



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

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# Final Audit Report

**Subject:**

## AUDIT OF BLUECROSS BLUESHIELD OF FLORIDA JACKSONVILLE, FLORIDA

**Report No. 1A-10-41-12-019**

**Date: October 17, 2012**

--CAUTION--

This audit report has been distributed to Federal officials who are responsible for the administration of the audited program. This audit report may contain proprietary data which is protected by Federal law (18 U.S.C. 1905). Therefore, while this audit report is available under the Freedom of Information Act and made available to the public on the OIG webpage, caution needs to be exercised before releasing the report to the general public as it may contain proprietary information that was redacted from the publicly distributed copy.

## AUDIT REPORT

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

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BlueCross BlueShield of Florida  
Plan Codes 90/590  
Jacksonville, Florida

REPORT NO. 1A-10-41-12-019

DATE: October 17, 2012



Michael R. Esser  
Assistant Inspector General  
for Audits

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## EXECUTIVE SUMMARY

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

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BlueCross BlueShield of Florida  
Plan Codes 90/590  
Jacksonville, Florida

REPORT NO. 1A-10-41-12-019

DATE: October 17, 2012

This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at BlueCross BlueShield of Florida (Plan), doing business as Florida Blue, in Jacksonville, Florida, questions \$448,133 in health benefit charges. The BlueCross BlueShield Association agreed (A) with these questioned charges.

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covers claim payments from January 1, 2010 through December 31, 2011 as reported in the Annual Accounting Statements.

The questioned health benefit charges are summarized as follows:

- **Continuous Stay Claims (A)** **\$352,639**

During our review of continuous stay claims, we determined that the Plan incorrectly paid 30 groups of continuous stay claims, resulting in net overcharges of \$352,639 to the FEHBP. Specifically, the Plan overpaid 19 claim groups by \$421,779 and underpaid 11 claim groups by \$69,140.

- **Duplicate Payments – Professional/Facility Claims (A)** **\$90,354**

The Plan paid 94 duplicate professional claims, resulting in overcharges of \$90,354 to the FEHBP. These claims were included in duplicate payment groups that contained one facility claim and one or more duplicate professional claims.

- **System and Discount Review (A)** **\$5,140**

The Plan incorrectly paid 459 claims, resulting in net overcharges of \$5,140 to the FEHBP. Specifically, the Plan overpaid 120 claims by \$53,505 and underpaid 339 claims by \$48,365.

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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 BlueCross BlueShield of Florida (Plan), doing business as Florida Blue. The Plan is located in Jacksonville, Florida.

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 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 BlueCross and BlueShield plans throughout the United States to process the health benefit claims of its federal subscribers. The Plan is one of approximately 64 local BlueCross and BlueShield plans participating in the FEHBP.

The Association has established a Federal Employee Program (FEP<sup>1</sup>) 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 BlueCross and BlueShield 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 payments of FEHBP claims (using computerized system edits), maintaining a history file of all FEHBP claims, and maintaining an accounting of all program funds.

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

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

All findings from our previous audit of the Plan (Report No. 1A-10-41-10-012, dated May 12, 2011), which included claim payments from 2006 through September 30, 2009, have been satisfactorily 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 June 15, 2012. The Association's comments offered in response to the draft report were considered in preparing our final report and are included as an Appendix to this report.

## **II. OBJECTIVES, SCOPE, AND METHODOLOGY**

### **OBJECTIVES**

The objectives of our audit were to determine whether the Plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the contract. Specifically, our 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 90 and 590 for contract years 2010 and 2011. During this period, the Plan paid approximately \$2.5 billion in health benefit charges (See Schedule A). Specifically, we reviewed approximately \$31 million in claim payments from January 1, 2010 through December 31, 2011 for proper adjudication.

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 operations. However, since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on the Plan's system of internal controls taken as a whole.

