



---

---

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

---

---

# Final Audit Report

**Audit of Health Care Service Corporation**

**Report Number 1A-10-17-14-037**

**November 19, 2015**

**-- CAUTION --**

This audit report has been distributed to Federal officials who are responsible for the administration of the audit 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 (<http://www.opm.gov/our-inspector-general>), 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.

# EXECUTIVE SUMMARY

## *Audit of Health Care Service Corporation*

Report No. 1A-10-17-14-037

November 19, 2015

### **Why Did We Conduct the Audit?**

The objectives of our audit were to determine whether Health Care Service Corporation (HCSC or Plan) charged costs to the Federal Employees Health Benefits Program (FEHBP) and provided services to the FEHBP members in accordance with the terms of its contract with the U.S. Office of Personnel Management. Specifically, our objectives were to determine whether the Plan complied with contract provisions relative to claim payments.

### **What Did We Audit?**

The Office of the Inspector General has completed a limited scope audit of the FEHBP operations at Health Care Service Corporation. The audit covered Health Care Service Corporation claim payments from January 1, 2011 through January 31, 2014, as reported in the Blue Cross and Blue Shield Association's Government-wide Service Benefit Plan Annual Accounting Statements.

### **What Did We Find?**

Our limited scope audit was conducted in accordance with Government Auditing Standards. The report questions \$35,759,457 in health benefit charges. The questioned health benefit charges are summarized as follows:

- A. Veterans Affairs Claim Review
  - The Plan incorrectly paid 13,108 claims to U. S. Department of Veterans Affairs service providers, resulting in overcharges of \$35,562,962 to the FEHBP.
- B. Retroactive Enrollment Review
  - The Plan incorrectly paid 74 claims requiring retroactive enrollment adjustments, resulting in overcharges of \$97,510 to the FEHBP.
- C. Modifier ■ and ■ Review
  - The Plan incorrectly paid 39 claim lines that contained a procedure code modifier ■ or ■, resulting in net overcharges of \$35,393 to the FEHBP.
- D. System Pricing Review
  - The Plan incorrectly paid four claims where the FEHBP paid as primary insurer, resulting in overcharges of \$30,018 to the FEHBP.
- E. Debarred Provider Review
  - The Plan incorrectly paid 163 claims that were billed by providers debarred by the FEHBP, resulting in overcharges of \$14,959 to the FEHBP.
- F. Modifier ■ Review
  - The Plan incorrectly paid four claim lines that contained procedure code modifier ■, resulting in overcharges of \$11,700 to the FEHBP.
- G. Multiple Procedure Review
  - The Plan incorrectly paid seven claims that contained a multiple procedure, resulting in net overcharges of \$5,979 to the FEHBP.
- H. Non-Participating Provider Review
  - The Plan incorrectly paid one claim to a non-participating service provider, resulting in overcharges of \$936 to the FEHBP.



**Michael R. Esser**  
*Assistant Inspector General  
for Audits*

# ABBREVIATIONS

<b>Association</b>	<b>Blue Cross Blue Shield Association</b>
<b>APM</b>	<b>Administrative Procedures Manual</b>
<b>BCBS</b>	<b>Blue Cross Blue Shield</b>
<b>CFR</b>	<b>Code of Federal Regulations</b>
<b>DO</b>	<b>Director's Office</b>
<b>FEHB</b>	<b>Federal Employee Health Benefits</b>
<b>FEHBP</b>	<b>Federal Employee Health Benefits Program</b>
<b>FEP</b>	<b>Federal Employee Program</b>
<b>FEP OC</b>	<b>Federal Employee Program Operations Center</b>
<b>HCSC or Plan</b>	<b>Health Care Service Corporation</b>
<b>IHS</b>	<b>Indian Health Services</b>
<b>OIG</b>	<b>Office of the Inspector General</b>
<b>OPM</b>	<b>U.S. Office of Personnel Management</b>
<b>VA</b>	<b>U.S. Department of Veterans Affairs</b>

# TABLE OF CONTENTS

	<u>Page</u>
<b>EXECUTIVE SUMMARY</b> .....	i
<b>ABBREVIATIONS</b> .....	ii
<b>I. BACKGROUND</b> .....	1
<b>II. OBJECTIVES, SCOPE, AND METHODOLOGY</b> .....	3
<b>III. AUDIT FINDINGS AND RECOMMENDATIONS</b> .....	5
A. Veterans Affairs Review .....	5
B. Retroactive Enrollment Review .....	13
C. Modifier ■ and ■ Review .....	15
D. System Pricing Review.....	17
E. Debarred Provider Review .....	17
F. Modifier ■ Review.....	18
G. Multiple Procedure Review .....	19
H. Non-Participating Provider Review .....	20
<b>IV. MAJOR CONTRIBUTORS TO THIS REPORT</b> .....	22
<b>V. SCHEDULE A – HEALTH BENEFIT CHARGES AND AMOUNTS QUESTIONED</b>	
<b>APPENDIX:</b> Blue Cross Blue Shield Association’s July 31, 2015 response to the Draft Audit Report, issued June 2, 2015.	
<b>REPORT FRAUD, WASTE, AND MISMANAGEMENT</b>	

# I. BACKGROUND

This final audit report details the findings, conclusions, and recommendations resulting from our limited scope audit of the Federal Employees Health Benefits Program (FEHBP) operations at Health Care Service Corporation (HCSC or Plan). The Plan's primary location for claims processing is located in Abilene, Texas. The audit was performed by the U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as authorized by the Inspector General Act of 1978, as amended.

The FEHBP was established by the Federal Employees Health Benefits (FEHB) Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for federal employees, annuitants, and dependents. OPM's Healthcare and Insurance Office has overall responsibility for administration of the FEHBP. The provisions of the FEHB Act are implemented by OPM through regulations, which are codified in Title 5, Chapter 1, Part 890 of the Code of Federal Regulations (CFR). Health insurance coverage is made available through contracts with various health insurance carriers.

The Blue Cross Blue Shield Association (Association), on behalf of participating Blue Cross and Blue Shield (BCBS) plans, has entered into a Government-wide Service Benefit Plan contract (CS 1039) with OPM to provide a health benefit plan authorized by the FEHB Act. The Association delegates authority to participating local BCBS plans throughout the United States to process the health benefit claims of its federal subscribers. There are 64 BCBS plans participating in the FEHBP.

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

The Association has also established an FEP Operations Center (OC). The activities of the FEP OC 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.

---

<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.

The following were the most recent audit reports issued that covered claim payments for HCSC service areas:

- Report No. 1A-10-03-06-079 (BCBS of New Mexico), dated June 5, 2007;
- Report No. 1A-99-00-07-043 (BCBS of Illinois and Texas), dated September 5, 2008; and
- Report No. 1A-10-83-08-018 (BCBS of Oklahoma), dated January 9, 2009.

All findings from these previous audits of HCSC 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 audit report, dated June 2, 2015. 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

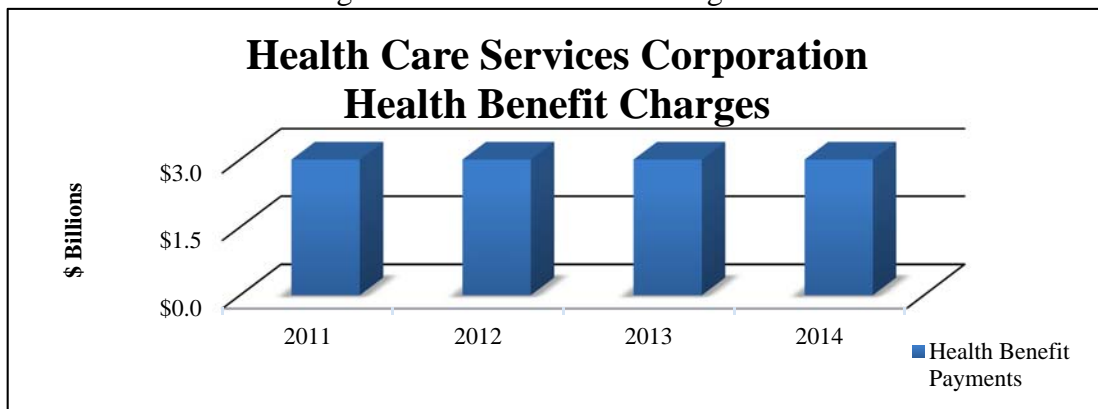
The objectives of our audit were to determine whether the Plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the contract. Specifically, our objective was to determine whether the Plan complied with contract provisions relative to health benefit payments.

