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

Final Audit Report

AUDIT OF BLUE CROSS BLUE SHIELD OF MICHIGAN

Report Number 1A-10-32-17-009
April 24, 2018

EXECUTIVE SUMMARY

Audit of Blue Cross Blue Shield of Michigan

Report No. 1A-10-32-17-009 **April 24, 2018**

Why Did We Conduct the Audit?

The objectives of our audit were to determine whether Blue Cross Blue Shield of Michigan (Plan) charged costs to the Federal Employees Health Benefits Program (FEHBP) and provided services to FEHBP members in accordance with the terms of the Blue Cross Blue Shield Association's (Association) contract with the U.S. Office of Personnel Management. Specifically, our objective was to determine whether the Plan complied with contract provisions relative to health benefit payments.

What Did We Audit?

The Office of the Inspector General has completed a limited scope performance audit of the FEHBP operations of Blue Cross Blue Shield of Michigan. The audit covered claim payments from January 1, 2013, through September 30, 2016, as reported in the Association's Government-wide Service Benefit Plan Annual Accounting Statements.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

Our audit identified several minor incidents of erroneous claim payments, but we do not believe that the errors are indicative of major system control problems. Therefore, we conclude that the Plan's processing of FEHBP claims generally complies with the terms of its contract with the U.S. Office of Personnel Management and industry standards. The report questions $27,745 in health benefit charges summarized as follows:

A. System Pricing Review
   - The Plan incorrectly paid five claims resulting in overcharges of $13,918.

B. Omnibus Budget Reconciliation Act of 1993 (OBRA 93) Review
   - The Federal Employee Program Operations Center did not properly price 30 claim lines in accordance with OBRA 93 pricing guidelines, resulting in overcharges of $9,671.

C. Non-Participating Provider Review
   - The Plan incorrectly paid 13 claims to providers that are not part of the plan's provider network, resulting in overcharges of $4,156.

ABBREVIATIONS

The Act	Federal Employees Health Benefits Act
Association	Blue Cross Blue Shield Association
BCBS	Blue Cross and Blue Shield
FEHBP	Federal Employees Health Benefits Program
FEP	Federal Employee Program
Non-par	Non-Participating
OBRA 93	Omnibus Budget Reconciliation Act of 1993
OIG	Office of the Inspector General
OPM	U.S. Office of Personnel Management
Plan	Blue Cross Blue Shield of Michigan

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I. BACKGROUND

This final report details the findings, conclusions, and recommendations resulting from our limited scope audit of the Federal Employees Health Benefits Program (FEHBP) operations at Blue Cross Blue Shield of Michigan (Plan). The Plan is located in Detroit, Michigan. 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 Act (the Act), 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 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 Blue Cross Blue Shield Association (Association), on behalf of participating Blue Cross and Blue Shield (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 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 36 BCBS companies participating in the FEHBP. The 36 companies are comprised of 64 local BCBS plans.

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 managed by CareFirst Blue Cross Blue Shield, located in Owings Mills, Maryland. 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. 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, Plan management is responsible for establishing and maintaining a system of internal controls.

The most recent audit report issued that covered claim payments for Blue Cross Blue Shield of Michigan was Report No. 1A-10-32-05-034, dated March 24, 2006. All findings from the previous audit have been resolved.

The results of this current audit were discussed with Plan and Association officials throughout the audit and at an exit conference dated September 22, 2017. 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

