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

# Final Audit Report

## AUDIT OF
## INDEPENDENCE BLUE CROSS
## PHILADELPHIA, PENNSYLVANIA

**Report Number 1A-10-55-14-027**
**December 2, 2014**

**-- CAUTION --**

# EXECUTIVE SUMMARY

*Audit of Independence Blue Cross*

Report No. 1A-10-55-14-027 December 2, 2014

**Why Did We Conduct The Audit?**

The objectives of our audit were to determine whether Independence Blue Cross (IBX or Plan) charged costs to the Federal Employee Health Benefits Program (FEHBP) and provided services to the FEHBP members in accordance with the terms of the contract. Specifically, our objectives were to determine whether the Plan complied with contract provisions relative to claim payments.

**What Did We Audit?**

The Office of the Inspector General (OIG) has completed a limited scope audit of the FEHBP operations at Independence Blue Cross, located in Philadelphia, Pennsylvania. We reviewed approximately $6.8 million in claim payments, from a universe of $721 million in health benefit charges. The audit covered IBX's claim payments from January 1, 2011 through December 31, 2013 as reported in the Annual Accounting Statements.

**Michael R. Esser**
***Assistant Inspector General for Audits***

**What Did We Find?**

Our limited scope audit was conducted in accordance with Government Auditing Standards. The report questions $86,594 in health benefit charges. The questioned health benefit charges are summarized as follows:

1. Non-Participating Facility Review
   - The Plan incorrectly paid six non-participating facility claims, resulting in overcharges of $46,933 to the FEHBP.
2. Retroactive Enrollment Review
   - The Plan incorrectly paid four claims requiring retroactive enrollment adjustments, resulting in overcharges of $25,399 to the FEHBP.
3. Dialysis Review
   - The Plan incorrectly paid 11 dialysis claims, resulting in overcharges of $14,262 to the FEHBP.

# ABBREVIATIONS

| | |
|---|---|
| **AAS** | **Annual Accounting Statements** |
| **Association** | **BlueCross BlueShield Association** |
| **BCBS** | **BlueCross BlueShield** |
| **COB** | **Coordination of Benefits** |
| **CFR** | **Code of Federal Regulations** |
| **FEHBP** | **Federal Employee Health Benefit Program** |
| **FEHB** | **Federal Employee Health Benefits** |
| **FEP** | **Federal Employee Program** |
| **FOIA** | **Freedom of Information Act** |
| **IG** | **Inspector General** |
| **OIG** | **Office of the Inspector General** |
| **OPM** | **Office of Personnel Management** |
| **IBX or Plan** | **Independence Blue Cross** |

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# I. BACKGROUND

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 Independence Blue Cross (IBX or Plan). IBX is located in Philadelphia, Pennsylvania. The audit was performed by the Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as authorized by the Inspector General Act of 1978, as amended.

The FEHBP was established by the Federal Employees Health Benefits (FEHB) Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for federal employees, annuitants, and dependents. OPM's Healthcare and Insurance Office has overall responsibility for administration of the FEHBP. The provisions of the FEHB Act are implemented by OPM through regulations, which are codified in Title 5, Chapter 1, Part 890 of the Code of Federal Regulations (CFR). Health insurance coverage is made available through contracts with various health insurance carriers.

The BlueCross BlueShield Association (Association), on behalf of participating BlueCross and BlueShield (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 64 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 Association and Plan management. Also, management of the Plan is responsible for establishing and maintaining a system of internal controls.

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

All findings from our prior audit of IBX (Report No. 1A-10-55-04-010, dated December 15, 2004), which included claim payments from 2000 through 2002, have been satisfactorily resolved.

The results of this audit were provided to the Plan in written audit inquiries; were discussed with Plan and/or Association officials throughout the audit and at an exit conference; and were presented in detail in a draft audit report, dated August 7, 2014. The Association's comments offered in response to the draft report were considered in preparing our final report and are included as an Appendix to this report.

# II. OBJECTIVES, SCOPE, AND METHODOLOGY

**Objective**

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

**Scope and Methodology**

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

We reviewed the BlueCross and BlueShield FEHBP Annual Accounting Statements as they pertain to Plan code 362 for contract years 2011 through 2013. During this period, the Plan paid approximately $721 million in health benefit charges (See Figure 1 and Schedule A). Specifically, we reviewed approximately $6.8 million in claim payments for the period January 1, 2011 through December 31, 2013 for proper adjudication.