### Scope and Methodology

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 Blue Cross Blue Shield Association's Government-wide Service Benefit Plan Annual Accounting Statements as they pertain to Plan codes 121/621 (BCBS of Illinois), 250/751 (BCBS of Montana), 290/790 (BCBS of New Mexico), 340/840 (BCBS of Oklahoma), and 400/900 (BCBS of Texas) for contract years 2011 through 2014. During this period, the Plan paid approximately \$10.6 billion in health benefit charges (See Figure 1 and Schedule A). From this universe, we judgmentally selected various samples for review. We reviewed approximately 2,022 claims, totaling \$15.5 million in payments, for the period January 1, 2011 through January 31, 2014, for proper adjudication. In addition, we performed an expanded review of approximately 14,426 claims, totaling \$66 million in payments to the U.S. Department of Veterans Affairs service providers, for the period January 1, 2012 through December 31, 2014. We used the FEHBP contract, the 2011 through 2014 Service Benefit Plan brochures, the Plans' provider agreements, and the Association's FEP Administrative Procedures Manual

Figure 1 – Health Benefit Charges



(APM) to determine the allowability of benefit payments. The results of these samples were not projected to the universe of claims.

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. 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 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 are explained in detail in the "Audit Findings and Recommendations" section of this audit report. With respect to the items not tested, nothing came to our attention that caused us to believe that the 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 DO, the FEP OC, and the Plan. Through audits and a reconciliation process, we have verified the reliability of the BCBS claims data in our data warehouse, which was used to identify the universe of claims for each type of review. The BCBS claims data is provided to us on a monthly basis by the FEP OC, and after a series of internal steps, uploaded into our data warehouse. However, due to time constraints, we did not verify the reliability of the data generated by the Plan's local claims system. While utilizing the computer-generated data during our audit, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

Audit fieldwork was performed at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida through April 2015.



# III. AUDIT FINDINGS AND RECOMMENDATIONS

## A. Veterans Affairs Claim Review

**\$35,562,962**

Our review of claims paid to non-participating (non-par) providers detected significant problems with claims paid by HCSC to U.S. Department of Veterans Affairs (VA) medical providers. The full results of our non-par provider review are detailed in section H below. However, due to the significant number of claim payment errors paid to VA providers, we performed an expanded review of VA claims and separated this audit finding from the non-par review for reporting purposes.

For the scope of January 1, 2012 through December 31, 2014, we identified 542,650 claims totaling \$232,910,665 in payments that were paid to VA service providers. From this universe, we selected to review a sample of claims paid for the following periods from each Plan site:

- Illinois - January 1, 2012 through December 31, 2014;
- Montana - January 1, 2012 through December 31, 2014;
- New Mexico - January 1, 2012 through December 31, 2014;
- Oklahoma - January 1, 2012 through January 31, 2014 (minimal claim payment errors identified); and
- Texas - January 1, 2012 through January 31, 2014 (minimal claim payment errors identified).

Our sample selection contained all claim payments of \$1,000 or more where the amount paid to the provider was greater than or equal to the amount billed by the provider. We consider these claims to be high risk for payment error because paying a claim at or above billed charges could indicate that the FEP did not receive a discount in the pricing of that claim. We reviewed the 14,426 claims, totaling \$65,953,793 in payments that met this criteria to determine if the claims were properly priced and paid by the Plan.

Our review determined that the VA's billed charge was substantially higher than the local Plans' preferred provider pricing allowances and the FEP reasonable rates. In July 2011, the Code of Federal Regulations (CFR) was modified to allow VA providers to bill third-party payers for services that were not related to a military service connected injury. The regulation states that VA providers can accept payment for these services using either the limited charge of a geographic area (e.g., preferred provider pricing allowance) or the VA's "reasonable charge" (i.e., billed charges). The VA's reasonable charge is determined by the Office of Management and Budget and is designed for VA facilities to use these rates to bill third-party payers, such as HCSC. As a result of the July 2011 regulation change, the FEP Administrative Procedures Manual (APM), which provides guidance to all BCBS Plans on how to process and pay FEP

claims, was modified. The APM, Chapter 12, provides guidance to Plans on how to process and pay FEP claims billed by VA providers. This guidance from the APM states that:

- Plans are “Encouraged to take the initiative” to contract with VA service providers using preferred or member level benefits;
- Plans are suggested “to keep in mind that VA claims are subject to limitations, exclusions, and cost-sharing provisions as claims from non-VA providers”; and
- The Plan should price VA claims using the lesser of the VA’s reasonable charge for non-preferred VA providers or the preferred provider pricing allowance.

HCSC is a fee-for-service Plan, meaning the benefit structure is designed for the Plan to develop reasonable compensation rates (e.g., preferred provider allowances) with providers, such as VA providers, on behalf of the FEHBP. If a provider does not contract with the Plan, FEP’s policy is to apply non-par rates, which are limited to local preferred pricing allowances. For most of the claims we reviewed, the Plan did not provide sufficient documentation to support how the Plan determined that paying these claims using the VA’s reasonable charge and/or billed charges was cost effective and advantageous to the FEHBP. As a result, we determined these health benefit charges to be unreasonably priced and overcharged to the FEHBP.

**HCSC overpaid  
13,108 claims to VA  
providers, resulting  
in overcharges of  
\$35,562,962 to the  
FEHBP.**

Our review concluded that the Plan incorrectly paid 13,108 VA claims, resulting in overcharges of \$35,562,962 to the FEHBP. Specifically, these claim payment errors resulted from the following:

a) Claims Paid at an Unreasonably High Rate

For 11,579 claims, totaling \$30,603,012 in overpayments, the Plan paid the claims at the billed charges, which is substantially higher than FEP’s non-par pricing allowances and the Plans’ preferred pricing allowances.

Based on the various criteria from the CFR and APM, the Plan had the option to pay these claims using the following methods:

- The Plans’ preferred provider pricing allowances;
- FEP’s non-par rates; or
- The VA’s reasonable charge (i.e., billed charges).

For two of the five HCSC service areas, the Plan made the most cost effective choice and contracted with VA providers using preferred provider pricing allowances. For the

remaining three service areas, the Plan had the same option to pay at a lower rate, but instead deliberately forced these claims to pay at the highest possible option of billed charges instead of the lower FEP non-par rates or preferred provider pricing allowances.

If the Plan had not intervened with the pricing of these claims at all, a more reasonable discounted rate using the FEP non-par pricing guidelines would have been automatically applied by the Association's FEP Express nation-wide claims processing system - which would have resulted in savings to the FEHBP. Since the Plan did not provide a preferred provider allowance rate, we calculated the Plan's approximate overpayment amounts using the FEP non-par pricing allowances.

