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

Final Audit Report

Audit of the Coordination of Benefits with Medicare for BlueCross and BlueShield Plans Fiscal Year 2018

Report Number 1A-99-00-19-001
September 19, 2019

EXECUTIVE SUMMARY

Audit on the Global Coordination of Benefits for Blue Cross and Blue Shield Plans

Report No. 1A-99-00-19-001 **September 19, 2019**

Why Did We Conduct the Audit?

The objective of our audit was 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 (BCBSA) 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 (COB) 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 the coordination of claim payments from October 1, 2017, through June 30, 2018. Specifically, we identified and audited claims incurred on or after September 15, 2017, that were reimbursed from October 1, 2017, through June 30, 2018, and were potentially not coordinated with Medicare.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

For many years, we have had serious concerns with the BCBS plans' and BCBSA's efforts to implement corrective actions to prevent COB claim payment errors. Since our last audit, BCBSA has implemented prior OIG audit recommendations to reduce COB payment errors, and the results of this current audit indicate that these corrective actions have been effective in reducing the amount of the errors. Specifically, our current audit identified $3,149,770 in FEHBP COB overpayments, which equates to a 73 percent reduction in identified overpayments from our last COB audit.

Of the $3,149,770 in total identified overpayments:

- $1,057,603 represents the projected total of improper payments identified through our statistical sample that is not being questioned in this report; and

- $736,653 was identified by BCBSA prior to our audit notification, and is also not being questioned in this report.

This report does question the remaining **$1,355,514**, which represents health benefit charges that we determined were not properly coordinated with Medicare.

Finally, as previously mentioned, we projected error rates identified from a statistical sample of COB claims to a universe of 124,733 claim lines, totaling $20,478,518. From this projection, we determined that $1,227,977 was likely overcharged to the FEHBP. Of this amount, the $1,057,603 mentioned above, is not being questioned in this report. The remaining $170,374 is included as part of the $1,355,514 in total questioned costs.

ABBREVIATIONS

BCBS	**Blue Cross Blue Shield**
BCBSA	**Blue Cross Blue Shield Association**
COB	**Coordination of Benefits**
FEHB	**Federal Employees Health Benefits**
FEHBP	**Federal Employees Health Benefits Program**
FEP	**Federal Employee Program**
FEP Express	**BCBSA's nation-wide claims processing system**
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, as it relates to the coordination of benefits with Medicare, at all Blue Cross and/or 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, codified in Title 5, Chapter 1, Part 890 of the Code of Federal Regulations. Health insurance coverage is provided through contracts with various health insurance carriers.

The Blue Cross Blue Shield Association (BCBSA), 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. BCBSA 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.

BCBSA 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 BCBSA, member BCBS plans, and OPM.

BCBSA also established an FEP Operations Center. The activities of the FEP Operations Center are performed by CareFirst Blue Cross Blue Shield, located in Owings Mills, Maryland. These activities include acting as fiscal intermediary between BCBSA 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 BCBS 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 BCBSA and Blue Cross and Blue Shield Plan (Plan) management. Also, management of each BCBS plan is responsible for establishing and maintaining a system of internal controls.

According to an audit resolution letter dated February 13, 2019, the findings from our previous global coordination of benefits (COB) audit of all BCBS plans (Report No. 1A-99-00-16-062, dated March 15, 2018), for claims reimbursed from December 1, 2015, through August 31, 2016, have been satisfactorily resolved.

Our sample selections, instructions, and preliminary audit results of the potential COB errors were presented to BCBSA in a draft report, dated October 4, 2018. BCBSA'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. We also considered additional documentation provided by BCBSA and BCBS plans on various dates through April 17, 2019.

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 the coordination of health benefit payments from October 1, 2017, through June 30, 2018. Specifically, we queried our claims data warehouse to identify all claim payments incurred on or after September 15, 2017, that were reimbursed from October 1, 2017, through June 30, 2018, and potentially were not coordinated with Medicare. This search identified 423,719 claim lines, totaling $56,001,477 in potential COB overcharges.

