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

Final Audit Report

Subject:

AUDIT OF WELLPOINT, INC.
MASON, OHIO

Report No. 1A-99-00-10-013

Date: March 17, 2011

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Office of the
Inspector General

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

AUDIT REPORT

Federal Employees Health Benefits Program
Service Benefit Plan Contract CS 1039
BlueCross BlueShield Association
Plan Code 10

WellPoint, Inc.
Plan Codes 041, 050/550, 060/560, 100, 130/630, 160/660, 180/680, 241/741, 265/765, 270/770, 303/803/808, 332/339, 423/923, and 450/950
Mason, Ohio

REPORT NO. 1A-99-00-10-013 DATE: 3/17/2011

Michael R. Esser
Assistant Inspector General
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UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

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EXECUTIVE SUMMARY

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Mason, Ohio

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This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at WellPoint, Inc. (Plan), which specifically included 14 BlueCross and/or BlueShield plans in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia, and Wisconsin, questions $2,644,595 in health benefit charges. The BlueCross BlueShield Association (Association) and/or Plan agreed (***A***) with $1,539,400 and disagreed (***D***) with $1,105,195 of the questioned charges.

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covered claim payments from January 1, 2008 through December 31, 2009 as reported in the Annual Accounting Statements. In addition, we expanded our audit scope to include inpatient facility claims with duplicate or overlapping dates of service from 2006 through September 30, 2009.

Questioned health benefit charges are summarized as follows:

- **Inpatient Facility Claims – Duplicate or Overlapping Dates of Service** **$1,761,013**

  During our review of inpatient facility claims with duplicate or overlapping dates of service, we determined that the Plan incorrectly paid 181 claims, resulting in overcharges of $1,761,013 to the FEHBP. The Association agreed with $786,251 ***(A)*** and disagreed with $974,762 ***(D)*** of the questioned charges.

- **System Review** **$484,037**

  Based on our review of a judgmental sample of 1,195 claims, we determined that the Plan incorrectly paid 30 claims, resulting in net overcharges of $484,037 to the FEHBP. Specifically, the Plan overpaid 27 claims by $485,771 and underpaid 3 claims by $1,734. The Association agreed with $353,604 ***(A)*** and disagreed with $130,433 ***(D)*** of the questioned charges.

- **Continuous Stay Claims *(A)*** **$318,279**

  During our review of continuous stay claims, we determined that the Plan incorrectly paid 18 claims, resulting in net overcharges of $318,279 to the FEHBP. Specifically, the Plan overpaid 10 claims by $329,029 and underpaid 8 claims by $10,750.

- **Omnibus Budget Reconciliation Act of 1993 Review *(A)*** **$51,695**

  The Plan incorrectly paid 154 claim lines that were priced under the Omnibus Budget Reconciliation Act of 1993 pricing guidelines, resulting in net overcharges of $51,695 to the FEHBP. Specifically, the Plan overpaid 132 claim lines by $56,421 and underpaid 22 claim lines by $4,726.

- **Non-Participating Providers *(A)*** **$29,571**

  During our review of claims submitted by non-participating providers, we determined that the Plan incorrectly paid four claims, resulting in net overcharges of $29,571 to the FEHBP. Specifically, the Plan overpaid three claims by $30,888 and underpaid one claim by $1,317.

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I. INTRODUCTION AND BACKGROUND

INTRODUCTION

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 WellPoint, Inc. (Plan), which specifically included 14 BlueCross and/or BlueShield plans in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia, and Wisconsin. The Plan's headquarters are located in Indianapolis, Indiana; however, most of the audit support functions are located in Mason, Ohio. Also, the Plan's claims processing operations are located in Albany, New York; Cincinnati, Ohio; Columbus, GA; Indianapolis, Indiana; Roanoke, Virginia; and Reno, Nevada.

The audit was performed by the Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as established by the Inspector General Act of 1978, as amended.

BACKGROUND

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 (CFR). Health insurance coverage is made available through contracts with various health insurance carriers.

The BlueCross BlueShield Association (Association), on behalf of participating BlueCross and BlueShield (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. The Plan includes 14 of the 63 local BCBS plans participating in the FEHBP.

The Association has established a Federal Employee Program (FEP[1]) Director's Office in Washington, D.C. to provide centralized management for the Service Benefit Plan. The FEP Director's Office coordinates the administration of the contract with the Association, member BCBS plans, and OPM.

The Association has also established an FEP Operations Center. The activities of the FEP Operations Center are performed by CareFirst BlueCross BlueShield, 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

[1] Throughout this report, when we refer to "FEP" we are referring to the Service Benefit Plan lines of business at the Plan. When we refer to the "FEHBP" we are referring to the program that provides health benefits to federal employees.

payments of FEHBP claims (using computerized system edits), maintaining a history file of all FEHBP claims, and maintaining an accounting of all program funds.

Compliance with laws and regulations applicable to the FEHBP is the responsibility of the Association and Plan management. Also, management of the Plan is responsible for establishing and maintaining a system of internal controls.

The following were the most recent audit reports issued for the WellPoint, Inc. plans:

- Report No. 1A-10-63-08-044, WellPoint Southeast, dated March 03, 2009
- Report No. 1A-10-01-07-058, Empire BCBS, dated June 25, 2008
- Report No. 1A-10-18-06-052, Anthem Midwest BCBS, dated February 20, 2008
- Report No. 1A-10-05-07-045, WellPoint BCBS of Georgia, dated November 20, 2007
- Report No. 1A-10-05-06-008, WellPoint BCBS of Georgia, dated November 16, 2007
- Report No. 1A-10-30-05-069, WellPoint BCBS of Colorado, dated April 25, 2007
- Report No. 1A-10-52-05-021, BC of California, dated February 22, 2006
- Report No. 1A-10-47-05-009, BCBS United of Wisconsin, dated June 5, 2006
- Report No. 1A-10-61-04-009, Anthem BCBS of Nevada, dated August 2, 2004
- Report No. 1A-10-76-03-015, BCBS of Missouri, dated April 7, 2003

All findings from our previous audits of the WellPoint, Inc. plans, covering various contract years from 1999 through 2007, were satisfactorily resolved, except for a few claim payment findings that are in the process of being resolved.

