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

Final Audit Report

Audit of the Claims Processing and Payment Operations as Administered by Blue Cross and Blue Shield of South Carolina for Contract Years 2020 through 2022

Report Number 2024-CAAG-011
March 25, 2025

EXECUTIVE SUMMARY

Audit of the Claims Processing and Payment Operations as Administered by
Blue Cross and Blue Shield of South Carolina for Contract Years 2020 through 2022

Report No. 2024-CAAG-011 **March 25, 2025**

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 FEHBP members by Blue Cross and Blue Shield of South Carolina (Plan), (U.S. Office of Personnel Management (OPM) plan codes 10, 11, and 13), were in accordance with the terms of the Blue Cross and Blue Shield Association's contract with OPM and the related Service Benefit Plan brochures.

What Did We Audit?

The Office of the Inspector General has completed a performance audit of the Plan's FEHBP claim operations. Specifically, we performed various claim reviews to determine if the internal controls over the claims processing systems were sufficient to ensure that claims were properly processed and paid by the Plan during contract years 2020 through 2022. Our audit work was conducted by staff in our Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida offices.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

Apart from the procedural issues identified below, we found that the Plan's internal controls over its claims processing system, for the areas under review, were generally effective in ensuring that health care claims were properly processed and paid.

The procedural issues identified included:

- The Plan did not follow its internal policies and procedures when adjudicating three claim samples which were deferred because the unlisted procedure code allowances were not in the Plan's claims system.

- The Plan improperly applied, or failed to apply, procedure code modifier pricing adjustments for 11 claim lines. The errors occurred due to processor errors caused by either a lack of processor training when adjudicating the claim lines or a lack of a focused quality control review process on these types of claims.

While the specific dollar impact to the FEHBP for the errors identified is minimal, improved policies and procedures will help alleviate the issues identified and reduce future FEHBP improper payments.

ABBREVIATIONS

Act	**Federal Employees Health Benefits Act**
Association	**Blue Cross and Blue Shield Association**
BCBS	**Blue Cross and Blue Shield**
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**
HI	**Office of Healthcare and Insurance**
MPR	**Multiple Procedure Reductions**
Non-Par	**Non-Participating**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
Plan	**Blue Cross and Blue Shield of South Carolina**
POS	**Place of Service**
SBP	**Service Benefit Plan**

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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 as administered by Blue Cross and Blue Shield of South Carolina (Plan), (U.S. Office of Personnel Management (OPM) plan codes 10, 11, and 13) for contract years 2020 through 2022.

The audit was conducted pursuant to the provisions of contract CS 1039 (Contract) between OPM and the Blue Cross and Blue Shield Association (Association); Title 5, United States Code, Chapter 89; and Title 5, Code of Federal Regulations, Chapter 1, Part 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 (Title 5, United States Code sections 401 through 424).

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 Title 5, United States Code, Chapter 89; and Title 5, Code of Federal Regulations, Chapter 1, Part 890.

The Association, on behalf of participating Blue Cross and Blue Shield (BCBS) plans, entered 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[1]) 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 member 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 the management of the

[1] Throughout this report, when we refer to FEP, we are referring to the SBP lines of business at the local BCBS Plans. When we refer to the FEHBP, we are referring to the program that provides health benefits to federal employees.

local BCBS plans. In addition, the local BCBS plans are responsible for establishing and maintaining a system of internal controls.

The most recent audit of claims processing and payment operations at the Plan was detailed in report number 1A-10-24-05-004, dated November 21, 2005, which covered the period January 1, 2001, through December 31, 2003. Any findings related to that audit were considered obsolete and not considered as part of planning for this audit.

The results of this audit were discussed with the Association and Plan throughout the audit, including the issuance of two Notices of Findings and Recommendations and at an exit conference on September 4, 2024. We issued a draft report, dated September 30, 2024, to solicit the Association's comments on 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.

II. OBJECTIVE, SCOPE, AND METHODOLOGY

OBJECTIVE

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

Specifically, our objective was to determine whether the Plan's internal controls over its claims processing and payment operations were sufficient to ensure claims are properly processed and paid.

SCOPE AND METHODOLOGY

We conducted our performance audit in accordance with the 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.

