



**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 Florida, Inc.**

**Report Number 1A-10-41-16-029
March 30, 2020**

EXECUTIVE SUMMARY

Audit of Claims Processing and Payment Operations at Blue Cross and Blue Shield of Florida, Inc.

Report No. 1A-10-41-16-029

March 30, 2020

Why Did We Conduct The Audit?

The objective was to determine if 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 Florida, Inc. (Plan) were in accordance with the terms of the Blue Cross Blue Shield Association's (Association) contract with the U.S. Office of Personnel Management (OPM).

What Did We Audit?

The Office of the Inspector General has completed a limited scope performance audit of the FEHBP claim operations at the Plan. Our audit scope covered all claim payments from January 1, 2012, through October 31, 2015. Additionally, we expanded the scope of our durable medical equipment review to cover claims paid through March 9, 2016, due to errors identified with our initial sample.

What Did We Find?

Our audit identified three findings where the Plan needs to strengthen its procedures and controls related to claim payments. Additionally, we identified one area of program improvement related to non-participating providers.

1. Payments to Non-Participating (Non-Par) Providers

The Plan incorrectly allowed payments for 49 Non-Par claims, resulting in overcharges of \$152,933 (net) to the FEHBP.

2. Omnibus Budget Reconciliation Act of 1993 (OBRA 93)

The Federal Employee Program Operations Center did not properly price 198 claim lines in accordance with OBRA 93 pricing guidelines, resulting in overcharges of \$87,982 to the FEHBP.

3. Lack of Medical Review of Durable Medical Equipment Claims

We determined that the Plan's local system did not defer claims requiring medical review prior to payment. We issued a procedural finding in this area.

4. Program Improvement – Claims for Non-Par Providers

The payment provisions of the Service Benefit Brochure and the Association's contract with OPM permitted payments to Non-Par providers at billed charges, rather than at more reasonable rates. Having such rates in place could have saved the FEHBP approximately \$25 million.



Michael R. Esser
*Assistant Inspector General
for Audits*

ABBREVIATIONS

Association	Blue Cross Blue Shield Association
BCBS	Blue Cross and Blue Shield
Contract	Contract CS 1039 between OPM and the Association
DME	Durable Medical Equipment
FAM	FEP Administrative Manual
FEHB Act	Federal Employees Health Benefits Act
FEHBP	Federal Employees Health Benefits Program
FEP	Federal Employee Program
Non-Par	Providers not participating in the Plan's Provider Networks
OBRA93	Omnibus Budget Reconciliation Act of 1993
OPM	U.S. Office of Personnel Management
Plan	BCBS of Florida, Inc.
SBP	Service Benefit Plan

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I. BACKGROUND

This final report details the findings, conclusions, and recommendations resulting from our limited scope audit of the Federal Employees Health Benefits Program (FEHBP) claim processing and payment operations at Blue Cross and Blue Shield of Florida, Inc. (Plan), located in Jacksonville, Florida. The U.S. Office of Personnel Management's (OPM) Office of the Inspector General performed the audit, as authorized by the Inspector General Act of 1978, as amended.

The FEHBP was established by the Federal Employees Health Benefits Act (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 (HIO) has overall responsibility for administration of the FEHBP. As part of its administrative responsibilities, the HIO contracts with various health insurance carriers that provide service benefits, indemnity benefits, and/or comprehensive medical services. 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.

The Blue Cross Blue Shield Association (Association), on behalf of participating Blue Cross and Blue Shield (BCBS) plans, entered into contract CS 1039 (Contract), a Government-wide Service Benefit Plan (SBP) contract, 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 36 BCBS companies participating in the FEHBP. The 36 companies are comprised of 64 local BCBS plans.

The Association has established a Federal Employee Program (FEP¹) 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 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 SBP lines of business at the Plan. When we refer to the "FEHBP," we are referring to the program that provides health benefits to Federal employees.

Compliance with laws and regulations applicable to the FEHBP is the responsibility of the Association and Plan management. In addition, management of each BCBS 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-10-41-12-019, dated October 17, 2012. All recommendations from the previous audit have been closed.

The results of this current audit were discussed with Plan and Association officials throughout the audit and at an exit conference held on June 29, 2018. 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 and the Plan on various dates through July 7, 2019, was also considered in preparing our final report.

II. OBJECTIVE, SCOPE, AND METHODOLOGY

OBJECTIVE

The objective of our audit was to determine whether the Plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the Contract.

Specifically, our objective was to determine whether the Plan complied with the Contract's provisions relative to health benefit payments.