The results of this audit were provided to the Plan in written audit inquiries; were discussed with Plan and/or Association officials throughout the audit and at an exit conference; and were presented in detail in a draft report, dated October 15, 2010. 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 Plan on various dates through February 4, 2011 was considered in preparing our final report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

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

SCOPE

We conducted our limited scope performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient and appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We reviewed the BlueCross and BlueShield FEHBP Annual Accounting Statements as they pertain to Plan codes 041 (California), 050/550 (Colorado), 060/560 (Connecticut), 100 (Georgia), 130/630 (Indiana), 160/660 (Kentucky), 180/680 (Maine), 332/339 (Ohio), 241/741 (Missouri), 265/765 (Nevada), 270/770 (New Hampshire), 303/803/808 (Empire BCBS), 423/923 (Virginia), and 450/950 (Wisconsin) for contract years 2008 and 2009. In addition, we expanded our audit scope to include inpatient facility claims with duplicate or overlapping dates of service from 2006 through September 30, 2009. During the period 2006 through 2009, the Plan paid approximately $15.2 billion in health benefit charges (See Schedule A). Specifically, we reviewed approximately $146 million in claim payments from January 1, 2008 through December 31, 2009 for proper adjudication, and from 2006 through September 30, 2009 for our review of inpatient facility claims with duplicate or overlapping dates of service.

In planning and conducting our audit, we obtained an understanding of the Plan's internal control structure to help determine the nature, timing, and extent of our auditing procedures. This was determined to be the most effective approach to select areas of audit. For those areas selected, we primarily relied on substantive tests of transactions and not tests of controls. Based on our testing, we did not identify any significant matters involving the Plan's internal control structure and its operation. However, since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on the Plan's system of internal controls taken as a whole.

We also conducted tests to determine whether the Plan had complied with the contract, the applicable procurement regulations (i.e., Federal Acquisition Regulations (FAR) and Federal Employees Health Benefits Acquisition Regulations (FEHBAR), as appropriate), and the laws and regulations governing the FEHBP. The results of our tests indicate that, with respect to the items tested, the Plan did not comply with all provisions of the contract and federal procurement regulations. Exceptions noted in the areas reviewed are set forth 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 Plan had not complied, in all material respects, with those provisions.

In conducting our audit, we relied to varying degrees on computer-generated data provided by the FEP Director's Office, the FEP Operations Center, the Plan, and the Centers for Medicare and Medicaid Services. Due to time constraints, we did not verify the reliability of the data generated by the various information systems involved. However, while utilizing the computer-generated data during our audit testing, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

The audit was performed at the Plan's office in Mason, Ohio from April 19, 2010 through April 30, 2010. While on-site, we also made site visits to the Plan's offices in Cincinnati, Ohio; Indianapolis, Indiana; and Louisville, Kentucky. Audit fieldwork was also performed at our offices in Cranberry Township, Pennsylvania and Jacksonville, Florida.

METHODOLOGY

We obtained an understanding of the internal controls over the Plan's claims processing systems by inquiry of Plan officials.

To test the Plan's compliance with the FEHBP health benefit provisions, we selected and reviewed samples of 3,612 claims.[2] We used the FEHBP contract, the Service Benefit Plan brochure, the Plan's provider agreements, and the Association's FEP administrative manual to determine the allowability of benefit payments. The results of these samples were not projected to the universe of claims.

[2] See the audit findings for "Inpatient Facility Claims – Duplicate or Overlapping Dates of Service" (A1), "System Review" (A2), "Continuous Stay Claims" (A3), "Omnibus Budget Reconciliation Act of 1993 Review" (A4), and "Non-Participating Providers" (A5) on pages 5 through 17 for specific details of our sample selection methodologies.

III. AUDIT FINDINGS AND RECOMMENDATIONS

HEALTH BENEFIT CHARGES

1. Inpatient Facility Claims – Duplicate or Overlapping Dates of Service $1,761,013

During our review of inpatient facility claims with duplicate or overlapping dates of service, we determined that the Plan incorrectly paid 181 claims, resulting in overcharges of $1,761,013 to the FEHBP.

Contract CS 1039, Part III, section 3.2 (b)(1) states, "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable." Part 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 . . . ."

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, other group health benefits coverage's, and the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. (b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary carrier . . . ."

We performed a computer search for potential duplicate payments on inpatient facility claims paid during the period January 1, 2006 through September 30, 2009. We identified 765 groups of claims with duplicate or overlapping dates of service. These 765 groups included 1,582 claims with total amounts paid of $15,818,849. Based on our review, we determined that 181 of these claims were paid incorrectly, resulting in overcharges of $1,761,013 to the FEHBP.

We determined that 178 of these claim payment errors were duplicates, resulting in overcharges of $1,721,510 to the FEHBP. These duplicate claim payments occurred due to the following reasons:

- The Plan overpaid a provider when making a series of claim adjustments and/or additional payments to correct an initial claim that was not properly coordinated with Medicare. The last claim that was paid in this series resulted in an overcharge of $974,762 to the FEHBP.

