



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

Final Audit Report

**AUDIT OF
GLOBAL COORDINATION OF BENEFITS FOR
BLUE CROSS AND BLUE SHIELD PLANS**

**Report Number 1A-99-00-16-062
March 15, 2018**

OFFICE OF
PERSONNEL MANAGEMENT

EXECUTIVE SUMMARY

Audit of Global Coordination of Benefits

Report No. 1A-99-00-16-062

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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 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 coordination of benefits with Medicare.

What Did We Audit?

The Office of the Inspector General (OIG) has completed a limited scope performance audit of the FEHBP operations at all BCBS plans. The audit covered claim payments from December 1, 2015, through August 31, 2016. Specifically, we identified claims incurred on or after November 15, 2015, that were reimbursed from December 1, 2015, through August 31, 2016, and were potentially not coordinated with Medicare (referred to as coordination of benefits or COB).



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*Assistant Inspector General
for Audits*

What Did We Find?

For many years, we have had serious concerns with the efforts of the BCBS plans and the Association to implement corrective actions to prevent COB claim payment errors. Our audits (performed annually since 2001) routinely show that the primary reason for COB claim payment errors is the fact that BCBS plans fail to review and/or adjust a patient's prior paid claims when that member's Medicare enrollment information is subsequently obtained.

Although the Association has made several modifications to its claims adjudication system in an effort to reduce COB errors, the results of this audit continue to indicate that these corrective actions have not had a substantial impact in reducing the amount of COB payment errors. Our audit determined that \$11,738,240 in COB overpayments from the FEHBP were paid in error over a nine-month period. Since 2004, the Association has allowed over \$167 million in COB-related claim overpayments. The BCBS plans and the Association have not met their contractual obligation to proactively identify or retroactively adjust overpayments through a robust internal control program. Considering the length of time that the Association has allowed these material errors to occur, the OIG does not believe that the improper payments were made 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 Association had initiated recovery for \$5,231,401 of the claim overpayments prior to the start of this audit. This report questions the remaining **\$6,506,839** in health benefit charges that were potentially not coordinated with Medicare.

ABBREVIATIONS

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

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I. BACKGROUND

This final audit report details the findings, conclusions, and recommendations resulting from our limited scope audit of the Federal Employees Health Benefits Program (FEHBP) operations at 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 (FEP¹) 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.

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-99-00-15-060, dated October 13, 2016) for claims reimbursed from October 1, 2014, through June 30, 2015, are currently in the process of being resolved.

Our sample selections, instructions, and preliminary audit results of the potential COB errors were presented to the Association in a draft report, dated October 31, 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 August 2, 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 plans complied with contract provisions relative to coordination of benefits with Medicare.

SCOPE

The audit covered health benefit payments from December 1, 2015, through August 31, 2016, as reported in the Blue Cross and Blue Shield Association's Government-wide Service Benefit Plan FEP Annual Accounting Statements. We performed a computer search on our BCBS claims data warehouse to identify all claim payments incurred on or after November 15, 2015, that were reimbursed from December 1, 2015, through August 31, 2016, and potentially were not coordinated with Medicare. This search identified 481,417 claim lines, totaling \$61,049,780 in payments, that were potentially not coordinated with Medicare.

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 (See Exhibit I for the summary of our universe by Category).

- 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.
- Categories C and D include inpatient claims with ancillary items that should have been coordinated with Medicare Part B. 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.

Exhibit I – Universe of Potentially Uncoordinated Claim Lines

Category	Patients	Claim Lines	Amount Paid
Category A: Medicare Part A Primary for Inpatient Facility	373	447	\$6,463,463
Category B: Medicare Part A Primary for Skilled Nursing/Home Health Care (HHC)Hospice Care	1,070	11,935	\$2,920,009
Category C: Medicare Part B Primary for Certain Inpatient Facility Charges	37	42	\$463,126
Category D: Medicare Part B Primary for Skilled Nursing/HHC/Hospice Care	36	83	\$227,662
Category E: Medicare Part B Primary for Outpatient Facility and Professional	3,457	20,631	\$6,296,832
Category F: Medicare Part B Primary for Outpatient Facility and Professional (with processor manual override using code 'F')	141,653	448,279	\$44,678,688
Total	146,626	481,417	\$61,049,780