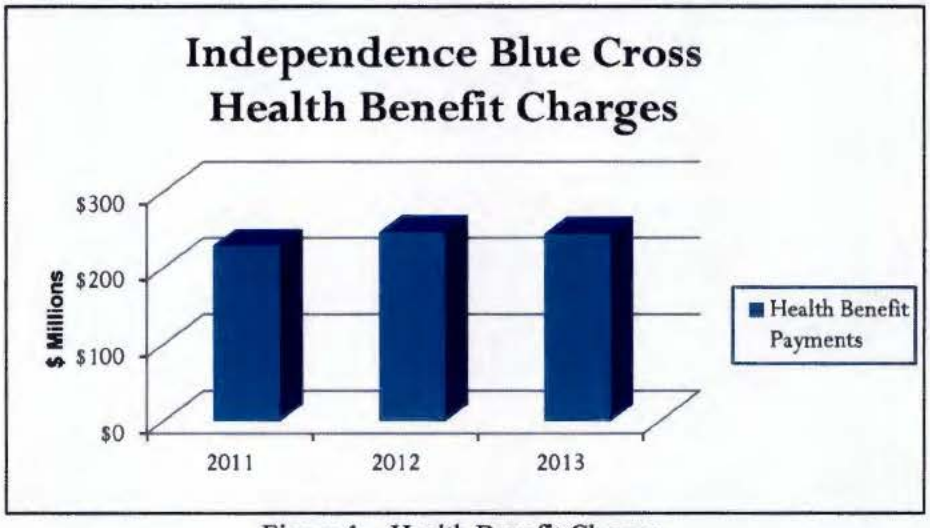


Figure 1 – Health Benefit Charges

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

We also conducted tests to determine whether the Plan had complied with the contract and the laws and regulations governing the FEHBP as they relate to claim payments. The results of our tests indicate that, with respect to the items tested, the Plan did not fully comply with the provisions of the contract relative to claim payments. Exceptions noted in the areas reviewed are explained in detail in the "Audit Findings and Recommendations" section of this audit report.

With respect to the items not tested, nothing came to our attention that caused us to believe that the Plan had not complied, in all material respects, with those provisions.

In conducting our audit, we relied to varying degrees on computer-generated data provided by the FEP Director's Office, the FEP Operations Center, and the Plan. Through audits and a reconciliation process, we have verified the reliability of the BCBS claims data in our data warehouse, which was used to identify the universe of claims for each type of review. The BCBS claims data is provided to us on a monthly basis by the FEP Operations Center, and after a series of internal steps, uploaded into our data warehouse. However, due to time constraints, we did not verify the reliability of the data generated by the Plan's local claims system. While utilizing the computer-generated data during our audit testing, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

The audit was performed at the Plan's office in Philadelphia, Pennsylvania in May 2014. Audit fieldwork was also performed at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida through July 2014.

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

To test the Plan's compliance with the FEHBP health benefit provisions, we selected and reviewed a sample of 438 claims. We used the FEHBP contract, the 2011 through 2013 Service Benefit Plan brochures, the Plan's provider agreements, and the Association's FEP Administrative Manual to determine the allowability of benefit payments. The results of these samples were not projected to the universe of claims.

# III. AUDIT FINDINGS AND RECOMMENDATIONS

## 1. Non-Participating Facility Review — $46,933

**IBX overcharged the FEHBP $46,933 as a result of claims processing errors related to non-participating providers.**

We performed a computer search to identify all non-participating provider claims from inpatient and outpatient facilities for the period January 1, 2011 through December 31, 2013. Non-participating providers are those that do not have a contract with IBX, and have not agreed to accept the IBX allowed amount as payment in full. Our search produced 3,672 claims (representing 37,418 claim lines), totaling $5,714,439 in payments. From this universe, we judgmentally selected the 75 highest paid claims, (representing 1,309 claim lines), totaling $2,265,805 in payments, to determine if these claims were correctly priced by the FEP Operations Center and paid by the Plan.

Our review of claims submitted by non-participating facilities determined that the Plan incorrectly paid six claims, resulting in overcharges of $46,933 to the FEHBP. These claim payment errors resulted from the following:

- The Plan did not appropriately coordinate one claim with Medicare, resulting in an overcharge of $20,362 to the FEHBP.
- The Plan's local processors incorrectly allowed non-covered services to be paid for members with "basic" enrollment coverage. As a result, the Plan incorrectly paid three claims, totaling $20,305 in overcharges to the FEHBP.
- The FEP Operations Center did not properly calculate the deductible or coinsurance amount on two claims, resulting in overcharges of $6,266 to the FEHBP.

