



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

Final Audit Report

AUDIT OF GLOBAL COORDINATION OF BENEFITS FOR BLUECROSS AND BLUESHIELD PLANS

Report Number 1A-99-00-14-046
July 29, 2015

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EXECUTIVE SUMMARY

Audit of Global Coordination of Benefits

Report No. 1A-99-00-14-046

July 29, 2015

Why Did We Conduct the Audit?

The objectives of our audit were to determine whether the BlueCross and BlueShield (BCBS) plans charged costs to the Federal Employee Health Benefit Program (FEHBP) and provided services to the FEHBP members in accordance with the terms of the contract with the U.S. Office of Personnel Management. Specifically, our objective was to determine whether the BCBS plans complied with contract provisions relative to coordination of benefits with Medicare.

What Did We Audit?

The Office of the Inspector General has completed a limited scope audit of the FEHBP operations at all BCBS plans. The audit covered claims incurred on or after August 15, 2013 that were reimbursed from September 1, 2013 through May 31, 2014 and potentially were not coordinated with Medicare.



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What Did We Find?

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covered BCBS claim payments from September 1, 2013 through May 31, 2014 as reported in the Annual Accounting Statements. The report questioned \$7,434,591 in health benefit charges. Specifically, these questioned charges are a result of the following:

A. Survey Review

- Our survey review determined that the FEHBP was overcharged \$2,947,816 in health benefit charges for claims not properly coordinated with Medicare.

B. Statistical Review of Category F

- Our review of a statistical sample of Category F claims for patients with cumulative claim line payments less than \$2,500 projected that the FEHBP was overcharged \$4,486,775 in health benefit charges for claims not properly coordinated with Medicare. Category F claims include outpatient facility and professional claims where Medicare Part B should have been the primary payer.

ABBREVIATIONS

AAS	Annual Accounting Statements
Association	BlueCross BlueShield Association
BCBS	BlueCross and BlueShield
CARC	Claim Adjustment Reason Codes
CFR	Code of Federal Regulations
COB	Coordination of Benefits
DO	Director's Office
FAM	Federal Employee Program Administrative Manual
FEHB	Federal Employee Health Benefits
FEHBP	Federal Employee Health Benefit Program
FEP	Federal Employee Program
FOIA	Freedom of Information Act
IG	Inspector General
OC	Operations Center
OIG	Office of the Inspector General
OPM	U.S. Office of Personnel Management
Plan(s)	BlueCross and BlueShield Plan(s)
RARC	Remittance Advice Remark Codes

TABLE OF CONTENTS

	<u>Page</u>
EXECUTIVE SUMMARY	i
ABBREVIATIONS	ii
I. BACKGROUND	1
II. OBJECTIVES, SCOPE, AND METHODOLOGY	3
III. AUDIT FINDINGS AND RECOMMENDATIONS	7
Global Coordination of Benefits Review.....	7
A. Survey Review	7
B. Statistical Review of Category F Claims	13
IV. MAJOR CONTRIBUTORS TO THIS REPORT	17
 APPENDIX A: BlueCross BlueShield Association’s October 31, 2014 response to the Draft Audit Report, issued August 1, 2014.	
 APPENDIX B: BlueCross BlueShield Association’s February 25, 2015 response to the Statistical Review Audit Inquiry, issued February 11, 2015.	
 REPORT FRAUD, WASTE, AND MISMANAGEMENT	

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 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 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 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 local BCBS plans participating in the FEHBP.

The Association has established a Federal Employee Program (FEP¹) Director's Office (DO) in Washington, D.C. to provide centralized management for the Service Benefit Plan. The FEP DO coordinates the administration of the contract with the Association, member BCBS plans, and OPM.

The Association has also established an FEP Operations Center (OC). The activities of the FEP OC 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.

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

Compliance with laws and regulations applicable to the FEHBP is the responsibility of the Association and plan management. Also, management of each BCBS plan is responsible for establishing and maintaining a system of internal controls.

Findings from our previous global coordination of benefits (COB) audit of all BCBS plans (Report No. 1A-99-00-13-032, dated November 22, 2013) for claims reimbursed from April 1, 2012 through January 31, 2013 are currently in the process of being resolved.