From this universe, we selected two separate samples of claims to review as part of this audit. The first sample was a *high dollar threshold sample*, and the second was a *statistical sample*. 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:

- For the *high dollar threshold* review, we selected claims from each category for a cumulative sample of 55,061 claim lines totaling \$24,194,872 in payments (see Exhibit II for the summary of our high-dollar review claim selections). We *did not* project the results of this particular review to the universe of claims paid for potentially uncoordinated claim lines.
- For the *statistical* review, we randomly selected 3,389 claim lines, totaling \$3,553,544 in payments, from Category F claims for patients with cumulative claim payments less than \$10,000. The results of this sample review were projected to the universe.

When we notified the Association of these potential errors on October 31, 2016, these claims were within the Medicare timely filing requirement and could be filed with Medicare for coordination of benefits.² 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.

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.

METHODOLOGY

The claims selected for review were submitted to each BCBS plan for its 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., February 6, 2017) for the claim payment errors in our sample.

The determination of the questioned amount is based on the FEHBP contract, the 2015 and 2016 Service Benefit Plan brochures, the Association's FEP Procedures Administrative Manual, 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.

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 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 coordination of benefit 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 August 2017.

III. AUDIT FINDINGS AND RECOMMENDATIONS

GLOBAL COORDINATION OF BENEFITS REVIEW

The sections below detail the results of our 2016 global COB audit. The audit was done as two separate reviews – a review of claims over a high dollar threshold and a review of a statistical sample of claims. Any recommendations from prior COB audits that have not yet been resolved have been rolled forward below.

A. High Dollar Threshold Review

\$3,657,586

As mentioned in the Scope section above, our universe consisted of 481,417 claim lines, totaling \$61,049,780 in payments, that potentially were not coordinated with Medicare. Our first review from this universe included claims above various high dollar thresholds for each category. See Exhibit II for a summary of our sample selection methodologies and claims reviewed by category.

Exhibit II – Summary of Claim Lines Reviewed

Category	Sample Selection Methodology	Claim Lines	Amounts Paid	Potential Overcharges
Category A	All patients selected (373 patients)	447	\$6,463,463	\$6,463,463
Category B	All patients selected (1,070 patients)	11,935	\$2,920,009	\$2,920,009
Category C	All patients selected (37 patients)	42	\$463,126	\$115,781
Category D	All patients selected (36 patients)	83	\$227,662	\$56,916
Category E	Patients with cumulative claim lines of \$1,000 or more (825 patients)	13,852	\$5,636,058	\$4,508,846
Category F	Patients with cumulative claim lines of \$10,000 or more (333 patients)	28,702	\$8,484,554	\$6,787,644
Total		55,061	\$24,194,872	\$20,852,659

In general, if we could not reasonably determine the actual overcharge for a claim, we determined the overpayment amount accordingly:

- Category A and B – Medicare Part A pays all covered costs (except for deductibles and coinsurance) for inpatient care in hospitals, skilled nursing facilities and hospice care. We

calculated the overcharges by reducing the questioned amount using the applicable Medicare deductible and/or copayment.

- Category C and D – 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. We estimated that the FEHBP was overcharged 25 percent for these inpatient claim lines ($0.30 \times 0.80 = 0.24 \sim 25$ percent).
- Category E and F – 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 these claim lines.

These 55,061 claim lines, totaling \$24,194,872 in payments, were reviewed to determine whether the BCBS plans complied with contract provisions relative to COB with Medicare. Our review determined that the plans incorrectly paid 7,679 claim lines, totaling \$4,212,741 in payments. We estimate that the FEHBP was overcharged \$3,657,586 for these claim line payments. See Exhibit III for a summary of the questioned costs by category.