We separated the uncoordinated claims into six categories based on the place of service and whether Medicare Part A or Part B should have been the primary payer (See Exhibit I on page 4 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, 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	850	962	$3,640,697
Category B: Medicare Part A Primary for Skilled Nursing/HHC/Hospice Care	565	9,219	$1,733,690
Category C: Medicare Part B Primary for Certain Inpatient Facility Charges	63	66	$648,620
Category D: Medicare Part B Primary for Skilled Nursing/HHC/Hospice Care	32	77	$172,831
Category E: Medicare Part B Primary for Outpatient Facility and Professional	33,356	104,566	$15,342,255
Category F: Medicare Part B Primary for Outpatient Facility and Professional (with processor manual override using code 'F')	68,976	308,829	$34,463,384
Total	**103,842**	**423,719**	**$56,001,477**

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.* Specifically, 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 89,543 claim lines, totaling $28,989,577 in payments (see Exhibit II on page 7 for the summary of our high-dollar review claim selections). We *did not* project the results of this particular review to the universe in Exhibit 1 above.

- For the *statistical* review, we randomly selected 2,873 claim lines, totaling $2,358,593 in payments (see Exhibit VI on page 12), from Category F claims for patients with cumulative claim payments greater than or equal to $50 and less than $5,000. The results of this sample review were projected to the universe.

At the time the BCBSA was notified of these potential errors on August 13, 2018, the 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 COB overcharges 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 then conducted a limited review of the responses by selecting a small sample of claims that the plans determined were correctly paid, and a larger sample of claims the plans determined were incorrectly paid. As part of this limited review, we also verified the adequacy of the supporting documentation and the accuracy and completeness of the plans' responses. For those claims that were incorrectly paid, we calculated the amount of the claim payment errors. Finally, we tested the claim payment errors to determine 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., October 12, 2018).

We used the FEHBP contract, the 2017 and 2018 Service Benefit Plan brochures, the BCBSA's FEP Procedures Administrative Manual, and various manuals and other documents available from the Center for Medicare and Medicaid Services that explain Medicare benefits to determine the amounts questioned.

We conducted our limited scope 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 the

performance of audits and an in-house claims data reconciliation process, we have verified the reliability of the BCBS claims data in our data warehouse, which was used to identify the universe of potential COB 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 May 2019.

III. AUDIT FINDINGS AND RECOMMENDATIONS

The sections below detail the results of our fiscal year 2018global COB audit. The audit was comprised of two separate reviews – a review of claims over a high dollar threshold and a review of a statistical sample of claims.

A. High Dollar Threshold Review $1,185,140

As mentioned in the Scope section above, our universe consisted of 423,719 claim lines, totaling payments of $56,001,477 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 below 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 (850 patients)	962	$3,640,697	$3,640,697
Category B	All patients selected (565 patients)	9,219	$1,733,690	$1,733,690
Category C	All patients selected (63 patients)	66	$648,620	$162,155
Category D	All patients selected (32 patients)	77	$172,831	$43,208
Category E	Patients with cumulative claim lines of $1,000 or more (2,260 patients), judgmentally selected	39,736	$12,294,037	$9,835,230
Category F	Patients with cumulative claim lines of $5,000 or more (717 patients), judgmentally selected	39,483	$10,499,702	$8,399,762
Total		**89,543**	**$28,989,577**	**$23,814,742**

From the above exhibit, we noted the following for each claim category:

- 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 potential overcharges by reducing the amount paid 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, and pays 80 percent for these services after the calendar year deductible has been met. Based on our experience, ancillary items account for approximately 30 percent of the total inpatient claim payment. Consequently, we estimated that the FEHBP was potentially overcharged 25 percent for these inpatient claim lines (0.30 x 0.80 = 0.24 ~ 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. Consequently, we determined that the FEHBP was potentially overcharged by 80 percent of the amount paid for these claim lines.

We reviewed the 89,543 claim lines, totaling $28,989,577, to determine whether the BCBS plans complied with contract provisions relative to COB with Medicare. Our review determined that the plans incorrectly paid 2,022 claim lines, resulting in Program overcharges of $1,185,140. See Exhibit III below for a summary of the questioned costs by category.

Various Plan processing/payment errors resulted in improper claim payments of $1,185,140, representing 2,022 claim lines.

