



**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 Hawaii Medical Service Association
as a Participating Fee-For-Service Health Plan**

Report Number 1A-10-47-19-013

January 24, 2020

EXECUTIVE SUMMARY

Audit of Claims Processing and Payment Operations at Hawaii Medical Service Association as a Participating Fee-For-Service Health Plan

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Why Did We Conduct The Audit?

The objectives of our audit were to determine if the health benefit costs charged to the Federal Employees Health Benefits Program (FEHBP) and services provided to FEHBP members by the Hawaii Medical Service Association (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. The audit covered claim payments from January 1, 2016, through October 31, 2018, and was conducted in Honolulu, Hawaii pursuant to contract CS 1039 with OPM.

What Did We Find?

Our audit identified three findings that indicate the need for strengthened procedures and controls related to claim payments on the part of the Plan.

Specifically, our reviews determined that the Plan paid 16 claims, totaling \$205,621 in overcharges to the FEHBP, incorrectly due to claims processing errors.



Michael R. Esser
*Assistant Inspector General
for Audits*

ABBREVIATIONS

Association	Blue Cross Blue Shield Association
BCBS	Blue Cross Blue Shield
Contract	CS 1039
FEHB Act	Federal Employees Health Benefits Act
FEHBP	Federal Employees Health Benefits Program
FEP	Federal Employee Program
FEP Direct	Association's National Claims System
HIO	Healthcare and Insurance Office
OIG	Office of the Inspector General
OPM	U.S. Office of Personnel Management
Plan	Hawaii Medical Service Association
SBP	Service Benefit Plan
VA	Veterans Affairs

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I. BACKGROUND

This final audit report details the results of our limited scope audit of the Federal Employees Health Benefits Program's (FEHBP) claims processing and payment operations at Hawaii Medical Service Association (Plan) located in Honolulu, Hawaii. 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 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.

This is the first claim payment audit that the OIG's Claims Audit and Analytics Group performed of the Plan. Previous audits of claims of the Plan were incorporated into audits performed by the OIG's Experience-Rated Audits Group.

The results of the current audit were discussed with the Plan and Association officials throughout the audit and at an exit conference dated September 3, 2019. 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 November 2019 was also considered in preparing our final report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

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

Specifically, our objective was to determine whether the Plan complied with those provisions of the Contract related to health benefit payments.

SCOPE AND METHODOLOGY

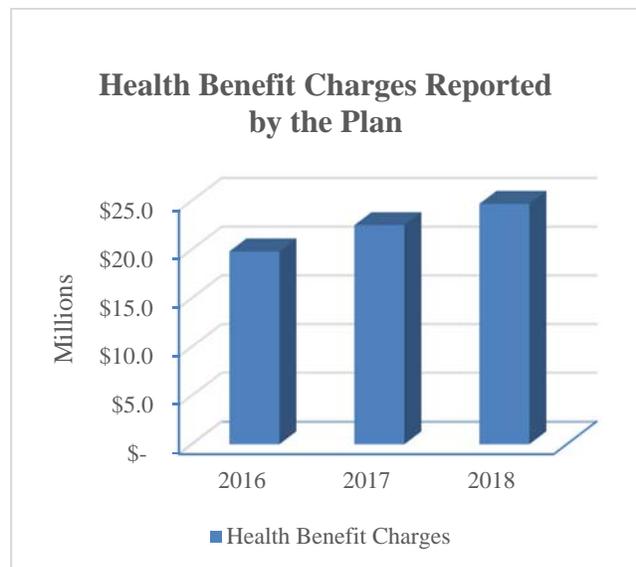
We conducted our limited scope performance audit in accordance with the generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient and appropriate evidence to provide a reasonable basis for our findings and conclusions based on our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

This performance audit included the following claim payment reviews: system pricing, contract, and licensing; provider network status; unlisted procedure codes; and Veterans Affairs (VA) claims for the period January 1, 2016, through October 31, 2018. Additionally, we conducted a claims system test for the same period.