OBJECTIVES

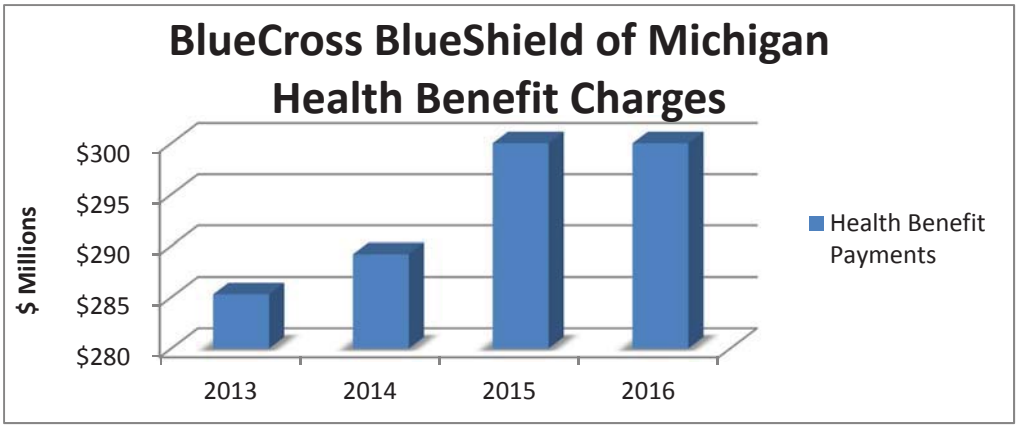
The objectives of our audit were to determine whether the Plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the contract. Specifically, our objective was to determine whether the Plan complied with contract provisions relative to health benefit payments.

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 Association's Government-wide Service Benefit Plan Annual Accounting Statements as they pertain to Plan codes 210 and 710 (Blue Cross Blue Shield of Michigan) for contract years 2013 through 2016 (see Exhibit I) and determined the Plan paid approximately $1.2 billion in health benefit charges. From this universe, we judgmentally selected various samples for review. We reviewed approximately 429 claims, totaling $5.4 million in payments, for the period of January 1, 2013, through September 30, 2016, for proper adjudication. The determination of our audit findings is based on the FEHBP contract, the 2013 through 2016 Service Benefit Plan brochures, the Plan's provider agreements, and the Association's FEP Administrative Procedures Manual. The results of these samples were not projected to the universe of claims.

Exhibit I – 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. Our audit approach consisted mainly of 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 is generally in compliance with the provisions of the contract relative to claim payments. A summary of our reviews was noted and explained in detail in the "Audit Reviews and Conclusion" 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, 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 from May through September 2017.

III. AUDIT FINDINGS AND RECOMMENDATIONS

Our audit identified several minor incidents of erroneous claim payments, but we do not believe that the errors are indicative of major system control problems. Therefore, we conclude that the Plan's processing of those FEHBP claims generally complies with the terms of its contract with the U.S. Office of Personnel Management and industry standards.

The sections below summarize the improper overpayment results identified in the reviews we performed on claim payments made by Blue Cross Blue Shield of Michigan. As mentioned in the "scope" section above, all of our samples were selected from claim payments for services reimbursed between January 1, 2013, and September 30, 2016.

A. System Pricing Review $13,918

We reviewed a sample of claims where the FEHBP paid as the primary insurer to determine whether the Plan's local claims adjudication system properly processed and priced these claims in accordance with contract CS 1039. See Exhibit II for a summary of our System Pricing Review.

Exhibit II – Summary of System Pricing Review

Population		Sample		Errors	
Claim Count	Amount Paid	Claim Count	Amount Paid	Claim Count	Overcharges
8,478,209	$985,474,689	200	$3,686,363	5	$13,918

Sample Selection Criteria

We selected 200 claims that were stratified by place of service (such as provider's office or inpatient hospital) and payment category (such as $50 to $99). Our sample size was judgmentally determined by the number of sample items from each place of service stratum based on the stratum's total claim dollars paid.

Review Summary

- The Plan's local system incorrectly processed four claims for professional therapy services that were billed by a skilled nursing facility, resulting in overcharges of $13,495 to the FEHBP.

- The Plan incorrectly paid one claim where the incorrect rate was loaded to the Plan's local system, resulting in an overcharge of $423.

Criteria

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." Additionally, 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 … ."

Recommendation 1

We recommend that the contracting officer disallow $13,918 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 evidence that skilled nursing facilities are properly educated on how to submit claims.

