



---

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

---

# Final Audit Report

## GLOBAL AUDIT OF DUPLICATE CLAIM PAYMENTS FOR BLUE CROSS AND BLUE SHIELD PLANS

Report Number 1A-99-00-16-043  
June 21, 2017

-- CAUTION --

This report has been distributed to Federal officials who are responsible for the administration of the subject program. This non-public version may contain confidential and/or proprietary information, including information protected by the Trade Secrets Act, 18 U.S.C. § 1905, and the Privacy Act, 5 U.S.C. § 552a. Therefore, while a redacted version of this report is available under the Freedom of Information Act and made publicly available on the OIG webpage (<http://www.opm.gov/our-inspector-general>), this non-public version should not be further released unless authorized by the OIG.

# EXECUTIVE SUMMARY

## *Global Audit of Duplicate Claim Payments*

Report No. 1A-99-00-16-043

June 21, 2017

### **Why Did We Conduct the Audit?**

The objectives of our audit were to determine whether the Blue Cross and Blue Shield (BCBS) plans charged costs to the Federal Employees Health Benefits Program (FEHBP) and provided services to the FEHBP members in accordance with the terms of the BCBS Association's (Association) 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 duplicate claim payments.

### **What Did We Audit?**

The Office of the Inspector General has completed a limited scope performance audit of the FEHBP operations at all BCBS plans. The audit covered claim payments from June 1, 2013, through March 31, 2016, as reported in the Association's Government-wide Service Benefit Plan Annual Accounting Statements. Using various search criteria, we identified and reviewed claims paid during the audit scope for potential duplicate payments charged to the FEHBP.



---

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

### **What Did We Find?**

Our audit identified \$5,967,324 in duplicate claim overpayments. The majority of the claim payment errors were related to manual processing errors, which we believe are indicative of systemic internal control problems. Our recurring audits continue to identify claim payment errors resulting from manual processing errors, and we therefore recommend that the contracting office ensure the corrective actions in this report are promptly implemented.

We do not believe that the BCBS plans have exercised due diligence in implementing controls to eliminate erroneous duplicate claim payments. As a result, we conclude that these claims were not paid in good faith, and therefore were not paid in compliance with the terms of the Association's contract with the U.S. Office of Personnel Management.

# ABBREVIATIONS

<b>Association</b>	<b>Blue Cross Blue Shield Association</b>
<b>BCBS</b>	<b>Blue Cross Blue Shield</b>
<b>FEHB</b>	<b>Federal Employees Health Benefits</b>
<b>FEHBP</b>	<b>Federal Employees Health Benefits Program</b>
<b>FEP</b>	<b>Federal Employee Program</b>
<b>FEP Express</b>	<b>Federal Employee Program Claims Processing System</b>
<b>OIG</b>	<b>Office of the Inspector General</b>
<b>OPM</b>	<b>U.S. Office of Personnel Management</b>
<b>Plan(s)</b>	<b>Blue Cross and Blue Shield Plan(s)</b>

# TABLE OF CONTENTS

	<u>Page</u>
<b>EXECUTIVE SUMMARY</b> .....	i
<b>ABBREVIATIONS</b> .....	ii
<b>I. BACKGROUND</b> .....	1
<b>II. OBJECTIVES, SCOPE, AND METHODOLOGY</b> .....	3
<b>III. AUDIT FINDINGS AND RECOMMENDATIONS</b> .....	6
Duplicate Claim Payments.....	6
<b>APPENDIX A: Blue Cross Blue Shield Association’s October 13, 2016, response to the Draft Audit Report, issued June 22, 2016.</b>	
<b>REPORT FRAUD, WASTE, AND MISMANAGEMENT</b>	

# 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 Blue Cross and Blue Shield (BCBS) plans. The audit was performed by the U.S. 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. Health insurance coverage is made available through contracts with various health insurance carriers.