**Exhibit III – Summary of Questioned Costs by Category
High Dollar Threshold Review**

Category	Claim Lines	Amount Paid	Amount Questioned
Category A	85	\$1,285,526	\$1,241,666
Category B	3,288	\$662,380	\$662,049
Category C	5	\$59,938	\$14,985
Category D	11	\$46,966	\$11,742
Category E	3,134	\$1,757,692	\$1,406,690
Category F	1,156	\$400,239	\$320,454
Total	7,679	\$4,212,741	\$3,657,586

These claim payment errors are comprised of the following (See Exhibit IV for a summary of questioned costs by cause of error):

- For 2,926 of the claim lines questioned, the BCBS plans failed to retroactively review and/or adjust the patient's prior paid claim(s) when the member's Medicare information was subsequently added to the FEP Express Claims Processing System (FEP Express). We estimate that the FEHBP was overcharged \$2,175,538 for these COB errors.
- For 3,362 of the claim lines questioned, the BCBS plans incorrectly paid these claims because FEP Express did not defer the claims for Medicare COB review. Although FEP Express has systematic processes to review claims that potentially should be coordinated with Medicare, the system deferrals "FCH," "FF2," and "FPY" within FEP Express were missing processing rules pertaining to home health claims that caused FEP to overpay in error³. We estimate that the FEHBP was overcharged \$683,112 for these errors.
- For 504 of the claim lines questioned, the BCBS plans incorrectly paid these claims due to manual processor errors. In most cases, there was special information present in FEP Express to identify Medicare as the primary payer when these claims were paid. However, a Medicare Payment Disposition Code was incorrectly used to override the system's automatic deferral of these claims. The Medicare Payment Disposition Code designates Medicare's responsibility for payment on each charge line of a claim. According to the BCBS Administrative Procedures Manual, the completion of this field is required on all claims for patients who are age 65 or older. We estimate that the FEHBP was overcharged \$592,665 for these COB errors.
- For 680 of the claim lines questioned, the overpayments were not COB-related errors but were processed and paid incorrectly by the plans. We estimate that the FEHBP was overcharged \$115,694 for these non-COB errors.
- For 149 of the claim lines questioned, the BCBS plans incorrectly paid these claims due to provider billing errors. We estimate that the FEHBP was overcharged \$69,855 for these COB errors.

³ **FCH** - Medicare Part B is on file, but there is no indication of Medicare Part B payment or input for inpatient facility claims, skilled nursing facility or home health agency claims; **FF2** - Medicare Part A special information record is on file that corresponds with service dates on claim for home health, but there is no indication of Medicare payment available; and **FPY** - there is no Medicare payment on Medicare crossover professional or outpatient facility claim, but member is not liable.

- For 58 of the claim lines questioned, the BCBS plans incorrectly paid these claims because the plans' local claims processing systems did not appropriately defer the claims for Medicare COB review. We estimate that the FEHBP was overcharged \$20,722 for these errors.

Exhibit IV – Questioned Cost by Cause of Error

Cause of Error	Claim Lines	Amount Paid	Amount Questioned
Retroactive Changes	2,926	\$2,533,177	\$2,175,538
FEP Express	3,362	\$686,855	\$683,112
Processor Errors	504	\$732,224	\$592,665
Non-COB Errors	680	\$144,617	\$115,694
Provider Billing	149	\$89,966	\$69,855
Local System	58	\$25,902	\$20,722
Total	7,679	\$4,212,741	\$3,657,586

For many years, we have had serious concerns with the BCBS plans' and Association's efforts to implement corrective actions to

prevent COB claim payment errors. Our audits (performed annually since 2001) routinely show that failure to retroactively adjust a patient's prior claims after Medicare information is obtained is the primary reason for COB claim payment errors. Due to the nature of the COB process, we recognize that some COB errors will occur; however, we continue to identify material errors year after year.

For the period of December 1, 2015, through August 31, 2016, we identified \$6,506,839 in COB claim payment errors. In addition, the Association had itself already identified and recovered \$5,231,401 in overcharges. In other words, a total of \$11,738,240 in COB overpayments were made over a nine-month period. Although the

A total of \$11,738,240 in COB overpayments were made during a nine-month period.