**HCSC paid claims to VA providers at unreasonably high billed charges when it could have taken steps to pay at a lower contracted rate or non-par rate.**

In addition to paying these claims at unreasonably high rates, the Plan's local system incorrectly allowed these VA claims to bypass automatic claim reviews that ensure proper billing, such as identifying duplicate payments and non-covered services. APM Chapter 12 states that "Local Plans should make sure that the facility claim does not include professional service fees that duplicate those reported on the professional claim." It also states that the Plan should verify the services billed by the VA are covered benefits of the FEHBP. Despite this guidance, the Plan continued to process these claims without reviewing for potential provider billing errors.

b) Preferred Provider Indicator

For 1,512 claims, totaling \$4,934,372 in overpayments, the Plan did load a preferred pricing allowance to the FEP Express System, but did not properly load a preferred provider indicator to ensure proper payment on the claim. As a result, the FEP Express System overrode the Plan's allowance and the Plan inadvertently paid the claim line at billed charges.

c) Erroneous Processing Errors

For 17 claims, totaling \$25,578 in overpayments, the Plan contracted with the VA providers; however, the claim processed incorrectly due to a local system processing error, fee schedule rate loading error, or manual processing error.

The following criteria supports our position that these claims were priced incorrectly and that the overcharges should be returned to the FEHBP:

- 48 CFR 31.201-3 states, "(a) cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person in the conduct of competitive business."

- 48 CFR 17.101-4 states, “(a) A third-party payer liable under a health plan contract has the option of paying either the billed charges. . . or the amount the health plan demonstrates is the amount it would pay for care or services furnished by providers . . . for the same care or services in the same geographic area. If the amount submitted by the health plan for payment is less than the amount billed, VA will accept the submission as payment, subject to verification at VA’s discretion in accordance with this section.”
- 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 . . . . The recovery of any overpayment must be treated as an erroneous benefit payment, overpayment, or duplicate payment . . . regardless of any time period limitations in the written agreement with the provider.”
- APM, Volume II, Chapter 12, page 25, states, “In processing . . . claims for services provided by non-preferred VA facilities, the local Plan should base its reimbursement on the lower of, the VA’s reasonable charge or the local Plan’s allowance for Preferred providers – if that allowance is the same as the amount the Plan would allow for the same care or services in the same geographic area furnished by Preferred providers other than the VA . . . . If the Plan bases its payment on a PPA allowance that is lower than the VA’s reasonable charge, the Plan must be prepared to provide documentation to the VA to support its action.”
- The 2014 BCBS Service Benefit Brochure provides general guidance on the FEP’s policy for pricing and paying non-participating provider claims.

**HCSC’s Response:**

In response to the draft report which questioned \$48,491,213 in overpayments, the Plan agrees with \$11,543,846 in overpayments and states, “***The Plan identified a number of claims in which the amount billed by the VA providers exceeded the reasonable amount that the VA could charge based upon the applicable federal regulations . . . . The Plan[‘s] contest[ed] charges are within the Plan’s allowance and reflect the correct payments for the billed services. For the remaining questioned claims, the Plan did provide a pricing allowance to the FEP Express System and systematically placed the preferred provider network status code in the FEP Express Systems alternate network status field. During the scope of this audit the FEP Express System did not read the alternate network status field resulting in billed charges being used as the allowed amount. Enhancements were implemented by the FEP Operations Center in April of 2015 to ensure local Plan allowances are applied appropriately based on the alternate network status field. Where possible, recovery was initiated on the confirmed overpayments and the Plan will return all refunds received to the FEP Program.***”

In regards to the contested overcharges the Plan states, ***“The Plan respectfully disagrees that the FEP was overcharged \$36,947,367 in VA claim payments . . . .***

***The Plan disagrees that an overpayment occurred due to physician outpatient contracted rates not being properly loaded into the local Plan’s system . . . . The Plan’s payments were consistent with industry and governmental practices, which allow for payments to hospitals for the technical component of physician services when the services are performed at the hospital facility or the physician practice is owned by the hospital . . . . In addition . . . it is equally important to note that there are no OPM or FEHBP rules that prohibit such payments . . . the findings and related recommendation to disallow the charges . . . for OIG’s stated reason should be stricken . . . .***

***The Plan disagrees that the contracted rate paid [to] the VA is unreasonable and outside of the FEP contracting limits. The OIG appears to rely heavily on specifications in the FAM [APM] . . . . The claims at issue in the findings at hand are Illinois VA claims, and . . . the Plan is contracted with the Illinois VA. OIG has mistakenly applied the referenced FAM [APM] section and requirements of “lower of” reimbursement, which applies to NON-preferred VA facilities . . . the finding is erroneous and the finding and related recommendation should be stricken . . . .***

***To the extent that OIG is attempting to substitute its judgment for the Plan’s on the amount the Plan should pay its contracted provider, there is no authority under law or contract for such a position. There is no support for the finding that the payment of billed charges to the contracted Illinois VA is inappropriate as long as the amounts paid did not exceed the Federal Register reasonable charge rates that can be charged by the VA as determined by the Office of Management and Budget (“OMB”). According to the applicable regulations for VA providers, the VA is authorized to set rates that it can bill for services that are paid by third party payers. 38 CFR 17.101. The preface to the applicable VA regulations notes that the rates to be charged by the VA are intended to be reasonable and are designed to replicate, as much as possible, the 80th percentile of the community charges for such services. 68 Fed. Reg. 56876 (October 2, 2003). The government cannot on one hand say that its VA provider rates are reasonable and simultaneously assert that the rates are unreasonable when the government itself is asked to pay such charges.***

***The finding of the Draft Report with respect to the VA’s charge rates is therefore inconsistent with the U.S. government’s own regulations that set the VA charges at a reasonable rate, and such findings and associated recommendations should be stricken . . . .***

***For contested claims totaling for the New Mexico Plan, the charges are within the Plan’s allowance and reflect the correct payments for the billed services. For contested claims paid***

*by the Montana Plan, Montana does not have a Plan allowance for preferred providers that would be applicable to VA facilities. The Plan based its pricing for facility providers on the VA's Reasonable Charge which was submitted on the claim by the VA facility provider and payable consistent with 38 CFR Chapter 17. This pricing methodology is utilized by the Plan across all lines of business including FEP. . . ."*

**Association's Response:**

*"When the FEP Claims System was modified to apply VA pricing, Plans were notified that the system was unable to apply Plan local allowances unless the Plan submitted the VA claims with a PPO network status; however, the claim overpayments questioned during this audit were submitted with an alternate network status, resulting in the claim overpayments. Enhancements were made to the FEP Operations Center in April of 2015 to ensure local Plan allowances are applied appropriately based on either the alternate network status field or the PPO network status field . . . ."*

**OIG Comments:**

After reviewing the Plan's response and additional documentation, we revised our questioned charges from our draft report to \$35,562,962. The Plan agrees with \$11,543,846 and disagrees with \$24,019,116 of the questioned charges. The \$24,019,116 in contested overcharges mostly represents the difference between the amount the Plan paid at billed charges and the amount calculated by the OIG using the FEP non-par allowances. Also, the variance in questioned charges between the draft and final report represents a more conservative calculation using the FEP non-par pricing allowances instead of an estimated percentage using the Plan's local pricing allowances.

Before outlining the specific reasons we continue to question the contested overcharges, we would like to address our concern regarding HCSC's overall management of VA service providers in the Illinois, Montana and New Mexico service areas. In its response to our draft report, the Plan stated, *"to the extent that OIG is attempting to substitute its judgment for the Plan's on the amount the Plan should pay its contracted provider, there is no authority under law or contract for such a position."* In our opinion, it appears the Plan did not practice good judgement or provide proper oversight for payments made to VA service providers on behalf of the FEHBP. As a result of the Plan's poor oversight of these claims, the FEHBP was overcharged substantially for claim expenses, and FEP members faced an average 60 percent increase in their out-of-pocket expenses. In such a situation, it is absolutely our responsibility to substitute our judgment for the Plan's. As referenced above, the CFR states that a cost is reasonable if it does not exceed that which would be incurred by a prudent business person in the conduct of competitive business.

**A prudent, competitive business would not unnecessarily pay claims at a higher rate when lower options are available.**

HCSC is a third-party administrator for the FEHBP, meaning that all claims expenses and the associated administrative costs are drawn from the Federal FEHBP trust fund, as opposed to HCSC's commercial funds. The Plan assumes minimal risk while acting as a third-party administrator for the FEHBP.