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

Category	Claim Lines	Amount Paid	Amount Questioned
Category A	18	$425,439	$416,810
Category B	627	$147,768	$136,443
Category C	11	$111,520	$27,880
Category D	17	$70,378	$17,595
Category E	555	$317,532	$250,115
Category F	794	$441,239	$336,297
Total	2,022	$1,513,876	$1,185,140

These claim payment errors are comprised of the following (See Exhibit IV on page 9 for a summary of questioned costs by cause of error):

Exhibit IV – Questioned Cost by Cause of Error

Cause of Error	Claim Lines	Amount Paid	Amount Questioned
Processor Error	1,073	$884,716	$634,046
Retroactive Changes	431	$373,700	$347,394
System Errors	290	$133,139	$110,049
Provider Billing	60	$68,238	$55,070
Non-COB Errors	168	$54,083	$38,581
Total	2,022	$1,513,876	$1,185,140

- We questioned 1,073 claim lines because the BCBS plans incorrectly used a Medicare Payment Disposition Code to override the system's automatic deferral of these claims. We estimate that the FEHBP was overcharged $634,046 for these errors.

- We questioned 431 claim lines because the BCBS plans did not retroactively review and/or adjust the patient's prior paid claim(s) when the member's Medicare information was added to BCBSA's nation-wide claims processing system (FEP Express). We estimate that the FEHBP was overcharged $347,394 for these errors.

- We questioned 290 claim lines because the BCBS plans' local or FEP Express claims processing systems did not appropriately defer the claim lines for Medicare COB review. We estimate that the FEHBP was overcharged $110,049 for these errors.

- We questioned 60 claim lines due to provider billing errors. We estimate that the FEHBP was overcharged $55,070 for these errors.

- We questioned 168 claim lines that were not COB-related errors but were processed and paid incorrectly by the BCBS plans. In most cases, the claims were paid using an incorrect plan pricing allowance. We estimate that the FEHBP was overcharged $38,581 for these errors.

We used the following criteria to support our questioning of these claim payments:

- Contract CS 1039, Part II, section 2.6 states, "(a) The Carrier shall coordinate the payment of benefits under this contract with the payment of benefits under Medicare . . . (b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary carrier . . . ." Also, Part III, section 3.2 (b)(1) states, "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable . . . [and]

on request, document and make available accounting support for the cost to justify that the cost is actual, reasonable and necessary . . . ."

- Contract CS 1039, Part II, section 2.3(g) states, "If the Carrier [or OPM] determines that a Member's claim has been paid in error for any reason . . . the Carrier shall make a prompt and diligent effort to recover the erroneous payment . . . until the debt is paid in full or determined to be uncollectible by the Carrier because it is no longer cost effective to pursue further collection efforts or it would be against equity and good conscience to continue collection efforts . . . ."

- Contract CS 1039, Part III, section 3.16(b) states, "Claim payment findings (i.e., claim overpayments) in the scope of an OIG audit are reportable as questioned charges unless the Carrier provides documentation supporting that these findings were already identified (i.e., documentation that the plan initiated recovery efforts) prior to audit notification and corrected (i.e., claims were adjusted and/or voided and overpayments were recovered and returned to the FEHBP) by the original due date of the draft report response."

- The 2017 Blue Cross and Blue Shield Service Benefit Plan brochure, page 145, Primary Payer Chart, illustrates when Medicare is the primary payer. In addition, page 147 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."

***BCBSA's Response*:**

BCBSA agrees with our questioned amount. However, they have exhausted recovery efforts on $35,651 of the total amount questioned, leaving $1,149,489 that either has been or remains to be recovered. "Where possible, the Plans will continue to pursue the remaining overpayments as required by CS 1039, Section 2.3(g)(l)." BCBSA also indicated that it "will continue to provide periodic updates and evidence to the Contracting Officer ensuring that Medicare COB edits are properly detecting and preventing COB-related claim payment errors."

OIG Comments:

We concur that BCBSA should continue their recovery efforts to return $1,149,489 to the FEHBP. However, we maintain that the $35,651 should also be recovered, as we were not provided with documentation supporting the Plan's recovery efforts on these amounts.