Association proactively recovered a portion of the overpayments, we assert that controls should be in place to prevent these payments from occurring in the first place. The Association has made several modifications to FEP Express in an effort to reduce COB errors, but the results of this audit continue to indicate that these corrective actions have not had a substantial impact in reducing the amount of COB payment errors. Since 2004, the Association has allowed an average of \$10.5 million per year (for a total of \$167 million) in COB overpayments. Only \$119 million of the \$167 million in overpayments have been recovered by the Association and/or OPM, further demonstrating that the Association's post-payment recovery strategy is not effective. We also note that the amount of overpayments identified in this audit (\$11.7 million in nine months) is higher than the *annual* average of overpayments since 2004 (\$10.5 million).

Based on the above we conclude that the Association has not met its contractual obligation to proactively identify overpayments through a robust internal control program. Considering the unreasonable length of time that these material errors occurred after the issue had been brought to

the Association's attention, we believe that these erroneous claim payments were not made in good faith. Therefore, we recommend that the entire questioned amount be returned to the FEHBP regardless of the Plan's 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 COB errors.

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

- Contract CS 1039, Part III, section 2.3 (g) states, "It is the Carrier's responsibility to proactively identify overpayments through comprehensive, statistically valid reviews and a robust internal control program.
- 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 2.3 (g)(8)(ii) states that "the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments (or to correct processes or procedures that caused erroneous benefit payments) when the errors are egregious or repeated."
- 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 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 2016 Blue Cross and Blue Shield Service Benefit Plan brochure, page 141, Primary Payer Chart, illustrates when Medicare is the primary payer. In addition, page 143 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 Response:

In response to the draft audit report, which questioned \$20,852,659 in potential overpayments, the Association states, “BCBS Plans identified ... claim overpayments totaling \$3,672,937. BCBS Plans also responded that of the \$3,672,937 in claim overpayments, recovery was initiated on ... claim overpayments totaling \$1,042,319 before the OIG Audit Notification Letter and the actual listing of potential claim overpayments were received. The remaining ... claim overpayments totaling \$2,630,618 were identified as a result of the audit.”

Of the remaining \$17,179,722 in potential overpayments that were questioned, the plans stated that \$11,948,321 in claim payments were paid correctly and that \$5,231,401 in claim payment errors were identified and returned to the Program before the OIG Audit Notification letter.

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 to accept the Medicare denial reason code from Plans for Medicare Crossover claims.*
- *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.*
- *Implemented several new Medicare edits that stop claims for review before payment.*
- *Implemented a new denial that automatically denies charges that were denied by Medicare for various contractor obligation reasons.*
- *Reviewed all Medicare edits to determine if they are working as intended. Edits that are not working as intended will be corrected.”*

OIG Comments:

The Association’s response and supporting documentation provided indicate that the BCBS plans acknowledge that \$3,657,586 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., October 31, 2016) and adjusted or voided by the draft report response due date (i.e., February 6, 2017), we did not consider these as claim payment errors in the final report.

Acknowledged Claim Overpayments

The \$3,657,586 of acknowledged claim overpayments is comprised of the following:

- \$2,848,666 represents claim overpayments for which the BCBS plans have committed to pursue recovery; and
- \$808,920 represents claim overpayments for which the BCBS plans state the recovery efforts have been exhausted. Documentation supporting all recovery efforts has not been provided.

As stated above, the Association has not met its contractual obligation to proactively identify or retroactively adjust overpayments through a robust internal control program. We do not agree that these claim payments were made in good faith, and therefore, we recommend that the entire questioned amount be returned to the FEHBP regardless of the Plan's ability to recover the funds from the providers. Furthermore, per the contract, the Association cannot charge OPM for its efforts in correcting these egregious and repeated deficiencies.

We do not agree that the claim payments were made in good faith.

Recommendation 1

We recommend that the contracting officer disallow \$3,657,586 for claim overpayments and verify that the BCBS plans return all amounts recovered to the FEHBP, regardless of the plans' ability to recover the claim payments from providers.

Recommendation 2

Failure to retroactively adjust a patient's prior claim after Medicare information is obtained is the primary reason for COB claim payment errors, and therefore we recommend that the contracting officer require the Association to perform an analysis on these types of errors and determine the reason why the members' Medicare enrollment information is not being updated in FEP Express prior to the payment of the Medicare claims. Once this analysis has been completed, the contracting officer should require the Association to implement additional controls to eliminate retroactive enrollment errors from occurring.