We do not know the volume of claims HCSC paid to VA service providers for its commercial lines of business, but they paid over \$105 million from FEHBP funds to VA providers between 2012 and 2014 for Illinois, Montana, and New Mexico alone (VA claims in Texas and Oklahoma were appropriately paid at a discount rate using local plan allowances). We do not believe that any competitive business would unnecessarily pay these claims at a higher rate if the funds were exclusively paid from its commercial lines of business, as opposed to Federal money that it does not have the same vested interest in protecting.

We acknowledge the VA is supposed to limit its billing to the "reasonable charge" as set by the CFR. However, the CFR also allows VA providers to enter into provider agreements with the Plan and to accept lower payment rates. The fact that the VA's billing practices are subject to regulation does not exempt HCSC from implementing controls that ensure claims are paid at competitive rates.

Specific examples of the Plan's mismanagement of VA claims include:

- As previously cited, if the Plan had simply taken no action to intervene with the payment to the VA service providers, the FEP non-contracted rates (i.e., non-par) would have automatically been applied and resulted in significant savings to the FEHBP. The Plan deliberately paid these claims at the higher billed charges, but has not provided sufficient documentation to support why these payments were considered reasonable in nature in comparison to other contracted providers. Therefore, we conclude that HCSC's management exercised poor judgement in determining what is considered a reasonable pricing allowance when a much lower rate was available.
- Throughout the audit, the Plan provided inconsistent documentation which made it difficult to understand fact from intent throughout our review. During the initial phases of our audit the Plan stated multiple times that it did not contract with VA facilities in the Illinois service areas. Subsequently, in its response to the draft report the Plan stated that it did, in fact, contract with VA facilities in the Illinois service areas to pay claims at billed charges. However, the contracts with the VA service areas provided by the Plan appeared to be severely out-of-date. The Plan's contracts dated as far back as February 1993, contained no interim contract addendums, and did not contain any statements from the VA stating the contractual intent. As previously cited, the APM was updated in 2011 to reflect changes to

the CFR related to third-party (such as the FEP) payments to VA service providers. Despite the notification from the Association, the Plan did not update and/or renegotiate its VA facility contracts that were established in 1993. It appears HCSC's management has either provided little oversight to its VA service area contracts or the Plan and the VA service areas were not in a binding contract for the scope of our audit.

In addition to the above examples highlighting the unreasonable nature of HCSC's management of VA claims for FEP members, we continue to question these claims for the following reasons:

- Regardless of whether the Plan did or did not contract with the VA service providers, the Plan paid these VA claims at a much higher rate than FEP's reasonable rates. In its response to our draft report, the Plan stated, "*the OIG has mistakenly applied the referenced FAM [APM] section and requirements of "lower of" reimbursement, which applies to NON-preferred VA facilities.*" We appropriately applied the referenced APM guidance only to non-preferred VA facilities, and our review determined that for the Illinois non-preferred VA facilities, the Plan did not use the lower of the VA's "reasonable charge" or preferred provider pricing allowance. For the facilities that the Plan had contracted with, we applied the appropriate preferred provider APM criteria, which provides guidance to the Plan to contract using the Plan's preferred pricing allowances. Our review determined that for the Illinois preferred VA facilities the Plan contracted at an unreasonably high rate (i.e., billed charges), instead of preferred pricing allowances
- We concur with the Plan that the VA's billing practices are used by Medicare and industry standards. However, our review of the VA billing rate schedules indicated that they are developed using an Ambulatory Payment Classification (APC) pricing methodology. The APC methodology bundles the payment for dependent, ancillary, supportive, and adjunctive items and services into the payment for the primary independent service. Also, the VA rates often include the professional and technical components within the billed services. As previously cited above, the Plan's local system incorrectly allowed these VA claims to bypass automatic claim reviews that ensure proper billing, such as identifying duplicate payments and non-covered services. The billing rates developed for the VA include bundled and professional component services that were clearly not excluded during the pricing of these claims, resulting in duplicate overpayments.
- In instances where the Plan did not have any contract in place with a VA provider (i.e., the VA was a non-participating provider), the Plan's policy of paying the claims at billed charges is, in fact, a direct violation of FEP's non-par pricing guidelines.



**Recommendation 1**

We recommend that the contracting officer disallow \$35,562,962 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP. Due to the nature of this finding and the substantial amount questioned, we also recommend that the contracting officer contact the Illinois, Montana, and New Mexico VA service areas to discuss a practical approach for recovery of these claims. Based on regulations, the contracting office should not allow the Plan to offset these recoveries against future payments.

**Recommendation 2**

We recommend that the contracting officer ensure the Plan is properly negotiating and/or contracting reasonable rates with VA providers on behalf of the FEHBP. Additionally, the contracting office should ensure the Plan updates its policy to limit VA non-par providers to the FEP’s non-par rates.

**Recommendation 3**

We recommend that the contracting officer ensure the Association instructs the FEP Operations Center to determine why the FEP Express System is overriding the local plans’ preferred provider pricing allowances for VA claims and ensure the system is properly limiting the allowances to the FEP benefit brochure guidelines when a VA provider is non-par.

**Recommendation 4**

Due to the amount of claim overcharges identified in this finding, we recommend that the contracting officer request the Association to perform a risk assessment on the Plan to determine FEP’s impact for administrative cost (e.g., cost allocation methods and indirect expenses) and service charge. Any material differences identified should be properly adjusted in the Plan’s accounting records and returned to the FEHBP.

**B. Retroactive Enrollment Review**

**\$97,510**

The retroactive enrollment report identifies paid claims that are potentially affected by enrollment changes (i.e., claims paid before the member’s eligibility status is updated in the FEP Express enrollment system). The report is generated by the FEP OC and is distributed to the Plan on a daily basis. For the period of December 1, 2013 through January 31, 2014, this report identified 14,974 claims, totaling \$5,447,558 in potential overpayments to the FEHBP. From this universe, we judgmentally selected 100 high dollar claims, totaling \$696,442 in potential overpayments, to determine if the Plan properly identified claims requiring retroactive adjustments and promptly initiated recovery from the providers.

**HCSC did not initiate recovery and/or return 74 claim payment errors related to enrollment changes, resulting in overcharges of \$97,510 to the FEHBP.**

Our review determined the Plan did not initiate recovery and/or return 74 claim payment errors, resulting in overcharges of \$97,510 to the FEHBP. These claim payment errors resulted from the following:

- The Plan’s local processors did not initiate recovery and/or complete the recovery process for 18 claims that required retroactive adjustments, which resulted in overcharges of \$81,235 to the FEHBP.

Of these claims, 15 displayed a “trans” field code of 80 (allows a 31-day grace period after the member’s termination) or 90 (coverage termination) in the FEP Express System. In general, the Plan has up to 60 days to initiate recovery if a “trans” field code of 80 or 90 is present in the FEP Express System. However, we determined that on average the Plan did not initiate recovery for 138 days from the initial date the claim payment error was identified on the retroactive report. Although the Plan initiated recovery for these claim payment errors, the Plan did not make a “prompt” effort to recover these overpayments as required by contract CS 1039.

- For three members, the Plan and/or FEP OC did not ensure that the member’s termination adjustments were properly updated in the FEP Express System, which caused claims to be paid after these members’ termination date. As a result, the Plan incorrectly paid 56 claims, totaling \$16,275 in overcharges to the FEHBP.

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

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 recovery of any overpayment must be treated as an erroneous benefit payment, regardless of any time period limitations in the written provider agreement.

**HCSC’s Response:**

The Plan agrees with this finding. The Plan states that where possible recovery has been initiated and all funds recovered will be returned to the FEP Program.