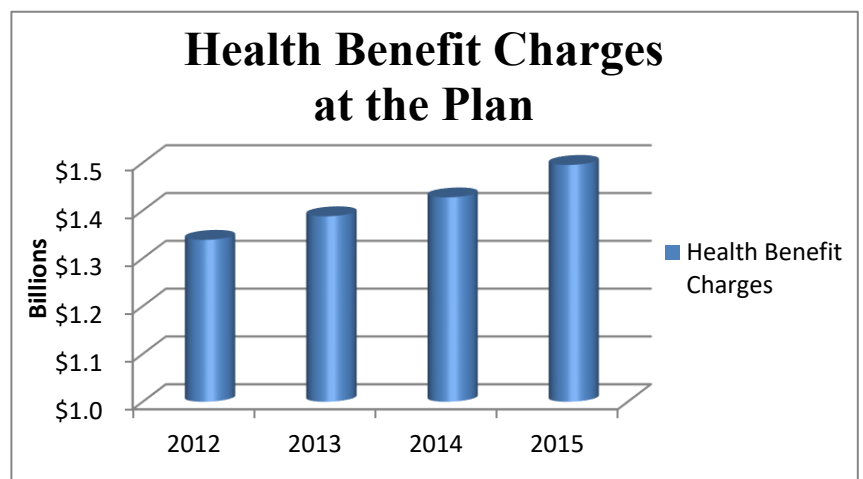
SCOPE AND METHODOLOGY

We conducted this limited scope performance audit in accordance with the U.S. Government Accountability Office's 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 claim payment reviews: high risk facility claims, Omnibus Budget Reconciliation Act of 1993 (OBRA 93) claims, ambulance service claims, claims with retroactive recoveries, claims with increased procedural services, and an overall system review for the period January 1, 2012, through October 31, 2015. Additionally, we extended our scope to March 9, 2016, for our review of Durable Medical Equipment (DME) claims because of errors identified.

As part of our audit fieldwork, we conducted a site visit at the Plan's offices in Jacksonville, Florida from April 6, 2016, through April 26, 2016. Remaining audit fieldwork was conducted at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida, from May 1, 2016, through July 7, 2019.

We reviewed the Association's Government-wide SBP Annual Accounting Statements as they pertain to Plan codes 090 and 590 (Plan Codes



related to the Plan) for Contract years 2012 through October 31, 2015² (see chart) and determined the Plan paid approximately \$5.65 billion in health benefit charges during this time period.

In planning and conducting our audit, we obtained an understanding of the Plan's internal control structure to help determine the nature, timing, and extent of our auditing procedures. 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 Plan's system of internal controls taken as a whole.

We also conducted tests to determine whether the Plan had complied with the Contract and the laws and regulations governing the FEHBP as they relate to claim payments. The results of our tests indicate that, with respect to the items tested, the Plan did not fully comply with the provisions of the Contract related to claim payments. The "Audit Findings and Recommendations" section of this audit report explains in detail the exceptions noted. With respect to the items not tested, nothing came to our attention that caused us to believe that the Plan had not complied, in all material respects, with those provisions.

In conducting our audit, we relied to varying degrees on computer-generated data provided by the FEP Director's Office, the FEP Operations Center, and the Plan. Through the performance of audits and an in-house claims reconciliation process, we have verified the reliability of the BCBS claims data in our data warehouse, which was used to identify the universe of claims for each type of review. The BCBS claims data is provided to us on a monthly basis by the FEP 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 Plan's local claims system. While utilizing the computer-generated data during our audit, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

To determine whether the health benefit costs charged to the FEHBP and the services provided to its members during the audit scopes described were in accordance with the Contract, applicable Federal regulations, and the SBP brochure, we conducted the following claim reviews: (Summarized in the following table)

² Although the audit scope covered January 1, 2012, through October 31, 2015, the Association's Government-wide SBP 2015 Annual Accounting Statement reports amounts through year-end December 31, 2015.

