



**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
CareFirst Blue Cross Blue Shield**

Report Number 1A-10-85-17-049

Original Issue Date: October 23, 2019

Corrected Report Issue Date: April 15, 2020

Errata page

The U.S. Office of Personnel Management Office of the Inspector General Office of Audit

Audit of Claims Processing & Payment Operations at CareFirst Blue Cross Blue Shield

On page 7 we incorrectly identified \$180,426 as increased member cost shares due to program overcharges. It was brought to our attention that member cost shares were both increased and decreased due to the program overcharges.

Our original text on page 7 was as follows: “Our review identified \$1,227,289 in Program overcharges due to billing an incorrect place of service. We also identified \$180,426 in increased member cost shares due to the Program overcharges.”

The page 7 text was changed to read: “Our review identified \$1,227,289 in Program overcharges due to billing an incorrect place of service. These program overcharges also caused increased cost shares to some members and decreased cost shares to other members.”

The corrections made to the paragraph on page 7 do not alter the conclusions and recommendations made in the final report.

EXECUTIVE SUMMARY

Audit of Claims Processing and Payment Operations at CareFirst Blue Cross Blue Shield

Report No. 1A-10-85-17-049

April 15,

Why Did We Conduct the Audit?

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

What Did We Audit?

The audit covered claim payments at the Plan from January 1, 2014, through July 31, 2017, as reported in the Association's Government-wide Service Benefit Plan Annual Accounting Statements.



Michael R. Esser
*Assistant Inspector General
for Audits*

What Did We Find?

Our audit identified a significant amount of claim payment errors. Additionally, this audit determined that the overall processing of claims from overseas participating providers (i.e., providers participating in the Plans' provider network (PPO)) is not in compliance with the contract terms. In most instances, the Plan incorrectly paid non-licensed providers that were within its PPO network. In addition to the identified overcharges, this non-compliance also creates a concern for member safety. This report questions \$3,058,657 in health benefit overcharges to the FEHBP. Specifically, our audit identified the following:

- A. Place of Service Overcharges – The Plan incorrectly paid 5,119 claims, totaling \$1,227,289 in overcharges to the FEHBP, due to billing an incorrect place of service, which also potentially resulted in duplicate payments.
- B. System Pricing, Contract and License Review – The Plan incorrectly paid 45 claims, totaling \$1,364,155 in overcharges to the FEHBP. In most instances, these errors were due to payments made to non-licensed PPO overseas providers.
- C. Amounts Paid Greater than / Equal to Billed Charges Review – The Plan incorrectly paid 119 claims, totaling \$467,213 in overcharges to the FEHBP. In most instances, these errors were due to payments made to non-licensed PPO overseas providers.

ABBREVIATIONS

ASC	Ambulatory Surgical Center
Association	Blue Cross Blue Shield Association
BCBS	Blue Cross and Blue Shield
CPT	Current Procedural Terminology
DDP	Digestive Disease Physicians
DOS	Date of Service
FEHB	Federal Employees Health Benefits
FEHBP	Federal Employees Health Benefit Program
FEP	Federal Employee Program
GIE	GI Endoscopy Center of Northern Virginia
OIG	Office of the Inspector General
OBRA	Omnibus Budget Reconciliation Act
OPM	U.S. Office of Personnel Management
Plan	CareFirst Blue Cross Blue Shield
POS	Place of Service
PPO	Preferred Provider Organization
RVU	Relative Value Unit

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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) claims processing and payment operations at CareFirst Blue Cross Blue Shield (Plan). The Plan is located in Owings Mills, Maryland. The U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG) performed the audit as authorized by the Inspector General Act of 1978, as amended.

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

The Blue Cross Blue Shield Association (Association), on behalf of participating Blue Cross and Blue Shield (BCBS) plans, has entered into a Government-wide Service Benefit Plan contract (CS-1039) with OPM to provide a health benefit plan authorized by the FEHB Act. The Association delegates authority to participating local BCBS plans throughout the United States to process the health benefit claims of its Federal subscribers. There are 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 Service Benefit Plan. The FEP Director's Office coordinates the administration of the contract with the Association, member BCBS plans, and OPM.

The Association has also established an FEP Operations Center. The Plan, 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 Service Benefit Plan 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 No. 1A-10-85-09-023 dated May 21, 2010. This report covered claim payments from January 1, 2003, through October 31, 2005. All findings from the previous audit have been resolved.

The results of this current audit were discussed with Plan and Association officials throughout the audit and at an exit conference dated October 15, 2018. The Plan's comments offered in response to the draft report were considered in preparing our final report and are included as Appendices to this report. Additional documentation provided by the Association and BCBS plans on various dates through July 15, 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 contract provisions relative to health benefit payments.