Contract CS 1039, Part III, section 3.2 (b)(1) states, "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable." Part II, section 2.3(g) states, "If the Carrier [or OPM] determines that a Member's claim has been paid in error for any reason . . . the Carrier shall make a prompt and diligent effort to recover the erroneous payment . . . . The recovery of any overpayment must be treated as an erroneous benefit payment, overpayment, or duplicate payment . . . regardless of any time period limitations in the written agreement with the provider."

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 . . . ."

The 2013 BlueCross and BlueShield Service Benefit Plan brochure, page 26, states, Non-participating providers – We have no agreements with these providers to limit what they can bill

you for their services. This means that using non-participating providers could result in your having to pay significantly greater amounts for the services you receive.

**Recommendation 1**

We recommend that the contracting officer disallow $46,933 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

**Recommendation 2**

We recommend that the contracting officer require the Plan to provide additional education and/or detailed training to all claims processors on how to properly adjudicate non-participating claims for members with "basic" enrollment coverage based on the BCBS Service Benefit Brochure.

**IBX's Response:**

The Plan agrees with this finding. The Plan states that their current claims processor training includes how to process non-participating claims. Additionally, the Plan states that the associates that processed the claims included in this finding have been coached and advised on the correct methods of claim adjudication, and that they will continue to monitor this activity to ensure that non-participating claims are paid correctly.

### 2. Retroactive Enrollment Review $25,399

The retroactive enrollment report identifies paid claims that are potentially affected by enrollment changes (i.e., claims paid before the member's eligibility status is updated in the FEP Direct enrollment system). The report is generated by the FEP Operations Center and is distributed to the Plan on a daily basis.

**IBX did not properly recover four claims paid for ineligible members, resulting in overcharges of $25,399 to the FEHBP**

For the scope of our audit, we requested copies of the retroactive reports for the following time periods:

- January 1, 2011 through March 31, 2011;
- April 1, 2012 through June 30, 2012; and
- July 1, 2013 through September 30, 2013.

From these three quarters combined, we identified 2,097 claims, totaling $3,604,184 in potential overpayments to the FEHBP. From this universe, we judgmentally selected 117 high dollar claims, totaling $1,418,887 in potential overpayments, to determine whether the Plan was properly reviewing these potential claim payment errors and appropriately initiating recovery from the providers.

Our review determined that the Plan's claim processors did not initiate recovery and/or complete the recovery process for four claims, resulting in overcharges of $25,399 to the FEHBP.

As previously cited from CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments. Also, the recovery of any overpayment must be treated as an erroneous benefit payment, regardless of any time period limitations in the written provider agreement.

**Recommendation 3**

We recommend that the contracting officer disallow $25,399 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

**Recommendation 4**

We recommend that the contracting officer require the Association to ensure on an ongoing basis that the Plan is identifying and properly returning claim payment errors identified on the FEP Operations Center daily retroactive reports.

**IBX's Response:**

The Plan agreed to this finding. The Plan states that the daily retroactive enrollment reports are now being monitored daily to ensure any aging issues are proactively addressed, or to report system issues that could potentially delay the timely recovery of an overpayment. The Plan's objective is to have all necessary retro adjustments completed within 20 calendar days.

**Association's Response:**

The Association states, "Beginning with the implementation of the third quarter release on September 27, 2014, all daily retroactive enrollment notices will be added to the Claims Audit Monitoring Tool. This will give the FEP Director's Office the ability to monitor Plan activity to ensure that the Plan is appropriately addressing all retroactive termination notices."

### 3. Dialysis Review — $14,262

We performed a computer search to identify all dialysis claims from inpatient and outpatient facilities for the period January 1, 2011 through December 31, 2013. Our search produced 12,292 claims, totaling $18,711,478 in payments. From this universe, we selected for review a judgmental sample of 127 claims, totaling $215,231 in payments, to determine if these claims were correctly priced and paid. Specifically,

**IBX incorrectly paid 11 dialysis claims, resulting in overcharges of $14,262 to the FEHBP.**

we selected the following:

- We identified the two members from each full year of the audit scope (2011 through 2013) with the highest utilization. For each member, we selected to review all claims from the month with the most incurred dates (i.e., highest utilization).
- We randomly selected 17 claims from the billing provider with the highest utilization for the scope of our audit.
- We selected to review one claim from each provider that billed a revenue code 0821 and the member had "basic" enrollment coverage.
- We selected to review all claims from the billing provider with the highest utilization and where the member had "basic" enrollment coverage.