Recommendation 1

We recommend that the contracting officer disallow $1,185,140 for claim overpayments and verify that the BCBS plans return all amounts recovered to the FEHBP.

Recommendation 2

We recommend that BCBSA review its local plans' override policies and procedures and provide training to those plans that are inappropriately using the Medicare Payment Disposition Code to override the automatic deferral of claims that should be reviewed for potential Medicare coordination.

Recommendation 3

We recommend that BCBSA work with its local plans to ensure that they are retroactively reviewing and adjusting patients' prior paid claims when members' Medicare information is added to FEP Express.

Recommendation 4

We recommend that BCBSA work with its local plans and review its FEP Express claims processing policies and procedures to determine why the system did not appropriately defer claim lines for Medicare COB review.

Recommendation 5

We recommend that BCBSA work with its local plans to ensure that they are paying claims using appropriate pricing allowances.

B. Statistical Sample Review $170,374

Our second sample of claims reviewed was a statistical sample, selected using the SAS Enterprise Guide software, that consisted of Category F claims for patients with cumulative claim payments greater than or equal to $50 and less than $5,000. Exhibit V below shows this universe of claim lines.

Exhibit V – Universe for Statistical Sample

Category F Claims	Claim Lines	Amount Paid
Patients with cumulative payments **greater than or equal to** $50 **and less than** $5,000	124,733	$20,478,518

From this population, we stratified all claim lines into five categories based on the amount paid. Specifically, using claim error rates from a prior audit[3], we determined the sample size necessary to achieve a margin of error on a 95 percent confidence interval that is no greater than 2 percent. This was done independently within each of the five 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 strata.

These criteria yielded a sample of 2,873 claim lines, totaling $2,358,593 in payments, for review. See Exhibit VI below 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
1	$50 - $199.99	103,370	$10,243,809	696	$70,683
2	$200 - $499.99	16,103	$4,677,379	702	$204,295
3	$500 - $999.99	3,349	$2,334,960	584	$402,848
4	$1,000 - $2,499.99	1,623	$2,361,531	643	$939,126
5	$2,500 - $4,999.99	288	$860,839	248	$741,641
TOTAL		124,733	$20,478,518	2,873	$2,358,593

Of the 2,873 claim lines selected for review, we determined that the BCBS plans incorrectly paid 223 claim lines, resulting in overcharges of $170,374 to the FEHBP. These claim payment errors are comprised of the following (See Exhibit VII on page 13 for a summary of questioned costs by cause of error):

Various Plan processing/payment errors resulted in improper claim payments of $170,374, representing 223 claim lines.

[3] [1] Per results of Global Coordination of Benefits for Blue Cross Blue Shield (BCBS) Plans (report number 1A-99-00-16-062), we applied error rates of 9%, 10%, 10%, 14%, 22%, for strata "1" through "5," respectively.

Cause of Error	Claim Lines	Amount Paid	Amount Questioned
Processor Error	160	$154,756	$122,566
Provider Billing	19	$22,487	$18,023
System Errors	18	$15,474	$12,379
Retroactive Changes	20	$13,805	$11,044
Non-COB Errors	6	$8,061	$6,362
Total	223	$214,583	$170,374

- We questioned 160 claim lines because the BCBS plans incorrectly used a Medicare Payment Disposition Code to override the system's automatic deferral of these claims. We estimate that the FEHBP was overcharged $122,566 for these errors.

- We questioned 19 claim lines due to provider billing errors. We estimate that the FEHBP was overcharged $18,023 for these errors.

- We questioned 18 claim lines because the BCBS plans' local or FEP Express claims processing systems did not appropriately defer the claims for Medicare COB review. We estimate that the FEHBP was overcharged 12,379 for these errors.

- We questioned 20 claim lines because the BCBS plans failed to retroactively review and/or adjust the patient's prior paid claim(s) when the member's Medicare information was added to FEP Express. We estimate that the FEHBP was overcharged $11,044 for these errors.

- We questioned six claim lines that were not COB-related errors but were processed and paid incorrectly by the plans. In most cases, the claims were paid using an incorrect plan pricing allowance. We estimate that the FEHBP was overcharged $6,362 for these errors.