- The Plan paid 149 claims that were deferred as potential duplicates on the claims system but were overridden by the processors, resulting in overcharges of $718,610 to the FEHBP.

- Providers submitted 10 claims with incorrect information causing the claims system not to defer these claims as potential duplicates, resulting in overcharges of $13,134 to the FEHBP.

- The Plan's processors made data entry errors when adjudicating 13 claims causing the claims system not to defer these claims as potential duplicates, resulting in overcharges of $8,348 to the FEHBP.

- For reasons unknown, the claims system did not defer four duplicate claims, resulting in overcharges of $5,632 to the FEHBP.

- In one instance, Medicare submitted a cross-over claim with an incorrect provider identification number and then later submitted a corrected claim. The Plan paid both claims, resulting in an overcharge of $1,024 to the FEHBP.

During our review of potential duplicate payments on inpatient facility claims, we also found three claims that were not duplicate claim payments but contained other Plan payment errors, resulting in overcharges of $39,503 to the FEHBP. These claim payment errors occurred due to the following reasons:

- In one instance, the Plan paid a claim using an incorrect pricing method, resulting in an overcharge of $31,396 to the FEHBP.

- In one instance, the Plan reprocessed a claim with revised charges and provider information but did not adjust or void the previous claim payment, resulting in an overcharge of $7,859 to the FEHBP.

- In one instance, the Plan processed a claim using an incorrect provider identification number, resulting in an overcharge of $248 to the FEHBP.

Association's Response:

In response to the amount questioned in the draft report, the Association agrees with $797,488. The Association states that the Plan has recovered and returned $652,632 to the FEHBP as of November 15, 2010. The Association also states that these payments were good faith erroneous benefit payments and fall within the context of CS 1039, Part II, section 2.3(g). Any payments the Plan is unable to recover are allowable charges to the FEHBP. As good faith erroneous payments, lost investment income does not apply to the claim payment errors identified in this finding.

In addition, the Association states, "For the remaining overpayment of $974,762, the Plan requests that OPM acknowledge the due diligence performed in trying to recover the overpayment. The Plan identified the overpayment and sent ten recovery letters to the provider in an attempt to recover the overpayment. Also, this activity was performed before the OPM OIG audit began. This activity demonstrates the Plans' due diligence to obtain overpayment from the provider. The Plans will continue with their recovery efforts."

The Association also states, "Currently, FEP Express has an edit that is designed to defer inpatient claims with overlapping dates of services. However, a review of this control indicates that this edit only generates a deferral if the claims are from the same provider. A request to enhance this editing process to defer inpatient claims when the dates of services overlaps and the services were provided by different providers has been submitted. Due to the large number of 2011 benefit changes, this edit modification will not be implemented until 2011.

In addition, the FEP Director's Office has expanded its System-wide Claims Review Process to include inpatient admissions with overlapping dates of services. This listing was implemented into the review process as of the 2nd Quarter 2010."

OIG Comments:

Based on our review of the Association's response and additional documentation provided by the Plan, we revised the amount questioned from the draft report to $1,761,013. Subsequent to receiving the Association's response, the Association and Plan provided additional documentation supporting agreement with $786,251 and disagreement with $974,762 of the revised questioned amount.

Regarding the contested amount, we are continuing to question this overpayment because the Plan has not recovered and returned the funds to the FEHBP. ***The FEHBP should not be expected to cover this material claim overpayment because of provider refund issues.*** The following is our understanding of this claim overpayment.

- Claim Number 2006213382488 – The Plan paid the provider a stop-loss amount of $402,687 on September 26, 2006. Subsequently, the Plan found out that this claim should have been coordinated with Medicare and that the Plan should have only paid the coinsurance amount. The Plan recouped $402,687 and then paid the provider $1,028,237 on October 5, 2006. The Plan subsequently voided this claim payment and performed an automatic recoupment for $1,028,237 on March 21, 2007. The Plan recouped this amount without consent from the provider, and therefore, was in breach of contract and had to repay the provider for this claim.

- Claim Number 2007173GC3896 – The Plan paid the provider $35,700 on July 19, 2007. This was the correct payment for the Medicare coinsurance amount.

- Claim Number 06213382488OXA – The Plan paid the provider $974,762 on December 19, 2007. This was an unnecessary payment. However, we believe that the Plan paid this claim due to breach of contract for making the aforementioned recoupment without the provider's consent.

- Starting on February 20, 2008 and ending on April 4, 2009, the Plan sent 10 refund request letters to the provider to recover $1,028,237 for claim number 2006213382488. To date, the Plan has not recovered these funds.

- We are not sure why the Plan sent letters to recover $1,028,237 for claim number 2006213382488 and not $974,762 for claim number 06213382488OXA. As noted above, the Plan discontinued recovery efforts on April 4, 2009 and did not recover the funds from the provider. However, we do acknowledge the Association's comments that the Plan has resumed recovery efforts for this claim overpayment. According to the Association, the Plan included this claim overpayment in its new collection agency process.

Recommendation 1

We recommend that the contracting officer disallow $1,761,013 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

2. System Review **$484,037**

The Plan incorrectly paid 30 claims, resulting in net overcharges of $484,037 to the FEHBP. Specifically, the Plan overpaid 27 claims by $485,771 and underpaid 3 claims $1,734.

As previously cited from CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments. Also, the Plan must coordinate the payment of benefits with Medicare and the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault.