As part of our audit fieldwork, we conducted a site visit at the Plan's office in Honolulu, Hawaii from March 4, 2019, through March 14, 2019. Additional audit fieldwork was performed at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida through September 2019.

We reviewed the Association's Government-wide SBP Annual Accounting Statements as they pertain to plan codes 471 and 971 (plan codes related to the Plan) for contract years 2016 through 2018² (see chart) and

determined that the Plan paid approximately \$67 million in health benefit charges.



² Although the audit scope covered January 1, 2016, through October 31, 2018, the Association's Government-wide SBP 2018 Annual Accounting Statement reports through year-end December 31, 2018.

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, 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. The results of our tests indicate that, with respect to the items tested, the Plan is in compliance with the provisions of the Contract relative to claim payments. Any exceptions noted in the areas reviewed are set forth in the "Audit Findings and Recommendations" section of this audit report. With respect to the items not tested, nothing came to our attention that caused us to believe that the Plan had not complied, in all material respects, with those provisions.

In conducting our audit, we relied to varying degrees on computer-generated data provided by the FEP Director's Office, the FEP Operations Center, and the BCBS plans. 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 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.

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

Summary of Samples Selected for Review

Review Type	Universe		Samples		
	Claim Count	Amount Paid	Selection Methodology	Claim Count	Amount Paid
1. System Pricing, Contract, and Licensing	262,095	\$55,746,227	Judgmental	159	\$4,118,572
2. Provider Network Status	252,955	\$59,570,636	Judgmental	158	\$53,582
3. Unlisted Procedure Codes	432	\$2,114,796	Judgmental	23	\$293,943
4. Veterans Affairs	4,157	\$2,167,952	Judgmental	38	\$243,347

1) System Pricing, Contract, and Licensing Review – Our universe consisted of all claims where the FEHBP paid as the primary insurer and which were potentially not priced according to the Omnibus Budget Reconciliation Acts of 1990 and 1993, or case management guidelines. From this universe, we utilized SAS to judgmentally select 159 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.

Additionally, from this sample we judgmentally selected 23 providers from this review to determine if the Plan’s contracted rates were accurately updated in its pricing system.

2) Provider Network Status Review – From the universe, we identified 96 providers that submitted claims both as participating and non-participating in the Plan’s network. We narrowed our sample to 43 providers with 1,738 claims based on the below criteria and then selected 158 claims to review:

- Provider submitted claims as participating, then at a point in time, all claims afterwards were non-participating.
- Provider submitted claims as non-participating between dates of other claims that indicated the provider was participating.
- Provider submitted claims as participating between dates of other claims that indicated the provider was non-participating.

3) Unlisted Procedure Code Review – Our universe consisted of all claims that contained an unlisted or miscellaneous procedure code. From this universe, we identified 17 unlisted or miscellaneous procedure codes in our data. We chose the highest paid claim for each procedure code. Additionally, if a claim had modifiers, we also chose the highest paid claim

for that procedure code. The resulting sample of 23 claims was reviewed to determine if proper documentation was maintained to support the charges and if there were other alternatives to price these claims.

- 4) Veterans Affairs Claim Review – Our universe consisted of all claims paid to VA service providers. We selected one claim from each place of service for each location, using the physical address (i.e., zip code) of the service provider. If there were multiple facility types, we selected a claim for each facility type for review. We reviewed the resulting sample of 38 claims to determine if the pricing was properly applied.

We utilized SAS to judgmentally determine all samples 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.

Additionally, we conducted claims system testing to review a sample of test claims to ensure that the Plan's local claim processing system is properly pricing and paying claims. During the claim cycle process, the Plan's local system adjudicates claims for pricing and medical editing, and the Association's national claims processing system, known as FEP Direct, applies FEP member benefits.