Regarding corrective actions the Plan states, ***“Retroactive Enrollment Reports are worked daily by the Plan. Effective September 27, 2014 memberships with a transaction code of 80 or 90 are systematically tracked by the FEP Express system and are populated on the Retroactive Enrollment Report on day 61 if the cancellation is still effective. This enhancement will help ensure that Plans appropriately and timely initiate recovery on retroactive enrollment activity.”***

**Recommendation 5**

We recommend that the contracting officer disallow \$97,510 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

**Recommendation 6**

We recommend that the contracting officer ensure the Association’s process for tracking “trans” codes of 80 or 90 is an effective procedure to timely initiate recovery on retroactive claim payment errors and ensure the FEP Express enrollment system is being timely updated to reflect proper enrollment termination.

**C. Modifier ■ and ■ Review**

**\$35,393**

From the universe of health benefit claims reimbursed between January 1, 2013 and January 31, 2014, we identified ■ claims, totaling \$ ■ in payments, that contained a procedure code modifier ■ or ■ ( ■ ). From this universe, we reviewed a random selection of 125 claims with amounts paid of \$100 or more to determine if the Plan properly applied its local pricing discounts related to ■ (modifier ■ and ■ ). These 125 claims represent 261 claim lines, totaling \$324,808 in payments.

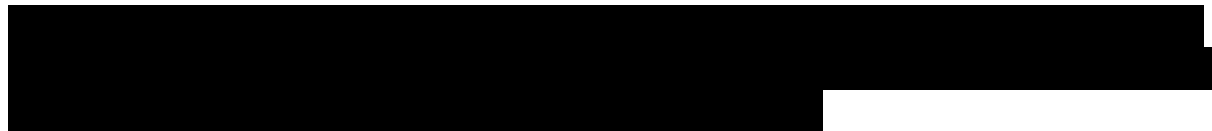
Our review determined that the Plan incorrectly paid 39 claim lines, resulting in net overcharges of \$35,393 to the FEHBP. Specifically, the Plan overpaid 32 claim lines by \$36,805 and underpaid 7 claim lines by \$1,412. These claim payment errors resulted from the following:

**HCSC did not apply the correct pricing allowance for 31 claim lines that contained a co-surgeon modifier.**

- The Plan incorrectly paid 31 claim lines due to processors manually applying the incorrect pricing allowance, resulting in net overcharges of \$33,183 to the FEHBP. Specifically, the Plan overpaid 24 claim lines, totaling \$34,595 and underpaid 7 claim lines, totaling \$1,412.
- The Plan incorrectly priced one claim line due to a provider billing error, resulting in an overcharge of \$1,160 to the FEHBP.

- For seven claim lines, the FEP Operations Center did not apply the Basic members' copay of \$150, resulting in overcharges of \$1,050 to the FEHBP.

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 recovery of any overpayment must be treated as an erroneous benefit payment, regardless of any time period limitations in the written provider agreement.



**HCSC's Response:**

The Plan agrees with this finding. The Plan states that they will conduct refresher training for all local Plan staff that performs manual pricing functions by the third quarter of 2015.

**Association's Response:**

Regarding corrective actions related to claims where the Basic member's copay of \$150 was not properly applied when a [REDACTED] was billed the Association states, *"claims related to this activity are currently under review and evaluation. Once the [Association's] review/evaluation is completed, appropriate corrective action will be developed and implemented."*

**Recommendation 7**

We recommend that the contracting officer disallow \$36,805 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 \$1,412 if additional payments are made to the providers to correct the underpayment errors. However, before making any additional payment(s) to the provider, the contracting officer should require the Plan to first recover any questioned overpayments from this provider.

**Recommendation 9**

We recommend that the contracting officer require the Association to instruct the FEP OC to determine why the Basic member's copay of \$150 was not applied when a [REDACTED] was billed and implement corrective actions to prevent these types of errors from occurring in the future.

#### D. System Pricing Review

**\$30,018**

From January 1, 2013 through January 31, 2014, the FEHBP paid as the primary insurer for [REDACTED] claim lines, totaling \$ [REDACTED] in payments. We judgmentally selected and reviewed 385 claims (representing 3,283 claim lines and totaling \$10,768,321 in payments), to determine if the Plan adjudicated these claims properly and/or priced them according to the provider contract rates.<sup>2</sup> We also selected 89 participating and preferred providers that were associated with the highest reimbursed claims in our sample for the purpose of verifying if these providers' contracted rates were accurately and timely updated in the Plan's local pricing system.

Our review determined that the local Plan processors incorrectly priced four claims, resulting in overcharges of \$30,018 to the FEHBP.

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 recovery of any overpayment must be treated as an erroneous benefit payment, regardless of any time period limitations in the written provider agreement.

#### **HCSC's Response:**

The Plan agrees with this finding. The Plan states that they will conduct refresher training for all local Plan staff that performs manual pricing functions by the third quarter of 2015.

#### **Recommendation 10**

We recommend that the contracting officer disallow \$30,018 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

#### E. Debarred Provider Review

**\$14,959**

There were 284 providers debarred from the FEHBP during the period of January 1, 2013 through January 31, 2014. From this universe, we randomly selected 86 debarred providers for review to determine whether these debarred providers had received payments for services provided after they were debarred.

**HCSC made claim payments to debarred providers.**

Our review determined the Plan incorrectly allowed payment to three providers in our sample after their debarred date. We identified 163 claims incorrectly paid to these three providers

---

<sup>2</sup> We selected our sample from an OIG-generated "Place of Service Report" that stratified the claims by place of service (POS), such as provider's office, and payment category, such as \$50 to \$99. We judgmentally determined the number of sample items to select from each POS stratum based on the stratum's total claim dollars paid.

during the period of January 1, 2011 through January 31, 2014, resulting in overcharges of \$14,959 to the FEHBP.

These claim payment errors resulted from the following:

- The Plan incorrectly paid 162 claims, totaling \$13,720 in overcharges to the FEHBP for two debarred providers. [REDACTED]
- For one provider, a processor overrode system edits on a claim, resulting in an overcharge of \$1,239 to the FEHBP.

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 recovery of any overpayment must be treated as an erroneous benefit payment, regardless of any time period limitations in the written provider agreement.

**HCSC's Response:**

The Plan agrees with this finding. The Plan states that where possible recovery has been initiated and all funds recovered will be returned to the FEP Program.

**Recommendation 11**

We recommend that the contracting officer disallow \$14,959 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

**F. Modifier [REDACTED] Review**

**\$11,700**

From the universe of health benefit claims reimbursed during the period between January 1, 2013 and December 31, 2014, we identified 3,410 claim lines, totaling \$515,584 in potential overcharges to the FEHBP, that contained procedure code modifier [REDACTED]. From this universe, we selected 204 claim lines for review, totaling \$200,590 in potential overpayments, to determine if the Plan properly priced and paid these claims. This was a judgmental sample of claims with potential overpayments of \$500 or more. In general, the Plan's local pricing system allows an additional payment when modifier [REDACTED] is billed and properly supported for the additional procedure performed.

Our review determined that the local Plan processors incorrectly priced four claim lines, resulting in overcharges of \$11,700 to the FEHBP.

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 recovery of any overpayment must be treated as an erroneous benefit payment, regardless of any time period limitations in the written provider agreement.

**HCSC's Response:**

The Plan agrees with this finding. The Plan states, where possible, recovery has been initiated and all funds recovered will be returned to the FEP Program.

**Recommendation 12**

We recommend that the contracting officer disallow \$11,700 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

**G. Multiple Procedure Review**

**\$5,979**

Using the Plan's universe of claims from January 1, 2013 through January 31, 2014, where the FEHBP paid as the primary insurer (previously cited in finding "D"), we selected and reviewed 302 claims (representing 789 claim lines), totaling \$270,816 in payments, to determine if the Plan properly priced and paid claims related to multiple and bilateral procedures. Our sample selections were a result of the following:

**HCSC incorrectly priced seven claims that contained bilateral or multiple procedures.**

- Random selection of 226 claims, totaling \$167,457 in payments, with amounts paid of \$100 or more that contained a bilateral or multiple procedure pricing indicator.
- Random selection of 76 claims, totaling \$103,359 in payments, with amounts paid of \$100 or more that did not contain a bilateral or multiple procedure pricing indicator.

