



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

Final Audit Report

AUDIT OF GLOBAL COORDINATION OF BENEFITS FOR BLUECROSS AND BLUESHIELD PLANS

Report Number 1A-99-00-15-060

October 13, 2016

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EXECUTIVE SUMMARY

Audit of Global Coordination of Benefits

Report No. 1A-99-00-15-060

October 13, 2016

Why Did We Conduct the Audit?

The objectives of our audit were to determine whether the Blue Cross and Blue Shield (BCBS) plans charged costs to the Federal Employees Health Benefits Program (FEHBP) and provided services to the FEHBP members in accordance with the terms of the BCBS Association's contract with the U.S. Office of Personnel Management. Specifically, our objective was to determine whether the BCBS plans complied with contract provisions relative to coordination of benefits with Medicare.

What Did We Audit?

The Office of the Inspector General (OIG) has completed a limited scope performance audit of the FEHBP operations at all BCBS plans. The audit covered claim payments from October 1, 2014 through June 30, 2015, as reported in the BCBS Association's Government-wide Service Benefit Plan Annual Accounting Statements. Specifically, we reviewed claims incurred on or after September 15, 2014, that were reimbursed from October 1, 2014 through June 30, 2015, and were potentially not coordinated with Medicare (referred to as Coordination of Benefits or COB).



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*Assistant Inspector General
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What Did We Find?

This report questions \$6,401,840 in health benefit charges that were potentially not coordinated with Medicare.

For many years, we have had serious concerns with the BCBS plans' and Association's efforts to implement corrective actions to prevent COB claim payment errors. Our audits (performed annually since 2001) routinely show that retroactive adjustments and manual processing errors are the primary reasons for COB claim payment errors.

We do acknowledge that the Association has taken several steps to implement prior OIG audit recommendations to reduce COB errors. However, the results of this current audit do not indicate that these corrective actions have had a substantial impact in reducing the amount of COB payment errors. Considering the length of time that the Association has allowed these material errors to occur, the OIG does not believe that these erroneous claim payment errors were paid in good faith. Therefore, we recommend that the entire questioned amount be returned to the FEHBP regardless of the plans' ability to recover the funds from the providers.

ABBREVIATIONS

Association	Blue Cross Blue Shield Association
BCBS	Blue Cross Blue Shield
COB	Coordination of Benefits
FEHB	Federal Employees Health Benefits
FEHBP	Federal Employees Health Benefits Program
FEP	Federal Employee Program
FEP Express	Federal Employee Program Claims Processing System
OIG	Office of the Inspector General
OPM	U.S. Office of Personnel Management
Plan(s)	Blue Cross and Blue Shield Plan(s)

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I. BACKGROUND

This final audit report details the findings, conclusions, and recommendations resulting from our limited scope audit of the Federal Employees Health Benefits Program (FEHBP) operations at all Blue Cross and Blue Shield (BCBS) plans. The audit was performed by the U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as authorized by the Inspector General Act of 1978, as amended.

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

The Blue Cross Blue Shield Association (Association), on behalf of participating BCBS plans, has entered into a Government-wide Service Benefit Plan contract (CS 1039) with OPM to provide a health benefit plan authorized by the FEHB Act. 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 local BCBS plans participating in the FEHBP.

The Association has established a Federal Employee Program (FEP¹) Director's Office in Washington, D.C. to provide centralized management for the Service Benefit Plan. The FEP Director's Office coordinates the administration of the contract with the Association, member BCBS plans, and OPM.

The Association has also established an FEP Operations Center. The activities of the FEP Operations Center are performed by CareFirst BlueCross BlueShield, located in Washington, D.C. These activities include acting as fiscal intermediary between the Association and member plans, verifying subscriber eligibility, approving or disapproving the reimbursement of local plan payments of FEHBP claims (using computerized system edits), maintaining a history file of all FEHBP claims, and maintaining an accounting of all program funds.

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

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

Findings from our previous global coordination of benefits (COB) audit of all BCBS plans (Report No. 1A-99-00-14-046, dated July 29, 2015) for claims reimbursed from September 1, 2013 through May 31, 2014, are currently in the process of being resolved.

Our sample selections, instructions, and preliminary audit results of the potential coordination of benefit errors were presented to the Association in a draft report, dated September 28, 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. Also, additional documentation provided by the Association and BCBS plans on various dates through May 11, 2016, was considered in preparing our final report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The objectives of our audit were to determine whether the BCBS plans charged costs to the FEHBP and provided services to the FEHBP members in accordance with the terms of the contract. Specifically, our objective was to determine whether the plans complied with contract provisions relative to coordination of benefits with Medicare.