Based on the errors identified, we used automated software to project the sample results using the ratio estimator methodology.[4] Using this methodology, we are 95 percent confident that the true value of claims that paid incorrectly, for the total population of strata "1" through "5," is between $1,030,728 and $1,425,226. Our best estimate of the true value, the projection estimate, is **$1,227,977**, and this is the amount we are projecting was overpaid from these strata**.** See Exhibit VIII for a summary of results of statistical review.

Exhibit VIII – Projected Overpayments

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

Using Ratio Estimator Methodology

Ratio Estimator	
Total Population - Amount Paid	$20,478,518
Samples Reviewed - Paid in Error	$170,374
Total Estimate (Projection)	**$1,227,977**
Margin of Error	+/- $197,249
Relative Precision	1.02 %
High Point	$1,425,226
Low Point	$1,030,728

Projecting the identified claim payment errors to the universe of claims results in additional potential overcharges of $1,057,603.

Contract CS 1039 does not provide guidance on returning estimated overcharges to the FEHBP based on statistical projections used during an audit. Projecting the results of our statistical sample to the audit universe results in an additional $1,057,603 in overcharges. We did not question these potential overcharges since the FEHBP contract language does not provide for recoupment of questioned costs identified as part of a statistical sample. Therefore, we did not make a recommendation for the $1,227,977 in estimated overcharges to be returned to the FEHBP. Our report limits the questioned amount to $170,374 in overcharges that were directly part of the statistical sample review.

As previously cited from CS 1039, the Carrier shall make prompt and diligent recovery efforts when claim payment errors have been determined.

***BCBSA Response*:**

BCBSA agrees with our questioned amount. However, "BCBSA contests any projected overpayment on payment errors identified in the statistical sample." They state "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 not included as an appropriate method to determine claim payment error in the FEP Contract, CS1039.***
- ***Is biased toward higher dollar claims and does not appear to be consistent with the distribution of the sample audited by the Plans thus inflating the estimated error amount.***

- ***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.***

- ***Applies an estimated error to Plans who reported that all claims were paid correctly.***

- ***Includes claims where the overpaid amount is less than $50. CS1039 does not require recovery initiation on claims where the overpayment amount is less than $50."***

Furthermore, all projected overpayments from the Medicare COB Tier 14, Tier 15, and Tier 16 audits [2014 through 2016 OIG audits] were deemed allowable charges to the FEP contract by OPM. "As a result, BCBSA disagrees that the Contracting Officer should use a projected amount to determine unallowable charges for this Medicare COB audit. BCBSA also believes that 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."

OIG Comments:

While we acknowledge BCBSA's concurrence with the amounts questioned, we assert that use of statistical projections 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 Internal Revenue Service. 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 BCBSA in its response to our draft audit report:

- Statistical projections are a valid way of questioning dollars for errors that occur year after year, and that are material and voluminous in nature.

- The sampling methodology used for our review was a purely stratified random sample. Therefore, it could not be deemed as biased towards any certain claim, regardless of the amount paid. Stratifying the data prior to selecting our samples was done in order to capture and apply weights based on the entire population of data. After the weights were calculated, an appropriate sample size was calculated so as to achieve a margin of error on a 95% confidence interval to be no greater than 2%. A random sample was then pulled from each strata. A random sample draws from the population in such a way that each item in the population has an equal opportunity to be selected.

- 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 BCBSA states that our sample "*Includes claims where the overpaid amount 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.

Recommendation 6

We recommend that the contracting officer disallow $170,374 for claim overpayments, and verify that the BCBS plans return all amounts recovered to the FEHBP.

Recommendation 7

Since many of the audit issues identified in our statistical sample review mirror those identified in our high dollar threshold review, we recommend that BCBSA apply similar corrective actions to resolve the statistical sample review claim payment errors.

Acknowledgment of Corrective Action Implementation

By implementing prior OIG audit recommendations, the BCBSA has reduced the amount of COB errors by 73%.