Our review determined that the local Plan processors incorrectly priced seven claims, resulting in net overcharges of \$5,979 to the FEHBP. Specifically, the Plan overpaid six claims by \$6,279 and underpaid one claim by \$300.

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 recovery of any overpayment must be treated as an erroneous benefit payment, regardless of any time period limitations in the written provider agreement.

**HCSC's Response:**

The Plan agrees with this finding. The Plan states that they will conduct refresher training for all local Plan staff that performs manual pricing functions by the third quarter of 2015.

**Recommendation 13**

We recommend that the contracting officer disallow \$6,279 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

**Recommendation 14**

We recommend that the contracting officer allow the Plan to charge the FEHBP \$300 if additional payments are made to the providers to correct the underpayment errors. However, before making any additional payment(s) to the provider, the contracting officer should require the Plan to first recover any questioned overpayments from this provider.

**H. Non-Participating Provider Review**

**\$936**

We performed a computer search to identify all claims paid to non-participating (non-par) providers between January 1, 2013 and January 31, 2014. This search identified [REDACTED] claims totaling \$ [REDACTED] in payments. Non-par providers are those that do not have a contract with HCSC, and have not agreed to accept the HCSC allowed amount as payment in full. From this universe, we selected and reviewed 296 claims, totaling \$787,366 in payments, to determine if the claims were properly priced by the FEP Operations Center and paid by the Plan. Our random sample selection included:

- 50 claims for a medical emergency and with amounts paid greater than \$100;
- 123 non-emergent claims where the amount paid was \$100 or more and the member was enrolled with the Standard option; and
- 123 non-emergent claims where the amount paid was \$100 or more and the member was enrolled with the Basic option.

Our review determined that the local Plan processors incorrectly priced one claim, resulting in an overcharge of \$936 to the FEHBP.

In addition to this questioned cost, our review determined that the APM guidance related to Indian Health Services (IHS) for payment to third party providers no longer reflects recent changes in federal regulations as described in the Indian Health Care Improvement Reauthorization and Extension Act.

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 recovery of any overpayment must be treated as an erroneous benefit payment, regardless of any time period limitations in the written provider agreement.

48 CFR 18.1621e -a states, “(f) An Indian tribe, or tribal organization shall have the right to recover . . . the reasonable charges billed by the Secretary, an Indian tribe, or tribal organization in providing health services through the Service, an Indian tribe, or tribal organization, or, if higher, the highest amount the third party would pay for care and services furnished by providers other than governmental entities. . . .”

**HCSC’s Response:**

The Plan disagrees with these questioned charges. In addition, since the procedural finding was as a result of the Plan’s response to the draft report, the Plan and/or Association has not had the opportunity to provide an official response to the procedural finding.

**OIG Comments:**

After reviewing the Plan’s responses and additional documentation, we revised our questioned charges from our draft report to \$936. Although the Plan contested this amount, we continue to question this claim due to the fact that these services were not provided by an IHS facility and the non-par claim was manually processed incorrectly. Additionally, we conclude that IHS claims are being properly priced and paid by the Plan; however, the Association’s APM guidance for processing IHS claims should be updated to reflect the recent changes in federal regulations.

**Recommendation 15**

We recommend that the contracting officer disallow \$936 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

**Recommendation 16**

We recommend that the contracting officer ensure the Association updates the APM’s guidance to reflect the proper pricing for IHS as stated in the Plan’s draft report response. Additionally, the contracting office should ensure that all BCBS Plans are properly notified of the changes for processing IHS claims.

# IV. MAJOR CONTRIBUTORS TO THIS REPORT

## Information Systems Audits Group

[REDACTED], Auditor

[REDACTED], Auditor

[REDACTED], Auditor

[REDACTED], Auditor

[REDACTED], Auditor

---

[REDACTED], Senior Team Leader

[REDACTED], Group Chief

# V. SCHEDULE A

<b>HEALTH CARE SERVICE CORPORATION</b>					
<b>CHICAGO, ILLINOIS</b>					
<b>PLAN CODES:</b>					
<b>121/621 - IL; 250/751 - MI; 290/790 - NM; 340/840 - OK; 400/900 - TX</b>					
<b>HEALTH BENEFIT CHARGES AND AMOUNTS QUESTIONED</b>					
<b>HEALTH BENEFIT CHARGES</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>TOTAL</b>
<b>CLAIM PAYMENTS</b>					
<b>MISCELLANEOUS PAYMENTS AND CREDITS</b>					
<b>TOTAL</b>					
<b>AMOUNTS QUESTIONED</b>					
<b>A. VETERANS AFFAIRS CLAIM REVIEW</b>	<b>\$0</b>	<b>\$10,012,817</b>	<b>\$13,696,465</b>	<b>\$11,853,680</b>	<b>\$35,562,962</b>
<b>B. RETROACTIVE ENROLLMENT REVIEW</b>	<b>1,036</b>	<b>561</b>	<b>23,205</b>	<b>72,708</b>	<b>97,510</b>
<b>C. MODIFIERS 62 AND 66 REVIEW</b>	<b>0</b>	<b>0</b>	<b>34,783</b>	<b>610</b>	<b>35,393</b>
<b>D. SYSTEM PRICING REVIEW</b>	<b>0</b>	<b>0</b>	<b>19,083</b>	<b>10,935</b>	<b>30,018</b>
<b>E. DEBARRED PROVIDER REVIEW</b>	<b>53</b>	<b>0</b>	<b>14,906</b>	<b>0</b>	<b>14,959</b>
<b>F. MODIFIERS 22 REVIEW</b>	<b>0</b>	<b>0</b>	<b>11,700</b>	<b>0</b>	<b>11,700</b>
<b>G. MULTIPLE PROCEDURE REVIEW</b>	<b>0</b>	<b>0</b>	<b>5,679</b>	<b>300</b>	<b>5,979</b>
<b>H. NON PARTICIPATING PROVIDER REVIEW</b>	<b>0</b>	<b>0</b>	<b>936</b>	<b>0</b>	<b>936</b>
<b>TOTAL QUESTIONED CHARGES</b>	<b>\$1,089</b>	<b>\$10,013,378</b>	<b>\$13,806,757</b>	<b>\$11,938,233</b>	<b>\$35,759,457</b>

## APPENDIX



### **BlueCross BlueShield Association**

An Association of Independent  
Blue Cross and Blue Shield Plans

Federal Employee Program  
1310 G Street, N.W.  
Washington, D.C. 20005  
202.942.1000  
Fax 202.942.1125

July 31, 2015

██████████, Group Chief  
Claims & IT Audits Group  
U.S. Office of Personnel Management  
1900 E Street, Room 6400  
Washington, D.C. 20415-1100

**Reference: OPM DRAFT AUDIT REPORT  
Health Care Service Corporation (HCSC)  
AuditReport Number 1A-10-17-14-037  
(Dated and Received June 2, 2015)**

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 HCSC. Our comments concerning the findings in this report are as follows:

**A. Veteran's Administration (VA) Claim Review \$48,491,213**

#### **Recommendation 1**

We recommend that the contracting officer disallow \$48,491,213 for VA claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

#### **Plan Response**

The Plan respectfully disagrees that the FEP was overcharged \$36,947,367 in VA claim payments and agrees that \$11,543,846 in VA claims were paid in error as explained below.

