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

Final Audit Report

Audit of Duplicate Claim Payments at All Blue Cross Blue Shield Plans for the period July 1, 2016, through July 31, 2019

Report Number 1A-99-00-19-002

February 12, 2021

EXECUTIVE SUMMARY

Audit of Duplicate Claim Payments at All Blue Cross Blue Shield Plans

Report No. 1A-99-00-19-002 **February 12, 2021**

Why Did We Conduct the Audit?

The objectives of our audit were to determine if the health benefit costs charged to the Federal Employees Health Benefits Program (FEHBP) and services provided to FEHBP members by the Blue Cross and Blue Shield (BCBS) plans were in accordance with the terms of the BCBS Association's (Association) contract with the U.S. Office of Personnel Management. Specifically, our audit focused on identifying duplicate claim payments.

What Did We Audit?

The Office of the Inspector General completed a performance audit of the FEHBP operations at all local BCBS plans. Our audit consisted of reviews of potential duplicate claim payments for the period July 1, 2016, through July 31, 2019. Audit work was completed at our offices in Washington, D.C. and Cranberry Township, Pennsylvania.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

Our audit identified 986 improperly paid claims totaling $2,095,900 in net overcharges to the FEHBP. Specifically, we identified the following:

- 668 duplicate claim payments, totaling $1,444,709 in net overcharges, due to processors overriding claims originally denied as duplicates;
- 129 duplicate claim payments, totaling $296,917 in net overcharges, that were not identified as duplicates due to variations in coding of provider billings;
- 50 duplicate claim payments, totaling $150,364 in net overcharges, due to the local BCBS plan's claim system and/or the Association failing to detect the duplicate payment;
- 59 duplicate claim payments, totaling $143,865 in overcharges, due to inter-plan duplicate errors; and
- 80 non-duplicate claim payments, totaling $60,045 in net overcharges, due to various pricing errors such as incorrect pricing allowances or incorrect coordination of other benefits.

ABBREVIATIONS

5 CFR 890	**Title 5, Code of Federal Regulations, Chapter 1, Part 890**
Act	**Federal Employees Health Benefits Act**
Association	**Blue Cross Blue Shield Association**
BCBS	**Blue Cross and Blue Shield**
Contract	**Contract CS 1039 - The contract between the Association and the U.S. Office of Personnel Management**
FEHBP	**Federal Employees Health Benefits Program**
FEP	**Federal Employee Program**
FEPDirect	**The Association's nation-wide claims processing system**
HIO	**OPM's Healthcare and Insurance Office**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
SBP	**Service Benefit Plan**

TABLE OF CONTENTS

I. BACKGROUND

This final report details the results of our performance audit of the Federal Employees Health Benefits Program (FEHBP) operations at all Blue Cross and Blue Shield (BCBS) plans for the period July 1, 2016, through July 31, 2019. The audit was performed at the U.S. Office of Personnel Mangement's (OPM) Office of the Inspector General (OIG) offices in Washington, D.C. and Cranberry Township, Pennsylvania.

The audit was conducted pursuant to the provisions of contract CS 1039 (Contract) between OPM and the BCBS Association (Association); Title 5, United States Code, Chapter 89; and Title 5, Code of Federal Regulations, Chapter 1, Part 890 (5 CFR 890). The audit was performed by OPM's OIG, as authorized by the Inspector General Act of 1978, as amended.

The FEHBP was established by the Federal Employees Health Benefits Act (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 (HIO) has overall responsibility for administration of the FEHBP, including the publication of program regulations and agency guidance. As part of its administrative responsibilities, the HIO contracts with various health insurance carriers that provide service benefits, indemnity benefits, and/or comprehensive medical services. The provisions of the Act are implemented by OPM through regulations codified in 5 CFR 890.

The Association, on behalf of participating BCBS plans, has entered into a Government-wide Service Benefit Plan (SBP) contract 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.

The Association has established a Federal Employee Program (FEP[1]) Director's Office in Washington, D.C. to provide centralized management for the SBP. 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. CareFirst BCBS, located in Owings Mills, Maryland, performs the activities of the FEP Operations Center. 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 SBP lines of business at the local BCBS plans. 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 management at the local BCBS plans. In addition, the local BCBS plans are responsible for establishing and maintaining a system of internal controls.