Our sample selections, instructions, and preliminary audit results of the potential coordination of benefit errors were presented to the Association in a draft report, dated August 1, 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. Also, additional documentation provided by the Association and BCBS plans on various dates through February 25, 2015 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 the FEHBP members in accordance with the terms of the contract. Specifically, our objective was to determine whether the plans complied with contract provisions relative to coordination of benefits with Medicare.

Scope

The audit covered health benefit payments from September 1, 2013 through May 31, 2014 as reported in the Annual Accounting Statements. We performed a computer search on our claims data warehouse to identify all BCBS claims incurred on or after August 15, 2013 that were reimbursed from September 1, 2013 through May 31, 2014 and potentially not coordinated with Medicare. This search identified 404,775 claim lines, totaling \$49,239,602 in payments that were potentially not coordinated with Medicare (See Exhibit I for the summary of our universe by Category).

Generally, Medicare Part A pays all covered costs (except for deductibles and coinsurance) for inpatient care in hospitals, skilled nursing facilities and hospice care. 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 will reduce 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 covers a portion 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 ($0.30 \times 0.80 = 0.24 \sim 25$ percent).

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

Exhibit I – Universe of Potentially Uncoordinated Claim Lines

Category	Patients	Claim Lines	Amount Paid
Category A: Medicare Part A Primary for I/P Facility	199	232	\$3,394,293
Category B: Medicare Part A Primary for Skilled Nursing/HHC/Hospice Care	958	8,864	\$1,756,315
Category C: Medicare Part B Primary for Certain Inpatient Facility Charges	38	79	\$2,177,720
Category D: Medicare Part B Primary for Skilled Nursing/HHC/Hospice Care	46	62	\$264,286
Category E: Medicare Part B Primary for Outpatient Facility and Professional	2,523	26,046	\$6,534,223
Category F: Medicare Part B Primary for Outpatient Facility and Professional (with processor manual override using code 'F')	134,540	369,492	\$35,112,765
Total	138,304	404,775	\$49,239,602

- Categories A and B consist of inpatient claims that should have been coordinated with Medicare Part A. If 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. If we could not reasonably determine the actual overcharges for the ancillary items, we questioned 25 percent of the amount paid for these inpatient claim lines. If 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 facility and professional claims where Medicare Part B should have been the primary payer. If we could not reasonably determine the actual overcharge for a claim line, we questioned 80 percent of the amount paid for the claim line.

To test each BCBS plan’s compliance with the FEHBP health benefit provisions related to coordination of benefits with Medicare, we selected the following for review:

- 67,542 claim lines, totaling \$23,772,591 in payments for survey review (See Exhibit II for the summary of our survey review claim selections). We did not project the results of our survey review to the universe of claims paid for potentially uncoordinated claim lines.
- A statistical review of Category F claims for patients with cumulative claim payments less than \$2,500. From a universe of 333,904 claim lines, totaling \$25,276,811 in payments, we selected to review 5,648 claim lines, totaling \$1,577,291 in payments. The results of our sample review were projected to the universe.

When we notified the Association of these potential errors on August 1, 2014, these claims were within the Medicare timely filing requirement and could be filed with Medicare for coordination of benefits.²

Methodology

The claims selected for review were submitted to each BCBS plan for their review and response. We then conducted a limited review of the plans' "paid correctly" responses and an expanded review of the plans' "paid incorrectly" responses. Specifically, we verified supporting documentation, the accuracy and completeness of the plans' responses, determined if the claims were paid correctly, and/or calculated the appropriate questioned amounts for the claim payment errors. Additionally, we verified on a limited test basis if the BCBS plans had initiated recovery efforts, adjusted or voided the claims, and/or completed the recovery process by the audit request due date (i.e., October 31, 2014) for the claim payment errors in our sample.

The determination of the questioned amount is based on the FEHBP contract, the 2013 and 2014 Service Benefit Plan brochures, and the Association's FEP Administrative Manual (FAM) and various manuals and other documents available from the Center for Medicare and Medicaid Services that explain Medicare benefits.

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 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.

² Claims received by Medicare more than one calendar year after the dates of service could be denied by Medicare as being past the timely filing requirement.

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 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 BCBS plans had not complied, in all material respects, with those provisions.

In conducting our audit, we relied to varying degrees on computer-generated data provided by the FEP DO, the FEP OC, 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 OC, 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 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.