For 41,221 claim lines totaling \$19,718,413, the Plan disagrees that an overpayment occurred due to physician outpatient contracted rates not being properly loaded into the local Plan's system. OIG acknowledged that the Plan had contracts with the Illinois VA but found that the Plan failed to apply its contracted rates for physician outpatient services. The Illinois VA billed the technical component of the professional services rendered by VA physicians that provided services in VA facilities. The Plan appropriately paid such claims according to its

Illinois VA facility contracts. The contract the Plan has for VA physician services is not relevant to these technical component claims billed through the VA facility and paid pursuant to the VA facility contract. The Illinois VA's claims submission for the physician's technical component was appropriate, and payment under the Plan's Illinois VA facility contract was also appropriate. The Plan's payments were consistent with industry and governmental practices, which allow for payments to hospitals for the technical component of physician services when the services are performed at the hospital facility or the physician practice is owned by the hospital.

In addition to these billing and payment practices being consistent with industry and government practices, it is equally important to note that there are no OPM or FEHBP rules that prohibit such payments. Conversely and instructive, under Medicare rules, hospitals may bill and be reimbursed for the technical component of a physician visit to allow the hospital to recover some of its cost related to providing the facility, 42 CFR 413.65. See also Medicare Claim Processing Manual, Ch. 4, 250.01. These same principles of reimbursement are used by many other health insurers, in addition to the Plan. Considering that the payment practices are consistent with industry and government practices, and that there is no prohibition on such payment practices under OPM and FEHBP rules, the findings and related recommendation to disallow the charges under bullet one above for OIG's stated reason should be stricken.

For 8,544 claim lines totaling \$17,079,923, the Plan disagrees that claims totaling \$12,239,017 were paid in error and agrees that claims totaling \$4,840,906 were paid in error. For the contested amount totaling \$12,239,017, the Plan disagrees that the contracted rate paid the VA is unreasonable and outside of the FEP contracting limits. The OIG appears to rely heavily on specifications in the FAM, Volume II, Chapter 12, page 25, which states "In processing . . . claims for services provided by non-preferred VA facilities, the local Plan should base its reimbursement on the lower of the VA's reasonable charge or the local Plan's allowance for preferred providers . . .". The claims at issue in the findings at hand are Illinois VA claims, and as noted above, the Plan is contracted with the Illinois VA. OIG has mistakenly applied the referenced FAM section and requirements of "lower of" reimbursement, which applies to NON-preferred VA facilities, to the contracted and preferred provider claims of the Illinois VA. Since the "lower of" payment is not applicable in this context, and per 38 CFR Chapter 17, section 101(a)(4) the Plan has the option of paying the VA's billed charges, the finding is erroneous and the finding and related recommendation should be stricken.

To the extent that OIG is attempting to substitute its judgment for the Plan's on the amount the Plan should pay its contracted provider, there is no authority under law or contract for such a position. There is no support for the finding that the payment of billed charges to the contracted Illinois VA is inappropriate as long as the amounts paid did not exceed the Federal Register reasonable charge rates that can be charged by the VA as determined by the Office of Management and Budget ("OMB"). According to the applicable regulations for VA providers, the VA is

authorized to set rates that it can bill for services that are paid by third party payors. 38 CFR 17.101. The preface to the applicable VA regulations notes that the rates to be charged by the VA are intended to be reasonable and are designed to replicate, as much as possible, the 80th percentile of the community charges for such services. 68 Fed. Reg. 56876 (October 2, 2003). The government cannot on one hand say that its VA provider rates are reasonable and simultaneously assert that the rates are unreasonable when the government itself is asked to pay such charges.

The finding of the Draft Report with respect to the VA's charge rates is therefore inconsistent with the U.S. government's own regulations that set the VA charges at a reasonable rate, and such findings and associated recommendations should be stricken.

Notwithstanding the preceding, the Plan identified a number of claims in which the amount billed by the VA providers exceeded the reasonable amount that the VA could charge based upon the applicable federal regulations. For claims totaling \$4,840,906, the Plan agrees that the difference in the payments that were made to the VA and the reasonable charge established in regulation constitute overpayments that should not have been charged to the FEP.

For 9,323 claim lines totaling \$8,626,632 in overpayments, the Plan disagrees that claims totaling \$2,163,326 were paid in error and agrees that claims totaling \$6,463,307 were paid in error. The Plan contests \$2,163,326 in claim payments as these charges are within the Plan's allowance and reflect the correct payments for the billed services. For the remaining questioned claims, the Plan did provide a pricing allowance to the FEP Express System and systematically placed the preferred provider network status code in the FEP Express Systems alternate network status field. During the scope of this audit the FEP Express System did not read the alternate network status field resulting in billed charges being used as the allowed amount. Enhancements were implemented by the FEP Operations Center in April of 2015 to ensure local Plan allowances are applied appropriately based on the alternate network status field.

For 4,191 claim lines, totaling \$2,961,039 in overpayments, the Plan disagrees with overpayments totaling \$2,769,320 and agrees that overpayments totaling \$191,719 were made. For contested claims totaling \$11,391 for the New Mexico Plan, the charges are within the Plan's allowance and reflect the correct payments for the billed services. For contested claims totaling \$2,757,929 paid by the Montana Plan, Montana does not have a Plan allowance for preferred providers that would be applicable to VA facilities. The Plan based its pricing for facility providers on the VA's Reasonable Charge which was submitted on the claim by the VA facility provider and payable consistent with 38 CFR Chapter 17. This pricing methodology is utilized by the Plan across all lines of business including FEP.

Also, the Plan also disagrees with OIG's methodology used to determine allowances. For the majority of the Montana Plan claims that were reviewed, OIG states that their methodology "utilized a designated discount percentage using PPO data". This percentage discount of price ranged from 46% to 54%. The Montana Plan does not have any PPO facility contracts with this type or amount of discount.

For the claims overpayments totaling \$191,719:

- \$163,823 in claim overpayments was the result of the New Mexico VA facilities billing in excess of the Plan's UCR allowances.
- \$27,896 in claim overpayments was the result of the Montana VA facilities billing in excess of the Federal Register reasonable charge rates as determined by OMB.

For 70 claim lines, totaling \$105,206 in overpayments, the Plan disagrees that \$57,292 was paid in error and agrees that \$47,915 was paid incorrectly. The Plan contests claims totaling \$57,292, as these charges are within the Plan's allowance and reflect the correct payments for the billed services.

The Plan has determined that the \$47,915 in claim overpayments occurred due to errors within the Plan. The Plan will conduct refresher training for all local Plan staff that performs these functions.

Where possible, recovery was initiated on the confirmed overpayments and the Plan will return all refunds received to the FEP Program.

## **Recommendation 2**

We recommend the contracting officer ensure the Plan is properly negotiating and/or contracting reasonable rates with VA providers on the behalf of the FEHBP.

## **Plan Response**

As stated in the response to recommendation 1 above, to the extent that OIG is attempting to substitute its judgment for the Plan's on the amount the Plan should pay its contracted provider, there is no authority under law or contract for such a position. There is no support for the finding that the payment of billed charges to the contracted Illinois VA is inappropriate as long as the amounts paid did not exceed the Federal Register reasonable charge rates that can be charged by the VA as determined by the Office of Management and Budget ("OMB"). According to the applicable regulations for VA providers, the VA is authorized to set rates that it can bill for services that are paid by third party payors. 38 CFR 17.101. The preface to the applicable VA regulations notes that the rates to be charged by the

VA are intended to be reasonable and are designed to replicate, as much as possible, the 80th percentile of the community charges for such services. 68 Fed. Reg. 56876 (October 2, 2003). The government cannot on one hand say that its VA provider rates are reasonable and simultaneously assert that the rates are unreasonable when the government itself is asked to pay such charges.

### **Recommendation 3**

We recommend the contracting officer ensure the Association instructs the FEP Operations Center to determine why the FEP Express System is overriding the local plans' preferred provider pricing allowances for VA claims.