Scope

The audit covered health benefit payments from October 1, 2014 through June 30, 2015, as reported in the Blue Cross and Blue Shield Association's Government-wide Service Benefit Plan FEP Annual Accounting Statements. We performed a computer search on our claims data warehouse to identify all BCBS claims incurred on or after September 15, 2014, that were reimbursed from October 1, 2014 through June 30, 2015, and potentially were not coordinated with Medicare. This search identified 432,402 claim lines, totaling \$54,169,293 in payments that were potentially not coordinated with Medicare.

We separated the uncoordinated claims into six categories based on the clinical setting and whether Medicare Part A or Part B should have been the primary payer (See Exhibit I for the summary of our universe by Category).

- Categories A and B consist of inpatient claims that should have been coordinated with Medicare Part A. If the BCBS plans indicated that Medicare Part A benefits were exhausted, we reviewed the claims to determine whether there were any inpatient services that were payable by Medicare Part B.
- Categories C and D include inpatient claims with ancillary items that should have been coordinated with Medicare Part B. If the BCBS plans indicated that members had Medicare Part B only and priced the claims according to the Omnibus Budget Reconciliation Act of 1990 pricing guidelines, we reviewed the claims to determine whether there were any inpatient services that were payable by Medicare Part B.
- Categories E and F include outpatient facility and professional claims where Medicare Part B should have been the primary payer.

Exhibit I – Universe of Potentially Uncoordinated Claim Lines

Category	Patients	Claim Lines	Amount Paid
Category A: Medicare Part A Primary for Inpatient Facility	325	379	\$4,296,848
Category B: Medicare Part A Primary for Skilled Nursing/HHC/Hospice Care	1,077	3,589	\$1,376,309
Category C: Medicare Part B Primary for Certain Inpatient Facility Charges	55	75	\$1,396,644
Category D: Medicare Part B Primary for Skilled Nursing/HHC/Hospice Care	47	68	\$266,188
Category E: Medicare Part B Primary for Outpatient Facility and Professional	2,707	13,965	\$4,332,891
Category F: Medicare Part B Primary for Outpatient Facility and Professional (with processor manual override using code 'F')	133,753	414,326	\$42,500,413
Total	137,964	432,402	\$54,169,293

From this universe, we selected two separate samples of claims to review as part of this audit. The first sample was a *high dollar threshold sample*, and the second was a *statistical sample*. To test each BCBS plan’s compliance with the FEHBP health benefit provisions related to coordination of benefits with Medicare, we selected the following for review:

- For the *high dollar threshold* review, we selected claims from each category for a cumulative sample of 37,794 claim lines totaling \$19,814,881 in payments (see Exhibit II for the summary of our high-dollar review claim selections). *We did not* project the results of this particular review to the universe of claims paid for potentially uncoordinated claim lines.
- For the *statistical* review, we randomly selected 3,483 claim lines, totaling \$2,505,759 in payments, from Category F claims for patients with cumulative claim payments less than \$10,000. The results of this sample review were projected to the universe.

When we notified the Association of these potential errors on August 21, 2015, these claims were within the Medicare timely filing requirement and could be filed with Medicare for coordination of benefits.² Since the BCBS plans are required to initiate recovery efforts immediately for the actual COB errors, our expectation is for the plans to recover and return all of the actual COB errors to the FEHBP.

Methodology

The claims selected for review were submitted to each BCBS plan for their review and response. We then conducted a limited review of the plans’ “paid correctly” responses and an expanded review of the plans’ “paid incorrectly” responses. Specifically, we verified supporting documentation, the accuracy and completeness of the plans’ responses, determined if the claims

² Claims received by Medicare more than one calendar year after the dates of service could be denied by Medicare as being past the timely filing requirement.

were paid correctly, and/or calculated the appropriate questioned amounts for the claim payment errors. Additionally, we verified on a limited test basis if the BCBS plans had initiated recovery efforts, adjusted or voided the claims, and/or completed the recovery process by the audit request due date (i.e., November 13, 2015) for the claim payment errors in our sample.

The determination of the questioned amount is based on the FEHBP contract, the 2014 and 2015 Service Benefit Plan brochures, the Association's FEP Procedures Administrative Manual, and various manuals and other documents available from the Center for Medicare and Medicaid Services that explain Medicare benefits.