The Blue Cross Blue Shield 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 (FEP<sup>1</sup>) 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 Blue Cross Blue Shield, 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.

---

<sup>1</sup> 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 audit of duplicate claim payments at all BCBS plans (Report No. 1A-99-00-13-061, dated August 19, 2014) for claims reimbursed from January 1, 2011, through May 31, 2013, have been resolved.

Our sample selections, instructions, and preliminary audit results of the potential duplicate claim payments were presented to the Association in a draft report, dated June 22, 2016. 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 6, 2017, 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 BCBS plans complied with contract provisions relative to duplicate claim payments.

### **SCOPE**

The audit covered health benefit payments from June 1, 2013, through March 31, 2016, as reported in the Blue Cross and Blue Shield Association's Government-wide Service Benefit Plan FEP Annual Accounting Statements. We performed various computer searches on BCBS claims data to identify potential duplicate payments charged to the FEHBP during the audit scope. Our searches identified 1,440,425 claim groups<sup>2</sup>, totaling \$80,158,131 in payments that potentially contained duplicate charges.

Our search results of potential duplicate claim payments are separated into three categories – “best matches,” “near matches,” and “inpatient facility matches.” Exhibit I, on the following page, summarizes our claim universe by category. The universe of potential duplicate claim groups was derived from the following search logic criteria:

- Our “best matches” logic identifies and groups unique claim numbers that contain most of the same claim data, including patient code, procedure code, diagnosis code, and sex code.
- Our “near matches” logic identifies and groups unique claim numbers that contain most of the same claim data, except for patient code, procedure code, diagnosis code, or sex code.
- Our “inpatient facility matches” search criteria identifies duplicate or overlapping dates of service.

---

<sup>2</sup> A claim group represents one claim payment “paid correctly” and one or more potential duplicate payments.

**Exhibit I – Universe of Potential Duplicate Claim Payments**

Duplicate Category	Duplicate Groups	Potential Overpayment Amount
<b>Best Matches</b>	282,161	\$20,175,848
<b>Near Matches</b>	1,157,735	\$56,433,507
<b>Inpatient Facility Matches</b>	529	\$3,548,776
<b><u>Total</u></b>	<b>1,440,425</b>	<b>\$80,158,131</b>

To test each BCBS plan’s compliance with the FEHBP health benefit provisions related to duplicate claim payments, we selected the following claims from this universe for review (see Exhibit II for a summary of claims selected for review):

- All duplicate claim groups with potential overpayments of \$1,000 or more; and
- A random sample of 12,339 claim lines from all duplicate claim groups with potential overpayments of less than \$1,000.

We *did not* project the results of this review to the universe of claims paid for potentially duplicated claim lines.

**Exhibit II – Samples Selected for Review by Duplicate Category**

Duplicate Category	Duplicate Groups	Potential Overpayment Amount
<b>Best Matches</b>	3,764	\$7,339,512
<b>Near Matches</b>	8,179	\$7,898,776
<b>Inpatient Facility Matches</b>	423	\$3,501,531
<b><u>Total</u></b>	<b>12,366</b>	<b>\$18,739,819</b>

**METHODOLOGY**

The claims selected for review were submitted to each BCBS plan for their analysis and response. We 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, and 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. On a limited test basis we also verified whether 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., September 1, 2016) for the claim payment errors in our sample.

The determination of the questioned amount is based on the FEHBP contract, the 2013 through 2016 Service Benefit Plan brochures, and the Association's FEP Procedures Administrative Manual.

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.

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 duplicate claim payments. The results of our tests indicate that, with respect to the items tested, the BCBS plans did not fully comply with the provisions of the contract relative to duplicate claim payments. 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 Director's Office, 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 duplicate claim payment 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 the data generated by the BCBS plans' local claims systems. While utilizing the computer-generated data during our audit, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

Audit fieldwork was performed at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida through April 2017.