Recommendation 3

In regards to FEP Express errors, we recommend that the contracting officer verify that the Association implements appropriate enhancements to FEP Express to include criteria for Master file edits FCH, FF2, and FPY to help reduce future home health claim payment errors.

Recommendation 4 (Rolled-forward from COB 2015, Report No. 1A-99-00-15-060)

We continue to recommend that the contracting officer monitor any enhancements or updates that the Association implements in FEP Express to help reduce COB errors.

B. Statistical Sample Review

\$2,849,253

Our second sample of claims selected for review was a statistical sample of Category F claims for patients with cumulative claim payments less than \$10,000. Exhibit V shows this universe of claim lines.

Exhibit V – Universe for Statistical Sample

Category	Criteria	Claim Lines	Amount Paid
Category F	Patients with cumulative payments less than \$10,000	419,577	\$36,194,133

We stratified each claim line into seven categories based on amount paid, then applied the following criteria to our sample selection:

- We selected to review all claim lines in stratum “0” (i.e., claim line payments between \$5,000 and \$10,000), since this additional tier was determined to have minimal effect on the precision when projecting the results of our statistical review.
- To select the sample size to review for strata “1” through “6,” we applied the “ratio estimator” methodology. Specifically, we used the claim error rates from a prior audit⁴ to determine the sample size necessary to achieve a margin of error on a 95% confidence interval to be no greater than 2%. This was done independently within each of the six strata. With the intent of projecting the results of the sample to the population, we used automated software to generate a random sample from each stratum.

⁴ Per results of Global Coordination of Benefits for Blue Cross Blue Shield (BCBS) Plans (report number 1A-99-00-15-060), we applied error rates of 4%, 9%, 11%, 9%, 13%, and 15% for strata “1” through “6,” respectively.

These criteria yielded a sample of 3,389 claim lines, totaling \$3,553,544 in payments, for review. See Exhibit VI for our total population and sample results by strata.

Exhibit VI – Total Population and Sample Selected for Review by Strata

Strata No.	Amount Paid Tier	Total Population		Samples for Review	
		Claim Lines	Amounts Paid	Claim Lines	Amounts Paid
0	Greater than or equal to \$5,000	49	\$324,045	49	\$324,045
1	\$0 - \$49.99	261,488	\$6,355,485	305	\$7,358
2	\$50 - \$199.99	125,839	\$12,468,668	698	\$70,045
3	\$200 - \$499.99	22,668	\$6,679,367	787	\$231,613
4	\$500 - \$999.99	6,464	\$4,529,264	572	\$404,682
5	\$1,000 - \$2,499.99	2,415	\$3,401,549	696	\$977,797
6	\$2,500 - \$4,999.99	654	\$2,435,755	415	\$1,541,134
TOTAL		419,577	\$36,194,133	3,522	\$3,556,674

Of the 3,522 claim lines selected for review, we determined that the BCBS plans incorrectly paid 400 claim lines, resulting in overcharges of \$532,194 to the FEHBP. See Exhibit VII for a summary by strata of overpayments identified by the review.

1) Stratum “0”

Our review determined the BCBS plans incorrectly paid 10 claims lines, totaling **\$56,459** in overcharges to the FEHBP and this is the amount we are questioning from this stratum in this finding.

2) Strata “1” through “6”

For these strata we identified 390 claim lines, totaling **\$475,735** in overcharges to the FEHB. We used automated software to project the sample results using the ratio estimator methodology.⁵ With a relative precision point of .98, we determined the ratio estimator to be the most precise estimator for determining the projection results. Based on our

Exhibit VII – Overpayments Identified by Manual Review

Strata	Claim Lines	Overpaid Amounts
0	10	\$56,459
1 – 6	390	\$475,735
TOTAL	400	\$532,194

⁵ Ratio estimator is discussed at length in Chapter 6 of Cochran, W. (1977). *Sampling Techniques. Third Edition.* New York, NY: Wiley.

review, we are 95 percent confident that the true value of claims that paid incorrectly, for the population⁶ of strata “1” through “6,” is between \$2,493,058 and \$3,092,529. Our best estimate of the true value, the projection estimate, is **\$2,792,794**, and this is the amount we are questioning from strata 1 - 6. See Exhibit VIII for a summary of results of statistical review.