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 did not consider each BCBS plan's internal control structure in planning and conducting our auditing procedures. Our audit approach consisted mainly of substantive tests of transactions and not tests of controls. Therefore, we do not express an opinion on each BCBS plan's system of internal controls taken as a whole.

We also conducted tests to determine whether the BCBS plans had complied with the contract and the laws and regulations governing the FEHBP as they relate to coordination of benefits. The results of our tests indicate that, with respect to the items tested, the BCBS plans did not fully comply with the provisions of the contract relative to coordination of benefits with Medicare. Exceptions noted are explained in detail in the "Audit Findings and Recommendations" section of this audit report. With respect to the items not tested, nothing came to our attention that caused us to believe that the BCBS plans had not complied, in all material respects, with those provisions.

In conducting our audit, we relied to varying degrees on computer-generated data provided by the FEP Director's Office, the FEP Operation Center, and the BCBS plans. 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 potential coordination of benefits claim payment errors. The BCBS claims data is provided to us on a monthly basis by the FEP Operations Center, and after a series of internal steps, uploaded into our data warehouse. However, due to time constraints, we did not verify the reliability of the data generated by the BCBS plans' local claims systems. While utilizing the computer-generated data during our audit, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

Audit fieldwork was performed at our offices in Washington, D.C., Cranberry Township, Pennsylvania and Jacksonville, Florida through May 2016.

III. AUDIT FINDINGS AND RECOMMENDATIONS

The sections below detail the results of our 2015 global COB audit. The audit was done as two separate reviews – a review of claims over a high dollar threshold and a review of a statistical sample of claims.

A. High Dollar Threshold Review \$2,986,416

As mentioned in the Scope section above, our universe consisted of 432,402 claim lines, totaling \$54,169,293 in payments that potentially were not coordinated with Medicare. Our first review from this universe included claims above various high dollar thresholds for each category. See Exhibit II for a summary of our sample selection methodologies and claims reviewed by category.

Exhibit II – Summary of Claim Lines Reviewed

Category	Sample Selection Methodology	Claim Lines	Amounts Paid	Potential Overcharges
Category A	All patients selected (325 patients)	379	\$4,296,848	\$4,296,848
Category B	All patients selected (1,077 patients)	3,589	\$1,376,309	\$1,376,309
Category C	All patients selected (55 patients)	75	\$1,396,644	\$349,161
Category D	All patients selected (47 patients)	68	\$266,188	\$66,547
Category E	Patients with cumulative claim lines of \$500 or more (1,224 patients)	10,528	\$4,149,532	\$3,319,626
Category F	Patients with cumulative claim lines of \$10,000 or more (283 patients)	23,155	\$8,329,360	\$6,663,488
Total		37,794	\$19,814,881	\$16,071,979

In general, if we could not reasonably determine the actual overcharge for a claim, we determined the overpayment amount accordingly:

- Category A and B - Medicare Part A pays all covered costs (except for deductibles and coinsurance) for inpatient care in hospitals, skilled nursing facilities and hospice care. We calculated the overcharges by reducing the questioned amount using the applicable Medicare deductible and/or copayment.
- Category C and D - Medicare Part B covers a portion of inpatient facility charges for ancillary services such as medical supplies, diagnostic tests, and clinical laboratory services. Based on our experience, ancillary items account for approximately 30 percent of the total inpatient claim payment. We estimated that the FEHBP was overcharged 25 percent for these inpatient claim lines ($0.30 \times 0.80 = 0.24 \sim 25$ percent).

- Category E and F - Medicare Part B pays 80 percent of most outpatient charges and professional claims after the calendar year deductible has been met. We questioned 80 percent of the amount paid for these claim lines.

These 37,794 claim lines, totaling \$19,814,881 in payments, were reviewed to determine whether the BCBS plans complied with contract provisions relative to COB with Medicare. Our review determined that the plans incorrectly paid 5,070 claim lines, totaling \$3,928,905 in payments. We estimate that the FEHBP was overcharged \$2,986,416 for these claim line payments. See Exhibit III for a summary of the questioned costs by category.