# III. AUDIT FINDINGS AND RECOMMENDATIONS

The sections below detail the results of our global audit of duplicate claim payments. As mentioned in the Scope section above, our review included a total of 12,366 claim groups, totaling \$18,739,819 in potential overcharges to the FEHBP (see Exhibit II on page 4).

## Duplicate Claim Payments

**\$5,967,324**

Our review determined that the BCBS plans incorrectly paid 3,089 claim lines, totaling \$5,967,324 in overcharges to the FEHBP. See Exhibit III for a summary of the questioned costs sorted by category and Exhibit IV for a summary of questioned costs sorted by cause of error.

### Exhibit III – Summary of Questioned Costs by Category

Category	Claim Lines	Amount Overcharged
Best Matches	1,528	\$3,155,137
Near Matches	1,473	\$2,086,216
Inpatient Matches	88	\$725,971
<b>Total</b>	<b><u>3,089</u></b>	<b><u>\$5,967,324</u></b>

### Exhibit IV – Questioned Costs by Cause of Error

Cause of Error	Claim Payments	Total Overpayment	Percentage
Manual Processor Errors	1,303	\$2,456,141	41%
Provider Billing Errors	947	\$1,696,306	29%
System Errors (Local and FEP Express)	374	\$966,212	16%
Non-Duplicate Pricing Errors	465	\$848,665	14%
<b>TOTALS</b>	<b>3,089</b>	<b>\$5,967,324</b>	<b>100%</b>

Additional detail regarding the cause of error follows:

- 1,303 duplicate payments, totaling \$2,456,141, were overcharged to the FEHBP as the result of manual processor errors. In most cases, the potential duplicate payment was detected by

the Federal Employee Program Claims Processing System (FEP Express) (i.e., FKA<sup>3</sup> denial code). However, the processors manually overrode the system to allow these claims to be paid.

- 947 duplicate payments, totaling \$1,696,306, were overcharged to the FEHBP as the result of various provider billing errors such as incorrectly billing with a modifier code, submitting the claim with an incorrect provider address, or providing an incorrect provider identification. In these instances, the provider re-billed the claim with the correct information; however, the processors overrode FEP Express and allowed the services to be paid twice.
- 374 duplicate claim payments, totaling \$966,212, were overcharged to the FEHBP as a result of the local plan's claim system and/or FEP Express failing to detect the duplicate payment.
- 465 non-duplicate claim payments, totaling \$848,665, were overcharged to the FEHBP due to various pricing errors such as incorrect pricing allowances, incorrect member liability calculations, or incorrect coordination of other benefits.

This audit highlights longstanding procedural issues regarding the controls that BCBS has in place to prevent duplicate claim payment errors. Our recurring global duplicate claims paid audits (performed since 2004) routinely show that manual processing errors are the primary reason for these material duplicate claim payments. Although the Association has reportedly taken steps to implement prior OIG audit recommendations related to duplicate claim errors, the results of this audit do not indicate that these corrective actions have had a substantial impact in reducing the amount of errors. Considering the length of time that these material errors occurred after the issue had been brought to the Association's attention, the OIG does not believe that these erroneous claim payment errors were paid in good faith. Therefore, we recommend that the entire questioned amount be returned to the FEHBP regardless of the plans' ability to recover the funds from the providers. The contracting officer should also continue monitoring the Association's ongoing system enhancements and efforts to reduce duplicate payment errors.

The following criteria were used to support our questioning of these claim payments:

- Contract CS 1039, Part III, section 2.3 (8)(i) states, "The Carrier may charge the contract for benefit payments made erroneously but in good faith . . . ."
- 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

---

<sup>3</sup> FKA refers to the denial code automatically applied by FEP Express when it detects a possible duplicate of a charge previously reported on a claim that has already processed through the system.

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 ... , overpayment, or duplicate payment ... regardless of any time period limitations in the written agreement with the provider.”