We also conducted tests to determine whether the Plan had complied with the contract and the applicable laws and regulations governing the FEHBP as they relate to claim payments. The results of our tests indicate that, with respect to the items tested, the Plan did not fully comply with the provisions of the contract relative to claim payments. 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, and the Plan. 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 Jacksonville, Florida on various dates from March 19, 2012 through May 8, 2012. Audit fieldwork was also performed at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida.

## **METHODOLOGY**

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

To test the Plan's compliance with the FEHBP health benefit provisions, we selected and reviewed samples of 1,194 claims.<sup>2</sup> We used the FEHBP contract, the 2010 and 2011 Service Benefit Plan brochures, 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.

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<sup>2</sup> See the audit findings for "Continuous Stay Claims" (1), "Duplicate Payments – Professional/Facility Claims" (2), and "System and Discount Review" (3) on pages 5 through 10 for specific details of our sample selection methodologies.

### **III. AUDIT FINDINGS AND RECOMMENDATIONS**

#### **HEALTH BENEFIT CHARGES**

##### **1. Continuous Stay Claims**

**\$352,639**

During our review of continuous stay claims, we determined that the Plan incorrectly paid 30 groups of continuous stay claims, resulting in net overcharges of \$352,639 to the FEHBP. Specifically, the Plan overpaid 19 claim groups by \$421,779 and underpaid 11 claim groups by \$69,140. Continuous stay claims are two or more inpatient hospital claims with consecutive dates of service that were billed by a provider for a patient with one length of stay.

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 . . . until it has determined whether it is the primary carrier . . . .”

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.” In addition, 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 . . . .”

For the period January 1, 2010 through September 30, 2011, we identified 2,079 continuous stay claim groups (representing 5,317 claims), totaling \$31,629,226 in payments. From this universe, we selected and reviewed a judgmental sample of 176 continuous stay claim groups (representing 436 claims), totaling \$18,437,024 in payments, to determine if these claims were correctly priced and paid by the Plan. Our sample included groups with cumulative claim payment amounts of \$30,000 or more. The majority of these groups contained claims with consecutive dates of service. This sample contained a 12 percent error rate (claims in 21 of the 176 continuous stay groups were paid incorrectly).

Since our sample contained a high error rate, we expanded our testing to include all groups with cumulative claim payment amounts of \$23,000 or more but less than \$30,000. This expanded sample included an additional 65 continuous stay claim groups (representing 147 claims), totaling \$1,703,249 in payments. Our expanded sample contained a 14 percent error rate (claims in 9 of the 65 continuous stay groups were paid incorrectly).

In total, our review identified 30 groups of continuous stay claims with payment errors (representing 47 claim payment errors), resulting in net overcharges of \$352,639 to the FEHBP. Of these, the Plan overpaid 19 claim groups by \$421,779 and underpaid 11 claim groups by \$69,140. These claim payment errors resulted from the following:

- Due to provider billing errors, the Plan incorrectly paid 28 claims in 14 of the groups, resulting in net overcharges of \$236,087 to the FEHBP. Specifically, the Plan overpaid 11 groups by \$301,887 and underpaid 3 groups by \$65,800. In each instance, the

provider billed the Plan two or more separate claims for the patient when only one claim should have been billed for the entire stay (admission).

- In two of the groups, the Plan did not properly coordinate four claims with Medicare, resulting in overcharges of \$91,594 to the FEHBP.
- In eight of the groups, the Plan paid eight claims using incorrect allowed amounts, resulting in net overcharges of \$20,905 to the FEHBP. Specifically, the Plan overpaid five groups by \$21,855 and underpaid three groups by \$950.
- In one of the groups, the Plan did not calculate the appropriate co-insurance amounts for two claims, resulting in overcharges of \$6,443 to the FEHBP.
- In five of the groups, the Plan inadvertently applied pre-certification penalties when pricing five claims, resulting in undercharges of \$2,390 to the FEHBP.

