U.S. Office of Personnel Management

Office of the Inspector General

Office of Audits

Final Audit Report

Audit of Claims Processing and Payment Operations at Blue Cross and Blue Shield of North Carolina for Contract Years 2018 through 2020

Report Number 2022-CAAG-0023
March 3, 2023

Executive Summary

Audit of Claims Processing and Payment Operations at
Blue Cross and Blue Shield of North Carolina for Contract Years 2018 through 2020

Report No. 2022-CAAG-0023 **March 3, 2023**

Why Did We Conduct the Audit?

The objective of our audit was to determine whether the health benefit costs charged to the Federal Employees Health Benefits Program (FEHBP) and services provided to its members by Blue Cross and Blue Shield of North Carolina (Plan) (plan codes 10, 11, and 13) were in accordance with the terms of the Blue Cross and Blue Shield Association's contract with the U.S. Office of Personnel Management.

What Did We Audit?

The Office of the Inspector General has completed a performance audit of the FEHBP claim operations at the Plan. Specifically, we performed various claim reviews to determine if the internal controls over the claims processing system were sufficient to ensure that claims were properly processed and paid by the Plan. Our audit work was remotely conducted by staff in the Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida areas.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

For the areas reviewed, our audit identified 5,102 claims paid incorrectly resulting in estimated overcharges of $1,948,361 to the FEHBP. The claim payment errors identified indicate a need to strengthen procedures and controls related to:

- Assistant Surgeon Procedure Code Modifiers; and
- Duplicate claim payments.

While we identified a large dollar finding related to a system error, based on our review we do not feel it is a significant matter involving the Association's and Plan's internal control structures and operations. The overall questioned amount represents 0.08 percent of the total health benefit charges during the scope of the audit. Additionally, for both errors identified, the Association is working on instituting corrective actions with the Plan and recovery efforts are in progress. Therefore, we feel that the Association's and Plan's internal controls over their claims processing systems were generally effective in ensuring that health care claims were properly processed and paid.

Abbreviations

5 CFR 980	**Title 5, Code of Federal Regulations, Chapter 1, Part 890**
Act	**Federal Employees Health Benefits Act**
Association	**Blue Cross and Blue Shield Association**
BCBS	**Blue Cross and Blue Shield**
CFR	**Code of Federal Regulations**
Contract	**Contract CS 1039 – The contract between the Blue Cross and Blue Shield Association and the U.S. Office of Personnel Management**
FEHBP	**Federal Employees Health Benefits Program**
FEP	**Federal Employee Program**
FEP Direct	**The Association's Nation-wide Claims Processing System**
HI	**OPM's Office of Healthcare and Insurance**
OIG	**The Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
Plan	**Blue Cross and Blue Shield of North Carolina**
POS	**Place of Service**
SBP	**Service Benefit Plan**

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Report Fraud, Waste, and Mismanagement

I. Background

This final report details the results of our performance audit of the Federal Employees Health Benefits Program (FEHBP) claims processing and payment operations at Blue Cross and Blue Shield of North Carolina (Plan) (plan codes 10, 11, and 13) for contract years 2018 through 2020. The audit was remotely conducted in the Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida areas.

The audit was conducted pursuant to the provisions of contract CS 1039 (Contract) between the U.S. Office of Personnel Management (OPM) and the Blue Cross and Blue Shield Association (Association); Title 5, United States Code, Chapter 89; and Title 5, Code of Federal Regulations (CFR), Chapter 1, Part 890 (5 CFR 890). The audit was performed by OPM's 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 Act (Act), Public Law 86-382, enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for Federal employees, annuitants, and dependents. OPM's Office of Healthcare and Insurance (HI) has overall responsibility for administration of the FEHBP, including the publication of program regulations and agency guidance. As part of its administrative responsibilities, the HI contracts with various health insurance carriers that provide service benefits, indemnity benefits, and/or comprehensive medical services. The provisions of the Act are implemented by OPM through regulations codified in 5 CFR 890.