Our review of dialysis facility claims determined that the Plan incorrectly paid 11 claims, resulting in overcharges of $14,262 to the FEHBP. These claim payment errors resulted from the following:

- The Plan's local processors incorrectly priced 10 claims, totaling $13,949 in overcharges to the FEHBP.
- The Plan did not appropriately coordinate one claim with Medicare, resulting in an overcharge of $313 to the FEHBP.

In addition to the questioned charges, our review identified a procedural issue requiring corrective action by the Plan and Association.

For 12 claims, the Plan's local claim processors did not properly adjust the FEP Direct system to reflect the actual paid amount on the claims. This inconsistency created a variance in the amount paid between FEP Direct and Plan's local system. These 12 claim payment variances resulted in an overstatement of the amounts paid in FEP Direct and the health benefit charges reported on the Annual Accounting Statements (AAS) by $117,170. Since claims expense is considered when developing premium rates, overstating the claims expense in the AAS may increase future rates.

As previously cited from CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments. Also, the recovery of any overpayment must be treated as an erroneous benefit payment, regardless of any time period limitations in the written provider agreement.

As previously cited from CS 1039, if the member's primary carrier is Medicare, the Carrier shall coordinate the payment of benefits under Medicare.

FEP Administrative Manual (FAM) Volume III, Chapter 3 states, "Plans receive claims from members and providers for FEP members that have received care. Plans will perform initial processing of these claims locally by varying degrees . . . once the Plan is ready to move a claim

through the adjudication process, the claims are sent to the FEP Operations Center for processing and approval using FEPExpress [FEP Direct], the FEP Claims processing system. FEPExpress performs various edits on the claim and sends the Plan a response record indicating whether the claims were rejected, deferred, or approved. Plans should not reimburse the provider or member until an approval has been received from the FEP Operations Center. Once an approval response is received for a claim, the Plan can then issue the checks or electronic payment to the provider or member."

**Recommendation 5**

We recommend that the contracting officer disallow $14,262 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

**Recommendation 6**

We recommend that the contracting officer verify that the Plan made proper adjustments to the applicable claims in FEP Direct to reflect the actual amounts paid to the providers, to correct variances between the Plan's local claims system and FEP Direct. Additionally, we recommend that the contracting officer ensure that the Plan continuously performs reconciliations between their local claims system and the FEP Direct system as described in FAM Volume 3.

**IBX's Response:**

The Plan agrees with this finding. The Plan states that a compare report is used to identify and correct claims that have payment variances between FEP Direct and the local claim system. As of June 1, 2014, the compare report is reviewed daily and the Plan's objective is to have all out-of-balance variances adjusted within 20 calendar days.

# IV. MAJOR CONTRIBUTORS TO THIS REPORT

**Information Systems Audits Group**

[redacted] Auditor

[redacted] Auditor-in-Charge

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[redacted] Senior Team Leader

[redacted] Group Chief

# V. SCHEDULE A

**INDEPENDENCE BLUE CROSS**
**PHILADELPHIA, PENNSYLVANIA**

**HEALTH BENEFIT CHARGES AND AMOUNTS QUESTIONED**

| HEALTH BENEFIT CHARGES | 2011 | 2012 | 2013 | TOTAL |
|---|---|---|---|---|
| PLAN CODE 362: | | | | |
| CLAIM PAYMENTS | $222,128,146 | $239,826,538 | $235,314,172 | $697,268,856 |
| MISCELLANEOUS PAYMENTS AND CREDITS | 7,145,114 | 7,588,507 | 9,256,886 | 23,990,507 |
| TOTAL | $229,273,260 | $247,415,045 | $244,571,058 | $721,259,363 |

| AMOUNTS QUESTIONED | 2011 | 2012 | 2013 | TOTAL |
|---|---|---|---|---|
| 1. NON-PARTICIPATING FACILITY REVIEW | $6,603 | $19,968 | $20,362 | $46,933 |
| 2. RETROACTIVE ENROLLMENT REVIEW | 24,920 | 479 | 0 | 25,399 |
| 3. DIALYSIS REVIEW | 2,128 | 12,134 | 0 | 14,262 |
| TOTAL QUESTIONED CHARGES | $33,651 | $32,581 | $20,362 | $86,594 |