**Association's Response:**

The Association agrees with this finding. The Association states that the Plan has initiated recoveries of the overpayments. As of July 13, 2012, the Plan has recovered and returned \$287,690 of the overpayments to the FEHBP. To the extent that errors did occur, 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 long as the Plan demonstrates due diligence in the collection of these overpayments. As good faith erroneous payments, lost investment income does not apply to the claim payment errors identified in this finding. Regarding the underpayments, the Association states that the Plan has already issued additional payments to the providers to correct these errors.

The Association also states that “the Plan completed causal analysis of the errors and determined that the errors were the result of manual coding errors and provider billing errors. The following processes have been implemented to reduce these types of claim payment errors in the future:

- Coaching and feedback was provided to the appropriate individuals and support areas within the Plan.
- Internal systems and guidelines were reviewed to verify the appropriate controls are in place, and based on the review new controls have been implemented to ensure similar errors will not occur in the future.
- The Plan will continue to randomly audit processors monthly to ensure compliance with the processing guidelines.”

### **Recommendation 1**

We recommend that the contracting officer disallow \$421,779 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

### **Recommendation 2**

We recommend that the contracting officer allow the Plan to charge the FEHBP \$69,140 if additional payments are made to the providers and/or members 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 3**

We recommend that the contracting officer have the Association verify that the Plan's corrective actions to minimize these types of claim payment errors in the future are being implemented. These corrective actions are included in the Association's response to the draft report.

## **2. Duplicate Payments – Professional/Facility Claims \$90,354**

The Plan paid 94 duplicate professional claims, resulting in overcharges of \$90,354 to the FEHBP. These claims were included in duplicate payment groups that contained one facility claim and one or more duplicate professional claims.

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.

Section 6(h) of the FEHB Act provides that rates should reasonably and equitably reflect the costs of benefits provided.

We performed computer searches on the BCBS claims database, using our data warehouse function, to identify potential duplicate professional claims that were paid by the Plan from January 1, 2010 through December 31, 2011.

- Using our “duplicate professional and inpatient match” search criteria, we identified 925 potential duplicate payment groups containing two or more claims, where one claim was the original inpatient facility claim and the other(s) were possible duplicate professional claims. These potential duplicate groups included 3,150 claim lines, totaling \$2,600,413 in payments. Of these payments, \$178,178 were considered potential duplicates. From this universe, we selected and reviewed a judgmental sample of 75 groups (representing 355 claim lines), totaling \$363,126 in payments. Of these payments in our sample, \$97,983 were considered potential duplicates. Our sample included all groups with potential duplicate payments of \$500 or more.

- Using our “duplicate professional and outpatient match” search criteria, we identified 18,657 potential duplicate payment groups containing two or more claims, where one claim was the original outpatient facility claim and the other(s) were possible duplicate professional claims. These potential duplicate groups included 47,787 claim lines, totaling \$5,152,013 in payments. Of these payments, \$1,911,037 were considered potential duplicates. From this universe, we selected and reviewed a judgmental sample of 442 groups (representing 1,820 claim lines), totaling \$896,114 in payments. Of these payments in our sample, \$629,611 were considered potential duplicates. Our sample included all groups with potential duplicate payments of \$750 or more.

Based on our review, we determined that 94 of the professional claim payments in our samples were duplicates, resulting in overcharges of \$90,354 to the FEHBP. These duplicate claim payments occurred due to the following reasons:

- Due to various provider billing errors, the Plan inadvertently paid 65 duplicate claims, resulting in overcharges of \$57,713 to the FEHBP.
- The Plan paid 29 claims that were deferred as potential duplicates on the claims system but were overridden by the processors, resulting in overcharges of \$32,641 to the FEHBP.

#### **Association’s Response:**

The Association agrees with this finding. The Association states that the Plan has initiated recoveries of the confirmed duplicate payments. As of July 13, 2012, the Plan has recovered and returned \$24,817 of the duplicate payments to the FEHBP. To the extent that errors did occur, 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 long as the Plan demonstrates due diligence in the collection of these overpayments. As good faith erroneous payments, lost investment income does not apply to the claim payment errors identified in this finding.