The most recent audit report issued that covered potential duplicate claim payments for all BCBS plans was Report 1A-99-00-16-043, dated June 21, 2017, which covered claim payments from June 1, 2013, through March 31, 2016. All findings from the previous audit have been satisfactorily resolved.

The results of our audit were discussed with Association officials throughout the audit and at an exit conference on December 3, 2020. We issued a draft report, dated September 8, 2020, to solicit the Association's comments to the findings. 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. Additional documentation provided by the Association on various dates through December 22, 2020, was also considered in preparing our final report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The objectives of our audit were to determine whether the local BCBS plans 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 local BCBS plans complied with the Contract's provisions relative to duplicate claim payments.

SCOPE AND METHODOLOGY

We conducted our 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.

The focus of this performance audit was to identify any unallowable duplicate claim payments that occurred from July 1, 2016, through July 31, 2019. Our audit fieldwork was performed at our offices in Washington, D.C. and Cranberry Township, Pennsylvania from March 2020 through December 2020.

In planning and conducting our audit, we obtained an understanding of the Association'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 Association'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 Association's system of internal controls taken as a whole.

We also conducted tests to determine whether the local BCBS plans and Association had complied with the Contract, the applicable procurement regulations (i.e., Federal Acquisition Regulations and Federal Employees Health Benefits Acquisition Regulations, as appropriate), and the laws and regulations governing the FEHBP as they relate to claim payments. With the exception of those areas noted in the "Audit Findings and Recommendations" section of this audit report, we found that the local BCBS plans and Association were in compliance with the health benefit provisions of the Contract. With respect to any areas not tested, nothing came to our attention that caused us to believe that the local BCBS plans and Association 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 Association. 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 potential duplicate claim payments selected in our samples. The BCBS claims data is provided

to the OPM OIG 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 local BCBS plans' 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.

Utilizing SAS software, we performed queries on the BCBS claims data to identify potential duplicate payments charged to the FEHBP during the audit scope. Our searches identified 1,037,045 claim groups, totaling $63,498,016 in potential overpayments to the FEHBP.

Our search results of potential duplicate claim payments are separated into three categories – "best matches," "near matches," and "inpatient facility matches." The universe of potential duplicate claim groups was derived from the following search criteria:

- Our "best match" logic identifies and groups unique claim numbers that contain most of the same claim data, including patient code, procedure code, diagnosis code, and sex code.

- Our "near match" logic identifies and groups unique claim numbers that contain most of the same claim data, except for patient code, procedure code, diagnosis code, or sex code.

- Our "inpatient facility match" search criteria identifies duplicate or overlapping dates of service.

To test each local BCBS plan's compliance with the FEHBP health benefit provisions related to duplicate claim payments, we selected all duplicate claim groups with potential overpayments of $1,000 or more from each search criteria. This resulted in a sample of 4,731 claim groups with a total potential overpayment by the FEHBP of $12,024,921. The samples selected and reviewed in performing the audit were not statistically based. Consequently, the results were not projected to the universe since it is unlikely that the results are representative of the universe taken as a whole.

The claims selected for review were submitted to the Association for its analysis and response. We then conducted a limited review of the responses to determine the reliability of the responses.

As part of this limited review, we also verified the adequacy of the supporting documentation and the accuracy and completeness of the local BCBS plan's 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 local BCBS plans had initiated recovery efforts, adjusted or voided the claims, and/or completed the recovery process by the date of our audit notification letter (October 21, 2019).

III. AUDIT FINDINGS AND RECOMMENDATIONS

The following represents the results of our audit. Except for the findings listed below, the health benefit costs charged to the FEHBP that were covered by this audit, and the services provided to its members during the audit scope, were in accordance with the Contract, applicable Federal regulations, and the SBP brochure.

DUPLICATE CLAIM PAYMENTS $2,095,900

Our review determined that the local BCBS plans incorrectly paid 986 claims totaling $2,095,900 in health benefit net overcharges to the FEHBP. Specifically, 973 claims were overpaid by $2,126,618 and 13 claims were underpaid by $30,718.

Part III, section 3.2 (b) (1) of the Contract states that the costs charged by the carrier must be actual, allowable, reasonable, and verifiable by accounting support.

Additionally, part II, section 2.3 (g) of the Contract states that when a claim overpayment is identified the carrier must make a prompt and diligent effort to recover the monies completely or until the debit is deemed uncollectable.

We identified $2,035,855 in net duplicate payment overcharges to the FEHBP.