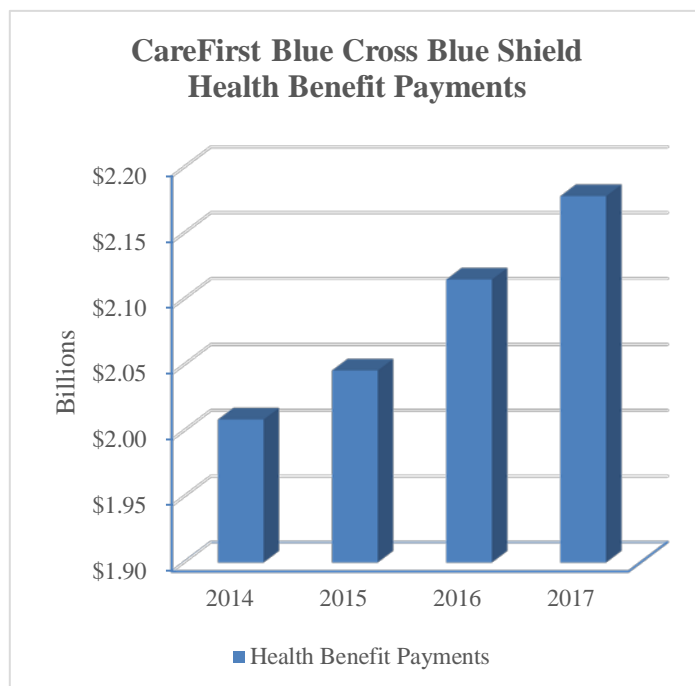
SCOPE

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.

We reviewed the Association's Government-wide Service Benefit Plan Annual Accounting Statements as they pertain to Plan codes 190 / 690 (Maryland service area), 080 / 081 / 086 / 580 (DC service area) and 082 / 582 (Overseas service area) for contract years 2014 through 2017² (see Exhibit I) and determined the Plan paid approximately \$8.4 billion in health benefit charges.

From this universe, we judgmentally selected various samples for review. We reviewed approximately 179,869 claims, totaling \$64.9 million in payments, for proper adjudication.

Exhibit I – Health Benefit Payments



² Although the audit scope covered January 1, 2014, through July 31, 2017, the Association's Government-wide Service Benefit Plan 2017 Annual Accounting Statement reports through year-end December 31, 2017.

METHODOLOGY

Exhibit II below describes the methodology we used to select our claims samples. The results of these samples were not projected to the universe of claims.

Exhibit II – Summary of Samples Selected for Review

Review	Total Population		Selection Methodology	Sample	
	Claim Count	Amount Paid		Claim Count	Amount Paid
A. Place of Service Overcharges*	20,571	\$6,705,137	All	20,571	\$6,705,137
B. System Pricing, Contract, and License Review	56,953,950	\$6,451,953,062	Judgmental	254	\$10,811,752
C-1. Amounts Paid Equal/Greater Than Billed Charges*	1,556,301	\$27,525,556	Judgmental	200	\$433,901
C-2. Overseas Participating Professional Providers	12,008	\$599,094,583	Judgmental	83	\$754,322
C-3. Ambulance Review	158,659	\$4,124,464	All	158,659	\$42,688,097
C-4. Remote Pricing Indicator “N”	8,639	\$42,688,097	Judgmental	24	\$297,380
D. Claims Processing	199	\$9,650,294	Judgmental	78	\$3,192,374
Totals				179,869	\$64,882,963

**Universe shown by claim lines.*

- 1) **Place of Service Overcharges Review** – We selected and reviewed all claims for the GI Endoscopy Center and Digestive Disease Physicians group reimbursed from January 1, 2014, through July 31, 2017.

- 2) **System Pricing, Contract, and License Review** – Our population consisted of all claims when the FEHBP paid as the primary insurer and which were potentially not priced according to Omnibus Budget Reconciliation Act (OBRA) of 1990 or 1993 or case management guidelines. From this population, we utilized SAS to judgmentally select 75 claims from CareFirst BCBS District of Columbia, 74 claims from CareFirst BCBS of Maryland, and 50 Overseas 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. Also, we judgmentally selected and reviewed all 55 claims paid to 5 unlicensed providers.