For health benefit claims reimbursed during the period January 1, 2008 through September 30, 2009, we identified 51,091,033 claim lines, totaling $6,117,841,218 in payments, using a standard criteria based on our audit experience. From this universe, we selected and reviewed a judgmental sample of 1,195 claims (representing 15,331 claim lines), totaling $62,775,626 in payments, to determine if the Plan adjudicated these claims properly.[3]

[3] For each WellPoint, Inc. FEP plan, we selected our sample from an OIG-generated "Place of Service Report" (SAS application) that stratified the claims by place of service (POS), such as provider's office and payment category, such as $50 to $99.99. We judgmentally determined the number of sample items to select from each POS stratum based on the stratum's total claim dollars paid.

Our review identified 30 claim payment errors, resulting in net overcharges of $484,037 to the FEHBP. Specifically, 27 claims were overpaid by $485,771 and 3 claims were underpaid by $1,734.

The claim payment errors resulted from the following:

- Due to various manual processing errors, the Plan priced eight claims without applying the appropriate procedure allowances, resulting in overcharges of $148,316 to the FEHBP. For example, in one instance, the Plan did not apply a multiple procedure discount of 50 percent when pricing the claim.

- The Plan inadvertently priced four claims using the billed charges instead of the Plan's procedure allowances, resulting in overcharges of $126,298 to the FEHBP.

- The Plan paid three claims using incorrect pricing methods, resulting in overcharges of $60,742 to the FEHBP.

- In one instance, the Plan did not correctly price a claim by using the lesser of billed charges or the non-member inpatient surgery per diem allowance, resulting in an overcharge of $56,853 to the FEHBP.

- In one instance, the Plan did not properly coordinate a claim with Medicare, resulting in an overcharge of $35,700 to the FEHBP.

- In one instance, the Plan did not apply the co-surgeon reimbursement rate of 62.5 percent when pricing the claim, resulting in an overcharge of $29,063 to the FEHBP.

- In one instance, the Plan paid a no-fault insurance claim at 100 percent of billed charges instead of using the professional fee schedule amounts, resulting in an overcharge of $14,232 to the FEHBP.

- The Plan priced two claims using incorrect provider numbers, resulting in overcharges of $6,174 to the FEHBP.

- The claims processors overrode system edits and entered incorrect pricing information for six claims, resulting in net overcharges of $3,920 to the FEHBP. Specifically, the Plan overpaid three claims by $5,654 and underpaid three claims by $1,734

- In one instance, the Plan paid a claim at the incorrect pricing rate, resulting in an overcharge of $2,389 to the FEHBP. This claim was paid incorrectly because the Plan's claims system was not updated with 2009 and 2010 contract rates for Porter Hospital.

Since more claims may have been affected, we requested the Plan to identify and review all FEP claims affected by this pricing error and determine if there were additional overpayments. On February 4, 2011, the Association informed us that the Plan is in the process of identifying the universe of all FEP claims affected by this pricing error and will initiate recoveries on the additional identified overpayments.

- The claims processors did not calculate the appropriate co-insurance for two claims, resulting in overcharges of $350 to the FEHBP.

Association's Response:

In response to the amount questioned in the draft report, the Association agrees with $347,471 and disagrees with $239,629 of the questioned charges. The Association states that the Plan has issued all underpayments to the providers and/or members, and initiated recoveries for the confirmed overpayments. As of November 15, 2010, the Plan had recovered and returned $120,294 to the FEHBP. The Association also states that these payments were good faith erroneous benefit payments and fall within the context of CS 1039, Part II, section 2.3(g). Any payments the Plan is unable to recover are allowable charges to the FEHBP. As good faith erroneous payments, lost investment income does not apply to the claim payment errors identified in this finding.

For the contested amounts that are being questioned in the final report, the Association states that the Plan disagrees with overpayments of $130,433 because these claim payment errors were identified in previous OPM audits.

In addition, the Association states that the Plan has taken corrective action to minimize these types of errors in the future.

OIG Comments:

Based on our review of the Association's response and additional documentation provided by the Plan, we revised the amount questioned from the draft report to $484,037. Subsequent to receiving the Association's response, the Plan provided additional documentation supporting agreement with $353,604 and disagreement with $130,433 of the revised questioned amount. For the contested amount, the Plan provided documentation supporting that proper claim adjustments were made. However, these claim adjustments were made after our audit request due date of February 1, 2010. Therefore, we will continue to question these claim overpayments. Also, we verified that the contested overpayments were not questioned in previous OPM audits.

Recommendation 2

We recommend that the contracting officer disallow $485,771 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 3

We recommend that the contracting officer allow the Plan to charge the FEHBP $1,734 if additional payments are made to the providers to correct the underpayment errors. However, before making any additional payment(s) to a provider, the contracting officer should require the Plan to first recover any questioned overpayment(s) for that provider.

Recommendation 4

We recommend that the contracting officer ensure that the Plan completes the expanded review of the Porter Hospital claims. Also, the contracting officer should ensure that the Plan makes the appropriate adjustments to correct all claim payment errors identified from this review.

3. **Continuous Stay Claims** **$318,279**

During our review of continuous stay claims, we determined that the Plan incorrectly paid 18 claims, resulting in net overcharges of $318,279 to the FEHBP. Specifically, the Plan overpaid 10 claims by $329,029 and underpaid 8 claims by $10,750.

As previously cited from CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments. Also, the Plan must coordinate the payment of benefits with Medicare.

Our review included continuous stay claims for the California, Georgia, New York, Ohio, and Virginia plans. During the period January 1, 2008 through December 31, 2009, we identified 4,350 continuous stay claim groups (representing 7,027 claims), totaling $146,052,843 in payments for these plans. From this universe, we selected and reviewed a judgmental sample of 170 continuous stay claim groups (representing 429 claims), totaling $58,338,902 in payments, to determine if these claims were correctly priced and paid by the Plan. Our sample included the top 10, 20, 40, or 80 high dollar claim payment groups from various dollar stratums within each service area.[4] The majority of these claim groups contained one admission claim, one or more continuous stay claims, and one discharge claim.