To meet these objectives, we performed reviews related to the Plan's internal controls over its claims processing and payment operations. Specifically, we conducted reviews of the following areas to achieve our objectives for contract years 2020 through 2022:

1. **Place of Service Review** – To determine if the claims were paid accurately according to the provider contract with the Plan and the SBP brochure;

2. **Unlisted Procedure Codes Review** – To determine if claims that have unlisted, miscellaneous, or unclassified Current Procedural Terminology or Healthcare Common Procedure Coding System codes were priced and paid correctly in accordance with Plan policies and procedures;

3. **Procedure Code Modifiers Review** – To determine if the Plan is properly applying allowance adjustments for all procedure code modifiers requiring them when pricing FEHBP claims;

4. **Basic Option Non-Participating (Non-Par) Provider Claims Review** – To determine if the Non-Par Basic option claims identified met appropriate circumstances to pay and were not unallowable payments;

5. **Claim System Pricing Updates Review** – To determine if the Plan has adequate controls in place to ensure that claim system pricing updates are input accurately and timely; and

6. **Fraud Case Reporting Review** – To determine if the Plan is meeting the requirements of Carrier Letter 2017-13 for the reporting of fraud cases to the OPM OIG.

We conducted a pre-audit visit at the Plan's Columbia, South Carolina, offices on May 29-30, 2024. Our audit fieldwork was performed by staff located in our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida, from June 12, 2024, through September 4, 2024.

We reviewed the Association's 2020 through 2022 annual accounting statements and determined that approximately $1.2 billion in health benefit payments were paid to the Plan during our audit scope.

In planning and conducting our audit, we obtained an understanding of both the Association's and Plan's internal control structure 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. 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 Association's or the Plan's system of internal controls taken as a whole.

We also conducted tests to determine whether the Association and the Plan 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. Except for those areas noted in the "Findings and Recommendations" section of this audit report, we found that the Association and the Plan complied with the health benefit provisions of the Contract and the SBP brochures. With respect to any areas not tested, nothing came to our attention that caused us to believe that they 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 select our samples. The BCBS claims data is provided to us monthly 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 data analytics software to judgmentally select all samples reviewed.

The following specific reviews were conducted during our audit (unless otherwise stated, the samples covered the full scope of the audit, contract years 2020 through 2022):

- **Place of Service Review**

  We identified all claims where the FEHBP paid as the primary insurer, the claim was not subject to the Omnibus Budget Reconciliation Acts of 1990 or 1993, or case management guidelines, and the total claim amount paid was $250 or greater.

  This resulted in an overall universe of 2,759,448 claims, with a total amount paid of $1,150,054,885, incurred during contract years 2020 through 2022 grouped by the claims' assigned place of service (POS) (the location where the service was performed).

  From this resulting universe, we judgmentally selected all POS groups with an amount paid percentage of 0.5 percent or greater (nine POS groups). We stratified each of these nine POS groups by total amount paid. Then, using a target sample of 100 claims, we judgmentally selected those strata where the amount paid percentage was greater than 10 percent. After calculating the remaining stratums percentage of amount paid, we randomly selected a number of claims for review from each using the calculated percentages.

  Based on our sampling methodology, we selected 125 claims with a total amount paid of $3,989,439.

- **Unlisted Procedure Codes Review**

  We identified a universe of 83 procedure codes and 4,691 claim lines with amounts paid totaling $2,208,512 where the procedure code utilized was identified as "unlisted," "miscellaneous," and "unclassified."

  From this universe, we judgmentally chose all procedure codes with $50,000 or greater in claim amount paid. This resulted in a sub-universe of 8 procedure codes and 3,252 claim lines with amounts paid of $1,836,304.

  From this sub-universe we judgmentally selected the four highest dollar claim lines from each procedure code (including any other claim lines from the same claim with the same procedure code). This resulted in a sample of 37 claim lines with a total amount paid of $219,604.

- **Procedure Code Modifiers Review**

  We identified a universe of 10 procedure code modifiers, with 24,320 claim lines totaling $14,895,280 in total amount paid, that the Plan indicated would affect claim pricing.

From this universe, we judgmentally selected all procedure code modifiers with a total amount paid of $1,000,000 or greater.

From each of the procedure code modifiers selected for review, we then, based on high dollar claim amount paid, judgmentally selected up to 5 claims each where the modifier appeared in modifier positions 1 or 2 with a traditional procedure code. Additionally, for claim lines where the procedure code was populated with a non-traditional code (Z code), we selected up to 2 claims each where the modifier appeared in positions 1 or 2. This selection resulted in a sample of 54 claims (131 claim lines) with a total amount paid of $326,885.

- **Basic Option Non-Par Provider Claims Review**

  We identified all claims in which the Plan was the primary payer, the claim amount paid was $100 or higher, and a member had Basic Option coverage and listed a Non-Par provider for a potentially non-covered service. This resulted in an overall universe of 812 claims, with a total amount paid of $315,999, incurred during contract years 2020 through 2022.