Exhibit III – Summary of Questioned Costs by Category

Category	Claim Lines	Amount Paid	Amount Questioned
Category A	77	\$901,535	\$901,535
Category B	1,031	\$368,587	\$368,587
Category C	28	\$705,485	\$176,371
Category D	25	\$92,006	\$23,002
Category E	2,826	\$1,042,297	\$833,889
Category F	1,083	\$818,995	\$683,032
Total	5,070	\$3,928,905	<u>\$2,986,416</u>

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

- For 2,782 of the claim lines questioned, the BCBS plans failed to review and/or adjust the patient’s prior paid claim(s) when the member’s Medicare information was subsequently added to the FEP Express Claims Processing System (FEP Express). We estimate that the FEHBP was overcharged \$1,420,442 for these COB errors.
- For 925 of the claim lines questioned, the BCBS plans incorrectly paid these claims due to processor errors. In most cases, there was special information present in FEP Express to identify Medicare as the primary payer when these claims were paid. However, a Medicare Payment Disposition Code was incorrectly used to override the system’s automatic deferral of these claims. The Medicare Payment Disposition Code designates Medicare’s responsibility for payment on each charge line of a claim. According to the BCBS Administrative Procedures Manual, the completion of this field is required on all claims for patients who are age 65 or older. We estimate that the FEHBP was overcharged \$1,068,291 for these COB errors.

- For 835 of the claim lines questioned, the BCBS plans incorrectly paid these claims because either the plans’ local claims processing system or FEP Express did not appropriately defer the claims for Medicare COB review. We estimate that the FEHBP was overcharged \$337,414 for these COB errors.

- For 180 of the claim lines questioned, the BCBS plans incorrectly paid these claims due to provider billing errors. We estimate that the FEHBP was overcharged \$93,507 for these COB errors.

Exhibit IV – Questioned Cost by Cause of Error

Cause of Error	Claim Lines	Amount Paid	Amount Questioned
Retroactive Changes	2,782	\$2,000,821	\$1,420,442
Manual Processing	925	\$1,237,740	\$1,068,291
System Processing	835	\$476,516	\$337,414
Provider Billing	180	\$117,144	\$93,507
Non-COB Errors	348	\$96,684	\$66,762
Total	5,070	\$3,928,905	\$2,986,416

- For 348 of the claim lines questioned, the overpayments were not COB-related errors but were processed and paid incorrectly by the plans. We estimate that the FEHBP was overcharged \$66,762.

Procedural Issue

For many years, we have had serious concerns with the BCBS plans’ and Association’s efforts to implement corrective actions to prevent COB claim payment errors. Our audits (performed annually since 2001) routinely show that retroactive adjustments and manual processing errors are the primary reasons for COB claim payment errors. Due to the nature of the COB process, we recognize that some COB errors will occur; however, we continue to identify material errors year after year. We do acknowledge that the Association has taken several steps to implement prior OIG audit recommendations to reduce COB errors. However, the results of this current audit do not indicate that these corrective actions have had a substantial impact in reducing the amount of COB payment errors. Considering the length of time that these material errors occurred after the issue had been brought to the Association’s attention, the OIG does not believe that these erroneous claim payment errors were paid in good faith. Therefore, we recommend that the entire questioned amount be returned to the FEHBP regardless of the plans’ ability to recover the funds from the providers. The contracting officer should also continue monitoring the Association’s ongoing system enhancements and efforts to reduce COB errors.

The following criteria were used to support our questioning of these claim payments:

- Contract CS 1039, Part III, section 2.3 (8)(i) states, “The Carrier may charge the contract for benefit payments made erroneously but in good faith”

- Contract CS 1039, Part II, section 2.6 states, “(a) The Carrier shall coordinate the payment of benefits under this contract with the payment of benefits under Medicare . . . (b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary carrier” Also, Part III, section 3.2 (b)(1) states, “The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable . . . [and] on request, document and make available accounting support for the cost to justify that the cost is actual, reasonable and necessary. . . .”
- Contract CS 1039, Part II, section 2.3(g) states, “If the Carrier [or OPM] determines that a Member’s claim has been paid in error for any reason . . . the Carrier shall make a prompt and diligent effort to recover the erroneous payment . . . until the debt is paid in full or determined to be uncollectible by the Carrier because it is no longer cost effective to pursue further collection efforts or it would be against equity and good conscience to continue collection efforts”
- Contract CS 1039, Part III, section 3.16(b) states, “Claim payment findings (i.e., claim overpayments) in the scope of an OIG audit are reportable as questioned charges unless the Carrier provides documentation supporting that these findings were already identified (i.e., documentation that the plan initiated recovery efforts) prior to audit notification and corrected (i.e., claims were adjusted and/or voided and overpayments were recovered and returned to the FEHBP) by the original due date of the draft report response.”
- The 2015 Blue Cross and Blue Shield Service Benefit Plan brochure, page 142, Primary Payer Chart, illustrates when Medicare is the primary payer. In addition, page 144 of that brochure states, “We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), regardless of whether Medicare pays.”