**Exhibit VIII – Projected Overpayments
Using Ratio Estimator Methodology**

Projected Overpayments for Strata 1 - 6	
Total Population - Amount Paid	\$36,194,133
Samples Reviewed - Paid in Error	\$532,194
Total Overpayments (Projection)	\$2,792,794⁷
Margin of Error	+/- \$299,735
Relative Precision	.98%
High Point	\$3,092,529
Low Point	\$2,493,059

Summary of Statistical Sample Review

Overall, our review of Category F claims with cumulative claim payments less than \$10,000 determined that **the FEHBP was overcharged a total of \$2,849,253**. See Exhibit IX for a summary of total questioned overcharges by strata.

Exhibit IX – Summary of Questioned Overcharges – Statistical Sample Review

Total Questioned Overcharges			
Strata	“0”	“1 – 6”	“0 – 6”
Overcharges	\$56,459	\$2,792,794	\$2,849,253

⁶ Our population that was used to project the results of our review represented 3,522 claim lines, totaling \$3,556,674 in payments.

⁷ In accordance with contract CS 1039, the projected overpayment excludes claims where the total claim amount (as opposed to individual claim lines) is \$50 or under.

Association Response:

In response to the draft report, the BCBS plans stated that \$532,678 of the questioned claim overpayments were paid in error, and that the remaining questioned claim overpayments totaling \$2,312,662 were paid correctly.

Further, “the BCBSA [Association] contests any projected overpayment on payment errors identified in the statistical sample. Based upon an analysis of the OIG’s sampling and estimating methodology for previous Medicare COB audits, BCBSA [Association] determined that the OIG estimation methodology:

- Is biased toward higher dollar claims, thus inflating the estimated error amount.*
- Results a heavily biased estimate to the lower dollar end of the strata and does not appear to be consistent with the distribution of the sample audited by the Plans.*
- Appears to assume consistency across the universe; however, the claims are for different amounts, procedure codes, denial reasons and processed by different claim processing systems.*
- Treats all errors identified as universal errors in the population; however, 43% of all errors identified were related to paying non covered durable medical claims for members where services were provided in another Plan’s service area. In this instance the only error was that the claim was paid by the wrong Plan; however, the FEP Program is required to pay these claims.*
- Includes claims where the paid amount for the claim is less than \$50. CS1039 does not require recovery initiation on claims where the overpayment amount is less than \$50. . . .*

As a result, BCBSA [Association] disagrees that the Contracting Officer should use a projected amount to determine unallowable charges. The use of a projection to determine an appropriate error amount is inaccurate and does not result in a true error amount and therefore should not be used in the OIG audit process. Instead, BCBSA [Association] will work with Plans to review additional claims to identify actual claims that were paid in error, if any. The population to be reviewed by Plans will exclude claims that are below the recovery threshold (where recovery is not required by CS1039), non-covered Medicare providers, non-covered Medicare services as well as charges that were denied by Medicare but represents FEP benefits. Recovery will be initiated on any overpayment amounts identified and any amount recovered will be returned to the Program [FEHBP].”

OIG Comments:

Although the Association disagrees with the use of statistical projections in OIG audits, we assert that this is a scientifically valid approach to estimate claim overpayments. This estimating technique is used by the American Institute of Certified Public Accountants, the U.S. Department of Health and Human Services, and the U.S. Internal Revenue Service. The use of statistical sampling and extrapolation for determining overpayments in government benefits programs, including Medicare and Medicaid, is both longstanding and commonplace. Statistical sample testing carries evidential weight in a court of law, and conclusions drawn from statistical sampling are defensible in court because the risk of error in the population is objectively determined. The following points address the specific concerns raised by the Association in its response to our draft audit report:

- The sampling methodology used for our review was purely a stratified random sample using the ratio estimator methodology, therefore, could not be deemed as biased towards any certain claim, regardless of the amount paid. We stratified the data prior to selecting our samples in order to capture and apply weights based on the entire population of data. The calculation to determine the sample size for each stratum also incorporated the known error rates from prior audits, and was performed to achieve a margin of error on a 95% confidence interval to be no greater than 2%. This approach is not biased toward any subset of claims, and it allows for a more precise projection than simply selecting a sample size proportionate to the volume of claims in each stratum.
- The sampling methodology used for our review was purely a stratified random sample, therefore, cannot be deemed as biased towards any certain claim, regardless of the amount paid.**
- The error estimates are purposely based on dollar amount, as this is a consistent characteristic for every unit selected within the population. Other characteristics, such as procedure codes, denial codes, error reasons, and plan sites, are variable characteristics for each unit within the universe and would result in a biased error estimate. The error estimates were consistently designed for this sampling approach and ultimately compensate for variable characteristics identified in the random sample review.
 - The Association states that our sample *“Includes claims where the paid amount for the claim is less than \$50. CS1039 does not require recovery initiation on claims where the overpayment amount is less than \$50.”* In response to this comment, we adjusted the statistical projection to exclude total claim payments that were \$50 or under.

As stated above, the Association has not met its contractual obligation to proactively identify overpayments through a robust internal control program. The claim payment errors are egregious and repeated, and we do not believe they were paid in good faith. Therefore, we recommend that the entire questioned amount be returned to the FEHBP regardless of the Plan's ability to recover the funds from the providers.

Recommendation 5

We recommend that the contracting officer disallow \$2,849,253 for claims that were not paid in good faith and were unreasonably charged to the FEHBP, and verify that the BCBS plans return all amounts recovered to the FEHBP, regardless of the plans' ability to recover the claim payments from providers.

APPENDIX A



April 10, 2017

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**Reference: OPM DRAFT AUDIT REPORT
Tier XVI Global Coordination of Benefits
Audit Report #1A-99-00-16-062**

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 incurred on or after November 15, 2015 and paid from December 1, 2015 thru August 31, 2016. Our comments concerning the findings in the report are as follows:

Recommendation 1:

Coordination of Benefits with Medicare Questioned Amount \$20,852,659

The OPM OIG submitted their sample of potential Medicare Coordination of Benefits errors to the Blue Cross Blue Shield Association (BCBSA) on October 31, 2016. The BCBS Association and/or the BCBS Plans were requested to review these potential errors and provide responses by February 6, 2017. These listings included claims incurred on or after November 1, 2015 that were reimbursed from December 1, 2015 thru August 31, 2016 and potentially not coordinated with Medicare. OPM OIG identified 481,417 claim lines, totaling \$61,049,780 in payments, which potentially were not coordinated with Medicare. From this universe, OPM OIG selected for review a sample of 55,061 claim lines, totaling \$24,194,872 in payments with a potential overpayment of \$20,852,659 to the Federal Employee Health Benefit Program (FEHBP).

The OIG recommended that the contracting officer disallow \$20,852,659 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 \$20,852,659, BCBS Plans identified 3,641 claim overpayments totaling \$3,672,937. BCBS Plans also responded that of the \$3,672,937 in claim overpayments, recovery was initiated on 1,851 claim overpayments totaling \$1,042,319 before the OIG Audit Notification Letter and the actual listing of potential claim overpayments were received. The remaining 1,790 claim overpayments totaling \$2,630,618 were identified as a result of the audit.

For the remaining \$17,179,722 in potential claim overpayments questioned, Plans reported that:

- \$11,948,321 in potential overpayments were paid correctly.
- \$5,231,401 in potential overpayments were identified and returned to the Program before the response to the OIG Draft Report was due.

Of the \$1,042,319 in overpayments identified before the audit began:

- \$905,369 in claim payments were paid correctly initially based upon Medicare coverage information known at the time the claim was paid.
- \$136,950 in overpayment errors were identified before the audit began, based upon processes in place to identify payment errors if they occur.

The above claim payment errors were identified and recovery was initiated in accordance with CS1039, Section 2.3(g). Where possible, the Plans will continue to pursue the remaining overpayments as required by CS 1039, Section 2.3(g) (I).