Our review identified 906 duplicate claim payments, with net overpayments to the FEHBP of $2,035,855, which were comprised of the following:

- 668 claim payments, totaling $1,444,709 in net overcharges, resulting from manual claim processors' errors. Specifically, 663 claims were overpaid by $1,451,048 and 5 claims were underpaid by $6,339.

In most cases, the FEPDirect system (the Association's nation-wide claims processing system) identified the claim as a potential duplicate payment and denied the claim by applying an FKA denial code. The FKA denial code is automatically applied by the system when it detects a possible duplicate charge. However, upon reviewing the claim suspension, we found that the local BCBS plan processor manually overrode the system to allow these claims to be paid.

The Association was unable to provide specific details and reasons why these claims were paid incorrectly and/or why the processors overrode the claims. As these errors are the result of manual human intervention and the Association is unable to determine why this is happening, it shows the need for increased training and additional attention to detail at the local BCBS plan level.

Recommendation 1

We recommend that the Association work with its local BCBS plans to ensure that claims processors are properly trained on how to review and process claims that defer for manual review from both the local systems and FEPDirect to try to minimize future processor errors.

Association Response

The Association agrees with the recommendation and stated they will identify the local BCBS plans that require additional training by November 30, 2020. Once identified it will develop and provide training on how to review and process claims that defer for manual review by the 1st quarter of 2021.

OIG Comments

While helpful, we consider the Association's suggested corrective action to be reactive rather than proactive. Limiting the required training to only certain local BCBS plans does not address potential future issues. The Association should devise an annual training program for all local BCBS plan processors to ensure that proper procedures are known and not addressed only when errors are identified.

- 129 claim payments, totaling $296,917 in overcharges, that were not identified by the local BCBS plan's claims systems and FEPDirect due to coding variations in the claims submitted. In these situations, the provider billed the claim twice, but due to slight differences between the two claims submitted (modifier codes, incorrect provider address, or incorrect provider identification) the claim systems did not identify the claims as duplicates and allowed improper payments to be made. Although these claims are not exact duplicates, it is our opinion that these types of claims should have first deferred in the local BCBS and/or FEPDirect system for manual review prior to payment.

Recommendation 2

We recommend that the Association work with its local BCBS plans to review system issues within their systems and/or within the FEPDirect system that have allowed duplicates such as these to occur. Specifically, they should focus on why these claims were not deferred prior to payment.

Association Response

The Association agrees with the recommendation and stated they will perform a detailed analysis of the reported claim errors and determine if these are system errors or processor

errors. Once the review is completed, it will determine the next steps and expect to complete the review and determine next steps by the 1st quarter of 2021.

- 50 claim payments, totaling $150,364 in net overcharges, where the local BCBS plan's claim system and/or the FEPDirect system failed to detect the duplicate payment. Based on the Association's responses to our requests it stated that these claims should have been detected, but in most cases it did not provide details regarding what actually caused the system errors. As part of its response to this report, we would like an explanation for why these errors occurred. Of the 50 claim payments identified, 46 claims were overpaid by $157,832 and 4 claims were underpaid by $7,468.

Recommendation 3

We recommend that the Association work with its local BCBS plans to review and correct system issues (either at the local level or in FEPDirect) that have permitted duplicate claim payments to go undetected.

Association Response

The Association agrees with the recommendation and stated they will perform a detailed analysis of the reported claim errors and determine if these are system errors or processor errors. Once the review is completed, it will determine the next steps and expect to complete the review and determine next steps by the 1st quarter of 2021.

- 59 claim payments, totaling $143,865 in overcharges, due to inter-plan duplicate payment errors. Inter-plan duplicates occur when a claim, or portion of a claim, is paid by two different local BCBS plans. A majority of these errors (53 of the 59) occurred due to processors manually overriding the duplicate edit that deferred the claims for review. In these instances, the claim edit was overridden before ensuring that another local BCBS plan did not pay for the same service(s).

Recommendation 4

We recommend that the Association work with its local BCBS plans to ensure that claims processors are properly trained on how to review and process claims that defer for manual review for these inter-plan duplicate errors.

Association Response

The Association agrees with the recommendation and stated they will include training on correct processing of inter-plan duplicate claims in the training developed as described in its response to Recommendation 1.

OIG Comments

As stated in our comment after Recommendation 1, while helpful, the Association's suggested corrective action is reactive rather than proactive. Limiting the required training to only certain local BCBS plans does not address potential future issues. The Association should devise an annual training program for all local BCBS plan processors to ensure that proper procedures are known and not addressed only when errors are identified.