Association Response:

In response to the draft audit report, which questioned \$16,071,978 in potential overpayments, the Association stated that the BCBS plans agreed that claim payments totaling \$3,039,121 were paid in error. From this amount, the plans reported that they initiated the recovery on claim payments totaling \$1,109,604 prior to receiving the OIG audit notification letter, but did not complete the recovery process prior to the date that plans’ response to the draft audit report was due. In addition, the recovery of \$6,602 of claim payments was initiated after the OIG audit notification letter but before the receipt of the actual potential claim overpayments listing.

Of the remaining \$13,032,857, the plans stated that \$10,459,110 in claim payments were paid correctly and that \$2,573,747 in claim payment errors were identified and returned to the FEHBP before the OIG Audit Notification letter.

Regarding corrective actions, the Association indicated that to improve COB claims processing and to timely detect and prevent claim payment errors the Association has implemented and updated the following:

- *“Modified the FEP claims system to accept the Medicare denial reason code from Plans for Medicare Crossover claims.*
- *Enhanced the FEP Claims Audit Monitoring Tool (CAMT) to include all retroactive enrollment notices processed (including Medicare) so that Plan processing can be monitored and Plans contacted if they do not appear to be addressing the Medicare retro notices.*
- *Implemented a new claim deferral in 3rd quarter 2015 to defer claims for review when Medicare denial information is not received on a claim.*
- *Implemented a new claim deferral effective January 1, 2016 that will defer claims where certain Medicare deferral reason codes are included on the claim.*
- *Implemented a new audit of Plans’ timely and accurate completion of Medicare retroactive enrollment notices in 4th quarter 2015.*
- *Implemented a new deferral effective January 1, 2016 that will defer claims that include GY modifiers where the procedure code is not a statutory Medicare exclusion for additional review and support from the Provider as to why the GY modifier was used on the claim.*
- *BCBSA [Association] will also identify additional opportunities to implement new Medicare deferrals in the FEP claims system in 2016.”*

OIG Comments:

The Association’s response and supporting documentation provided indicate that the BCBS plans acknowledged that \$2,986,416 in claim overpayments were made during the scope of our audit. If claim overpayments were identified by the BCBS plans before our audit notification date (i.e., August 6, 2015) and adjusted or voided by the draft report response due date (i.e., November 13, 2015), we did not consider these as claim payment errors in the final report.

Acknowledged Claim Overpayments

The \$2,986,416 of acknowledged claim overpayments is comprised of the following:

- \$2,281,844 represents claim overpayments for which the BCBS plans have committed to pursue recovery; and
- \$704,572 represents claim overpayments for which the BCBS plans state the recovery efforts have been exhausted; however, we continue to question these costs because they have not provided documentation supporting that all recovery efforts have been exhausted.

As previously cited from CS 1039, the Carrier may charge the contract for benefit payments made erroneously but in good faith. However, we do not agree that these claim payment errors were made in good faith, and therefore we recommend that the entire questioned amount be returned to the FEHBP regardless of the plans’ ability to recover the funds from the providers.

Recommendation 1

We recommend that the contracting officer disallow \$2,986,416 for claim overpayments and verify that the BCBS plans return all amounts recovered to the FEHBP, regardless of the plans’ ability to recover the claim payments from providers.

Recommendation 2

We recommend that the contracting officer continue to monitor any enhancements or updates that the Association implements in FEP Express to help reduce COB errors.

B. Statistical Sample Review \$3,415,424

As mentioned in the Scope section above, our second review from the universe of claims was a statistical sample of Category F claims for patients with cumulative claim payments less than \$10,000. See Exhibit V for our population universe for the statistical sample.

Exhibit V – Total Population for Statistical Sample

Category F Claims	Claim Lines	Amount Paid
Patients with cumulative payments less than \$10,000	391,171	\$34,171,154

From this population we stratified all claim lines into seven categories based on the amount paid, then reviewed the following:

- 1) We reviewed all claim lines in strata “0” (i.e., claim line payments between \$5,000 and \$10,000), since this additional tier was determined to have minimal effect on the precision when projecting the results of our statistical review.