The Association, on behalf of participating Blue Cross and Blue Sheild (BCBS) plans, has entered into a Government-wide Service Benefit Plan (SBP) contract with OPM to provide a health benefit plan authorized by the Act. The Association delegates authority to participating local BCBS plans throughout the United States to process the health benefit claims of its Federal subscribers.

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

The Association has also established an FEP Operations Center. CareFirst BCBS, located in Owings Mills, Maryland, performs the activities of the FEP Operations Center. These activities include acting as fiscal intermediary between the Association and its member BCBS plans, verifying subscriber eligibility, approving or denying 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.

Compliance with laws and regulations applicable to the FEHBP, as well as the terms and conditions of the Contract, is the responsibility of the Association and management at the Plan. In addition, the Plan is responsible for establishing and maintaining a system of internal controls.

The most recent audit report issued that covered claim payments for the Plan was report number 1A-10-33-15-009, dated November 10, 2016, which covered claim payments for contract years 2011 through 2014. All findings related to that report have been closed.

The results of our audit were discussed with Association and Plan officials throughout the audit, including the issuance of two Notices of Findings and Recommendations, and at an exit conference on August 4, 2022. We issued a draft report, dated August 31, 2022, to solicit the Association's comments to the findings and recommendations. The Association's comments offered in response to the draft report were considered in preparing our final report and are included as an appendix to this report. Additional documentation provided by the Association on various dates through October 20, 2022, was also considered in preparing our final report.

II. Objective, Scope, and Methodology

Objective

The objective of our audit was to determine if the health benefit costs charged to the FEHBP and the services provided to FEHBP members were in accordance with the terms of the Contract.

Scope and Methodology

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

This performance audit included the following reviews for contract years 2018 through 2020:

a) **Procedure Code Modifier Review** – To determine if the Plan is properly applying reductions to its Plan allowances for all procedure code modifiers which require them when pricing FEHBP Claims.

b) **Duplicate Claims Review** – To determine if the Plan's processes in place for duplicate claim payments are adequate to ensure that duplicate claims are identified before payment and those that are paid are identified and recovery is started.

c) **Place of Service Review** – To determine if claims were paid accurately in accordance with the provider contract with the Plan and with the SBP brochure.

d) **Unlisted Procedure Codes** – To determine if the Plan followed its internal processes for reviewing clams with unlisted or miscellaneous procedure codes and that the appropriate Plan allowance is applied to the claims.

Due to the COVID-19 pandemic, we were unable to conduct site visits during the audit. Consequently, all audit fieldwork was remotely conducted by staff in the Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida areas from April 2022 through August 2022.

We reviewed the Association's annual accounting statements for contract years 2018 through 2020 as they relate to the Plan and determined that it paid approximately $2.5 billion in health benefit payments.

In planning and conducting our audit, we obtained an understanding of both the Association's and Plan's internal control structures to help determine the nature, timing, and extent of our auditing procedures. Our audit approach consisted mainly of substantive tests of transactions and not tests of controls. While we identified a large dollar finding related to a system error, based on our review we do not feel it is a significant matter involving the Association's and

Plan's internal control structures and operations as the error was identified and corrected during our audit and because recoveries are now initiated. Additionally, the overall questioned amount represents 0.08 percent of the total health benefit charges during the scope of the audit. Finally, for both errors identified, the Association is working on instituting corrective actions with the Plan and recovery efforts are in progress. Therefore, we feel that the Association's and Plan's internal controls over their claims processing systems were generally effective in ensuring that health care claims were properly processed and paid. However, since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on the Association's or the Plan's systems of internal controls taken as a whole.

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

In conducting our audit, we relied to varying degrees on computer-generated data provided by the FEP Director's Office, the FEP Operations Center, the Association, and the Plan. Through the performance of audits and an in-house claims data reconciliation process, we have verified the reliability of the BCBS claims data in our data warehouse, which was used to identify areas to test and to select our samples. The BCBS claims data is provided to the OPM OIG on a monthly basis by the FEP Operations Center, and after a series of internal steps, uploaded into our data warehouse. 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.