The Association also states that the Plan completed a causal analysis of the errors and determined that these errors were caused by manual overrides by processors and billing errors by providers. The Plan has implemented processes to reduce these types of errors from occurring in the future.

#### **Recommendation 4**

We recommend that the contracting officer disallow \$90,354 for duplicate claim payments charged to the FEHBP, and verify that the Plan returns all amounts recovered to the FEHBP.

## **Recommendation 5**

We recommend that the contracting officer have the Association verify that the Plan's corrective actions to minimize these types of duplicate claim payments in the future are being implemented. These corrective actions are included in the Association's response to the draft report.

### **3. System and Discount Review**

**\$5,140**

The Plan incorrectly paid 459 claims, resulting in net overcharges of \$5,140 to the FEHBP. Specifically, the Plan overpaid 120 claims by \$53,505 and underpaid 339 claims by \$48,365.

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 from January 1, 2010 through September 30, 2011 (excluding Omnibus Budget Reconciliation Act of 1990, Omnibus Budget Reconciliation Act of 1993, and case management claims), we identified 8,963,100 claim lines, totaling \$1,138,964,008 in payments, where the FEHBP paid as the primary insurer. From this universe, we selected and reviewed a judgmental sample 200 claims (representing 2,149 claim lines), totaling \$9,639,298 in payments, for the purpose of determining if the Plan adjudicated these claims properly and/or priced them according to the provider contract rates.<sup>3</sup> As part of our review, we also selected 50 participating and preferred providers, which were associated with the highest reimbursed claims in our sample, for the purpose of verifying if these providers' contract rates were accurately and timely updated in the Plan's local network pricing system.

Our review identified eight claim payment errors, resulting in net undercharges of \$1,597 to the FEHBP. These claim payment errors resulted from the following:

- In one instance, the Plan did not properly coordinate the claim with Medicare, resulting in an overcharge of \$6,245 to the FEHBP.
- In one instance, the Plan incorrectly applied the allowed pricing amount when processing the claim, resulting in an overcharge of \$4,368 to the FEHBP.
- In one instance, the Plan incorrectly applied the co-payment amount when processing the claim, resulting in an undercharge of \$20 to the FEHBP.

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<sup>3</sup> 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.

- In one instance, the Plan paid a claim using the incorrect pricing rate, resulting in an undercharge of \$72 to the FEHBP. This claim was paid incorrectly because the Plan's local claims system was not updated with the 2011 contract rates in the Physician Group Medical Services Agreement (see below for our expanded review of the issue).
- In one instance, the Plan inadvertently applied a pre-certification penalty when pricing the claim, resulting in an undercharge of \$500 to the FEHBP.
- In one instance, the Plan paid a claim using the incorrect pricing information, resulting in an undercharge of \$2,877 to the FEHBP.
- In two instances, the Plan entered an incorrect deferral code when processing the claims, resulting in net undercharges of \$8,743 to the FEHBP. Specifically, the Plan underpaid one claim by \$34,488 and overpaid one claim by \$25,745.

After researching the claim that was paid using an incorrect pricing rate (see above), we requested the Plan to identify all claims paid from August 1, 2011 (effective date of the updated rates) through September 30, 2011 (when claims system was updated) that were potentially processed with this type of error, and determine if these claims were paid correctly. The error was due to the Plan's local claims system not being updated with the 2011 contract rates in the Physician Group Medical Services Agreement. The Plan identified 483 claims, totaling \$427,193 in payments, that were potentially processed with this type of error. We reviewed these claims and determined that 451 additional claims were paid incorrectly, resulting in net overcharges of \$6,737 to the FEHBP. Of these additional claim payment errors, 116 were overpaid by \$17,217 and 335 were underpaid by \$10,480.