- 2) For purposes of sample size determination, we assumed the “mean-per-unit” (MPU) estimator for claim lines in strata “1” through “6”. Specifically, using claim error rates from a prior audit³, we determined the sample size necessary to achieve a margin of error on a 95 percent confidence interval that is no greater than 4 percent. This was done independently within each of the six strata. With the intent of projecting the results of the sample to the population, we used automated software to generate a random sample from each strata.

These criteria yielded a sample to review of 3,483 claim lines totaling \$2,505,759 in payments. See Exhibit VI for the total population and sample size by strata.

Exhibit VI – Total Population and Sample Results by Strata

Strata No.	Amount Paid Tier	Total Population		Samples for Review	
		Claim Lines	Amounts Paid	Claim Lines	Amounts Paid
0	\$5,000 - \$9,999.99	57	\$360,386	57	\$360,386
1	\$0 - \$49.99	240,611	\$5,870,628	715	\$17,193
2	\$50 - \$199.99	118,741	\$11,794,321	910	\$91,340
3	\$200 - \$499.99	22,492	\$6,773,834	603	\$182,571
4	\$500 - \$999.99	6,609	\$4,548,842	406	\$272,993
5	\$1,000 - \$2,499.99	2,178	\$3,101,692	562	\$788,381
6	\$2,500 - \$4,999.99	483	\$1,721,451	230	\$792,895
TOTAL		391,171	\$34,171,154	3,483	\$2,505,759

Of the 3,483 claim lines reviewed, we determined that the BCBS plans incorrectly paid 329 claim lines, resulting in overcharges of \$281,195 to the FEHBP. See Exhibit VII for a summary of overpayments by strata.

1) Strata “0”

Our review determined the BCBS plans incorrectly paid 11 claim lines, totaling \$54,338 in overcharges to the FEHBP, and this amount is questioned in this finding.

³ Per results of Global Coordination of Benefits for Blue Cross Blue Shield (BCBS) Plans (report number 1A-99-00-14-046), we applied error rates of 14%, 25%, 23%, 19%, 31%, 18% for strata “1” through “6”, respectively.

2) Strata “1” through “6”

For these strata we identified 318 claim lines, totaling \$226,857 in overcharges to the FEHBP. We used automated software to project these sample results to the population using the ratio estimator method.⁴ With a relative precision point of 1.06, we determined the ratio estimator to be the most precise estimator for determining the projection results. Based on our review, we are 95 percent confident that the true value of claims that paid incorrectly, for the population⁵ of strata “1” through “6”, is between \$3,038,450 and \$3,683,722. **Our best estimate of the true value, the projection estimate, is \$3,361,086, and this projected amount is questioned in this finding.** See Exhibit VIII for a summary of the results of this statistical review.

Exhibit VII – Strata Summary

Overpayments by Strata		
Strata	Claim Lines	Overpaid Amounts
0	11	\$54,338
1 – 6	318	\$226,857
TOTAL	329	\$281,195

Exhibit VIII – Ratio Estimator

Ratio Estimator	
Total Population - Amount Paid	\$33,810,768
Samples Reviewed - Paid in Error	\$226,857
Total Estimate (Projection)	\$3,361,086
Margin of Error	+/- \$322,636
Relative Precision	1.06 %
High Point	\$3,683,722
Low Point	\$3,038,450

In summary, our review determined that the FEHBP was overcharged a total of \$3,415,424 for Category F claims for patients with cumulative claim payments less than \$10,000. See Exhibit IX for a summary of total questioned overcharges by strata.

Exhibit IX – Questioned Overcharges by Strata

Total Questioned Overcharges			
Strata	“0”	“1 – 6”	“0 – 6”
Overcharges	\$54,338	\$3,361,086	\$3,415,424

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

⁵ Our population that was used to project the results of our review represented 3,426 claim lines, totaling \$2,145,373 in payments.

As previously cited from CS 1039, the Carrier shall make prompt and diligent recovery efforts when claim payment errors have been determined. Also, the Carrier may charge the contract for benefit payments made erroneously but in good faith.