Additionally, in its review of the potential duplicate claim payments the Association and/or local BCBS plans identified 80 claim payments, totaling $60,045 in net overcharges, due to various other (non-duplicate) pricing errors. Specifically, 76 claims were overpaid by $76,956 and 4 claims were underpaid by $16,911. These claim payment errors resulted from the following:

- 69 claim payment errors, with net overcharges of $60,636 that occurred due to the application of incorrect pricing allowances on the local BCBS plan's claim system. Specifically, 66 claims were overpaid by $61,536 and 3 claims were underpaid by $900.

The FEHBP was overcharged $60,636 (net) as a result of incorrect pricing allowances.

Recommendation 5

We recommend that the Association work with its local BCBS plans to ensure that contract rates are updated accurately and timely when there is a contractual change with any provider, and that retroactive adjustments to affected claims are performed to reflect rate changes.

Association Response

The Association agrees with the recommendation and stated they will perform an analysis of the reported claim errors and determine if these are local pricing errors or processor errors. The Association will work with its local BCBS plans to identify the cause of incorrect claim allowances and provide training as needed by the 1st quarter of 2021.

- 11 claim payment errors, with net undercharges of $591, occurred because the FEPDirect system did not have current information on other insurance or failed to properly coordinate with other primary insurance before payment was made. Specifically, 10 claims were overpaid by $15,420 and 1 claim was underpaid by $16,011.

Recommendation 6

We recommend that the Association ensure that other insurance benefits are accurate within FEPDirect so that claim payments are properly coordinated.

Association Response

The Association agrees with the recommendation and stated they will perform an analysis of the reported claim errors and determine if these are COB errors or processor errors. The Association will work with its local BCBS plans to identify the cause of incorrect claim allowance and provide training as needed by the 1st quarter of 2021.

In total, we identified 986 improperly paid claims totaling $2,095,900 in FEHBP health benefit overcharges. Specifically, 973 claims were overpaid by $2,126,618 and 13 claims were underpaid by $30,718. Prior to the issuance of this final report, BCBSA had already returned $340,317 of the $2,126,618 overpaid, leaving an overpayment balance of $1,786,301. Consequently, our monetary recommendations only recommend a return of the remaining overpayment amount.

Recommendation 7

We recommend that the contracting officer disallow $2,126,618 for claim overpayments and verify that its local BCBS plans return all amounts questioned to the FEHBP, regardless of the plan's ability to recover the claim payments from providers. In accordance with the Association's response below, following the return of $340,317, the remaining amount due to the FEHBP is $1,786,301.

Association Response

The Association agrees with the erroneous payments identified as duplicate claim payments. It also stated that $340,317 of the amounts questioned have been returned to the FEHBP. However, it has identified 266 claims, totaling $594,902, as uncollectable following its diligent efforts to recover the overpayments. It stated that for the remaining amounts it will continue to recover and return those amounts to the FEHBP in accordance with section 2.3 (g) of the Contract.

OIG Comments

We accept the Association's response in regards to the amounts it is still attempting to recover. However, for those items it identifies as uncollectable it failed to provide sufficient supporting documentation to show that it has met the due diligence requirements stated in section 2.3 (g) of the Contract. In these cases, the Association must provide supporting documentation to support that it has made all required efforts. If any of the efforts cannot be made (e.g., offsets), then it must provide documentation to support why.

We acknowledge that the Association has returned $340,317 and reduced the remaining amount to be recovered, as stated above.

Recommendation 8

We recommend that the contracting officer allow the local BCBS plans to charge the FEHBP $30,718 if additional payments are made to the providers to correct the underpayments. However, before making any additional payment(s) to a provider, the contracting officer should require the local BCBS plans to first recover any questioned overpayment(s) for that provider.

Association Response

The Association agrees with the recommendation and stated that it will ensure the local BCBS plans recover any questioned overpayment from the provider first, prior to processing additional payments.

APPENDIX

BlueCross BlueShield Association

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

October 14, 2020

[redacted]
Advanced Claims Analysis Team
Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, Room 6400
Washington, DC 20415-11000

Reference: OPM DRAFT AUDIT REPORT
Audit of Duplicate Claim Payments
Audit Report Number 1A-99-00-19-002
Issued September 8, 2020

[redacted]

Below is the Blue Cross and Blue Shield Association (BCBSA) response to the recommendations included in the above referenced U.S. Office of Personnel Management ("OPM") Draft Audit Report.