Our review identified 18 claim payment errors, resulting in net overcharges of $318,279 to the FEHBP. Specifically, 10 claims were overpaid by $329,029 and 8 claims were underpaid by $10,750.

[4] For cumulative amounts paid less than $15,000,000, we selected the top 10 groups. For cumulative amounts paid of $15,000,000 or more but less than $30,000,000, we selected the top 20 groups. For cumulative amounts paid of $30,000,000 or more but less than $45,000,000, we selected the top 40 groups. For cumulative amounts paid of $45,000,000 or more, we selected the top 80 groups.

These claim payment errors resulted from the following:

- The Plan incorrectly applied the outlier threshold discount when pricing two claims, resulting in overcharges of $160,173 to the FEHBP.
- The Plan incorrectly applied the stop-loss rate when pricing nine claims, resulting in net overcharges of $147,592 to the FEHBP. Specifically, the Plan overpaid six claims by $157,442 and underpaid three claims by $9,850.
- In one instance, the Plan did not properly coordinate a claim with Medicare, resulting in an overcharge of $5,717 to the FEHBP.
- In one instance, the Plan incorrectly applied the billed charges on a claim, resulting in an overcharge of $5,697 to the FEHBP.
- The Plan did not apply the coinsurance and/or deductible when pricing five claims, resulting in undercharges of $900 to the FEHBP.

Association's Response:

The Association agrees with this finding. The Association states that the Plan has issued all underpayments to the providers and initiated recoveries for the overpayments where applicable. As of November 15, 2010, the Plan had recovered and returned $165,890 to the FEHBP. The Association also states that these payments were good faith erroneous benefit payments and fall within the context of CS 1039, Part II, section 2.3(g). Any payments the Plan is unable to recover are allowable charges to the FEHBP. As good faith erroneous payments, lost investment income does not apply to the claim payment errors identified in this finding.

The Association states that these claim payment errors were caused by manual coding errors. In addition, the Association states that the Plan has taken corrective action to minimize these types of errors in the future.

Recommendation 5

We recommend that the contracting officer disallow $329,029 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 6

We recommend that the contracting officer allow the Plan to charge the FEHBP $10,750 if additional payments are made to the providers to correct the underpayment errors. However, before making any additional payment(s) to a provider, the contracting officer should require the Plan to first recover any questioned overpayment(s) for that provider.

4. Omnibus Budget Reconciliation Act of 1993 Review $51,695

The Plan incorrectly paid 154 claim lines that were priced under the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) pricing guidelines, resulting in net overcharges of $51,695 to the FEHBP. Specifically, the Plan overpaid 132 claim lines by $56,421 and underpaid 22 claim lines by $4,726.

As previously cited from CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments. Also, the Plan must coordinate the payment of benefits with Medicare.

OBRA 93 limits the benefit payments for certain physician services provided to annuitants age 65 or older who are not covered under Medicare Part B. The FEHBP fee-for-service plans are required to limit the claim payment to the lesser of the amount equivalent to the Medicare Part B payment or billed charges.

Using a program developed by the Centers for Medicare and Medicaid Services to price OBRA 93 claims, we recalculated the claim payment amounts for the claims in our samples that were subject to and/or processed as OBRA 93.

We judgmentally selected for review the service areas with universe totals of $400,000 or more for OBRA 93 claims. Our review included OBRA 93 claims for the Georgia, New York, Ohio, and Virginia plans. During the period January 1, 2008 through December 31, 2009, we identified 36,116 claims (73,938 claim lines), totaling $4,682,164 in payments, that were subject to OBRA 93 pricing guidelines for these plans. From this universe, we selected and reviewed a judgmental sample of 200 claims (1,152 claim lines), totaling $490,642 in payments, to determine if these claims were correctly priced by the FEP Operations Center and paid by the Plan. Our sample included the 50 highest dollar claims from each service area.

Based on our review, we determined that 154 claim lines were paid incorrectly, resulting in net overcharges of $51,695 to the FEHBP. Specifically, 132 claim lines were overpaid by $56,421 and 22 claim lines were underpaid by $4,726. These claim payment errors resulted from the following:

- The FEP Operations Center did not price 112 claim lines according to OBRA 93 pricing guidelines, resulting in net overcharges of $42,662 to the FEHBP. Specifically, the Plan overpaid 99 claim lines by $47,060 and underpaid 13 claim lines by $4,398. These errors resulted from the FEP national claims system, by design, automatically generating an "OFMA" override code when the system did not receive a timely response (i.e., with 15 days) from Palmetto (an OBRA 93 pricing vendor). Consequently, the FEP Operations Center used the allowable charge (covered charge minus preferred provider allowance/participating savings amount) instead of the Medicare allowance to calculate the claim line payments.

- The Plan incorrectly paid 21 claim lines due to Palmetto not recognizing the second and third procedure code modifiers and erroneously calculating the payments, resulting in overcharges of $5,851 to the FEHBP.

- The FEP Operation's Center applied incorrect OBRA 93 Medicare allowances to 18 claim lines, resulting in net overcharges of $3,272 to the FEHBP. Specifically, the Plan overpaid 12 claim lines by $3,510 and underpaid 6 claim lines by $238.

- The Plan inadvertently did not price three claim lines under OBRA 93, resulting in undercharges of $90 to the FEHBP.