**Association Response:**

*In response to the draft audit report, which questioned \$17,356,434 in potential overpayments, the Association stated that, \$10,200,056 in claim payments paid correctly and \$3,859,536 in duplicate claim payments were identified by the audit. \$251,614 in claim payment errors resulted from the use of an incorrect allowance when originally paying the claim, and \$3,045,227 in duplicate payments were identified before the audit started and were either returned to the Program, are still in collections, or were determined to be uncollectible.*

*“For duplicate claims and other claims identified during the audit, Plans will initiate recovery where possible.”*

*Regarding corrective actions, the Association indicated that to reduce duplicate payments or to timely detect duplicate payment errors, the Association has implemented and updated the following:*

- *“Enhanced the current duplicate edit in 3<sup>rd</sup> quarter 2015 to defer claims incurred on the same day, for the same service, that were paid by different providers.*
- *Enhanced the BCBSA [Association] post payment duplicate reports in 3<sup>rd</sup> quarter 2014 to better improve identification of potential duplicate payments for Plan review and adjustment.*
- *Scheduled additional modification to the duplicate edits for 1<sup>st</sup> Quarter 2017 to defer claims with the same incurred date and procedure code (or revenue code) but paid on a different bill type (i.e., professional claim versus a facility claim). See Attachment 1 for a description of this enhancement.*
- *Beginning 4<sup>th</sup> quarter 2016, BCBSA [Association] will also enhance its review of Plan responses to the BCBSA post payment duplicate reports to ensure that Plans are responding timely and appropriately to the potential duplicate payments identified.*
- *Provided a sample of the duplicate payment errors to the FEP Operations Center (FEPOC) for review and determination as to why the duplicate payments did not defer for Plan review. After the FEPOC completes their review, BCBSA [Association] will*

*implement any additional deferrals determined to be necessary to reduce duplicate payments.”*

**OIG Comments:**

The Association’s response and supporting documentation indicated that the BCBS plans acknowledge that \$5,967,324 in claim overpayments were made during the scope of our audit. If claim overpayments were identified by the BCBS plans before our audit notification date (i.e., June 1, 2016) and adjusted or voided by the draft report response due date (i.e., September 1, 2016), we did not consider these as claim payment errors in the final report.

**Acknowledged Claim Overpayments**

The \$5,967,324 of acknowledged claim overpayments is comprised of the following:

- \$4,839,538 represents claim overpayments for which the BCBS plans have committed to pursue recovery; and
- \$1,127,786 represents claim overpayments for which the BCBS plans state the recovery efforts have been exhausted; however, we continue to question these costs.

**Recommendation 1**

We recommend that the contracting officer disallow \$5,967,324 for claim overpayments and verify that the BCBS plans return all amounts questioned to the FEHBP, regardless of the plans’ ability to recover the claim payments from providers.

**Recommendation 2**

Due to the substantial amount of manual processor errors found in this audit, we recommend that the contracting officer require the Association to disallow manual processing overrides for the FKA master file deferral code. We also recommend that the contracting office require the Association to perform training on this new process to instruct the processors how to deny claims that are incorrectly billed by providers and/or deny claims that are billed twice.

**Recommendation 3**

Due to the significant number of provider billing errors identified, we recommend that the contracting officer require the Association to perform a risk analysis to determine high-risk areas related to duplicate provider billing errors. This should include determining the cost efficiency of implementing a system edit(s) in the plans’ local systems and FEP Express to prevent these

types of errors from occurring in the future. If the analysis results in material savings to the FEHBP, we recommend that the contracting officer require the Association to add the system edits to the local plans' systems and/or FEP Direct to defer future provider billing errors for payment.