We selected various samples of claims or claim lines to determine whether the Plan complied with the Contract's provisions relative to health benefit payments. We utilized SAS software to judgmentally select all samples reviewed.

The following specific reviews were conducted during our audit (unless otherwise stated, the samples cover the full scope of the audit, contract years 2018 through 2020):

1. **Procedure Code Modifier Review** – We identified a universe of 33,573 claim lines with procedure code modifiers of 50, 51, 62, 80, 81, 82, and AS (with total amounts paid of $21,427,374). From this universe we judgmentally selected five claims with the highest amounts paid from each procedure code modifier for review. This resulted in a sample of 35 claim lines with amounts paid totaling $557,745.

2. **Duplicate Claim Payments Review** – As part of our review, we categorized separate potential duplicate claim payments into three categories – "best matches," "near

matches," and "inpatient facility matches." The universe of potential duplicate claim groups was derived from the following search criteria:

- Our "best match" logic identifies and groups unique claim numbers that contain most of the same claim data, including patient code, procedure code, diagnosis code, and sex code.
- Our "near match" logic identifies and groups unique claim numbers that contain most of the same claim data, except for patient code, procedure code, diagnosis code, or sex code.
- Our "inpatient facility match" search criteria identified duplicate or overlapping dates of service.

From the period August 1, 2019, through December 31, 2020, for each of the duplicate claim groups we identified the following universes with potential overpayments of $1,000 or more:

Universe of Duplicate Claim Payments Identified

Group/ Overpayment	Best Matches	Near Matches	Inpatient Facility Matches	Total
Duplicate Groups	42	49	4	95
Potential Overpayments	$120,750	$98,751	$25,151	$244,652

From these universes, we judgmentally selected all duplicate groups from each group with potential duplicate payments totaling $2,500 or greater. (See the table below for a summary of the total samples selected.)

Duplicate Claim Payment Samples Selected

Group/ Overpayment	Best Matches	Near Matches	Inpatient Facility Matches	Total
Duplicate Groups	17	11	2	30
Potential Overpayments	$80,531	$42,739	$22,473	$145,743

3. **Place of Service (POS) Review** – We identified all claims where the FEHBP paid as the primary insurer and the claim was not subject to the Omnibus Budget Reconciliation Acts of 1990 or 1993, or case management guidelines. This resulted in an overall universe of

13,954,115 claim lines, with an amount paid of approximately $2.2 billion, grouped by the claim's assigned POS (the location where the service was performed).

From this universe, we judgmentally selected all POS groups where the total amount paid represented three percent or more of the total claims paid. This narrowed our results to seven POS groups. With a target of 120 samples, we judgmentally selected the number of claims to be reviewed from each POS group based on a ratio of amount paid in each group compared to the total of all groups. In total, we selected 124 claims with a total claim amount paid of $4,978,244.

4. **Unlisted Procedure Code Review** – We identified a universe of 8,678 claim lines, totaling $6,045,053, where the procedure code utilized was either "unlisted," "miscellaneous," or "unclassified."

   We sorted and quantified this universe by the applicable Current Procedural Technology code and Healthcare Common Procedure Coding System code categories and judgmentally selected all codes with a cumulative amount paid of $50,000 or greater. This resulted in seven codes, with 5,591 claim lines totaling $5,449,564. From each procedure code selected we chose a random sample of five claim lines, resulting in a sample of 35 claim lines, totaling $57,892.

During our reviews, we utilized the Contract, the 2018 through 2020 SBP brochures, the Association's FEP Administrative Manual, and various manuals and other documentation provided by the Association and/or Plan to determine compliance with program requirements, as well as deriving any amounts questioned. The samples selected and reviewed were not statistically based. Consequently, the results were not projected to their respective universes since it is unlikely that the results are representative of the universes taken as a whole.