Association's Response:

The Association agrees with this finding. The Association states that these claims have been repriced by Palmetto and where appropriate, refunds have been initiated. The Plan had recovered and returned $15,360 to the FEHBP as of November 15, 2010. The Association also states that these payments were good faith erroneous benefit payments and fall within the context of CS 1039, Part II, section 2.3(g). Any payments the Plan is unable to recover are allowable charges to the FEHBP. As good faith erroneous payments, lost investment income does not apply to the claim payment errors identified in this finding.

In addition, the Association states, "To enhance the accuracy of OBRA '93 claims pricing, the FEP Director's Office has taken the following actions:

- The FEP Director's Office is currently working with Palmetto to enhance pricing procedures to ensure that all applicable FEP claims are priced in accordance with Medicare pricing requirements.

- Established a chain of communication between the FEP Operations Center and Palmetto in an effort to improve the pricing process.

- Will include claims that were not OBRA '93 priced (Claims with the information Code OFMA) in the quarterly System-Wide Claims Review process. These claims will be included starting with the 4th Quarter 2010 reports.

- Conduct Plan trainings on how OBRA '93 claims should be to coded and submitted to the Operations Center. The first training was held at the FEP 2010 System Information Meeting in October 2010. Future trainings will be held via Webinars, and Plan meetings, visits and correspondence.

- We are currently evaluating our OBRA '93 system edits to determine whether there are changes that can be made to further promote the accuracy of the claims select and sent to Palmetto for pricing."

Recommendation 7

We recommend that the contracting officer disallow $56,421 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 8

We recommend that the contracting officer allow the Plan to charge the FEHBP $4,726 if additional payments are made to the providers to correct the underpayment errors. However, before making any additional payment(s) to a provider, the contracting officer should require the Plan to first recover any questioned overpayment(s) for that provider.

5. Non-Participating Providers **$29,571**

During our review of claims submitted by non-participating providers, we determined that the Plan incorrectly paid four claims to non-participating facility providers, resulting in net overcharges of $29,571 to the FEHBP. Specifically, the Plan overpaid three claims by $30,888 and underpaid one claim by $1,317.

As previously cited from CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments. Also, the Plan must coordinate the payment of benefits with Medicare.

We reviewed claims submitted by non-participating professional providers for the Georgia, New York, Ohio and Virginia plans. During the period January 1, 2008 through December 31, 2009, we identified 1,676,506 claim lines, totaling $51,705,091, that were paid to non-participating professional providers by these plans. From this universe, we selected and reviewed a judgmental sample of 317 claim lines (representing 75 claims), totaling $1,305,739 in payments, to determine if these claims were correctly priced by the FEP Operations Center and paid by the Plan. Our sample included the 25 highest dollar claims within each service area. Based on our review, we determined that all of these claims were paid correctly.

In addition to non-participating professional providers, we reviewed a sample of non-participating facility providers. Our review of non-participating facility providers covered the period January 1, 2008 through December 31, 2009 for the following plans:

- For the California, Georgia, New York, Ohio, and Virginia plans, we identified 102,149 inpatient surgery, mental health and substance abuse, rehabilitation, and medical non-participating facility claim lines, totaling $23,443,900 in payments. From this universe, we selected and reviewed a judgmental sample of 85 inpatient claims (representing 1,068 claim lines), totaling $4,877,095 in payments, to determine if these claims were correctly priced by the FEP Operations Center and paid by the

Plan. Our inpatient sample included the five highest dollar claims per inpatient admission type for each service area.

- For the California, Georgia, and New York plans, we identified 25 outpatient surgery non-participating facility claims, totaling $220,283 in payments, that may not have been paid in accordance with the non-participating provider allowance. From this universe, we selected and reviewed 21 outpatient claims, totaling $201,290 in payments, to determine if these claims were correctly priced by the FEP Operations Center and paid by the Plan. We only selected our outpatient sample from the California plan because the Georgia and New York plans' universes were immaterial. Our outpatient sample included all claims in the universe for the California plan.

Based on our review, we determined that four of the inpatient and outpatient claims were paid incorrectly, resulting in net overcharges of $29,571 to the FEHBP. Specifically, three claims were overpaid by $30,888 and one claim was underpaid by $1,317.

The claim payment errors resulted from the following:

- In one instance, the Plan did not correctly pay a claim by using the lesser of billed charges or the non-member inpatient rehabilitation per diem allowance, resulting in an overcharge of $17,550 to the FEHBP.

- In one instance, the Plan did not properly coordinate a claim with Medicare, resulting in an overcharge of $11,793 to the FEHBP.

- The Plan inadvertently priced two claims using the billed charges instead of the authorized case management per diem rates, resulting in net overcharges of $228 to the FEHBP. Specifically, the Plan overpaid one claim by $1,545 and underpaid one claim by $1,317.

Association's Response:

In response to the amount questioned in the draft report, the Association agrees with $17,778 and disagrees with $11,793 of the questioned charges. The Association states that refund recovery efforts have been initiated. The Association also states that these payments were good faith erroneous benefit payments and fall within the context of CS 1039, Part II, section 2.3(g). Any payments the Plan is unable to recover are allowable charges to the FEHBP. As good faith erroneous payments, lost investment income does not apply to the claim payment errors identified in this finding.

OIG Comments:

Subsequent to receiving the Association's response, the Plan provided additional documentation supporting concurrence with the questioned amount of $29,571.

Recommendation 9

We recommend that the contracting officer disallow $30,888 for claim overcharges and verify that the Plan has returned all amounts recovered to the FEHBP.