  From the resulting universe, we judgmentally selected the highest paid claim from each of the 20 members with the highest total amount of paid claims. In total, we selected 20 claims, with a total amount paid of $133,166.

- **Claim System Pricing Updates Review**

  We reviewed the Association's FEP Administrative Procedures Manual, met with the Plan, and issued follow-up questions to ensure that the Plan has adequate controls in place to ensure that claim system pricing updates are input accurately and timely.

- **Fraud Case Reporting Review**

  We reviewed all legal and/or fraud cases identified by the Plan that were not reported to the OPM OIG Office of Investigations.

During our review, we utilized the Contract, the 2020 through 2022 SBP brochures, the Association's FEP Administrative Procedures and Benefit Policy Manual, and various manuals and other documents provided by the Plan and the Association to determine compliance with program requirements, as well as deriving any amounts questioned. The samples selected 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. AUDIT FINDINGS AND RECOMMENDATIONS

1. Management Approval Process Not Followed — Procedural

As a result of not following its internal policies and procedures requiring management approval of claims paid at the billed charge when D7NET or D7002 deferral codes were triggered on a claim, the Plan did not review and potentially catch processor errors present on three claims.

By not following its policies and procedures requiring management approval, the Plan missed the opportunity to prevent improper payments before they were made.

The Plan's FEP Operations Policy, Desk Procedure No. FEP005-00004-16, in place during the scope of audit, establishes guidelines to assist operations staff in resolving pricing deferrals on the Automated Medical Management System (the Plan's local claims system). The policy defines D7NET and D7002 as the deferral codes triggered when the claims system cannot locate a professional procedure code allowance in the Provider Information Management System. Once triggered, these deferral codes alert processors of claims requiring manual pricing intervention. Some of the manual pricing intervention procedures processors are to follow include (but are not limited to): forwarding claims for medical review, following the medical reviewer's recommendations, and obtaining management approval for reimbursing deferred claims at billed charges.

The Plan's processors did not properly adjudicate three sample claims with deferral code D7NET. In each of these cases the processors adjudicated the claims to pay at the billed charge and did not receive the required management approval for such reimbursement. If the Plan followed its procedures and completed the management approval (and the associated management review), the errors identified may have been caught and corrected prior to payment.

When we brought this to the attention of the Plan, it stated that the policy was "outdated," stating that "It is not feasible for management to review every claim processed at billed charges. Only high dollar claims receive that type of scrutiny. Quality Assurance is the only control for catching claims processor errors." As such, the Plan provided a revised policy, dated July 10, 2024. We compared the revised policy to the policy in place during the scope of audit and noted that the language requiring management's approval to pay claims at billed charges was removed altogether. This policy update now fosters a greater risk of claims being erroneously reimbursed at billed charges, resulting in the increased likelihood of provider overpayments.

To determine the level of effort that would be required of the Plan to keep its policy of management review of these types of claims, we reviewed the claims universe to identify similar claims. Our review identified 24 unlisted procedure code claim occurrences (for claim lines exceeding $100) having reported allowable amounts equal to billed charges for

the three-year scope of our audit. This makes the Plan's position, that requiring it to review these types of claims (only where the line is paid at billed charges when deferral codes D7NET and/or D7002 were present) is too time consuming and/or difficult, untenable. Additionally, Contract section 2.3 (g) states that the Plan must "proactively identify overpayments through … a robust internal control program." Based on the few occurrences of these types of claims being reimbursed at billed charges, we believe it would be manageable for the Plan to reestablish a process to validate billed charges as the correct payment method for D7NET and D7002 deferrals rather than reduce or remove suitable internal controls.

As a result of not following its procedures and completing required management approvals for D7NET deferrals paid at billed charges, the Plan missed its opportunity to identify and correct three claim payment errors prior to payment. Additionally, the Plan's solution of simply removing the management review requirement will not fix, but likely worsen, the problems identified. Not only will it subject the Plan to continued and potentially increased manual processor errors, it will also subject the Program to continued and potentially increased provider overpayments.

Recommendation 1

We recommend the Contracting Officer require the Association to direct the Plan to reestablish its policies and procedures requiring management approval of claims paid at the billed charge when D7NET or D7002 deferral codes are triggered on a claim.

Association's Response:

The Association stated that the Plan has implemented the recommendation and has re-established the previous procedures that were in place for deferral codes D7NET and D7002.