Audit fieldwork was performed at our offices in Washington, D.C., Cranberry Township, Pennsylvania and Jacksonville, Florida through March 2015.

III. AUDIT FINDINGS AND RECOMMENDATIONS

Global Coordination of Benefits Review

The sections below detail the results of our 2014 global coordination of benefits (COB) audit. Many recommendations were issued in prior COB audits and are rolled forward from the COB audit (Report No. 1A-99-00-12-029, issued March 20, 2013).

A. Survey Review

\$2,947,816

From claims with dates of service on or after August 15, 2014 that were reimbursed from September 1, 2013 through May 31, 2014, we performed a computer search that identified 404,775 claim lines, totaling \$49,239,602, that potentially were not coordinated with Medicare. From this universe, we performed a survey review of 67,542 claim lines, totaling \$23,772,591 in payments, to determine whether the BCBS plans complied with contract provisions relative to COB with Medicare. The following table outlines our sample selection methodology by Category.

Exhibit II – Claim Lines Reviewed

Category	Sample Selection Methodology	Claim Lines	Amounts Paid	Potential Overcharges
<u>Category A</u>	All patients selected (199 patients)	232	\$3,394,293	\$3,394,293
<u>Category B</u>	All patients selected (958 patients)	8,864	\$1,756,315	\$1,756,315
<u>Category C</u>	All patients selected (38 patients)	79	\$2,177,720	\$544,430
<u>Category D</u>	All patients selected (46 patients)	62	\$264,286	\$66,072
<u>Category E</u>	Patients with cumulative claim lines of \$500 or more (1,468 patients)	22,717	\$6,344,023	\$5,075,218
<u>Category F</u>	Patients with cumulative claim lines of \$2,500 or more (1,660 patients)	35,588	\$9,835,954	\$7,878,763
Total		67,542	\$23,772,591	\$18,715,091

At the time we submitted our sample of potential COB errors to the Association on August 1, 2014, the claims were within the Medicare timely filing requirement and could be filed with Medicare for coordination of benefits. 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.

Our survey review determined that the BCBS plans incorrectly paid 9,028 claim lines, totaling \$3,639,226 in payments. We estimate that the FEHBP was overcharged \$2,947,816 for these claim line payments. The following table details the six categories of questioned claim lines:

BCBS Plans overpaid \$2.9 million due to errors related to coordinating benefits with Medicare.

Exhibit III – Claim Lines Questioned

Category	Claim Lines	Amount Paid	Amount Questioned
<u>Category A</u>	27	\$509,633	\$509,633
<u>Category B</u>	2,926	\$374,981	\$374,981
<u>Category C</u>	13	\$244,903	\$61,226
<u>Category D</u>	9	\$35,739	\$8,935
<u>Category E</u>	1,268	\$719,157	\$578,927
<u>Category F</u>	4,785	\$1,754,813	\$1,414,114
Total	9,028	\$3,639,226	\$2,947,816

These 9,028 claim line payment errors are comprised of the following:

- For 3,274 (36 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 Express Claims System for Medicare COB review by the processors. As a result, the FEHBP was overcharged \$602,490 for these COB errors.
- For 2,613 (29 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 Express 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 Express 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 FAM, the completion of this field is required on all claims for patients who are age 65 or older. As a result, we estimate that the FEHBP was overcharged \$1,043,360 for these COB errors.

- For 1,219 (14 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 \$352,138 for these COB errors.
- For 1,028 (11 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 Express 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 Express 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 \$581,281 for these COB errors.
- For 894 (10 percent) of the claim lines questioned, the overpayments were not COB errors, but were processed and paid incorrectly by the Plans. As a result, we estimate that the FEHBP was overcharged \$368,547.

Of the \$2,947,816 in total questioned charges, \$843,493 (29 percent) was identified by the BCBS plans before receiving our audit notification letter (i.e., June 26, 2014). However, since the BCBS plans had not completed the recovery process and/or adjusted these claims by draft report due date (i.e., October 31, 2014), we continue to question these charges. The remaining questioned charges of \$2,104,323 (71 percent) were identified as a result of our audit.

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. . . .”

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 . . . until the debt is paid in full or determined to be uncollectible by the Carrier because it is no longer cost effective to pursue further collection efforts or it would be against equity and good conscience to continue collection efforts”

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 draft report response.”