III. Findings and Recommendations

The objective of our audit was to determine if the internal controls over the Plan's claims processing system were sufficient to ensure that claims were properly processed and paid by the Plan. Although we identified estimated overcharges of $1,948,361 to the FEHBP, the overall results of our audit indicated that the internal controls implemented by the Association and the Plan were generally working as intended.

1. Claim Payment Errors: $1,948,361

Our claim reviews found that the Plan incorrectly paid 5,102 claims, resulting in estimated overpayments to the FEHBP of $1,948,361. The claim payment errors we found were a result of the following review areas which we cover in more detail below:

- Assistant Surgeon Procedure Code Modifiers; and
- Duplicate Claim Payments.

Section 3.2 (b) (1) of the Contract states that carriers may only charge costs to the Contract that are "actual, allowable, allocable, and reasonable."

Additionally, Section 2.3 (g) of the Contract amendment states, "If the Carrier 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."

A. Assistant Surgeon Procedure Code Modifiers

Due to a system error, the Plan's claim system did not apply allowance discounts to claims with assistant surgeon procedure code modifiers, resulting in overcharges to the FEHBP.

Our review identified a system pricing error related to claims with assistant surgeon procedure code modifiers, resulting in estimated FEHBP overcharges of $1,876,349 for 5,098 claims.

According to Plan protocols, claims with an assistant surgeon procedure code modifier are supposed to be paid at a reduced allowance. However, system pricing updates implemented on October 1, 2018, inadvertently caused the system to not apply the allowance reduction for claims processed after that date. The Plan stated that the error was corrected by a system update on February 2, 2021.

Our initial review identified five claims with assistant surgeon procedure code modifiers where the allowance reduction was not applied, leading to the identification of the system error. For these claims we identified an overpayment of $29,888. Once the system error was found, we asked the Plan to identify all claims impacted by this error so we could determine the financial impact to the FEHBP. In response, the Plan provided us a listing of 5,093 additional claims. Due to the voluminous number of claims impacted, the Plan has

not fully reviewed all the claims to determine actual overcharges. However, based on the work we performed, we were able to estimate total overpayments for these additional claims at $1,846,461. These estimated overcharges will be corrected once the necessary supporting documentation is provided.

In total, we estimate that the Plan overcharged the FEHBP $1,876,349 for 5,098 claims with assistant surgeon procedure code modifiers that were priced with an incorrect allowance.

As this error and its correction encompass time periods that are before and after our audit scope, there are claims requiring review, adjustment, and recovery in 2017 and 2021 that are not included in the totals noted in this finding. The Plan should continue its efforts to identify all claim payment errors related to this system error and initiate recoveries of all funds due to the FEHBP.

Recommendation 1:

We recommend that the contracting officer disallow $1,876,349 in overcharges to the FEHBP due to procedure code modifier claim payment errors.

Recommendation 2:

We recommend that the contracting officer direct the Association to initiate recovery on and return all funds recovered for those FEHBP claims affected by this system error incurred in 2017 and 2021 that are not included in the totals of this finding.

Association's Response to Recommendations 1 and 2:

The Association stated that the Plan is in the process of reviewing the claims identified to determine the overpaid amount and initiate recovery of FEHBP funds.

Recommendation 3:

We recommend that the contracting officer verify that the system error was corrected by the Plan and the current claims containing assistant surgeon modifier codes are processing and paying correctly.

Association's Response:

The Association stated that the Plan updated their claims system in February 2021 and the system is now processing claims with assistant surgeon procedure code modifiers correctly.

OIG Comments:

While the Association stated that the Plan's system has been updated, we were unable to verify if the update fixed the problem or not as it occurred outside of the scope of our audit.

B. Duplicate Claim Payments

Our review identified four improperly overridden duplicate claim payment deferrals, that did not go through secondary review. As a result, the FEHBP was overcharged $72,012.