Recommendation 10

We recommend that the contracting officer allow the Plan to charge the FEHBP $1,317 if an additional payment is made to the provider to correct the underpayment error. However, before making any additional payment(s) to a provider, the contracting officer should require the Plan to first recover any questioned overpayment(s) for that provider.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Experience-Rated Audits Group

[redacted] Auditor-In-Charge

[redacted], Auditor

[redacted] Auditor

[redacted], Auditor

[redacted] Chief [redacted]

[redacted] Senior Team Leader

V. SCHEDULE A

WELLPOINT, INC.
MASON, OHIO

HEALTH BENEFIT CHARGES AND AMOUNTS QUESTIONED

HEALTH BENEFIT CHARGES*	2006	2007	2008	2009	TOTAL
CLAIM PAYMENTS	$3,194,817,112	$3,577,054,506	$4,017,858,892	$4,285,045,147	$15,074,775,657
MISCELLANEOUS PAYMENTS	13,679,582	15,270,948	30,895,069	34,724,617	94,570,215
TOTAL HEALTH BENEFIT CHARGES	$3,208,496,694	$3,592,325,454	$4,048,753,961	$4,319,769,764	$15,169,345,872

AMOUNTS QUESTIONED	2006	2007	2008	2009	TOTAL
1. INPATIENT FACILITY CLAIMS - DUPLICATE OR OVERLAPPING DATES OF SERVICE	$68,385	$1,093,357	$282,406	$316,865	$1,761,013
2. SYSTEM REVIEW	0	0	(200)	484,237	484,037
3. CONTINUOUS STAY CLAIMS	0	0	311,119	7,160	318,279
4. OMNIBUS BUDGET RECONCILIATION ACT OF 1993 REVIEW	0	0	26,475	25,220	51,695
5. NON-PARTICIPATING PROVIDERS	0	0	13,338	16,233	29,571
TOTAL QUESTIONED CHARGES	$68,385	$1,093,357	$633,138	$849,715	$2,644,595

* Includes all amounts reported in the Annual Accounting Statements under Plan codes 041 (California), 050/550 (Colorado), 060/560 (Connecticut), 100 (Georgia), 130/630 (Indiana), 160/660 (Kentucky), 180/680 (Maine), 241/741 (Missouri), 265/765 (Nevada), 270/770 (New Hampshire), 303/803/808 (New York), 332/839 (Ohio), 423/923 (Virginia), and 450/950 (Wisconsin).

BlueCross BlueShield
Association

An Association of Independent
Blue Cross and Blue Shield Plans

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December 15, 2010

[REDACTED] Group Chief
Experience-Rated Audits Group
Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, Room 6400
Washington, DC 20415-1100

Reference: OPM DRAFT AUDIT REPORT
Anthem BlueCross BlueShield Plans (WellPoint)
Audit Report Number 1A-99-00-10-013
(Dated October 15, 2010 and Received October 15, 2010)

Dear [REDACTED]

This is our response to the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report covering the Federal Employees' Health Benefits Program (FEHBP) concerning the WellPoint, Inc. BlueCross BlueShield Plans (14 Plans in total). Our comments concerning the findings in the report are as follows:

A. HEALTH BENEFIT CHARGES

1. **Inpatient Facility Claims-Duplicate Dates of Service** **$1,782,325**

The Plans agree that $797,488 of the questioned claims may have been overpaid. As November 15, 2010, the Plans have recovered and returned to the Program a total of $652,632. For the remaining overpayment of $974,762, the Plan requests that OPM acknowledge the due diligence performed in trying to recover the overpayment. The Plan identified the overpayment and sent ten recovery letters to the provider in an attempt to recover the overpayment. Also, this activity was performed before the OPM OIG audit began. This activity demonstrates the Plans' due diligence to obtain overpayment from the provider. The Plans will continue with their recovery efforts. The Plan also contests $10,075 in claim overpayments as the auditors sited the entire amount of the claim payment; however, there are FEP liabilities to pay for those days that are non-overlapping days. Documentation to support the Plans' position was provided to the auditors.

Currently, FEPExpress has an edit that is designed to defer inpatient claims with overlapping dates of services. However, a review of this control indicates that this edit only generates a deferral if the claims are from the same provider. A request to enhance this editing process to defer inpatient claims when the dates of services overlaps and the services were provided by different providers has been submitted. Due to the large number of 2011 benefit changes, this edit modification will not be implemented until 2011.

In addition, the FEP Director's Office has expanded its System-wide Claims Review Process to include inpatient admissions with overlapping dates of services. This listing was implemented into the review process as of the 2nd Quarter 2010.

Accordingly, to the extent that errors did occur, the payments are good faith erroneous benefits payments and fall within the context of CS 1039, Section 2.3(g). Any benefit payments the Plan is unable to recover are allowable charges to the Program. In addition, as good faith payments, the Plan continues to initiate recovery in a timely manner for confirmed overpayments. Because these are good faith erroneous payments, they are not subject to lost investment income.

2. <u>System Review</u> <u>$587,279</u>

The Plan agrees that $347,471 of the questioned claims may have been overpaid. These claims payments were caused by manual errors. All underpayments have been issued to the providers and/or members. Recoveries have been initiated on the confirmed overpayments. As of November 15, 2010, the Plans have recovered and returned $120,294 to the Program. The Plans will continue in its recovery efforts.

The Plan disagrees that $239,629 was paid incorrectly. Documentation to support the Plan's position has been provided to the auditors. The Plans disagree for the following reasons:

- Payments were made based on Non-Par Pricing for claims totaling $12,522.
- A facility payment corrected in the Hospital Settlement Process for claims totaling $2,389.
- Claims totaling $130,433 were identified in previous OPM Audits. These claims are still in the recovery process for the Uncoordinated Medicare Tier 8 audit and the Amount Paid Greater than Charges audit. To include these again would be double counting the overpayment.
- Claims totaling $93,039 were adjusted prior to the OPM Information Request Date.
- For one claim totaling $1,216, the provider file is correct based on the rate loading form for the date of service of August 27, 2009. It was determined at a later date that the rate was changed to 96.48% on July 1, 2009.
- The OIG Auditors miscalculated the value of this finding by $178. They stated the total questioned amount was $587,279 when it should be $587,101.