- 3) **Amounts Paid Equal/Greater Than Billed Charges Review** – Our population consisted of all claims in the scope where the amount paid was greater than or equal to the billed amount. Our population excluded all Veteran Affairs and Indian Health Service providers, OBRA 90 and OBRA 93 claims. We judgmentally selected and reviewed 125 participating provider claims and 75 non-participating provider claims based on stratified payment categories (e.g., \$500 to \$999.99) and the stratum's total dollars. From this review, we identified several high-risk areas which resulted in additional reviews (refer to numbers 4 through 6 for these reviews).
- 4) **Overseas Participating Professional Providers Review** – Our population consisted of all participating overseas providers where the amounts paid were equal or greater than billed charges. We judgmentally selected a sample of 34 professional overseas claims where the billed amounts were less than \$2,000. We also judgmentally selected a sample of 25 professional overseas claims where the billed amounts were greater than or equal to \$2,000. Finally, we expanded our review by selecting 24 claims for 6 overseas providers who were unlicensed.
- 5) **Ambulance Review** – Selected and reviewed all 158,659 ambulance claims.
- 6) **Remote Pricing Indicator “N” Review** – Our population consisted of all claims containing a pricing indicator “N” field, which essentially allows the claim to bypass the pricing system and use billed charges instead of appropriate negotiated allowances. These claims should be manually reviewed and adjusted using correct pricing after the initial processing. From this population, we judgmentally selected 24 high dollar claims.
- 7) **Claims Processing Review** – Our population consisted of 199 claims taken from the System Pricing sample. Of these 199 claims, we judgmentally selected 78 claims for system testing based on type of service and procedure performed.

In planning and conducting our audit, we also 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.

Additionally, we 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 the processing and payment of claims. 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 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.

Audit fieldwork was performed at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida through June 2019.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. Place of Service Overcharges Review

\$1,227,289

Our review identified \$1,227,289 in Program overcharges due to billing an incorrect place of service. These program overcharges also caused increased cost shares to some members and decreased cost shares to other members. Digestive Disease Physicians (DDP) is a participating gastroenterology physicians group that sees patients and performs outpatient surgical procedures in an endoscopy suite out of the same office location. This endoscopy suite, known as the GI Endoscopy Center (GIE), is a participating ambulatory surgical center (ASC).

While reviewing claims for patients who had procedures performed at the GIE, we found claims were submitted for the same person for the same procedures on the same day by both DDP and GIE. Consequently, we initially identified one of the claims as a duplicate payment. However, after reviewing additional documentation provided by the Plan, we discovered the real issue was DDP improperly billed their services performed in the endoscopy suite as an office visit place of service (POS) code 11, instead of as an ambulatory surgical visit POS 24, which resulted in overcharges to the Program. Specifically, we found 4,140 occurrences of members billed by DDP and GIE in this manner, resulting in 5,119 claims that were paid. Office visits for these procedures have a higher reimbursement rate than if billed as an ASC, causing overcharges to the FEHBP.

In order to re-price all of the improperly paid POS 11 claims as POS 24 claims, we requested the provider contracts for both DDP and GIE. However, the Plan redacted the pricing information in both contracts. The Plan did provide separate pricing support from their pricing system for 13 procedure codes, which we used to re-price the claims. For any procedure codes that were unsupported, we used Medicare allowances to re-price the claims.

A lack of internal controls in the Plan’s claims processing system allowed claims to be billed using an incorrect place of service, resulting in \$1,227,289 in overcharges to the FEHBP.

Contract CS 1039, Part III, section 3.2 (b)(1) states, “The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable . . . [and] on request, document and make available accounting support for the cost to justify that the cost is actual, reasonable and necessary”

The FEHBP has been overpaying this provider since 2013 and will continue overpaying for services if these errors are not resolved.

Association Response:

“Digestive Disease Physicians may perform digestive related procedures either in office (POS 11) or in an Ambulatory Surgical Center (ASC) (POS 24) but not both at the same time. Digestive Disease Physicians performed the surgical services in GI Endoscopy Center (an Ambulatory Surgery Center Entity) (POS 24). Digestive Disease Physicians however submitted claims for those surgical services as having been performed in the office setting (POS 11), thereby resulting in an improper overpayment. To understand how this results in an overpayment, there must be an understanding of how POS impacts reimbursement to the provider.

Reimbursement Calculation: The reimbursement amount assigned to a Current Procedural Terminology (CPT®) code is determined using Procedural Relative Value Units (RVU). RVUs contain 3 expense elements: physician work, practice expense, and malpractice expense. These elements are weighted based on the level of provider effort, supplies and office administration, and risk.

In a Professional Office, which is billed as POS 11, the average RVU expense element ratio in the allowed amount is 52/44/4. The practice expense portion of the reimbursement includes the provider’s office related expenses. When a physician provides services in an ASC, POS 24, it is the expectation that the provider is using the ASC’s facility and as a result the POS 24 has a much lower RVU due to the exclusion or reduction of the practice expense element of the RVU. The ASC submits a separate facility claim to recover the related facility expenses. These arrangements help ensure the appropriate party is reimbursed for their contribution to the member’s services.