# APPENDIX

**BlueCross BlueShield Association**

An Association of Independent Blue Cross and Blue Shield Plans

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

September 22, 2014

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

**Reference:** **OPM FINAL AUDIT REPORT**
**Independence Blue Cross**
**Audit Report Number 1A-10-55-14-027**
**(Dated and Received August 7, 2014)**

Dear [redacted]:

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

## HEALTH BENEFIT CHARGES

### A. Non Participation Facility Review — $46,933

**Recommendation 1**

We recommend that the contracting officer disallow $46,933 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

**Plan Response:**

Plan agrees with the finding. Claim adjustments were completed on May 13, 2014 to recover the overcharges.

**Recommendation 2**

We recommend that the contracting officer require the Plan to provide additional education and/or detailed training to all claims processors on how to properly adjudicate non-participating claims for members with "basic" enrollment option

based on the benefit brochure, so that these claims are properly adjudicated going forward.

**Plan Response:**

The Plan agrees with the finding. In recent years, the Plan has put a lot of time and effort in making sure our associates have the knowledge and the tools they need to help mitigate errors from occurring. The Plan hold associates accountable for their mistakes through the performance evaluation process. In the FEP claims department, quality is a critical part of the associates overall performance. On a monthly basis, associates are expected to meet the 99% quality expectations.

The Plan's current training includes how to process non-par claims. As such the Plan does not believe additional formal training is required; however, the associates that have processed claims included in this finding have been coached and counselled on the correct methods of claims adjudication. The Plan will also continue to monitor this activity to ensure that non-par claims are paid correctly.

**B. Retroactive Enrollment Review** **$25,399**

**Recommendation 3**

We recommend that the contracting officer disallow $25,399 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

**Plan Response:**

Plan agrees with the finding. Claim adjustments were completed on May 18, 2014 to recover the overcharges.

**Recommendation 4**

We recommend that the contracting officer require the Association to ensure on an ongoing basis that the Plan is identifying and properly returning claim payment errors identified on the FEP Operations Center daily retroactive reports.

**Plan Response**

The retro report that we receive from FEP are reviewed daily. The inventory is worked from oldest to youngest. The objective is to have all retro adjustments completed within 20 calendar days. As of June 1, 2014, Plan management

ensures that the inventory is monitored daily to proactively address any aging issues or to report any system issues that could delay the overpayment from being recovered timely.

**BCBSA Response**

Beginning with the implementation of the 3rd quarter release on September 27, 2014, all daily retroactive enrollment notices will be added to the Claims Audit Monitoring Tool. This will give the FEP Director's Office the ability to monitor Plan activity to ensure that the Plan is appropriately addressing all retroactive termination notices.

**C. Miscellaneous Dialysis Review** **$14,262**

**Recommendation 5**

We recommend that the contracting officer disallow $14,262 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

**Plan Response**

Plan agrees with the finding. Claim adjustments were completed on June 26, 2014 to recover the overcharges.

**Recommendation 6**

We recommend that the contracting officer require the Plan to adjust the applicable claims in FEP Direct to reflect the actual amounts paid to the providers for variances between the Plan's local claims system and FEP Direct. Additionally, we recommend that the contracting officer ensure that the Plan continuously performs reconciliations between their local claims system and the FEP Direct system to check and properly adjust claim payment variances.

**Plan Response**

The Plan is in the process of adjusting the claims related to this recommendation. A compare report was created by the Plan to identify all FEP claims that have payment variances between FEP Direct and the Plan's local claim system. This report gives the Plan the ability to quickly identify, trend and rectify all claims that

are out-of balance (OOB). A copy of the compare report was provided during the audit.

Beginning June 1, 2014, the Plan ensures that the compare report is reviewed daily. The inventory of claims is worked from oldest to youngest. The objective of the review is to have all OOB adjustments completed within 20 calendar days. The Plan also began monitoring the inventory age daily to proactively address any aging issues or to report any system issues that could delay the overpayment from being recovered timely.

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

Sincerely,

[redacted]

[redacted] CISA
Managing Director, Program Assurance

cc: [redacted] IBC
[redacted] FEP
[redacted] FEP

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