The 2013 BlueCross and BlueShield Service Benefit Plan brochure, page 133, Primary Payer Chart, illustrates when Medicare is the primary payer. In addition, page 135 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.”

Association’s Response:

In response to the draft audit report, which questioned \$18,715,091 in potential overpayments, the Association states, ***“The Plans responded that they agreed that claim overpayments totaling \$1,987,727 were paid in error and that recovery was initiated on these claim overpayments as a result of this audit. Of this amount, Plans reported that they have recovered \$1,557,529 to date.”***

Regarding corrective actions, the Association indicated that to improve COB claims processing, and to timely detect and prevent claim payment errors, the Association has implemented and updated the following:

- ***“Modified the FEP claims system on July 11, 2014 to accept the Medicare denial reason code from Plans for all Medicare denied claims.***
- ***Worked with Plans to ensure that Plans modify their claims systems . . . where possible.***
- ***Enhanced the FEP Claims Audit Monitoring Tool (CAMT) to include all retroactive enrollment notices processed (including Medicare).***
- ***In 2015, BCBSA [Association] will identify opportunities to implement new deferrals based upon the Medicare denial reason code. . . .***
- ***In January 2015, the CAMT will be enhanced to include additional uncoordinated Medicare claims based upon the OIG uncoordinated Medicare audit program for Plans to review and initiate recovery as appropriate.”***

The Association also states that to ensure the Plans review all claims incurred back to the Medicare effective date, the following corrective actions were implemented by the Association:

- Updated the Plan Administrative Manual to instruct Plans on how to work the Retroactive Enrollment Report.

- Review each Plan's procedures for reviewing the retroactive enrollment reports and how they test to ensure claims are reviewed and properly updated and/or adjusted back to Medicare effective dates.
- Updated the FEP CAMT on October 27, 2014 to capture all retroactive enrollment activity.
- Starting in 2015, require Plans to perform a self-assessment on the retroactive enrollment process to ensure they are identifying all affected claims in member history. The Plans will be required to provide a report of this self-assessment to the Association and implement corrective actions where necessary.

OIG Comments:

After reviewing the Association's response and additional documentation provided by the BCBS plans, we revised the questioned charges from our draft report to \$2,947,816. If claim overpayments were identified by the BCBS plans before our audit notification date (i.e., June 26, 2014) and adjusted or voided by the draft report due date (i.e., October 31, 2014), we did not consider these as claim payment errors in the final report.

Based on the Association's response and the BCBS plans' documentation, we determined that the Association and/or plans agree with \$2,104,323 and disagree with \$843,493 of the questioned charges outlined in this final report. Although the Association only agrees with \$1,987,727 of the questioned charges in its written response, the BCBS plans' documentation supports concurrence with \$2,104,323.

The \$843,493 that the Association does not agree with represents the following items:

- \$651,538 of the contested amount represents claim overpayments where the BCBS plans did not initiate recovery efforts before our audit notification date (i.e., June 26, 2014) or did not complete the recovery process by the draft report due date (i.e., October 31, 2014).
- \$109,773 of the contested amount represents claims that the BCBS plans identified as paid correctly, but the diagnosis and procedure codes appear to be acceptable with Medicare billing guidelines.
- \$82,182 of the contested amount represents claim overpayments that the BCBS plans agree were COB errors, but the Plans state that all recovery efforts have been exhausted, and these overpayments are uncollectible.

Although the Association disagrees with \$843,493 of the questioned charges, we will continue to question these overpayments because either 1) the BCBS plans did not provide sufficient documentation to support why the FEHBP paid as the primary issuer, or 2) the plans did not provide sufficient documentation indicating all efforts for uncollectible recoveries had been exhausted as defined by CS 1039. All of the questioned charges were, in fact, identified as part of this audit - as opposed to claim payment errors identified by the BCBS plans prior to the start of the audit.

Recommendation 1

We recommend that the contracting officer disallow \$2,947,816 for claim overpayments and verify that the BCBS plans return all amounts recovered to the FEHBP.

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 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 (Rolled Forward from COB 2012)

We continue to recommend that the contracting officer require the Association to ensure that the FEP OC continues to utilize the Medicare Data Exchange Agreement that requires a quarterly exchange of enrollment data between Medicare and the FEHBP. We also continue to recommend that the contracting officer require the Association to ensure that the enrollment data provided by Medicare is updated in a timely manner in the FEP Express Claims System.