Association's Response:

“BCBSA [Association] contests the OIG projected overpayment of \$3,134,229 and agrees to overpayments totaling \$281,195. Based upon an analysis of the OIG’s sampling and estimating methodology, BCBSA [Association] determined that:

- *The sampling methodology is biased toward higher dollar claims.*
- *The distribution of the amount paid for the universe appears to be heavily biased to the lower dollar end of the strata and does not appear to be consistent with the distribution of the sample audited by the Plans.*
- *The error estimate appears to assume consistency across the universe; however, the claims are for different amounts, procedure codes, denial reasons and processed by different claim processing systems.*
- *The actual errors agreed to by Plans appear to be primarily due to two error reasons, representing 58% of the identified errors; however not all the Plans had errors, nor did all the sites have the error reasons representing 58% of the errors.*
- *The sampling approach doesn’t appear to result in a sample representative of the Universe and results in an estimated error amount that is biased towards hi-dollar claims, thus inflating the estimated error amount.*

As a result, the use of a projection to determine an appropriate error amount is inaccurate and does not result in a true error amount and therefore should not be used in the OIG audit process.”

OIG Comments:

The sampling approach we used during this audit represents a valid statistical sampling methodology and is consistent with industry standards for determining dollar impact amounts (i.e., overpayments). Additionally, the sample cannot be considered biased because weights were calculated and applied to each claim amount paid prior to the sampling selection process. Mathematical weighting is a standard approach to ensure all factors of sampling are kept in balance. If this technique had not been applied, only then could we agree that the sample was biased.

With regards to the details of the sampling and estimating methodology questioned by the Association above, we will directly address each specific element:

The sampling methodology used for our statistical review was purely a stratified random sample and was calculated using statistical software.

- The sampling methodology used for our review was purely a stratified random sample; therefore, it could not be deemed biased towards any certain claim, regardless of the amount paid. Stratifying the data prior to selecting our samples was done to capture and apply weights based on the entire universe of data. After the weights were calculated, an appropriate sample size was calculated to achieve a margin of error on a 95 percent confidence interval to be no greater than 4 percent, and then a random sample was pulled from each strata. A random sample draws from a population in such a way that each item in the population has an equal opportunity to be selected.
- The error estimates are purposely meant to be based on dollar amounts and claim overpayments which are consistent characteristics for every unit selected within the population. Specific characteristics, such as procedure codes, denial codes, error reasons, and plan sites are variable characteristics for each unit within the universe and would result in a biased error estimate. The error estimates were consistently designed for this sampling approach and ultimately compensate for variable characteristics identified in the random sample review.

As stated above, the OIG does not believe these claim payment errors were paid in good faith since the errors continue to occur year after year. Therefore, we recommend that the entire questioned amount be returned to the FEHBP regardless of the plans' ability to recover the funds from the providers.

Recommendation 3

We recommend that the contracting officer disallow \$3,415,424 for claims that were not paid in good faith and unreasonably charged to the FEHBP, and verify that the BCBS plans return all amounts recovered to the FEHBP, regardless of the plans' ability to recover the claim payments from providers.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Information Systems Audits Group

██████████, Auditor-in-Charge

██████████, Lead Auditor

██████████, Senior Team Leader

██████████, Group Chief

APPENDIX A



BlueCross BlueShield Association

An Association of Independent
Blue Cross and Blue Shield Plans

Federal Employee Program
1310 G. Street, NW
Washington, DC 20005
202.942.1000
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November 25, 2015

██████████, Lead Auditor
Information Systems Audit Group
Office of the Inspector General
U.S. Office of Personnel Management
800 Cranberry Woods Drive, Suite 130
Cranberry Township, PA 16066

**Reference: OPM DRAFT AUDIT REPORT
Tier XV Global Coordination of Benefits
Audit Report #1A-99-00-15-060**

Dear ██████████:

This is in response to the above – referenced U.S. Office of Personnel Management (OPM) Draft Audit Report concerning the Global Coordination of Benefits Audit for claims paid from October 1, 2015 thru June 30, 2015. Our comments concerning the findings in the report are as follows:

Recommendation 1:

Coordination of Benefits with Medicare Questioned Amount \$16,071,978

The OPM OIG submitted their sample of potential Medicare Coordination of Benefits errors to the Blue Cross Blue Shield Association (BCBSA) on August 21, 2015. The BCBS Association and/or the BCBS Plans were requested to review these potential errors and provide responses by November 25, 2015. These listings included claims incurred on or after September 15, 2014 that were reimbursed from October 1, 2014 through June 30, 2015 and potentially not coordinated with Medicare. OPM OIG identified 432,402 claim lines, totaling \$54,169,293 in payments, which potentially were not coordinated with Medicare. From this universe, OPM OIG selected for review a sample of 37,794 claim lines, totaling \$19,814,880 in payments with a potential overpayment of \$16,071,978 to the Federal Employee Health Benefit Program (FEHBP).