We created 44 test claims using fictitious subscribers and members for our test environment that closely resembled the demographics of the claims' real subscribers and members. With our created claims, we tested the Plan's claims adjudication process to validate the system's processing controls. The exercise involved processing our sample test claims through the Plan's local system and FEP Direct and evaluating the manner in which the Plan's system adjudicated the claims. Our test results did not identify any issues using the parameters the Plan required us to use during testing.

III. AUDIT FINDINGS AND RECOMMENDATIONS

The following represents the results of our audit. Except for these findings listed, the health benefit costs charged to the FEHBP and the services provided to its members during the audit scope were in accordance with the Contract, applicable Federal regulations, and the SBP brochure.

A. System Pricing Review

\$198,252

For the 159 claim samples selected for review, we verified each claim was properly processed and paid according to the provider's license and reimbursement methodology. Of these 159 claims, the Plan incorrectly paid 3 claims, totaling \$198,252 in overcharges to the FEHBP, due to manual processor errors. In most instances, the processor manually applied the incorrect fee rate when recalculating the claim.

Part III, Section 3.2 (b) (1) of the Contract, requires carriers to only charge costs to the FEHBP that are actual, allowable, allocable, and reasonable. Additionally, 3.2 (b) (1) (i) states that carriers must be able to support and justify that the costs are actual, reasonable and necessary.

In response to our draft audit report, the Plan conducted a training exercise for their claims processors regarding manual pricing of claims. The training covered Medical Management review, when to deny claims, checking for providers billing in their scope of practice, and how to look up the correct eligible charge for a billed service. Based on the documentation related to this training that was provided by the Association as part of its draft report response, we believe this training should adequately mitigate the errors identified in this review going forward.

Recommendation 1

We recommend the contracting officer disallow \$198,252 in overcharges to the FEHBP due to manual processor errors.

Association Response:

The Association agrees with the recommendation and stated that it has recovered and returned \$196,812 of the monies questioned and is still trying to recover the remaining \$1,440.

B. Provider Network Review

\$4,833

After reviewing the provider contracts for each of the sampled providers to determine their network status, we determined that seven claims, totaling \$4,833, were overcharged to the FEHBP.

Part III, section 3.2 (b) (1) of the Contract, requires carriers to only charge costs to the FEHBP that are actual, allowable, allocable, and reasonable. Additionally, Part II, section 2.3 (g) states the Carrier is required to make a prompt and diligent effort to recover erroneous payments.

For each of these claims, we found that the provider's network status had changed during the scope of the audit, yet the claims processor still applied the fee rate associated with an incorrect network status when recalculating the claim.

Additionally, we also found 42 other claims where the provider network status was not accurate according to the provider contracts. In these cases, the finding amounts were immaterial. However, applying the incorrect provider's network status could result in an incorrect calculation of the patient's liability amount, which could result in overcharges to FEHBP members, as was identified above.

In response to our draft audit report, the Plan conducted a training exercise for their claims processors regarding maintaining the provider files so all providers are reimbursed accurately according to their contracted network status. The training also covered how to find the correct provider network. It additionally covered the pricing of dental benefits based on the type of claim form and procedures submitted by the dental provider. Based on the documentation related to this training that was provided by the Association as part of its draft report response, we believe the training should adequately mitigate the errors identified in this review going forward.

Recommendation 2

We recommend the contracting officer disallow \$4,833 in overcharges to the FEHBP due to processor errors.

Association Response:

The Association agrees with the recommendation and states that it has returned \$4,270 of the amount questioned, \$430 is in the recovery phase, and \$133 is uncollectible.

C. Unlisted Procedure Code Review

\$2,536

We tested claims in this area because unlisted procedure codes typically require more documentation to support the claim, and because many of these claims require manual intervention for pricing.

Of the 23 claims selected for review, we identified 6 claims totaling \$2,536 in overcharges to the FEHBP due to manual processor errors. In most instances, the processor incorrectly applied an allowance of 65 percent of billed charges, instead of applying the provider's contracted reimbursement rate.