Submission of a facility claim (POS 24) in addition to a professional claim (POS 11) for the same service to a member results in duplicate reimbursement for the facility or the professional practice facility related charges.

Overpayment Calculations. In calculating the correct overpayment amount, all applicable ASC and professional claims were identified and segregated. ASC claims data was condensed to identify applicable patients and DOS. Professional claims were cleaned to remove non-applicable CPT® codes and claims with POS other than 11. A cross-query was performed to identify professional claims where a facility claim occurred for the same patient on the same DOS.

CPT® code payment differential ratios were consistent within CPT® codes for PPO networks, however there were variations by year. This ratio consistency permitted the differential to be

expressed as a percentage value rather than dollar value, allowing for a more accurate calculation of overpayment despite variables such as Coordination of Benefits or patient liabilities.

Utilizing OPM-OIG Draft Audit Report 1A-10-85-17-049 Digestive Disease Physicians' claim paid period of January 1, 2013 through December 31, 2017, the following chart summarizes the overpayments made by CareFirst FEP."

Overpayment Summary 1/1/2013 – 12/31/2017

	<i>Billed</i>	<i>Paid</i>	<i>Overpayment</i>	<i>Line Items</i>	<i>Claims</i>
<i>FEP</i>	<i>\$15,440,809.00</i>	<i>\$4,222,122.06</i>	<i>\$1,816,351.64</i>	<i>8622</i>	<i>5485</i>

OIG Comments:

The Plan's overpayment amount of \$1,816,352 covers 5,485 claims paid from January 1, 2013, to December 31, 2017. However, our audit scope only encompasses claims paid from January 1, 2014, through July 31, 2017. Consequently, this report only captures those overpayments that occurred during this time period. Our audit identified \$1,227,289 in overpayments from 5,119 claims. In responding to our draft report, the Plan explained their method of calculating overpayments. However, they did not support their method, so we were unable to verify their calculated overcharges. Consequently, we re-priced each claim individually based on procedure code pricing support received from the Plan as well as Medicare allowances when needed, also taking into account coordination of benefits and patient liability amounts. Given the data and documentation we had available, we feel our calculations are accurate representations of the FEHBP overpayments.

Recommendation 1

We recommend that the contracting officer require the Plan to return \$1,227,289 in overcharges to the FEHBP.

Recommendation 2

We recommend that the Plan ensure that all amounts overpaid to this provider, including those claims paid outside of the scope of this audit, are returned to the FEHBP.

Recommendation 3

We recommend that the Plan ensure that provider claims are paid in accordance with the appropriate place of service and according to their contracted rates.

B. System Pricing, Contract and License Review

\$1,364,155

We sampled and reviewed 254 claims to verify whether the provider was properly licensed and the claims were processed and paid according to the provider's contracted rates. Of these 254 claims, the Plan incorrectly paid 45 claims, totaling \$1,364,155 in overcharges to the FEHBP. See below for the details of these questioned overcharges:

A lack of internal controls over the claims processing and provider credentialing areas resulted in FEHBP overcharges of \$1,364,155.

1. Provider Licensing

The Plan did not provide documentation of a medical license for five providers in the Plan's provider network. As a result, the Plan incorrectly paid 43 claims, totaling \$1,343,254 in overcharges to the FEHBP. Additionally, medical services provided by potentially non-licensed medical service providers creates a concern for member safety.

The FEHBP only allows health care providers to provide services to members when acting within the scope of their license or certification. Our review found five overseas providers participating in the Plan's provider network, where the Plan was unable to provide a medical license or provider enrollment form. When applying to be in the Plan's preferred provider organization (PPO) network, the provider completes an enrollment form. During this enrollment process, the provider submits information to the Plan that includes, but is not limited to, the following: registrations or licenses within the provider scope of practice, license renewal, and any local or international accreditations. Because the Plan could not produce a license or proof of enrollment for these providers, we questioned all claims paid to these providers.

2. System Pricing

We identified a system processing error where the Plan did not properly coordinate one claim with Medicare. The Plan did not provide documentation to support why the claim did not automatically defer for a Medicare coordination review. This resulted in an overcharge of \$18,609 to the FEHBP.

3. Contract Allowance

We identified a manual processing error on one claim where the Plan incorrectly paid multiple procedures at 100% of the allowance instead of applying the 50% discount. This resulted in an overcharge of \$2,292 to the FEHBP.