Procedural recommendations related to COB claims remain open since 2012.

Recommendation 4 (Rolled Forward from COB 2012)

We continue to recommend that the contracting officer require the Association to ensure that the implementation of the FEP OC's corrective action of inputting a field(s) in the FEP Express Claims System to collect Remittance Advice Remark Codes (RARC) and Claim Adjustment Reason Codes (CARC) from the BCBS plans is underway, and that the progress of such is monitored. These Medicare generated codes (RARC and CARC) provide the reason Medicare denied a claim payment. The Association should also have the FEP OC and BCBS plans utilize the RARC and CARC field(s) when implementing the Medicare Disposition Code corrective actions.

B. Statistical Review of Category F Claims**\$4,486,775**

Category F claims are outpatient facility and professional claims for members with Medicare Part B primary coverage for which a processor manually overrode the FEP Express System claim deferral by applying a Medicare Payment Disposition code of “F.” For Category F claims with dates of service on or after August 15, 2013 and reimbursed from September 1, 2013 through May 31, 2014, we performed a computer search and identified 369,492 claim lines, totaling \$35,112,765 in payments, that were potentially not coordinated with Medicare.

From this universe, we reviewed 100 percent of the claim lines for patients with cumulative claim payments of \$2,500 or more, a review survey of 35,588 claim lines, totaling \$9,835,954 in payments. The results of our review of Category F claims are addressed in section A, above.

In addition to the review of Category F patients with cumulative claim payments over \$2,500, we performed a sample review of Category F claims for patients with cumulative payments under \$2,500. The universe of patients with cumulative claim line payments under \$2,500 contains 333,904 claim lines, totaling \$25,276,811 in payments, that potentially were not coordinated with Medicare. From this universe, we reviewed a statistical sample of 5,648 claim lines, totaling \$1,577,291 in payments. With the intent of projecting the results of the sample to the population, we used automated software to generate a random dollar-unit sample targeting a five percent margin of error and a 95 percent confidence level, with a presumed universe error rate of seven percent.³ Each sample unit was identified as a single FEHBP paid claim line.

Exhibit IV - Universe and Sample of Category F Claim Lines Reviewed

	Claim Line Universe		Claim Lines Sampled/Reviewed	
	Claim Lines	Amounts Paid	Claim Lines	Amounts Paid
Patients with cumulative payments <u>over</u> \$2500	35,588	\$9,835,954	35,588	\$9,835,954
Patients with cumulative payments <u>under</u> \$2500	333,904	\$25,276,811	5,648	\$1,577,291
Category F Total Universe	369,492	\$35,112,765	41,236	\$11,413,245

Our review of patients with cumulative payments under \$2,500 determined that the BCBS plans did not properly coordinate 1,124 of the 5,648 claim lines from the statistically valid sample,

³ The presumed universe error rate of seven percent was calculated using the results from our prior audit (Report No. 1A-99-00-13-032). Of the 41,363 Category F claims lines reviewed from our prior audit, the BCBS plans did not properly coordinate 2,898 claim lines with Medicare.

resulting in overcharges of \$302,001 to the FEHBP.⁴ These claim payment errors included the following:

- 454 claim lines, totaling \$135,391 in overcharges, were not coordinated with Medicare, due to manual processor overrides;
- 249 claim lines, totaling \$58,857 in overcharges, were not coordinated with Medicare, due to system processing errors;
- 289 claim lines, totaling \$64,563 in overcharges, were not coordinated with Medicare, due to provider billing errors;
- 107 claim lines, totaling \$36,667 in overcharges, were not coordinated with Medicare, due to various errors for which we were unable to determine a specific cause;
- 16 claim lines, totaling \$5,298 in overcharges, were due to retroactive adjustments to the members Medicare enrollment; and
- 9 claim lines, totaling \$1,225 in overcharges, were due to various pricing errors, which were not related to coordination of benefits with Medicare.

Based on our projection of the sample results, we are 95 percent confident that the true value of claims not properly coordinated with Medicare for the universe described above is between \$4,174,303 and \$4,799,248. Our best estimate of the true value, the point estimate, is \$4,486,755, and this is the amount we are questioning in this report.