Summary of Samples Selected for Review

Review Type	Universe		Samples		
	Claim Count	Amount Paid	Selection Methodology	Claim Count	Amount Paid
A. High Risk Facility Review	158,681	\$219,625,396	Judgmental	46,625	\$127,656,717
B. OBRA 93 Review	3,153	\$618,004	Judgmental	304	\$299,897
C. DME Review	183,567	\$8,914,641	Judgmental	751	\$1,904,256
D. System Pricing	16,124,677	\$2,262,503,681	Judgmental	145	\$3,267,955
E. Ambulance Services	59,860	\$20,183,348	Judgmental	99	\$1,695,064
F. Retroactive Recoveries	42,049	\$22,334,816	Judgmental	3,560	\$1,754,501
G. Increased Procedural Services	2,099	\$1,598,744	Judgmental	100	\$292,141

- A. High Risk Facility Review – Our universe consisted of all claims reimbursed from January 1, 2012, through October 31, 2015, with specific mental health or substance abuse diagnosis codes and where the bill type was an outpatient hospital where the amount paid was equal to or greater than billed charges. From this universe, we judgmentally selected providers with the highest cumulative payments from each year of the audit scope, resulting in a sample of 46,625 claims.
- B. OBRA 93 Review – Our universe consisted of all claims paid with an OBRA 93 indicator from January 1, 2012, through October 31, 2015. From this universe, we judgmentally selected for review all claims with amounts paid of \$400 or more that contained procedure code modifiers 62, 66, AS, 50, or 51. This resulted in a sample of 304 claims.
- C. DME Review – Our universe consisted of all claims paid containing DME procedure codes from January 1, 2012, through October 31, 2015. From this universe, we judgmentally selected 100 high dollar claims for review. The review identified a system error, where claims with procedure code E2402 were not suspended for a medical necessity review. As a result, we expanded our initial sample to cover claims paid from January 1, 2012, through March 9, 2016, and selected all claims with procedure code E2402 for review. This brought the total claims selected for review to 751 claims.
- D. System Pricing – Our universe consisted of all claims paid from January 1, 2012, through October 31, 2015, when the FEHBP paid as primary and where the claims were not priced according to the OBRA 90, the OBRA 93, or case management guidelines. From this universe, we judgmentally selected 145 claims that were stratified by place of service (e.g., inpatient hospital or provider office) and payment category (e.g., \$50 to \$99.99) to make up our initial sample. We judgmentally determined the sample size from the

number of sample items from each place of service stratum based on the stratum's total dollars.

- E. Ambulance Services – Our universe consisted of all ambulance service claims from the period of January 1, 2012, through October 31, 2015. From this universe, we judgmentally selected 50 claims based on the procedure code to determine if the claims were properly paid. In addition, we judgmentally selected 49 high dollar claims to verify if the claims were paid in accordance with the Contract and regulations.

- F. Retroactive Recoveries – Our universe consisted of all claims reported on the Plan's retroactive enrollment recovery report from the period of January 1, 2012, through October 31, 2015. From this universe, we judgmentally selected 33 members based on type of error and high dollar amounts, totaling 3,560 incurred claims, to verify the enrollment status and the recovery of these claim payments.

- G. Increased Procedural Services – Our universe consisted of all claims with modifier 22 (Increased Procedural Services) from the period of January 1, 2012, through October 31, 2015. From this universe, we judgmentally selected the top 100 claims by highest dollar amount for review.

The samples that were selected and reviewed in performing the audit were not statistically based. Consequently, the results were not projected to the universe since it is unlikely that the results are representative of the universe taken as a whole.

A separate issue, involving the Plan's arrangement with a third party vendor to administer its durable medical equipment, home therapy, and home infusion benefits, required a substantial amount of additional work. Thus, this issue was excluded from this final report and will be covered in a separate supplemental report.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. HEALTH BENEFIT PAYMENTS

1. Claim Payment Errors to Non-Participating Providers \$152,933

Our High Risk Facility Review identified multiple claim payment errors related to non-participating (Non-Par) providers. Our review determined that the Plan incorrectly allowed payments for 49 Non-Par claims, resulting in overcharges of \$152,933 (net) to the FEHBP.

The claim payment errors were comprised of two different scenarios:

- Medicaid reimbursement claims paid at billed charges, rather than the Medicaid allowance.
- Payment of Non-Par claims for Basic Option Subscribers

Medicaid Claims Reimbursed Incorrectly

The Plan incorrectly paid 37 Medicaid claims due to the Plan's processor using billed charges as the allowance instead of the Medicaid allowance when pricing FEHBP claims for members with Medicaid coverage. Specifically, the Plan overcharged 22 claims by \$178,623 and undercharged 15 claims by \$56,235, resulting in a net overcharge of \$122,388.

The Plan overcharged the FEHBP \$122,388 for incorrectly paid Medicaid claims at the billed charge rather than the Medicaid allowance.

