered and returned before the response was due to OPM; and
- $2,119,441 that was initially paid incorrectly but recovery was initiated before receiving the OIG sample, however overpayment was not recovered and returned before the response was due to OPM.

We agree that $2,650,791 of the questioned amount was paid in error and the error was not identified by the start of the audit.

We disagree with $17,610,616 in improper claim payments. For claims totaling $10,508,680 the initial payment was correct based on the following reasons:

- Medicare Part A/Part B was secondary (e.g., FEHBP primary, ESRD Medicare waiting period) for claim payments totaling $338,669;
- Medicare Part A/Part B benefit for period was exhausted for claim payments totaling $1,659,860;
- There were no Medicare Part B charges for claim payments totaling $249,360;
- The Provider opted out of Medicare pricing and FEHBP paid primary for claim payments totaling $133,274;
- Medicare denied the charges due to non-covered Medicare Home health provider for claim payments totaling $340,489;
- Medicare denied charges due to non-covered Medicare Long Term Care provider for claim payments totaling $3,906;
- Medicare denied charges due to non-covered Medicare provider for claim payments totaling $719,955;
- Medicare denied charges due to member being in hospice status for claim payments totaling $178,497;
- Medicare denied the charges for claim payments totaling $4,384,287;
- Services were provided by a non-covered Indian Health Service (IHS) facilities for claim payments totaling $7,268;

- The claim was coordinated with Medicare; however the claim line identified in the sample was not covered for claim payments totaling $826,538;
- Claim was priced according to case management guidelines for claim payments totaling $319,928;
- FEP paid the member's Medicare cost sharing (coinsurance or deductible) for claim payments totaling $330,502;
- Medicare Government facility not paid by Medicare - Veteran Affairs (VA), Dept. of Defense (DD), Uniform Health Services Family Health Plan (FM), Military Facility (MF) - for claim payments totaling $257,982;
- Member did not meet Home Health/Skilled Nursing three day stay for claim payments totaling $156,137;
- Member not home bound for claim payments totaling $14,870; and
- The claim was paid correctly for other reasons for claim payments totaling $587,160.

For claims totaling $9,752,727, the Plans initially paid these claims incorrectly largely because of the following reasons:

- Appropriate documentation was not available at the time of processing;
- Processor errors;
- Provider billing errors; and
- Local system errors.

For $4,405,315 or 45 percent of these claims, through post payments review controls implemented by the Plans and BCBS Association, the Plans identified the incorrect payments before the Audit Notification date and initiated recovery and/or returned the funds to the Program.

For $2,696,621 or 28 percent of these claims, the Plans initiated recovery after the Audit Notification date but before receiving the OIG sample.

For the remaining $2,650,791 questioned in the draft report, the Plans agreed that these were claim payment errors identified as a result of this audit. The Plans will continue to pursue the remaining overpayments as required by CS 1039, Section 2.3(g) (l).

The Association's Action Plan includes oversight and governance procedures to assure all BCBS Plans are following the corrective action plans. In addition, to reduce the number and frequency of uncoordinated Medicare claims, BCBSA has implemented the following corrective actions which are currently in process or under review:

- Provided additional Plan guidance on mapping data from Medicare crossover claims to the correct Medicare Payment Disposition code.

- The FEP claims system will be modified by December 31, 2013 to include the Medicare Payment Disposition code from Medicare denials. In conjunction with this change, the system will be modified to defer claims for additional Plan review for certain Medicare denial reason codes.

Documentation to support the contested amounts and the initiation of overpayment recovery before the audit has been provided. In addition, we have attached a schedule listed as Attachment A that shows the amount questioned, contested, and agreed to by each Plan location.

Recommendation 4:

OPM OIG recommended that the contracting officer require the Association to ensure that the BCBS Plans have procedures in place to review all claims incurred back to the Medicare effective dates when updated, Other Party Liability information is added to the FEP national claims system. When Medicare eligibility is subsequently reported, the Plans are expected to immediately determine if previously paid claims are affected and, if so, to initiate the recovery process within 30 days.

BCBSA Response:

To ensure that Plans review all claims incurred back to the Medicare effective date:

- FEP updated the Plan Administrative Manual to instruct the Plans on how to work the Retroactive Enrollment Report.
- As part of the FEP Control Performance Review, FEP reviews Plans procedures for reviewing retroactive enrollment reports as well as tests transactions to ensure that all claims are reviewed back to the Medicare effective dates.

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.

[redacted]
Managing Director
FEP Program Assurance

Attachments