As previously cited from Contract CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. In addition, the Carrier is required to make a prompt and diligent effort to recover erroneous payments.

In response to our draft audit report, the Plan conducted a training exercise for their claims processors regarding calculating reimbursement for unlisted procedure codes. The training covered Medical Management review and default pricing of benefits. Based on the documentation related to this training that was provided by the Association as part of its draft report response, we believe the training should adequately mitigate the errors identified in this review going forward.

Recommendation 3

We recommend the contracting officer disallow \$2,536 in overcharges to the FEHBP due to manual processor errors.

Association Response:

The Association agrees with the recommendation and stated that it has recovered and returned \$1,363 of the monies questioned and is still trying to recover the remaining \$1,173.

APPENDIX



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

October 28, 2019

Deleted by the OIG – Not Relevant to the Final Report

Advanced Claims Analysis Team
Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, Room 6400
Washington, DC 20415-11000

**Reference: OPM DRAFT AUDIT REPORT
HMSA Blue Cross and Blue Shield
Audit Report Number 1A-10-47-19-013
Issued: September 19, 2019 Received September 26, 2019**

Deleted by the OIG – Not Relevant to the Final Report

This is the HMSA 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:

A. System Pricing Review (IR1) \$198,358

Recommendation 1

We recommend the contracting officer require the Plan to return \$198,358 in overcharges to the FEHBP due to manual processor errors.

Plan Response

The Plan agrees to payment errors totaling \$198,252. The Plan has returned \$196,812 and \$1,440 is in the recovery phase. **Deleted by the OIG – Not Relevant to the Final Report**

Recommendation 2: *(Not included in the report.)*

Due to the amount of manual processing errors, we recommend the contracting officer require the Plan to perform training to ensure the Plan's processors understand how to calculate claims when a claim requires manual intervention.

Plan Response

The Plan developed a training program on how to process these types of claims and presented the training to Plan claims staff as of September 27, 2019. The training document and attendance list are included.

B. Provider Network Review (IR2)

\$4,932

Recommendation 3: *(Recommendation 2 in the report.)*

We recommend the contracting officer require the Plan to return \$4,932 in overcharges to the FEHBP due to manual processor errors.

Plan Response:

The Plan agreed to overpayments totaling \$4,833 of which \$4,270 has been returned to the Program, \$430 is in the recovery phase Program and \$133 is uncollectible.

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Recommendation 4: *(Not included in the report.)*

We recommend the contracting officer require the Plan to review their policies for maintaining the provider files so all providers are reimbursed accurately according to their contracted network status.

Plan Response:

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The Plan developed a training program on how to process these types of claims and presented the training to Plan claims staff as of September 27, 2019. The training document and attendance list are included.

C. Unlisted Procedure Code Review (IR8)

\$2,536

Recommendation 5: *(Recommendation 3 in the report.)*

We recommend the contracting officer require the Plan to return \$2,536 in overcharges to the FEHBP due to manual processor errors.

Plan Response:

The Plan agreed to overpayments totaling \$2,536 and have recovered \$1,363 and \$1,173 is in the recovery phase.

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Recommendation 6: *(Not included in the report.)*

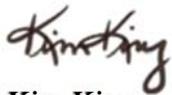
Due to the amount of manual processing errors, we recommend the contracting officer require the Plan to perform training to ensure the Plan's processors understand how to calculate claims for unlisted procedure codes.

Plan Response:

The Plan developed a training program on how to process these types of claims and presented the training to Plan claims staff as of September 27, 2019. The training document and attendance list are included.

Thank you for this opportunity to respond to the recommendations included in this draft report. If you have any questions, please contact me at 202.942.1285 or Lisa Taylor at 202.649.1759.

Sincerely,



Kim King
Managing Director, FEP Program Assurance

cc: Sylvia Pulley, OPM Contracting Officer



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