We first questioned improperly coordinated claims payments in our 2003 global coordination of benefits audit (Report No. 1A-10-00-03-013). Our audit recommendations in that and subsequent audit reports included specific corrective actions to reduce the amount of these improper payments. These corrective actions included pre-payment system enhancements and/or edits that would prevent improperly coordinated claims from being paid. The Association's FEPDO developed a corrective action plan on December 9, 2003 that was designed to "reduce Medicare Coordination of Benefits audit findings and maximize recovery efforts."

The FEPDO's corrective action has clearly been inadequate to resolve these issues. Since our first audit, we have questioned a total of approximately \$93 million in claim payments that were

⁴ Since Medicare Part B pays 80 percent of most outpatient charges and professional claims after the calendar year deductible has been met, we questioned 80 percent of the amount paid for the claim lines we could not reasonably determine the actual overcharge.

not appropriately coordinated with Medicare; approximately \$43 million of which were questioned after FEPDO developed its corrective action plan. CS 1039 states that costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. No prudent person would continue to knowingly make these improper payments in the conduct of competitive business without taking effective measures to prevent them. Therefore, we conclude that the FEPDO unreasonably charged the FEHBP for claims that were not paid in good faith in accordance with CS 1039. The full amount of the estimated improper payments should be returned to the FEHBP trust fund, regardless of the FEPDO's ability to recover the improper payments from the specific providers to whom they were made.

Claim payment errors were not paid in good faith.

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.

48 CFR 31.201-3 states, “(a) A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person in the conduct of competitive business.”

BCBS Association Response:

“The Plans agreed that claims totaling \$302,001 were paid in error and were not identified by the audit. . . . We contest OIG’s point estimate of [\$4,486,755] in claim payment errors for the universe of Medicare payments where the members total Medicare payments are >/= \$2,500. We contest this methodology for because it does not allow Plans to use the requirements as stated in CS1039 related to Audit Resolution and Reportable findings. Further, we do not agree to the validity of the statistical calculation used to determine the total estimated overpayment for the stated population.”

The full remainder of the Association’s response is included in the Appendix of this report. In summary, it states that it contests the finding because 1) it cannot resolve the audit finding because Plans do not have the exact claims that are being questioned, and 2) that there was not a mutually agreed upon understanding of the following elements of the statistical methodology:

- Population to be sampled;
- Sample Size determination;
- Error Rate Calculation;
- Factor(s) used to determine Point estimation; and

- Point estimation used (i.e., Average, Median).

OIG Comments:

We acknowledge that the statistical sampling methodology used in this review does not present the Association with the specific claim lines questioned, and that it is therefore unable to research and resolve these claims in accordance with CS 1039.

However, the elements of CS 1039 cited by the Association are only applicable to claim overpayments made in good faith. As mentioned above, the Association has continued to make these egregious and repeated overpayments without taking effective measures to prevent them. In other words, the payments were not “reasonable” as defined by the CFR, and therefore we do not consider the Association’s inability to associate the questioned dollars to a specific claim line applicable to this audit finding.

With regards to the details of the sampling methodology, we believe that all of the relevant statistical information is contained in the explanation above, but will directly address the specific elements questioned by the Association.

- The population sampled for this review was Category F claims with cumulative payments under \$2,500.
- The sample size was determined using statistical analysis software that applied a random dollar-unit sample targeting a five percent margin of error and a 95 percent confidence level, with a presumed universe error rate of seven percent.
- The error rate was calculated using the error rate identified in our prior COB audit (Report No. 1A-99-00-13-032).
- The point estimate was derived using the average ratio method, which is an appropriate estimator to use in the context of stratified dollar-unit sample designs, where each dollar in a stratum’s value has the same probability of selection.

The sampling approach we used during this audit represents a valid statistical sampling methodology, and all of the relevant details and variables have been outlined in this report.