Further, during 2016, the FEP Program coordinated 33,377,348 claims with Medicare, resulting in FEP Program Medicare savings of \$40.1 billion. The overpayments identified by the audit totaling \$2,630,618 represent .005% of the claims coordinated with Medicare and .0066% of reported Medicare COB savings. Although these identified overpayments represent a small percentage of the Program's overall Medicare processing, BCBSA and Plans are committed to recovering these overpayments as well as implementing additional internal controls to reduce or eliminate these types of overpayments.

Recommendation 2

Although the Association has developed corrective action plan 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. 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.

BCBSA Response:

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

- Modified the FEP claims system to accept the Medicare denial reason code from Plans for Medicare Crossover claims.
- 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.
- Implemented several new Medicare edits that stop claims for review before payment.
- Implemented a new denial that automatically denies charges that were denied by Medicare for various contractor obligation reasons.
- Reviewed all Medicare edits to determine if they are working as intended. Edits that are not working as intended will be corrected.

Statistical Sample Review

The OIG submitted a sample of potential COB errors to the Association on October 31, 2016. After receiving the BCBS plans' spreadsheet responses and supporting documentation and the Association's draft report response, the OIG will review the responses and applicable documentation for these 3,522 claim lines, and will determine the appropriate questioned amount by projecting the results of the statistical sample to the universe of Category F claims for patients with cumulative claim payments less than \$10,000. The OIG will determine the actual overcharges to the FEHB in its final report after reviewing the Association's response to the draft report.

Recommendation #3

The OIG recommend that the contracting officer disallow the claims overcharges (to be determined and included in the final report) and have the BCBS plans return all amounts recovered to the FEHBP.

BCBSA Response:

After reviewing the OIG statistical sample of uncoordinated Medicare COB claims totaling \$2,845,340, BCBS Plans responded that claim overpayments totaling \$532,678 were paid in error and that the remaining claims, totaling \$2,312,662 were paid correctly. BCBS Plans also responded that of the \$532,678 amount in claim payment errors, recovery was initiated on claim overpayments totaling \$4,020 before the OIG Audit Notification Letter and the actual listing of potential claim overpayments were received for review.

BCBSA contests any projected overpayment on payment errors identified in the statistical sample. Based upon an analysis of the OIG's sampling and estimating methodology for previous Medicare COB audits, BCBSA determined that the OIG estimation methodology:

- Is biased toward higher dollar claims, thus inflating the estimated error amount.
- Results a heavily biased estimate to the lower dollar end of the strata and does not appear to be consistent with the distribution of the sample audited by the Plans.
- Appears to assume consistency across the universe; however, the claims are for different amounts, procedure codes, denial reasons and processed by different claim processing systems.
- Treats all errors identified as universal errors in the population; however, 43% of all errors identified were related to paying non covered durable medical claims for members where services were provided in another Plan's service area. In this instance the only error was that the claim was paid by the wrong Plan; however, the FEP Program is required to pay these claims.
- Includes claims where the paid amount for the claim is less than \$50. CS1039 does not require recovery initiation on claims where the overpayment amount is less than \$50.
- Includes charges that are not covered by Medicare because:
 - The charges are statutory exclusions from payment of Medicare
 - The charges include drug charges that are not covered by Medicare part B
 - The charges represent services that were denied by Medicare because the provider is a non-covered Medicare provider.

As a result, BCBSA disagrees that the Contracting Officer should use a projected amount to determine unallowable charges. The use of a projection to determine an appropriate error amount is inaccurate and does not result in a true error amount and therefore should not be used in the OIG audit process. Instead, BCBSA will work with Plans to review additional claims to identify actual claims that were paid in error, if any. The population to be reviewed by Plans will exclude claims that are below the recovery threshold (where recovery is not required by CS1039), non-covered Medicare providers, non-covered Medicare services as well as charges that were denied by Medicare but represents FEP benefits. Recovery will be initiated on any overpayment amounts identified and any amount recovered will be returned to the Program.

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,

[REDACTED]

Managing Director, FEP Program Assurance



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