The Plan reviewed and re-processed all samples according to the guidance provided by the FEP Administrative Manual (FAM) Chapter 38, Volume II. This regulation states that "When benefits are payable under both FEP and ... the Social Security Act, FEP should always pay primary benefits." The chapter also states that, "Since FEP is the member's primary payer in this instance: FEP is therefore responsible for reimbursing Medicaid the lesser of

Medicaid's payments or the amount payable by FEP as the primary payer."

The claims in question were initially paid by Medicaid, but once FEHBP coverage was determined, a claim was sent to the Plan by Medicaid for reimbursement. Rather than apply the Medicaid allowance however, the Plan paid these claims in accordance with its Non-Par provider policy at the time and paid the billed charges.

Recommendation 1

We recommend that the Association return \$122,388 in net overcharges related to the incorrect payment of Medicaid reimbursement claims to the FEHBP.

Association's Response

The Association agrees with the recommendation.

Non-Par claims paid for Basic Option Subscribers

The Plan improperly paid 12 Non-Par claims for members with Basic Option coverage, resulting in an overcharge of \$30,545 to the FEHBP.

The Plan incorrectly paid Non-Par claims for Basic Option members.

The 2015 SBP brochure, page 28, states that “Under Basic Option, there are no benefits for care performed by Non-participating providers; you pay all charges.”

Basic option coverage offers no benefits for members opting to use providers that are not in the Plan’s provider network, and only provides benefits to members who use covered professional or facility providers. Allowing Non-Par claims to be paid at billed charges for members with Basic Option coverage does not incentivize members to use preferred providers, since their liability is less than or the same if they use a participating provider.

Recommendation 2

We recommend that the Association return \$30,545 in overcharges related to the payment of Non-Par claims for Basic Option members to the FEHBP.

Association's Response

The Association agrees with the recommendation.

2. OBRA 93 Claims Paid Incorrectly **\$87,982**

Our OBRA 93 review identified 198 claim lines paid incorrectly, resulting in an overcharge of \$87,982 to the FEHBP.

Due to an error in the FEP Express System, 198 claims were paid incorrectly because Medicare modifier discounts (for modifiers 62, 66, AS, 50 and 51) were not applied prior to payment.

OBRA 93 limits the benefit payment for certain physician services provided to annuitants age 65 or older who are not covered under Medicare Part B. The FEHBP fee-for-service plans are required to limit the claim payment to the lesser of the amount equivalent to the Medicare Part B payment or billed charges. Palmetto (an OBRA 93 pricing vendor) calculates the pricing amounts for the OBRA 93 claim lines on behalf of the FEP Operations Center.

The FEP Express System did not apply all modifier discounts properly.

Each SBP brochure in the audit scope states that “We limit our payment to an amount that supplements the benefits that Medicare would pay under . . . Medicare Part B (Medical Insurance), regardless of whether Medicare pays.”

Although the Association was aware of the fact that the FEP Express System was not properly applying the modifier discounts to these claim lines, resulting in higher payments to the FEHBP, a corrective action addressing this issue was not put in place until September 2015.

Recommendation 3

We recommend that the contracting officer ensure that \$87,982 is returned to the FEHBP.

Association’s Response

The Association agrees with the recommendation and states that most of the monies questioned have been returned to the FEHBP. Additionally, it stated that it modified its claims system in September 2015 to properly apply the modifier discounts in accordance with Medicare guidelines for OBRA 93 claims.

OIG Comments

We were unable to determine if the monies questioned were returned to the FEHBP.

3. Lack of Medical Review of DME Claims

Procedural

We determined the Plan’s local system did not properly defer 751 claims containing procedure code E2402 (negative pressure wound therapy pumps) for medical review.

B. PROGRAM IMPROVEMENT AREA

1. Non-Par Claims Paid at Billed Charges

Procedural

In our High Risk Facility Review we identified 5,665 Non-Par outpatient claims, totaling \$27,387,112 in payments, during the audit scope that were priced using billed charges as the allowance rather than a more reasonable rate such as a local Plan allowance, a usual customary rate, or a Medicare limiting charge.

Allowing Non-Par claims to be paid at billed charges has incurred significant unnecessary costs to the FEHBP.

While we recognize that these Non-Par outpatient claims were paid in accordance with the benefit structures in place during the audit scope, we determined that use of a more reasonable allowance amount to pay the Non-Par claims could have saved the FEHBP a significant amount in health care payments.

To OPM's credit, in 2019 it updated the FEHBP benefit structure for outpatient Non-Par non-emergency services that limited payment to the local Plan allowance rather than billed charges. While this change mitigates a large portion of this issue, it does not address the Non-Par emergency claims, which are still being paid at billed charges. The biggest hurdle OPM faces in correcting this issue is the impact to the member.