Plan's Response:

The Plan agrees with this finding and states, $13,495 in overcharges has been returned to the FEHBP and the remaining $423 will be returned by March 31, 2018.

Regarding the OIG's recommendation related to skilled nursing facilities, the Plan "will educate providers on how to properly submit these specific types of claims."

OIG Comments:

The Plan's response to the draft report and supporting documentation did not contain sufficient documentation to show the Plan returned the overcharged funds to the FEHBP. Therefore, we continue to recommend that the contracting officer disallow $13,918 in claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

As part of the audit resolution process, we recommend that the Plan provide OPM's Healthcare and Insurance Office with evidence that it has provided training to ensure that skilled nursing facilities are properly educated on how to submit claims.

B. Omnibus Budget Reconciliation Act of 1993 $9,671

The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) limits the benefit payments for physician services provided to annuitants age 65 or older who are not covered under Medicare Part B. The FEHBP fee-for-service plans are required to limit the claim payment to the lesser of the amount billed by the provider or the amount equivalent to the Medicare Part B payment. The FEP Operations Center contracts with Palmetto (an OBRA 93 pricing vendor) to calculate the pricing amounts for FEHBP claims subject to OBRA 93 pricing regulations. See Exhibit III for a summary of our OBRA 93 Review.

Exhibit III – Summary of OBRA 93 Review

Population		Sample		Errors	
Claim Count	Amount Paid	Claim Count	Amount Paid	Claim Lines	Overcharges
[redacted]	[redacted]	92	$72,279	30	$9,671

Sample Selection Criteria

We reviewed a sample of claim lines subject to OBRA 93 pricing with amounts paid of $400 or more that also contained procedure code modifiers 50, 51, 62, 66, 80, 81, or AS. Based on our audit experience, we consider these claim lines to be at high risk for claim payment error since the Association's nationwide claims adjudication system (FEP Express) was not configured to apply the Medicare modifier discount percentages.

Review Summary

Our review determined the Plan incorrectly paid 30 claim lines, totaling $9,671 in overcharges to the FEHBP. These claim overcharges were the result of the FEP Express system not deferring claims with modifier 59 for medical review. Based on the American Medical Association guidelines, modifier 59 indicates that a procedure separate and distinct from the primary procedure was performed, and additional documentation is required for the provider to receive a full payment of the distinct service. For these 30 claim lines, the Plan was unable to provide documentation to indicate that the separate and distinct procedure was medically necessary. Therefore, these multiple procedures should have paid at a discounted rate instead of the full Medicare allowance.

Criteria

As previously cited from contract CS1039, 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 limitations in written provider agreements.

Recommendation 3

We recommend that the contracting officer disallow $9,671 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 enhance the FEP Express system to defer all claims with modifier 59 for medical review before allowing the BCBS Plans to process the claims for payment.

Plan's Response:

The Plan agrees with this finding and states $6,173 has been returned to the FEHBP and the remaining $3,498 in overcharges will be returned by March 31, 2018.

Association's *Response:*

"BCBSA [Association] will evaluate the feasibility of implementing the recommendation by March 31, 2018."

OIG Comments:

The Plan's response to the draft report and supporting documentation did not contain sufficient documentation to show the Plan returned the overcharged funds to the FEHBP. Therefore, we continue to recommend that the contracting officer disallow $9,671 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

C. Non-Participating Providers Review $4,156

Non-Participating (non-par) providers are those that do not have a contract with the Plan and have not agreed to accept the Plan's standard rates as payment in full. See Exhibit IV for a summary of our non-par providers review.

Exhibit IV – Summary of Non-Par Provider Review

Population		Sample		Errors	
Claim Count	Amount Paid	Claim Count	Amount Paid	Claim Count	Overcharges
14,816	$1,946,611	146	$56,041	13	$4,156

Sample Selection Criteria

We judgmentally selected claims from the 21 non-par providers that received the highest payments from the FEHBP, and where the amount paid on the claim was greater than or equal to the amount billed.