The 2017 BlueCross and BlueShield Service Benefit Plan brochure, page 17, states, “We provide benefits for the services of covered professional providers Covered professional providers are health care providers who perform covered services when acting within the scope of their license or certification under applicable state law and who furnish, bill, or are paid for their health care services in the normal course of business. Covered services must be provided in the state in which the provider is licensed or certified. Your Local Plan is responsible for determining the provider’s licensing status and scope of practice.”

Additionally, Contract CS 1039, Part II, section 2.6 states, “(a) The Carrier shall coordinate the payment of benefits under this contract with the payment of benefits under Medicare . . . (b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary carrier”

Finally, Contract CS 1039 states the Carrier may charge a cost to the contract if the cost is actual, allowable, allocable, and reasonable.

While these errors were limited to a small number of claims, applied globally, the overcharges could be substantial if the root causes are not addressed.

Association Response:

In regards to the system and manual processing questioned charges, “The Plan agrees with \$20,900.73 for the claim identified as a system processing error and the claim identified as a manual processing error. The Plan returned \$2,291.52 to the Program on June 20, 2018 for the claim identified as a manual processing error and the Plan initiated recoveries for the remaining \$18,609.21 in connection with the system processing error.”

The Plan disagrees that \$1,343,254 is due to the FEHBP, related to the 43 claims paid to five overseas providers. “Per Section 3 of Appendix A to CS 1039, the FEP Brochure: ‘We provide benefits for the services of covered professional providers . . . Covered professional providers are physicians and other healthcare providers when they provide covered services and meet the state’s applicable licensing or certification requirements. If the state has no applicable

licensing or certification requirement, the provider must meet the requirements of the Local Plan.’

There is no state law that applies to overseas claims. Some foreign countries may impose licensing requirements on physicians at the national or local level, but the foreign processes are not consistent and do not align with the types of licensing/certification requirements that apply in the United States. Accordingly, the appropriate requirement for determining whether an overseas provider is a covered provider under the FEP contract, as reflected in the FEP Brochure, is that the provider must meet the requirements of the Local Plan.

With respect to providers who participate in the FEP network overseas, the Carrier’s overseas vendor is responsible for ensuring that the provider maintains appropriate licensure as required for the jurisdiction in which the provider is operating. . . . Accordingly, the Plan believes that it has adequate controls in place to meet the contractual requirements under CS 1039 with respect to providing benefits for services rendered by covered providers overseas . . .”

OIG Comments:

We acknowledge the Plan’s agreement with \$20,901 in questioned costs. We also acknowledge that the Plan provided copies of refund letters that were sent to the provider requesting the return of the \$2,292. However, we do not have evidence that the letter of credit account was adjusted for the actual return of funds. Regarding the contested amount of \$1,343,254, although the FEP Benefit brochure states, “the provider must meet the requirements of the Local Plan,” the Plan did not provide documentation to support that either the Plan or its vendor complied with CareFirst’s PPO overseas provider policy. This policy requires overseas providers to enroll with CareFirst’s overseas claims processing vendor to be considered a PPO provider and the Plan did not provide documentation showing the enrollment process was completed. Provider enrollment information should be readily available and maintained. Consequently, we maintain that the Plan does not have adequate controls in place to meet its contractual requirements. This lack of adequate controls resulted in our questioning of the \$1,343,254.

Recommendation 4

We recommend the contracting officer require the Plan to return \$1,364,155 in overcharges to the FEHBP.

Recommendation 5

We recommend that the Plan enhance their local policies to assure proper documentation for all PPO overseas providers is being maintained.

Recommendation 6

We recommend that the Plan identify the reason why the identified claim requiring coordination with Medicare did not defer in the local Plan or FEP Direct system and implement corrective actions to address the cause of the error.

C. Amounts Paid Greater than / Equal to Billed Charges \$467,213

Our review determined the Plan incorrectly paid 119 claims, totaling \$467,213 in overcharges to the FEHBP. We identified three high-risk areas in our initial sample of 200 claims that required further review. Consequently, we expanded our initial sample to review 158,766 claims, totaling \$43,739,799 in charges to the FEHBP. See below for the details of these questioned overcharges:

- We questioned 24 claims paid to 6 overseas PPO providers, totaling \$329,433, because the Plan was unable to provide licensing support or provider enrollment forms for the providers.
- We questioned 74 ambulance claims, totaling \$96,960, because FEP Direct and/or the Plan's local system allowed the claims to process as a non-participating benefit when the provider was participating in the Plan's local network.
- We questioned 12 claims, totaling \$29,390, due to manual processor errors. These claims deferred for review. However, a remote pricing indicator of "N" was applied in the FEP Direct system, which allowed the claim to bypass the local system pricing and use billed charges instead of the contracted rates.
- We identified six claims, totaling \$10,866, that were improperly paid due to manual processing errors, such as duplicate payments, Medicare coordination errors, allowing non-covered services, and no documentation of the provider bill.
- We identified three claims, totaling \$564, which were paid in error due to insufficient support for the claim or calculation errors during processing.