Recommendation 5

We recommend that the contracting officer disallow \$4,486,775 for claims that were not paid in good faith and unreasonably charged to the FEHBP.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Information Systems Audits Group

██████████, Auditor

██████████, Auditor-in-Charge

██████████, Senior Team Leader

██████████, Group Chief

APPENDIX A



BlueCross BlueShield Association

An Association of Independent
Blue Cross and Blue Shield Plans

Federal Employee Program
1310 G. Street, NW
Washington, DC 20005
202.942.1000
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October 31, 2014

██████████, Chief
Information Systems Audit Group
Office of the Inspector General
U.S. Office of Personnel Management
800 Cranberry Woods Drive, Suite 130
Cranberry Township, PA 16066

**Reference: OPM DRAFT AUDIT REPORT
Tier XIV Global Coordination of Benefits
Audit Report #1A-99-00-13-032**

Dear ██████████:

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 August 15, 2013 through May 31, 2014. Our comments concerning the findings in the report are as follows:

Recommendation 1:

Coordination of Benefits with Medicare Questioned Amount \$18,715,091

The OPM OIG submitted their sample of potential Medicare Coordination of Benefits errors to the Blue Cross Blue Shield Association (BCBSA) on August 1, 2014. The BCBS Association and/or the BCBS Plans were requested to review these potential errors and provide responses by October 31, 2014. These listings included claims incurred on or after August 15, 2013 that were reimbursed from September 1, 2013 through May 31, 2014 and potentially not coordinated with Medicare. OPM OIG identified 404,775 claim lines, totaling \$49,239,602 in payments, which potentially were not coordinated with Medicare. From this universe, OPM OIG selected for review a sample of 67,552 claim lines, totaling \$23,785,091 in payments with a potential overpayment of \$18,715,091 to the Federal Employee Health Benefit Program (FEHBP).

The OIG recommended that the contracting officer disallow \$18,715,091 for uncoordinated claim line payments and have the BCBS plans return all amounts recovered to the FEHBP.

BCBSA Response

After reviewing the OIG listing of potentially uncoordinated Medicare COB claims totaling \$18,715,091, the BCBS Association noted that the actual amount reviewed by Plans totaled \$18,775,814. The Plans responded that they agreed that claim overpayments totaling \$1,987,727 were paid in error and that recovery was initiated on these claim overpayments as a result of this audit. Of this amount, Plans reported that they have recovered \$1,557,529 to date.

For the remaining \$16,737,587 in claim payment errors questioned, Plans reported that:

- \$16,727,355 in claim payments were paid correctly.
- \$554,229 in claim payment errors were identified and returned to the Program before the OIG Audit Notification letter.
- \$84,996 in claim payment errors that were initially paid incorrectly but the error was identified before the OIG Audit Notification letter and the overpayment was recovered and returned before the response was due to OPM.
- \$529,548 in claim payment errors that were identified and recovery was initiated before the Audit Notification letter, but the overpayment has not yet been returned to the Program.
- \$203,463 that was initially paid incorrectly but recovery was initiated before receiving the OIG sample, however recovery was not initiated because the claim payment error was below the recovery threshold of \$50 or overpayment was not initiated because the claim was passed the Plan's provider contract overpayment recovery limit.

Where possible, the Plans will continue to pursue the remaining overpayments as required by CS 1039, Section 2.3(g) (l).

Recommendation 2

The OIG recommended that documentation to support each COB error that is included in the sample selections and part of this preliminary finding (even if the BCBS plan initiated the overpayment recovery prior to the audit notification date and completed the recovery process by the IR due date).

BCBSA Response

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 3

Although the Association has developed corrective actions to reduce COB findings, we recommend that the contracting officer instruct the Association to ensure that all BCBS plans are following the corrective action plan. Also, the Association should continue to identify additional corrective actions to further reduce COB findings.

BCBSA Response

As noted by the OIG, in order to continue to improve Medicare claims processing, and timely prevent Medicare claim payment errors and detect Medicare payment errors, BCBSA initiated/completed the following:

- Modified the FEP claims system on July 11, 2014 to accept the Medicare denial reason code from Plans for all Medicare denied claims.
- Worked with Plans to ensure that Plans modify their claims systems to submit of the Medicare denial reason code, where possible.
- Enhanced the FEP Claims Audit Monitoring Tool (CAMT) to include all retroactive enrollment notices processed (including Medicare) so that Plan processing can be monitored and Plans contacted if they do not appear to be addressing the Medicare retro notices.
- In 2015, BCBSA will identify opportunities to implement new deferrals based upon the Medicare denial reason code. The deferral will require the claims to either be reviewed by claims processors before payment or will deny the claim and instruct Plans to return the claim system will be modified to defer claims for additional Plan review for certain Medicare denial reason codes.
- In January 2015, the CAMT will be enhanced to include additional uncoordinated Medicare claims based upon the OIG uncoordinated Medicare audit program for Plans to review and initiate recovery as appropriate.