Review Summary

- We determined the Plan did not coordinate claims for one patient in our sample review with the member's primary insurer. As a result, the Plan incorrectly paid 10 claims, totaling $2,221 in overcharges to the FEHBP.

- The Plan incorrectly paid two claims due to a processor applying the incorrect pricing methodology while calculating the claims, resulting in overcharges of $926 to the FEHBP.

- The Plan incorrectly paid one claim to a provider who was not medically licensed during the patient's dates of service, resulting in an overcharge of $1,009 to the FEHBP.

Criteria

As previously cited from CS1039, 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 limitations in written provider agreements.

Recommendation 5

We recommend that the contracting officer disallow $4,156 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Plan's Response:

The Plan agrees with this finding and states $2,221 has been returned to the FEHBP and the remaining $1,935 in overcharges will be returned by March 31, 2018.

OIG Comments:

The Plan's response to the draft report and supporting documentation did not contain sufficient documentation to show the Plan returned the overcharged funds to the FEHBP. Therefore, we continue to recommend that the contracting officer disallow $4,156 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

APPENDIX

BlueCross BlueShield
Federal Employee Program.

Federal Employee Program
1310 G Street, N.W.
Washington, D.C. 20005
202.626.4800

February 9, 2018

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

Reference: OPM DRAFT AUDIT REPORT
Blue Cross Blue Shield of Michigan
Audit Report Number 1A-10-32-17-009
(Dated and Received December 13, 2017)

Dear [redacted]:

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

A. System pricing Review **$13,918**

Recommendation 1

We recommend that the contracting office disallow $13,918 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Plan Response

The Plan agrees with this error. $13,495 was returned to the Program through claim adjustments. The remaining balance of $423 will be return by March 31, 2018. Documentation to support the Letter Of Credit Account (LOCA) adjustment will also be submitted by March 31, 2018.

Recommendation 2

We recommend that the contracting office require the Plan to modify the local system to recognize when multiple professional therapy services are billed on the

same day by skilled nursing facilities. The local system should process the professional therapy claims according to the date of service for each service provided, as applicable to the providers' contracts and/or payment policy.

Plan Response

To prevent future occurrences of this issue, the Plan will educate providers on how to properly submit these specific types of claims.

[Redacted by OIG – not relevant to final report]

Recommendation 3

We recommend that the contracting office require the Plan to correct the rate loading error identified in our review.

Plan Response

The Plan agrees this was a manual error and that the system has been corrected. See attachment 1 showing the correct rate.

B. Omnibus Budget Reconciliation Act of 1993 (OBRA 93) $9,671

Recommendation 4

We recommend that the contracting office disallow $9,671 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Plan Response

The Plan agreed with this recommendation. Nine claims totaling $6,173 have been adjusted to pay correctly. The remaining $3,498 will be credited to FEP by March 31, 2018. Documentation to support the LOCA adjustment will also be submitted by March 31, 2018.

Recommendation 5

We recommend that the contracting office require the Association to enhance the FEP Express system to defer all claims containing

modifier 59 for medical review before allowing the BCBS Plans to process the claims for payment.

BCBSA Response

BCBSA will evaluate the feasibility of implementing the recommendation by March 31, 2018.

C. Non-Participating Providers Review **$5,267**

Recommendation 6

We recommend that the contracting office disallow $5,267 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Plan Response

The Plan agrees to overpayments totaling $4,156 and contests questioned claims totaling $1,111. The questioned amount represents the difference between questioned subrogation claims totaling $3,332 and the amount agreed to as a settlement with the other insurance carrier totaling $2,221.

See attachment 2 verifying the $2,221 check copies returning funds to the Program. The balance of $1,935 will be returned to the Program and documentation to support the LOCA adjustment will be submitted by March 31, 2018.

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 [redacted] at [redacted].

Sincerely,

[redacted]
Executive Director, FEP Program Integrity

cc: [redacted], BCBSM

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