## APPENDIX A



October 13, 2016

██████████  
Senior Team Leader  
Information Systems Audits Group  
OPM Office of the Inspector General  
1900 E. Street  
Washington, D.C. 20415

**Reference: Global Potential Duplicate Claims Draft Report  
Audit Report #1A-99-00-16-043**

Dear ██████████:

This is in response to the above – referenced U.S. Office of Personnel Management (OPM) Draft Audit Report concerning the Global Duplicate Claims Payments for claims paid from June 1, 2013 through March 31, 2016. Our comments concerning the findings in the report are as follows:

### **Recommendation 1**

We recommend that the contracting officer disallow \$17,356,434 in duplicate payments and have the BCBS plans return all amounts recovered to the FEHBP.

### **BCBSA Response**

BCBS Plans reviewed the claim samples provided by the OIG totaling \$17,356,434 and noted the following:

- \$10,200,056 in claim payments paid correctly.
- \$3,859,536 in duplicate claim payments identified by the audit.
- \$251,614 in claim payment errors resulting from the use of an incorrect allowance when originally paying the claim.
- \$3,045,227 in duplicate payments that were identified before the audit started that were either returned to the Program, are still in collections or were determined to be uncollectible before the audit started.

For duplicate claims and other claims identified during the audit, Plans will initiate recovery where possible.

### **Recommendation 2**

We recommend that the contracting officer instruct the Association to perform a risk analysis on the duplicate payments identified as a result of our audit. A description of the

Report No. 1A-99-00-16-043

corrective actions identified during this analysis needed to reduce these types of claim payment errors from occurring in the future should be included in the Association's response to the draft report.

### **BCBSA Response**

The following corrective actions have either been implemented or are currently in progress to either reduce duplicate payments or to timely identify duplicate payments once they have occurred include the following:

- Enhanced the current duplicate edit in 3<sup>rd</sup> quarter 2015 to defer claims incurred on the same day, for the same service, that were paid by different providers.
- Enhanced the BCBSA post payment duplicate reports in 3<sup>rd</sup> quarter 2014 to better improve identification of potential duplicate payments for Plan review and adjustment.
- Scheduled additional modification to the duplicate edits for 1<sup>st</sup> Quarter 2017 to defer claims with the same incurred date and procedure code (or revenue code) but paid on a different bill type (i.e., professional claim versus a facility claim). See Attachment 1 for a description of this enhancement.
- Beginning 4<sup>th</sup> quarter 2016, BCBSA will also enhance its review of Plan responses to the BCBSA post payment duplicate reports to ensure that Plans are responding timely and appropriately to the potential duplicate payments identified.
- Provided a sample of the duplicate payment errors to the FEP Operations Center (FEPOC) for review and determination as to why the duplicate payments did not defer for Plan review. After the FEPOC completes their review, BCBSA will implement any additional deferrals determined to be necessary to reduce duplicate payments.

If you have any questions, please contact me at [REDACTED] or [REDACTED] at [REDACTED].

Sincerely,

[REDACTED]  
Managing Director, FEP Program Assurance





## **Report Fraud, Waste, and Mismanagement**

Fraud, waste, and mismanagement in Government concerns everyone: Office of the Inspector General staff, agency employees, and the general public. We actively solicit allegations of any inefficient and wasteful practices, fraud, and mismanagement related to OPM programs and operations. You can report allegations to us in several ways:

**By Internet:** <http://www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse>

**By Phone:** Toll Free Number: (877) 499-7295  
Washington Metro Area: (202) 606-2423

**By Mail:** Office of the Inspector General  
U.S. Office of Personnel Management  
1900 E Street, NW  
Room 6400  
Washington, DC 20415-1100

-- CAUTION --

This audit report has been distributed to Federal officials who are responsible for the administration of the audited program. This audit report may contain proprietary data which is protected by Federal law (18 U.S.C. 1905). Therefore, while this audit report is available under the Freedom of Information Act and made available to the public on the OIG webpage (<http://www.opm.gov/our-inspector-general>), caution needs to be exercised before releasing the report to the general public as it may contain proprietary information that was redacted from the publicly distributed copy.