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:

- Updated the Plan Administrative Manual to instruct Plans on how to work the Retroactive Enrollment Report.
- Review 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.
- Updated its FEP CAMT on October 27, 2014 to capture all retro-active enrollment activity. The CAMT
 - Allows BCBSA to review Plan activity to ensure that Plans are reviewing member history.
 - Includes a message to all Plans that they must review history for all affected claims as part of the retroactive enrollment review process.

- Require Plans to perform a self-assessment on the retroactive enrollment process in 2015 to ensure that Plans are going back in the member history to identify all affected claims. The Plans will also be required to provide a report of this activity to our office and implement corrective action where necessary.

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,



**Managing Director
FEP Program Assurance**

Attachment

APPENDIX B

Response to **Audit Inquiry Global COB Tier 14**

Wednesday, February 25, 2015

Page 22

Audit Inquiry 1 Response

The Plans agreed that claims totaling \$302,001 were paid in error and were not identified by the audit. Of this amount:

- \$40,741 in claim payments were identified after the audit notification letter was received but before receipt of the OIG claim sample. These claims have now been fully recovered.
- \$8,662 in claim payments were identified before the audit notification letter was received but are still in the recovery process.
- \$4,793 in claim payments are below the CS1039 Overpayment Recovery threshold for Medicare Claims, or have been deemed uncollectible.

We contest OIG's point estimate of \$4,185,178 in claim payment errors for the universe of Medicare payments where the members total Medicare payments are \geq \$2,500. We contest this methodology for because it does not allow Plans to use the requirements as stated in CS1039 related to Audit Resolution and Reportable findings. Further, we do not agree to the validity of the statistical calculation used to determine the total estimated overpayment for the stated population.

CS1039 Requirements

SECTION 3.15 AUDIT RESOLUTIONS (JAN 2011)

When OIG issues a Draft Report of findings to the Carrier, the Carrier must respond with all available, accurate and relevant documentation to validate or invalidate the findings. This must be done within the timeframe specified in the OIG Draft Report transmittal letter.

To enable this, Carriers must expeditiously tender all documentation necessary for resolution of the audit. This includes overpayment recoveries via check or certification, full documentation of the Carriers position for findings being contested, evidence supporting due diligence assertions, and support for all other pertinent issues which OPM must consider, as appropriate

SECTION 3.16 REPORTABLE FINDINGS (JAN 2013)

(b) 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 letter.

Because Plans do not have the exact claims that are being questioned, there is no way that they can determine which claims to provide support for uncollectible, contested or recovered claims, thus Plans are unable to resolve the audit finding.

Evaluation of Statistical Validity of OIG’s Conclusion

Measure	Claim Line Universe (333,904)	Claim Line Reviewed/ Error(1,126)
Mean	\$ 76	\$ 327
Standard Deviation	\$ 35	\$ 435
Median	\$ 128	\$ 153
Minimum	\$ 10	\$ 11
Maximum	\$ 2,300	\$ 2,384

We performed a distribution graph of the Claims Paid in Error and of the Universe;

- The distribution of the Universe and the actual claim line errors appears to be skewed towards the lower dollar end of the scale. This does not appear to correlate to the OIG point estimate of \$4.1 million questioned in the AI.
- The mean value for the errors is \$327 and the median value is \$153. Based upon these values, we were not able to recalculate the total error point estimate of \$4.1 million. Without additional documentation to support the validity of methodology and estimate, we are not able to agree to the questioned amount.

If the approach is to be from a statistical perspective, we should have a clear and an agreed upon understanding of the Methodology used to determine the;

- Population to be sampled (how/why was a cumulative amount of \$2,500 derived)
- Sample Size determination
- Error Rate Calculation
- Factor(s) used to determine Point estimation
- Point estimation used (i.e., Average, Median)

In summary, because detail claims questioned as errors is not provided with the OIG questioned amount and because insufficient documentation was provided to replicate/validate the point value estimate of \$4.1 million used in the report, BCBSA disagrees to the proposed total questioned amount of \$4.1 million for Medicare COB claim errors paid by the Program as non-covered Medicare charges.



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