**Association's Response:**

The Association agrees with this finding. The Association states that the Plan has initiated recoveries of the confirmed overpayments. As of July 13, 2012, the Plan has recovered and returned \$31,990 of the overpayments to the FEHBP. To the extent that errors did occur, 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 long as the Plan demonstrates due diligence in the collection of these overpayments. As good faith erroneous payments, lost investment income does not apply to the claim payment errors identified in this finding. Regarding the underpayments, the Association states that the Plan has already issued additional payments to the providers to correct these errors.

The Association also states that "the Plan completed causal analysis of the errors and determined that the errors occurred due to lack of coordination between internal business partners.

- Internal systems and guidelines were reviewed as well to verify the appropriate controls are in place. Based on this review, internal guidelines have been updated.

- Procedures have been enhanced to include the necessary detail required to process claims accurately.
- Controls have been developed and implemented to minimize errors and identify outliers.”

**Recommendation 6**

We recommend that the contracting officer disallow \$53,505 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

**Recommendation 7**

We recommend that the contracting officer allow the Plan to charge the FEHBP \$48,365 if additional payments are made to the providers and/or members 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 8**

We recommend that the contracting officer have the Association verify that the Plan’s corrective actions to minimize these types of claim payment errors in the future are being implemented. These corrective actions are included in the Association’s response to the draft report.



## **IV. MAJOR CONTRIBUTORS TO THIS REPORT**

### Experience-Rated Audits Group

██████████ Lead Auditor

██████████ Auditor

██████████, Auditor

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██████████, Chief (██████████)

### Information Systems Audits Group

██████████, Senior Information Technology Specialist

██████████, Senior Information Technology Specialist

**V. SCHEDULE A**

**BLUECROSS BLUESHIELD OF FLORIDA  
JACKSONVILLE, FLORIDA**

**HEALTH BENEFIT CHARGES AND AMOUNTS QUESTIONED**

<b>HEALTH BENEFIT CHARGES</b>	<b>2010</b>	<b>2011</b>	<b>TOTAL</b>
<b>HEALTH BENEFIT CHARGES</b>			
<b>PLAN CODE 90:</b>			
<b>CLAIM PAYMENTS</b>	\$637,742,834	\$682,942,668	\$1,320,685,502
<b>MISCELLANEOUS PAYMENTS AND CREDITS*</b>	501,088	(2,004,401)	(1,503,313)
<b>PLAN CODE 590:</b>			
<b>CLAIM PAYMENTS</b>	564,237,987	578,302,946	1,142,540,933
<b>MISCELLANEOUS PAYMENTS AND CREDITS*</b>	0	0	0
<b>TOTAL</b>	<b>\$1,202,481,909</b>	<b>\$1,259,241,213</b>	<b>\$2,461,723,122</b>
<b>AMOUNTS QUESTIONED</b>			
	<b>2010</b>	<b>2011</b>	<b>TOTAL</b>
<b>1. CONTINUOUS STAY CLAIMS</b>	\$237,746	\$114,893	\$352,639
<b>2. DUPLICATE PAYMENTS - PROFESSIONAL/FACILITY CLAIMS</b>	18,241	72,113	90,354
<b>3. SYSTEM AND DISCOUNT REVIEW</b>	0	5,140	5,140
<b>TOTAL QUESTIONED CHARGES</b>	<b>\$255,987</b>	<b>\$192,146</b>	<b>\$448,133</b>

\* We did not review the miscellaneous payments and credits on this audit.