### **BCBSA Response**

When the FEP Claims System was modified to apply VA pricing, Plans were notified that the system was unable to apply Plan local allowances unless the Plan submitted the VA claims with a PPO network status; however, the claim overpayments questioned during this audit were submitted with an alternate network status, resulting in the claim overpayments. Enhancements were made to the FEP Operations Center in April of 2015 to ensure local Plan allowances are applied appropriately based on either the alternate network status field or the PPO network status field. See Attachment 1 for current guidance on processing VA claims.

## **B. Retroactive Enrollment Review \$97,510**

### **Recommendation 4**

We recommend that the contracting officer disallow \$97,510 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

### **Plan Response:**

The Plan agrees that \$97,510 in claim overpayments resulting from retroactive enrollment terminations were made. Where possible the Plan initiated recovery and all funds recovered will be returned to the FEP Program.

### **Recommendation 5**

We recommend that the contracting officer require the Association to ensure on an ongoing basis that the Plan is identifying and properly returning claim payment errors identified on the FEP Operations Center daily retroactive reports.



## **BCBSA and Plan Response**

Retroactive Enrollment Reports are worked daily by the Plan. Effective September 27, 2014 memberships with a transaction code of 80 or 90 are systematically tracked by the FEP Express system and are populated on the Retroactive Enrollment Report on day 61 if the cancellation is still effective. This enhancement will help ensure that Plans appropriately and timely initiate recovery on retroactive enrollment activity.

### **C. Modifier ■ and ■ Review**

**\$35,393**

#### **Recommendation 6**

We recommend that the contracting officer disallow \$36,805 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

#### **Plan Response**

The Plan agrees to \$36,805 in claim overpayments. Where possible, recovery has been initiated and any refunds received will be returned to the FEP Program.

#### **Recommendation 7**

We recommend that the contracting officer allow the Plan to charge the FEHBP \$1,412 if additional payments are made to the providers to correct the underpayment errors. However, before making any additional payment(s) to the provider, the contracting officer should require the Plan to first recover any questioned overpayments from this provider.

#### **Plan Response**

The Plan agrees that \$1,412 in claim underpayments were made and will issue payment to the provider as appropriate.

#### **Recommendation 8**

We recommend that the contracting officer require the Plan to determine the cause of error for claims where the multiple procedure discounts were not properly applied, and implement corrective actions to prevent these types of errors from occurring in the future.

## **Plan Response**

The Plan determined that the cause of these errors was due to incorrect manual pricing by local Plan processors. The Plan will conduct refresher training for all local Plan staff that performs manual pricing functions by third quarter 2015.

## **Recommendation 9**

We recommend that the contracting officer require the Association to determine the reason why the Basic member's copay of \$150 was not applied when a [REDACTED] was billed and implement corrective actions to prevent these types of errors from occurring in the future.

## **BCBSA Response**

The claims related to this activity are currently under review and evaluation. Once BCBSA's review/evaluation is completed, appropriate corrective action will be developed and implemented.

## **D. System Pricing \$30,018**

### **Recommendation 10**

We recommend that the contracting officer disallow \$30,018 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

## **Plan Response**

The Plan agrees with \$30,018 in claim overpayments. The Plan has determined that the cause of these errors was due to incorrect manual pricing by local Plan processors. The Plan will conduct refresher training for all local Plan staff that performs manual pricing functions by third quarter 2015.

Where possible, the Plan initiated recovery on the identified overpayments and will return all refunds received to the FEP Program.

## **E. Debarred Provider \$14,959**

### **Recommendation 11**

We recommend that the contracting officer disallow \$14,959 for claim

overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

**Plan Response**

The Plan agrees to \$14,959 in claim overpayments. Where possible, the Plan initiated recovery on the identified overpayments and will return all refunds received to the FEP Program.

**Recommendation 12**

We recommend that the contracting officer ensure the debarred provider listing provided by OPM to the Association includes the NPI number during distribution to the BCBS Plans.

**BCBSA and Plan Response**

BCBSA and the Plan supports the recommendation to include the NPI on the debarred provider listing. This will prevent providers from bypassing the Plan's system edits.

F. **Modifier █ Review** **\$11,700**

**Recommendation 13**

We recommend that the contracting officer disallow \$11,700 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

**Plan Response**

The Plan agrees that \$11,700 in claim overpayments were made. The Plan has determined that the cause of these errors was due to incorrect manual pricing by local Plan processors. The Plan will conduct refresher training for all local Plan staff that performs manual pricing functions by third quarter 2015.

Where possible, recovery was initiated on the confirmed overpayments and the Plan will return all refunds received to the FEP Program.

## G. Non-Participating Provider Review

\$6,815

### **Recommendation 14**

We recommend that the contracting officer disallow \$6,815 for claim overcharges made to Indian Health Services Providers and verify that the Plan returns all amounts recovered to the FEHBP.

### **Plan Response**

The Plan contests overpayments totaling \$6,815. Section 125 of the Indian Health Care Improvement Reauthorization and Extension Act (IHCIREA), enacted through the ACA, completely revised and replaced Section 206 of the Indian Health Care Improvement Act (IHCA), 25 U.S.C. § 1621e, entitled “**REIMBURSEMENT FROM CERTAIN THIRD PARTIES OF COSTS OF HEALTH SERVICES**”. The applicable portion of this federal law reads as follows:

(a) Right of recovery - Except as provided in subsection (f), the United States, an Indian tribe, or tribal organization shall have the right to recover from an insurance company, health maintenance organization, employee benefit plan, third-party tortfeasor, or any other responsible or liable third party (including a political subdivision or local governmental entity of a State) the reasonable charges billed by the Secretary, an Indian tribe, or tribal organization in providing health services through the Service, an Indian tribe, or tribal organization, or, if higher, the highest amount the third party would pay for care and services furnished by providers other than governmental entities, to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive damages, reimbursement, or indemnification for such charges or expenses if (1) such services had been provided by a nongovernmental provider; and (2) such individual had been required to pay such charges or expenses and did pay such charges or expenses.

As a result, Plans are no longer required to pay the lower of the Plan’s allowance or the Indian Health Services Providers charges and amounts paid to the provider are correct.

### **Recommendation 15**

We recommend the contracting officer instruct the Plan to identify why the Plan’s local system is not properly pricing and paying IHS claims. Additionally, the Plan should perform a cost analysis to determine the impact of this system error and implement local system edits if determined necessary to prevent future overpayments.

## **BCBSA Response**

BCBSA contests this recommendation as the claims were paid correctly in accordance with Section 125 of the IHCIREA. FEP will enhance its guidance on payment of Indian Health Claims by December 31, 2015 to reflect the appropriate requirements.

### **H. Multiple Procedure Review \$5,979**

#### **Recommendation 16**

We recommend that the contracting officer disallow \$6,279 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

#### **Plan Response**

The Plan agrees to \$6,279 in claim overpayments and \$300 in claim underpayments. Where possible, recovery was initiated on the confirmed overpayments and the Plan will return all refunds received to the FEP Program.

The Plan determined that the cause of these errors was due to incorrect manual pricing by local Plan processors. The Plan will conduct refresher training for all local Plan staff that performs manual pricing functions by third quarter 2015.

#### **Recommendation 17**

We recommend that the contracting officer allow the Plan to charge the FEHBP \$300 if additional payments are made to the providers to correct the underpayment errors. However, before making any additional payment(s) to the provider, the contracting officer should require the Plan to first recover any questioned overpayments from this provider.

#### **Plan Response**

The Plan agrees to \$300 in claim underpayments and will issue payment to the provider as appropriate.

We appreciate the opportunity to provide our response to each of the findings in this report and request that our comments be included in their entirety and are made a part of the Final Audit Report. If you have any questions, please contact me at 202.942.1285 or Connie Woodard at 202.942.1159.

Sincerely,

[REDACTED]

Managing Director, Program Assurance



## **Report Fraud, Waste, and Mismanagement**

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

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

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

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

**-- 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 (<http://www.opm.gov/our-inspector-general>), 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.