The Plan will take the following actions to minimize these types of errors in the future:

- Conducted re-fresher training in those areas impacted by the manual payment errors such as the requirements for the following:
  - the proper research required for deferral resolution prior to submitting the override codes;
  - the proper procedures for correctly coding claims so that FEPExpress applies the appropriate member cost share; and
  - the correct procedures for manually pricing claims.
- In addition, Plan management re-enforced the requirements for manual pricing of claims to include the proper usage of the non-par relief provision in the FEP Contract.

Accordingly, to the extent that errors did occur, the payments are good faith erroneous benefits payments and fall within the context of CS 1039, Section 2.3(g). Any benefit payments the Plan is unable to recover are allowable charges to the Program. In addition, as good faith payments, the Plan continues to initiate recovery in a timely manner for confirmed overpayments. Because these are good faith erroneous payments, they are not subject to lost investment income.

3. <u>Continuous Stay Claims</u> **<u>$318,279</u>**

The Plan agrees that $329,029 may have been over paid and $10,750 were underpaid. These claims payments were caused by manual coding errors. All underpayments have been issued to the providers. Recoveries have been initiated on the overpayments, where applicable. As of November 15, 2010, the Plans have recovered and returned $165,890 to the Program. The Plans will continue to show due diligence in its recovery efforts.

The Plan will take the following actions to minimize these types of errors in the future:

- Conducted re-fresher training in those areas where these manual payment errors occurred. Special emphasis was placed on the correct pricing procedures for interim facility billings and the impact on the pricing requirements for the entire admission.
- Reviewed the process to ensure that the proper research for deferral resolution was conducted prior to submitting the override codes; and
- Updated the correct procedures for the manual pricing of claims.

Accordingly, to the extent that errors did occur, the payments are good faith erroneous benefits payments and fall within the context of CS 1039, Section 2.3(g). Any benefit payments the Plan is unable to recover are allowable charges to the

Program. In addition, as good faith payments, the Plan continues to initiate recovery in a timely manner for confirmed overpayments. Because these are good faith erroneous payments, they are not subject to lost investment income.

4. **Omnibus Budget Reconciliation Act of 1993 Review $52,826**

The Plan agrees that $51,695 in professional claim payments were not subject to OBRA '93 pricing requirements. FEP OBRA '93 claims are priced by an outside vendor, Palmetto, GBA. The claims subject to OBRA '93 pricing are selected by the FEP Claims System based upon Medicare requirements and sent to the vendor for the appropriate Medicare allowance. These confirmed overpayments were sent to Palmetto for pricing but after 15 days with no pricing response from the vendor, the FEP Claims System applied the local Plan's allowance to these. These claims have been re-priced with the FEP OBRA '93 Pricing Vendor and where appropriate, refunds have been initiated. As of November 15, 2010, the Plans have recovered and returned $15,360 to the Program for these overpayments.

The Plans disagrees that $1,130 was paid incorrectly for one claim. The member was under age at the time of the services; therefore the claim was not eligible for OBRA '93 pricing.

To enhance the accuracy of OBRA '93 claims pricing, the FEP Director's Office has taken the following actions:

- The FEP Director's Office is currently working with Palmetto to enhance pricing procedures to ensure that all applicable FEP claims are priced in accordance with Medicare pricing requirements.
- Established a chain of communication between the FEP Operations Center and Palmetto in an effort to improve the pricing process.
- Will include claims that were not OBRA '93 priced (Claims with the information Code OFMA in the quarterly System-Wide Claims Review process. These claims will be included starting with the 4th Quarter 2010 reports.
- Conduct Plan trainings on how OBRA '93 claims should be to coded and submitted to the Operations Center. The first training was held at the FEP 2010 System Information Meeting in October 2010. Future trainings will be held via Webinars, and Plan meetings, visits and correspondence.
- We are currently evaluating our OBRA '93 system edits to determine whether there are changes that can be made to further promote the accuracy of the claims select and sent to Palmetto for pricing.

Accordingly, to the extent that errors did occur, the payments are good faith erroneous benefits payments and fall within the context of CS 1039, Section 2.3(g).

Any benefit payments the Plan is unable to recover are allowable charges to the Program. In addition, as good faith payments, the Plan continues to initiate recovery in a timely manner for confirmed overpayments. Because these are good faith erroneous payments, they are not subject to lost investment income.

5. Non-Participating Provider Claims $29,571

The Plan does not contest that $17,778 in claim payments resulted in overpayments and $1,317 in underpayments. Refund recovery efforts have been initiated. The Plan disagrees that $11,793 in claim payments were paid incorrectly. For these claims total billed charges were paid in full because Medicare was primary at the time of service, which required the Plan to pay the Medicare coinsurance in full leaving, the patient responsible for nothing. As a result, the Plan paid in full.

Accordingly, to the extent that errors did occur, the payments are good faith erroneous benefits payments and fall within the context of CS 1039, Section 2.3(g). Any benefit payments the Plan is unable to recover are allowable charges to the Program. In addition, as good faith payments, the Plan continues to initiate recovery in a timely manner for confirmed overpayments. Because these are good faith erroneous payments, they are not subject to lost investment income.

We appreciate the opportunity to provide our response to this Draft Audit Report and request that our comments be included in their entirety as n amendment to the Final Audit Report.

Executive Director
Program Integrity

Rcm/jb

cc: WellPoint BCBS Plans
FEP
FEP
, FEP