August 9, 2012

██████████ Group Chief  
Experience-Rated Audits Group  
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**BlueCross BlueShield  
Association**

An Association of Independent  
Blue Cross and Blue Shield Plans  
Federal Employee Program  
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202.942.1000  
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**Reference: OPM DRAFT AUDIT REPORT  
BlueCross BlueShield of Florida  
Audit Report Number 1A-10-41-12-019  
(Dated June 15, 2012 and Received June 15, 2012)**

Dear ██████████:

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

**A. HEALTH BENEFIT CHARGES**

**1. Continuous Stay Claims \$352,639**

The Plan agrees that \$421,779 in continuous stay claims were over paid and \$69,140 were underpaid. Recovery has been initiated on the overpayments, where applicable. This represented 1.1% of the \$31,629,000 in claim payments reviewed during the audit. As of July 13, 2012, the Plan has recovered and returned \$287,690 to the Program and will continue to show due diligence in its recovery efforts. All claims are adjusted to the correct payment amount during the initial review of the claims for the audit; therefore all underpayments have been issued to the providers.

As requested in the recommendation, the Plan completed causal analysis of the errors and determined that the errors were the result of manual coding errors and provider billing errors. The following processes have been implemented to reduce these types of claim payment errors in the future:

- Coaching and feedback was provided to the appropriate individuals and support areas within the Plan.

- Internal systems and guidelines were reviewed to verify the appropriate controls are in place, and based on the review new controls have been implemented to ensure similar errors will not occur in the future.
- The Plan will continue to randomly audit processors monthly to ensure compliance with the processing guidelines.

Accordingly, to the extent that errors did occur, the payments are good faith erroneous benefit 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 as long as the Plan is able to demonstrate due diligence in collection of the overpayment. In addition, as good faith erroneous benefit 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. Duplicate Payments – Professional/Facility Claims** **\$90,354**

The Plan agrees that 94 duplicate claim lines may have resulted in overcharges of \$90,354 to the FEHBP. These claim errors represented 1.3% of the \$6,752,426 in potential duplicate claim payments identified during the audit. Recovery has been initiated on the confirmed overpayments. As of July 13, 2012, the Plan has recovered and returned \$24,817 to the program and will continue to show due diligence in its recovery efforts.

As requested in the recommendation, the Plan completed causal analysis of the errors and determined that the errors were caused by manual overrides by processors and provider billing errors. The following processes have been implemented to reduce these types of errors from occurring in the future:

- Coaching and feedback was provided to the individual examiners as appropriate, and refresher training provided for all examiners in the claims processing area.
- Internal systems and guidelines were reviewed as well to verify the appropriate controls are in place. In addition, the Plan will continue to randomly audit processors monthly to ensure compliance with the processing guidelines.

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 as long as the Plan is able to demonstrate due diligence in collection of the overpayment. In addition, as good faith erroneous benefit. 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. System and Discount Review**

**\$5,140**

The Plan agrees that \$53,505 of the questioned claims may have been over paid and that \$48,365 of the questioned claims may have been underpaid. These claims payments errors represented .005% of the \$9,639,298 in claim payments reviewed. Recovery has been initiated on the confirmed overpayments. As of July 13, 2012, the Plan has returned \$31,990 to the Program and will continue to show due diligence in its recovery efforts. All claims are adjusted to the correct payment amount during the initial review of the claims for the audit; therefore all underpayments have been issued to the providers.

As requested in the recommendation, the Plan completed causal analysis of the errors and determined that the errors occurred due to lack of coordination between internal business partners.

- Internal systems and guidelines were reviewed as well to verify the appropriate controls are in place. Based on this review, internal guidelines have been updated.
- Procedures have been enhanced to include the necessary detail required to process claims accurately.
- Controls have been developed and implemented to minimize errors and identify outliers.

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) as long as the Plan is able to demonstrate due diligence in collection of the overpayment. In addition, as good faith erroneous benefit.. 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.

[REDACTED]  
August 9, 2012

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We appreciate the opportunity to provide our response to this Draft Audit Report and request that our comments be included in their entirety in the Final Audit Report. If you have any questions, feel free to call [REDACTED] at [REDACTED] or me at [REDACTED]

Sincerely,

[REDACTED]

Director, Program Integrity

cc: [REDACTED], OPM  
[REDACTED], Florida Blue  
[REDACTED], Florida Blue  
[REDACTED], FEP  
[REDACTED], FEP