While these errors were limited to a small number of claims, applied globally, the overcharges could be substantial if the root causes are not addressed.

As previously cited, the BCBS Service Benefit Plan brochure only covers services provided by licensed professional providers.

Additionally, Contract CS 1039 states that the Carrier may charge a cost to the contract if the cost is actual, allowable, allocable, and reasonable.

Association Response:

The Plan disagrees with our finding regarding overseas participating providers. As previously mentioned, the Plan believes it has adequate controls in place to meet contractual requirements under CS 1039 with respect to providing benefits for services rendered by covered overseas providers.

The Plan disagrees with one claim totaling \$523 for manual processing errors of claims with a remote pricing indicator of “N.”

The Plan disagrees with one claim totaling \$5,634. This claim was for ambulance transport from one facility to another. The Plan has requested medical records and a decision cannot be determined until the records have been reviewed.

For the remaining questioned items in the draft report, the Plan did not provide a statement of their position on these items as part of their draft report response.

OIG Comments:

After reviewing the Plan’s response to the draft report and supporting documentation, we maintain that \$467,213 is due to the FEHBP. Of this amount, the Plan agrees that \$34,099 was overcharged to the Program. We will continue to question the following:

- \$329,433 for licensing issues with six participating overseas providers, where the Plan could not support that the providers were licensed or enrolled as part of their overseas network;
- \$5,634 for a claim that is unsupported and the Plan is still reviewing;
- \$523 for manual processor errors on a claim with a remote indicator of “N”;

- \$96,960 in overpayments to participating ambulance providers who were reimbursed as non-participating providers. The Plan provided documentation to show that a majority of the questioned charges are unrecoverable due to provider contracting limits. However, we will continue to question these charges since Contract CS 1039, Part II, section 2.3 states, “(g) ... the Carrier shall make a prompt and diligent effort to recover the erroneous payment ... to the provider, from the provider. The recovery of any overpayment must be treated as an erroneous benefit payment, overpayment, or duplicate payment under 48 C.F.R. §1631.201-70(h) regardless of any time period limitations in the written agreement with the provider.”; and
- \$564 for three claims due to insufficient support for the claim or calculation errors during processing.

Recommendation 7

We recommend that the contracting officer require the Plan to return \$467,213 in overcharges to the FEHBP.

Recommendation 8

We recommend that the Plan identify the root cause of alterations to ambulance providers’ network status during the claim pricing process and implement needed corrective actions to address this issue

Recommendation 9

We recommend that the Plan identify all ambulance claims where the provider network status was incorrectly altered during the pricing process and return any amounts improperly paid to the FEHBP.

Recommendation 10

We recommend that the contracting officer require the Plan to create a policy to review all Remote Pricing “N” claims and ensure these claims are being manually reviewed and paid in accordance with the contracted rate.

D. Claims System Processing Review

The claims processing review provided an opportunity to test a sample of 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 FEP Direct system applies FEP member benefits.

We were able to conduct a complete test of the Plan's claims adjudication process to validate the system's processing controls related to the samples presented to the Plan. 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 did not identify any issues. Therefore, we conclude that the Plan's local claims' system is properly validating and paying claims.

APPENDIX A



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January 31, 2019

Ms. [REDACTED]
U.S. Office of Personnel Management
Office of the Inspector General
Advanced Claims Analysis Team
Senior Team Leader
300 N. Hogan Street, Suite 9-111
Mail Box 9-350
Jacksonville, FL 32202

**Reference: OPM DRAFT AUDIT REPORT
CareFirst Blue Cross and Blue Shield
Audit Report Number 1A-10-85-17-049
(Dated and Received December 21, 2018)**

Dear Ms. [REDACTED]:

The CareFirst Blue Cross and Blue Shield response to the findings in the above referenced U.S. Office of Personnel Management (“OPM”) Draft Audit Report is as follows:

A. Digestive Disease Physicians Review

\$3,983,505

Recommendation 1

We recommend the contracting officer require the Plan to return \$3,983,505 to the FEHBP for potential overcharges to the FEHBP.