The OIG recommended that the contracting officer disallow \$16,071,978 for uncoordinated claim line payments and have the BCBS plans return all amounts recovered to the FEHBP.

Report No. 1A-99-00-15-060

BCBSA Response

After reviewing the OIG listing of potentially uncoordinated Medicare COB claims totaling \$16,071,978, BCBS Plans responded that claim payments totaling \$3,039,121 were paid in error. BCBS Plans also responded that of the \$3,039,121 amount in claim payment errors, recovery was initiated on claim overpayments totaling \$1,109,604 before the OIG Audit Notification Letter was received; however, the recovery process had not been completed when the Plans' response was due to the OIG. Recovery on claims totaling \$6,602 was initiated after the Audit Notification letter but before the actual listing of potential claim overpayments was received.

For the remaining \$13,032,857 in potential claim payment errors questioned, Plans reported that:

- \$10,459,111 in claim payments were paid correctly.
- \$ 2,573,747 in claim payment errors were identified and returned to the Program before the OIG Audit Notification letter.

Where possible, the Plans will continue to pursue the remaining overpayments as required by CS 1039, Section 2.3(g) (l).

Recommendation 2

Although the Association has developed corrective action plan to reduce COB findings, we recommend that the contracting officer instruct the Association to ensure that all BCBS plans are following the corrective action plan. We also recommend that the contracting officer ensure that the Association's corrective actions for improving the prevention and detection of uncoordinated claim payments are being implemented.

BCBSA Response


As noted by the OIG, in order to continue to improve Medicare claims processing, and prevent Medicare claim payment errors and timely detect Medicare payment errors, BCBSA initiated/completed the following:

- Modified the FEP claims system to accept the Medicare denial reason code from Plans for Medicare Crossover claims.
- Enhanced the FEP Claims Audit Monitoring Tool (CAMT) to include all retroactive enrollment notices processed (including Medicare) so that Plan processing can be monitored and Plans contacted if they do not appear to be addressing the Medicare retro notices.
- Implemented a new claim deferral in 3rd quarter 2015 to defer claims for review when Medicare denial information is not received on a claim.
- Implemented a new claim deferral effective January 1, 2016 that will defer claims where certain Medicare deferral reason codes are included on the claim.

- Implemented a new audit of Plans' timely and accurate completion of Medicare retroactive enrollment notices in 4th quarter 2015.
- Implemented a new deferral effective January 1, 2016 that will defer claims that include GY modifiers where the procedure code is not a statutory Medicare exclusion for additional review and support from the Provider as to why the GY modifier was used on the claim.
- BCBSA will also identify additional opportunities to implement new Medicare deferrals in the FEP claims system in 2016.

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

Sincerely,


Senior Program Manager
FEP Program Assurance

Attachment

APPENDIX B

Response to **Audit Inquiry Global COB Tier 15**
Wednesday, May 11, 2016

Audit Inquiry 1 Response

BCBSA contests the OIG projected overpayment amount of \$3,134,229 and agrees to overpayments totaling \$281,195. Based upon an analysis of the OIG's sampling and estimating methodology, BCBSA determined that:

- The sampling methodology is biased toward higher dollar claims.
- The distribution of the amount paid for the universe appears to be heavily biased to the lower dollar end of the strata and does not appear to be consistent with the distribution of the sample audited by the Plans.
- The error estimate appears to assume consistency across the universe; however, the claims are for different amounts, procedure codes, denial reasons and processed by different claim processing systems.
- The actual errors agreed to by Plans appear to be primarily due to two error reasons, representing 58% of the identified errors; however not all the Plans had errors, nor did all the sites have the error reasons representing 58% of the errors.
- The sampling approach doesn't appear to result in a sample representative of the Universe and results in an estimated error amount that is biased towards hi-dollar claims, thus inflating the estimated error amount.

As a result, the use of a projection to determine an appropriate error amount is inaccurate and does not result in a true error amount and therefore should not be used in the OIG audit process.

Approved by:


Managing Director, FEP Program Assurance



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Room 6400
Washington, DC 20415-1100

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