According to the Plan, the four duplicate claim payments identified resulted from manual claim processor errors. In each case, the edits within FEPDirect (the Association's nation-wide claims processing system) identified the claims as potential duplicate payments and properly deferred them for further review. The deferred claims were then sent back to the local plan for further review and processing.

The Plan's claims processors made incorrect determinations and overrode FEPDirect duplicate payment deferral codes, causing the claims to be incorrectly paid.

The Plan's local processors reviewed the potential duplicate claims to confirm if they were duplicate payments. However, for these four claims, the Plan's processors did not follow proper procedures for reviewing claims deferred as duplicates and made incorrect determinations, overriding the duplicate payment deferrals, and pushed the claims through the system to pay.

During our review we asked the Plan if these types of processor overrides underwent any supervisory review and found that there was none. Of the claims identified, three paid more than $5,000, two of which paid more than $10,000, making these claims, while few, significant. Lack of secondary review by the Plan permitted the claims to pay incorrectly.

As a result of the Plan not having procedures in place for secondary review of duplicate payment deferral overrides, the FEHBP was overcharged $72,012. Based on our identification of these claim payment errors, the Plan initiated recovery efforts and as a result, the full amount has been recovered.

Recommendation 4:

We recommend that the overcharges, totaling $72,012, related to duplicate claim payments be disallowed. We have verified that the Plan recovered all overpayments prior to the issuance of this report. Therefore, no further action is required to address this recommendation and, consequently, we recommend its closure.

Recommendation 5:

We recommend that the Association direct the Plan to establish procedures to require a secondary review of duplicate payment deferrals overridden by its processors.

Association's Response:

"The Association [stated that it] will work with the Plan to establish additional post payment duplicate review procedures."

Appendix

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

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October 3, 2022

Ms. Stephanie M. Oliver
Group Chief, Claim Audits and Analytics Group
Office of the Inspector General
U.S. Office of Personnel Management
1900 E. Street, Room 6400
Washington, D.C. 20415-1100

Reference: **OPM Draft AUDIT REPORT**
BlueCross BlueShield of North Carolina
Report No. 2022-CAAG-0023
Dated August 31, 2022

Dear Ms. Oliver:

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

1. Claim Payment Errors **Amount Redacted by the OPM-OIG as amount questioned has changed**

A. Assistant Surgeon Modifier Codes

Recommendation 1

We recommend that the contracting officer disallow [redacted] in overcharges to the FEHBP. **[Amount Redacted by the OPM-OIG – as the amount questioned has changed.]**

Plan Response

The Plan is in the process of reviewing the claims identified to determine overpaid amount, initiate applicable recovery, and recoup overpayments.

Recommendation 2:

We recommend that the contracting officer ensure that the Plan reviews all claims that were impacted due to this error and initiate recovery of all monies overpaid.

Plan Response:

The Plan is in the process of reviewing the claims identified to determine overpaid amount, initiate applicable recovery, and recoup overpayments.

Recommendation 3:

We recommend that the contracting officer verify that the system error was corrected by the Plan and the current claims containing assistant surgeon modifier codes are processing and paying correctly.

Plan Response:

The system was updated February 4, 2021, and claims now process correctly. Attachment 1 depicts the percentages allowed for assistant surgeon modifiers. Desktop Procedures were created to ensure queries are created when system pricing changes are made that impact claims. Desktop Procedures were also created to develop an auditing process of creating new and modified pricing agreements.

Redacted by the OPM-OIG
Not relevant to the Final Report

B. Duplicate Claim Payments

Recommendation 4:

We recommend that the Association direct the Plan to establish procedures to require a secondary review of duplicate payment deferrals overridden by its processors.

Association Response:

The Association will work with the Plan to establish additional post payment duplicate review procedures.

Redacted by the OPM-OIG
Not relevant to the Final Report

Thank you for this opportunity to respond to the recommendations included in this draft report.

Sincerely,

[redacted], FEP Program Assurance

Redacted by the OPM-OIG
Not relevant to the Final Report

Report Fraud, Waste, and Mismanagement

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