We understand that OPM has a legitimate concern about the financial impact on FEHBP members who may unintentionally use a Non-Par provider in an emergency. However, allowing these types of providers to be paid at billed charges does not incentivize them to join a provider network, as their reimbursement is higher in a Non-Par role. Until this issue is addressed, amounts paid for these types of services will continue to incur a significant cost to the FEHBP.

Recommendation 5

We recommend that the contracting officer work with the Association to ensure that in the future all Non-Par services, including emergency services, are paid based upon the local Plan allowance and not at billed charges.

Association's Response

The Association stated that the Non-Par claims identified were paid in accordance with the Contract. However, it stated that beginning with Contract year 2019 changes were

implemented so that Non-Par facility claims (non-emergency) would be paid based upon the local plan's allowance and not on billed charges.

APPENDIX

Deleted by the OIG – Not Relevant to the Final Report



**BlueCross
BlueShield**

Association

Federal Employee Program
1310 G Street, N.W.
Washington, D.C. 20005
202.626.4800
www.BCBS.com

**Reference: OPM DRAFT AUDIT REPORT
Blue Cross and Blue Shield of Florida, Inc. dba Florida Blue
Audit Report Number 1A-10-41-16-029
(Dated and Received September 14, 2018)**

Deleted by the OIG – Not Relevant to the Final Report

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

A. High-Risk Facility Review

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Cost-Share Miscalculation

The Plan does agree that 12 of the 139 claims were paid in error for a total amount of \$30,545, and the Plan will take appropriate actions consistent with CS1039 for recovery of this amount.

Incorrect Allowance Used

The Plan has reviewed the claims sample and determined that 22 of the 37 claims were potential overpayments in the amount of \$178,622.55 and the remaining 15 claims were actually potential underpayments in the amount of \$56,235.14. The net payment error for the claims sample agreed to by the Plan is \$122,387.41. The Plan provided this information to the OIG by upload dated July 28, 2017 and the Plan will take appropriate actions consistent with CS1039 for recovery of this amount.

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Plan Response to Recommendation 5:

As stated above, the Plan paid non-par facility claims in the sample based on billed amounts as the plan allowance instead of the local plan allowance as required by the Contract. Changes for the 2019 benefit year have already been negotiated by and between the Association and OPM and the current proposal for the Service Benefit Plan for CY2019 is that non-par facility claims (except for emergency claims) will be paid based upon the local Plan allowance, not on billed charges.

B. Omnibus Budget Reconciliation Act of 1993 Review

\$87,982

Recommendation 6:

We recommend the contracting officer require the Plan to return \$87,982 in potential overcharges to the FEHBP.

Plan Response to Recommendation 6:

The Plan agrees that 198 claim lines did not have Omnibus Budget Reconciliation Act of 1993 (OBRA '93) pricing discounts for Medicare Part B correctly applied in FEP Express resulting in a payment error of \$87,982. FEP Express, which is managed by the BCBSA, has been corrected. To date, the Plan has verified that all 198 claim lines (186 claims) in the amount of \$87,982 have been reprocessed with the appropriate pricing discounts being applied. As a result of reprocessing, the Plan recovered and returned to the program \$87,587.66.

Recommendation 7:

We recommend the contracting officer require the Association to modify the FEP Express system to properly identify all claim modifiers on the claim and apply modifier percentages based on the Medicare guidelines.

Plan Response to Recommendation 7:

BCBSA modified the FEP claims system in September 2015 to properly apply the appropriate modifier reductions in accordance with Medicare guidelines for OBRA 93 claims. See Attachment 3 for a copy of the FEP claims system documentation related to paying these types of claims.

C. Durable Medical Equipment Review ~~Deleted by the OIG – Not Relevant to the Final Report~~

Plan Response to Recommendation 8:

The Plan agrees that during the audit period and for the claims in question the Plan's local system did not defer claims with procedure code E2402 (negative pressure wound therapy pumps) for medical review. That procedural error has been corrected, as of March 9, 2016, as noted by the OIG in the draft report.

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Plan has obtained adequate documentation supporting the claims using the applicable medical review guidelines for procedure code E2402.

Thank you for this opportunity to respond to the recommendations included in this draft report. If you have any questions, please contact me at [REDACTED] or [REDACTED] at [REDACTED].

Sincerely,

[REDACTED]

[REDACTED]

[REDACTED], FEP Program Assurance
cc: [REDACTED], OPM Contracting Officer



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