Recommendation 1

We recommend that the Association work with its local BCBS plans to ensure that claims processors are properly trained on how to review and process claims that defer for manual review from both the local systems and FEPDirect to try to minimize future processor errors.

BCBSA Response

BCBSA will identify Plans that require additional training by November 30, 2020. Once Plans are identified, BCBSA will develop and provide training to applicable Plans on how to review and process claims that defer for manual review by 1st quarter 2021.

Recommendation 2

We recommend that the Association work with its local BCBS plans to review system issues within their systems and/or within the FEPDirect system that have allowed duplicates such as these to occur. Specifically, why were these claims not deferred prior to payment?

BCBSA Response

BCBSA will perform a detailed analysis of the reported claim errors and determine if these are system errors or processor errors. Once the review is completed, BCBSA will determine next steps. We expect to complete the review and determine next steps by 1st quarter 2021.

Recommendation 3

We recommend that the Association work with its local BCBS plans to review and correct system issues (either at the local level or in FEPDirect) that have permitted duplicate claim payments to go undetected.

BCBSA Response

BCBSA will perform a detailed analysis of the reported claim errors and determine if these are system errors or processor errors. Once the review is completed, BCBSA will determine next steps. We expect to complete the review and determine next steps by 1st quarter 2021.

Recommendation 4

We recommend that the Association work with its local BCBS plans to ensure that claims processors are properly trained on how to review and process claims that defer for manual review for these inter-plan duplicate errors.

BCBSA Response

BCBSA will include training on correct processing of inter-plan duplicate claims in the training developed in Recommendation 1 above.

Recommendation 5

We recommend that the Association work with its local BCBS plans to ensure that contract rates are updated accurately and timely when there is a contractual change with any provider, and that retroactive adjustments to affected claims are performed to reflect rate changes.

BCBSA Response

BCBSA will perform an analysis of the reported claim errors and determine if these are local pricing errors or processor errors. BCBSA will work with Plans to identify the cause of incorrect claim allowance and provide training to the Plans as needed by 1st quarter 2021.

Recommendation 6

We recommend that the Association ensure that other insurance benefits are accurate within FEPDirect so that claim payments are properly coordinated.

BCBSA Response

BCBSA will perform an analysis of the reported claim errors and determine if these are COB errors or processor errors. BCBSA will work with Plans to identify the cause of incorrect claim allowance and provide training to the Plans as needed by 1st quarter 2021.

Recommendation 7 **$2,158,679**

We recommend that the contracting officer disallow $2,158,679 for claim overpayments and verify that the BCBS Plans return all amounts questioned to the FEHBP, regardless of the Plans' ability to recover the claim payments from providers.

BCBSA Response

Of the 974 claims totaling $2,158,679, noted above, BCBSA determined the following:

- 176 questioned claims totaling $340,317 were returned to the Program. Of this questioned claims amount, 14 of these claims totaling $43,715 were returned to the Program before the audit began
- 1 questioned claim totaling $32,061 is contested
- 531 questioned claims totaling $1,191,398 are still in recovery
- 266 questioned claims totaling $594,902 were determined to be uncollectible

BCBSA will continue to coordinate with Plans to ensure, where possible, that all recovered claims are returned to the Program and that all uncollectible claims are supported by due diligence recovery documentation in accordance with CS1039 Section 2.3g.

Recommendation 8 **$30,718**

We recommend that the contracting officer allow the BCBS Plans to charge the FEHBP $30,718 if additional payments are made to the providers to correct the underpayments. However, before making any additional payment(s) to a provider, the contracting officer should require the BCBS Plan to first recover any questioned overpayment(s) for that provider.

BCBSA Response

BCBSA will identify the Plans with underpayments and ensure the Plans recover any questioned overpayment from the provider first, prior to processing additional payments.

Thank you for this opportunity to respond to the recommendations included in this Draft Report. If you have any questions, please contact me at [redacted] or [redacted] at [redacted]

Sincerely,

[redacted]
Managing Director, FEP Program Assurance

cc: Connie Woodard, Director, FEP Program Assurance
Mitch Davis, Manager, FEP Program Assurance
Lisa Taylor, Senior Consultant, FEP Program Assurance

Report Fraud, Waste, and Mismanagement

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

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

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

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