CareFirst Response

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Digestive Disease Physicians may perform digestive related procedures either in office (POS 11) or in an Ambulatory Surgical Center (ASC) (POS 24) but not both at the same time. Digestive Disease Physicians performed the surgical services in GI Endoscopy Center (an Ambulatory Surgery Center Entity) (POS 24). Digestive Disease Physicians however submitted claims for those surgical services as having been performed in the office setting (POS 11), thereby resulting in an improper overpayment. To understand how this results in an overpayment, there must be an understanding of how POS impacts reimbursement to the provider.

Reimbursement Calculation: The reimbursement amount assigned to a Current Procedural Terminology (CPT®) code is determined using Procedural Relative Value Units (RVU). RVUs contain 3 expense elements: physician work, practice expense, and malpractice expense. These elements are weighted based on the level of provider effort, supplies and office administration, and risk.

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In a Professional Office, which is billed as POS 11, the average RVU expense element ratio in the allowed amount is 52/44/4. The practice expense portion of the reimbursement includes the provider’s office related expenses. When a physician provides services in an ASC, POS 24, it is the expectation that the provider is using the ASC’s facility and as a result the POS 24 has a much lower RVU due to the exclusion or reduction of the practice expense element of the RVU. The ASC submits a separate facility claim to recover the related facility expenses. These arrangements help ensure the appropriate party is reimbursed for their contribution to the member’s services.

Submission of a facility claim (POS 24) in addition to a professional claim (POS 11) for the same service to a member results in duplicate reimbursement for the facility or the professional practice facility related charges.

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Example:

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Overpayment Calculations. In calculating the correct overpayment amount, all applicable ASC and professional claims were identified and segregated. ASC claims data was condensed to identify applicable patients and DOS. Professional claims were cleaned to remove non-applicable CPT® codes and claims with POS other than 11. A cross-query was performed to identify professional claims where a facility claim occurred for the same patient on the same DOS.

CPT® code payment differential ratios were consistent within CPT® codes for PPO networks, however there were variations by year. This ratio consistency permitted the differential to be expressed as a percentage value rather than dollar value, allowing for a more accurate calculation of overpayment despite variables such as Coordination of Benefits or patient liabilities. Tables supplemented by the Pricing Inquiry Tool Screenshots included in **Attachment 1** include the Digestive Disease Physicians’ reimbursement rates for all impacted CPT® codes by year and Place of Service.

Utilizing OPM-OIG Draft Audit Report 1A-10-85-17-049 Digestive Disease Physicians’ claim paid period of January 1, 2013 through December 31, 2017, the following chart summarizes the overpayments made by CareFirst FEP.

Overpayment Summary 1/1/2013 – 12/31/2017

	Billed	Paid	Overpayment	Line Items	Claims
FEP	\$15,440,809.00	\$4,222,122.06	\$1,816,351.64	8622	5485

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B. System Pricing Review

\$1,385,420

Recommendation 2

We recommend the contracting officer require the Plan to return \$1,385,420 in potential overcharges to the FEHBP.

CareFirst Response

With respect to Recommendation No. 2, the Plan agrees with \$20,900.73 for the claim identified as a system processing error and the claim identified as a manual processing error. The Plan returned \$2,291.52 to the Program on June 20, 2018 for the claim identified as a manual processing error and the Plan initiated recoveries for the remaining \$18,609.21 in connection with the system processing error. See **Attachment 3** for copies of the adjustment showing that the Plan returned \$2,291.52 to the Program and copies of the four refund letters for \$18,609.21.

However, the Plan disagrees with the finding that \$1,364,520 for Non-licensed Overseas Professional Providers should be disallowed. Per Section 3 of Appendix A to CS 1039, the FEP Brochure: “We provide benefits for the services of covered professional providers... Covered professional providers are healthcare providers who perform covered services when acting within the scope of their license or certification under applicable state law... **Covered professional providers** are physicians and other healthcare providers when they provide covered services *and* meet the state’s applicable licensing or certification requirements. **If the state has no applicable licensing or certification requirement, the provider must meet the requirements of the Local Plan.**”

There is no state law that applies to overseas claims. Some foreign countries may impose licensing requirements on physicians at the national or local level, but the foreign processes are not consistent and do not align with the types of licensing/certification requirements that apply in the United States. Accordingly, the appropriate requirement for determining whether an overseas provider is a covered provider under the FEP contract, as reflected in the FEP Brochure, is that the provider must meet the requirements of the Local Plan.

With respect to providers who participate in the FEP network overseas, the Carrier’s overseas vendor is responsible for ensuring that the provider maintains appropriate licensure as required for the jurisdiction in which the provider is operating.