2. Modifier Adjustments Not Properly Applied — Procedural

We identified 11 claim lines (out of 38) paid in error due to processor errors related to procedure code modifiers 22, 62, 51, and other multiple procedure reductions (MPR). These errors resulted in net overpayments to the FEHBP of $11,575.

Due to either the lack of processor training or an insufficient quality control review focused on procedure code modifier claims, the Plan improperly applied procedure code modifier pricing.

For the modifiers and MPRs in question, the Plan has internal procedures in place already that the processors either failed to employ or incorrectly employed when manually processing the claims, leading to the errors identified. When approached regarding how to correct this, the Plan stated that the only way to identify these errors is through its post-processing quality control reviews. Those

consist of strictly random reviews of 15 percent of claims requiring manual intervention by processors.

Based on the number of errors identified in our sample and the fact that the errors are tied to a manual process which poses greater risk, we do not agree that the Plan's current protocols, by themselves, are the most effective way to identify these types of errors. Ideally, increased diligence on the part of the Plan in the areas of training and post-processing reviews can help either prevent the errors in the first place or catch them not too long after payment is made, increasing the likelihood of recovery.

A 2011 report of the American Medical Association identified a 19.3 percent average claims processing error rate at commercial health insurers. Related comments stated that a "20 percent error rate among health insurers represents an intolerable level of inefficiency." While the report at first glance may seem dated, we feel the sentiment remains. Consequently, our sample's error rate of 29 percent clearly indicates that increased diligence on the part of the Plan related to claim lines with procedure code modifiers 22, 62, 51, and other MPRs is needed.

While the FEHBP overcharges of $11,575 are immaterial, should the high error rate identified in our sample be extrapolated across the universe of approximately 12,500 claim lines, the resulting potential overpayments could be much more significant than what was identified in this audit.

Recommendation 2

We recommend that the contracting officer direct the Association to add increased processer training at the Plan related to procedure code modifiers, especially for modifiers 22, 62, 51, and other MPRs on a routine basis.

Association's Response:

The Association stated that the Plan has conducted refresher training on procedure code modifiers and other MPRs and that it will hold the training at least biannually.

Recommendation 3

We recommend that the contracting officer direct the Association to modify its quality control review process to ensure that claims with modifiers 22, 62, 51, and other MPRs are specifically included to catch potential errors.

Association's Response:

The Association stated that the Plan will revise its quality control review process to include a monthly 15 percent quality review of claims with modifiers 22, 62, 51, and other MPRs.

APPENDIX

BlueCross BlueShield
Federal Employee Program
750 9th Street N.W.
Washington, D.C. 20001
www.BCBS.com

October 24, 2024

Stephanie Oliver
Group Chief, Claims 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
Blue Cross Blue Shield of South Carolina
Audit Report Number 2024-CAAG-011

Dear Ms. Oliver:

This is the BlueCross BlueShield of South Carolina response to the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report covering the Federal Employees Programs Claims Processing and Payment Operations. Our comments concerning the findings in the report are as follows:

1. Management Approval Process Not Followed **Procedural**

Recommendation 1

We recommend the Contracting Officer require the Association to direct the Plan to reestablish its policies and procedures requiring management approval of claims paid at the billed charge when D7NET or D7002 deferral codes are triggered on a claim.

Plan Response: The Plan implemented the recommendation of the Contracting Officer and re-established their procedures requiring management approval of claims paid at the billed charge when D7NET or D7002 deferral codes are triggered on a claim.

2. Modifier Adjustments Not Properly Applied **Procedural**

Recommendation 2

We recommend that the contracting officer direct the Association to add increased processer training at the Plan related to procedure code modifiers, especially for modifiers 22, 62, 51, and other Multiple Procedure Reductions (MPRs) on a routine basis.

Plan Response: The Plan conducted refresher training on procedure code modifiers on September 5, 2024, especially for modifiers 22, 62, 51, and other MPRs. The Plan will continue holding this training twice a year, or more frequently, based on feedback from the Plans' Quality Assurance.

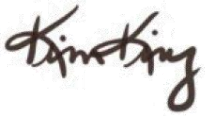
Recommendation 3

We recommend that the contracting officer direct the Association to modify its quality control review process to ensure that claims with modifiers 22, 62, 51, and other MPRs are specifically included to catch potential errors.

Plan Response: The Plan will revise its quality control review process to ensure that claims with modifiers 22, 62, 51, and other MPRs are specifically reviewed for errors. A 15% quality review will be conducted on these specific modifiers monthly.

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

Sincerely,



Kim King
Managing Director, FEP Program Assurance

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NOT RELEVANT TO THE FINAL REPORT

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