For many years, we have had serious concerns with the BCBS plans' and BCBSA's efforts to implement corrective actions to prevent COB claim payment errors. Our audits (performed annually since 2001) routinely had shown that failure to retroactively adjust a patient's prior claims after Medicare information was obtained was the primary reason for COB claim payment errors. However, after the performance of our last audit, which questioned $11,738,240[5], BCBSA began taking additional steps to implement prior OIG audit recommendations in order to reduce COB errors. When compared against the results of this audit, which identified $3,149,770 in COB overpayments (this amount includes $1,185,140 from the high dollar sample; $1,227,977 from the projected results from our statistical review; and $736,653 recovered prior to the start of the

[5] Refer to Report No. 1A-99-00-16-062, dated March 15, 2018, for claims reimbursed from December 1, 2015, through August 31, 2016.

audit), the lower amounts questioned represent a reduction in COB errors of 73 percent. This demonstrates significant improvements to reduce COB overpayments by the BCBS plans and the BCBSA and they should be commended for their efforts in implementing these corrective actions. While this is a good first step, the BCBS plans and the BCBSA should continue their monitoring and reporting efforts to mitigate the impact to the Program resulting from these payment errors going forward.

Recommendation 8

To ensure that the BCBS plans continue to identify and correct future COB claim payment errors, we recommend that the contracting officer require BCBSA to report all potential COB errors, recoveries, and cause errors on a monthly basis to OPM.

APPENDIX A

November 28, 2018

Ms. [redacted], Senior Team Lead
Advanced Claims Analysis Team
Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, Room 6400
Washington, DC 20415-1100 NW

BlueCross BlueShield Association

1310 G Street, N.W.
Washington, D.C. 20005
202.626.4800
www.BCBS.com

Reference: **OPM DRAFT AUDIT REPORT**
Tier 17 Global Coordination of Benefits
Audit Report # 1A-99-00-19-001

Dear Ms. [redacted]:

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 September 15, 2017 and paid from October 1, 2017 thru June 30, 2018. Our comments concerning the findings in the report are as follows:

Coordination of Benefits with Medicare Questioned Amount **$23,814,742**

Recommendation 1:

The OIG recommended that the contracting officer disallow $23,814,742 for uncoordinated claim line payments and have the BCBS plans return all amounts recovered to the FEHBP.

BCBSA Response

Section Deleted by the OIG – Not Relevant to the Final Report

The above claim payment errors were identified and recovery 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)(l). Where Plans are able to demonstrate due diligence in the recovery process, the claims are allowable charges to the FEP Contract.

Paragraph Deleted by the OIG – Not Relevant to the Final Report

BCBSA Response:

BCBSA will continue to provide periodic updates and evidence to the Contracting Officer ensuring that Medicare COB edits are properly detecting and preventing COB-related claim payment errors.

Statistical Sample Review **$2,358,593**

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:

Section Deleted by the OIG – Not Relevant to the Final Report

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 not included as an appropriate method to determine claim payment error in the FEP Contract, CS1039.
- Is biased toward higher dollar claims and does not appear to be consistent with the distribution of the sample audited by the Plans thus inflating the estimated error amount.
- 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.
- Applies an estimated error to Plans who reported that all claims were paid correctly.
- Includes claims where the overpaid amount is less than $50. CS1039 does not require recovery initiation on claims where the overpayment amount is less than $50.

Further, all estimated amounts from the Medicare COB Tier 14, Tier 15 and Tier 16 (performed in 2014 thru 2017) were determined to be allowable charges to the FEP contract. As a result, BCBSA disagrees that the Contracting Officer should use a projected amount to determine unallowable charges for this Medicare COB audit. BCBSA also believes that 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.

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,

Kim King
Managing Director, FEP Program Assurance

cc: Mr. [redacted], OIG
Ms. [redacted], OPM
Ms. [redacted], OPM

APPENDIX B

High Dollar Threshold Review – Status of Amounts to be Recovered

Recovery Process Status	Claim Lines	Amount Paid	Amount Questioned
Identified as result of audit	1,620	$872,589	$639,655
Recovery initiated before audit began but not returned prior to 10/12/2018	96	$356,619	$337,174
Recovered in full	229	$230,192	$172,660
Recovery efforts have been exhausted and determined uncollectable	77	$54,476	$35,651
Total	2,022	$1,513,876	$1,185,140

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