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Accordingly, the Plan believes that it has adequate controls in place to meet the contractual requirements under CS 1039 with respect to providing benefits for services rendered by covered providers overseas

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Recommendation 3

We recommend the contracting officer require the Association to develop FEP Direct system enhancements to disallow participating provider claims to be paid as a non-par benefit.

CareFirst Response

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C. Amounts Paid Greater Than/Equal to Billed Charges

\$1,361,407

Recommendation 4

We recommend the contracting officer require the Plan to return \$1,361,407 in potential overcharges to the FEHBP.

CareFirst Response

Non-licensed Overseas Professional Provider

The Plan disagrees with the finding regarding Non-licensed Overseas Professional Providers **Sentence Deleted by the OIG – Not Relevant to the Final Report** the Plan believes that it has adequate controls in place to meet the contractual requirements under CS 1039 with respect to providing benefits for services rendered by covered providers overseas.

The OIG questioned claims payments for services provided by certain of those providers in the amount of \$12,606. The Plan agrees that of this amount, \$5,232.30 was overcharged to the FEHBP. The Plan has returned \$5,191.05 to the program and is seeking to recover the remaining balance of \$41.25.

The Plan disagrees that \$7,273.80 was incorrectly charged to the Program for the following reasons:

- One claim totaling \$5,633.80 was for ambulance transport from 1 facility to another. The initial facility arranged the transport. Medical records have been requested and a determination on whether a potential overpayment occurred is pending the receipt and review of the records.

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System Processing Error – Ambulance Providers

See **Attachment 7** for documentation supporting the Plan's position with respect to these claims. See **Attachment 8** for copies of the ambulance provider contracts showing the date when the ambulance provider became PPO/Par with the Plan.

Manual Processing Errors

The Plan agrees with 11 claims totaling \$28,867.37 but disagrees with 1 claim for \$522.75. The Plan has adjusted the 11 claims and has already returned \$28,867.37 to the Program. The remaining claim was paid correctly. See **Attachment 9** for a copy of the FEP Direct screen-prints showing the return of funds and documentation to support the correct payment of one claim in the amount of \$522.75.

Recommendation 5

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CareFirst Response

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D. Claims System Processing Review

CareFirst Response:

The Plan acknowledges the OIG's comments regarding their testing a sample of claims in the Claims System Processing Review.

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]

Managing Director, FEP Program Assurance

cc: [REDACTED], OPM Contracting Officer

APPENDIX B

CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117-5559
www.carefirst.com



July 18, 2019

Office of Personnel Management
Office of the Inspector General
Mr. [REDACTED]
800 Cranberry Woods Drive, Suite 270
Cranberry Township, PA 16006

RE: **Audit Inquiry Response from CareFirst**

Dear Mr. [REDACTED]:

AUDIT INQUIRY #2 **Digestive Disease Physicians**

We reviewed the entire universe of 20,571 claims paid to the Digestive Disease Physicians and GI Endoscopy Center of Northern Virginia (collectively referred to as “provider”) during the scope of our audit. In total, the FEHBP paid the provider \$6,705,137 for various endoscopy services. The following summarizes our findings that resulted from our review.

Facility Claims

We searched for all occurrences where a member incurred claims for both a professional office visit with a place of service code (POS) 11 and an ambulatory surgical center (ASC) facility visit type of bill code 831 or 837 on the same day. In total, we identified 4,140 occurrences.

Provider Billing Error

We found for each occurrence where a facility claim was billed, there was also a separate professional claim billed for the same services. To determine which claim should be considered the duplicate, we contacted the Virginia Department of Health, Office of Licensure and Certification regarding this provider. They stated providers wishing to have operating rooms must seek certificate of public need approval, then licensure as an outpatient surgical hospital. They may then proceed towards federal certification as an ambulatory surgery center. However, providers may choose to do procedures, such as endoscopy, in procedure rooms, as office-based procedures, which does not require licensure as an outpatient surgical hospital.

We found the doctors who billed under the provider are licensed individually. However, there is no facility license for the provider group as an ASC. Therefore, any claims billed by the provider as an ASC are not covered according to FEHBP guidelines.

Based on our analysis, we consider the ASC claims to be duplicate claims. We are questioning all ASC claims totaling \$2,570,945 in payments as a result. We also found that 796 FEHBP members were potentially impacted by overpaying copayments or coinsurances as well as deductible charges by \$89,882.

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Professional Claims

We reviewed the pricing methodology used by the Plan to price professional claims that were paid to the provider. In total, 14,885 claims were paid totaling \$3,970,978.

No Pricing Support

The Plan did not provide pricing allowance support for 1,943 claims totaling \$139,237 in overcharges. Specifically, the Plan only provided support for thirteen procedure codes. For all other procedure codes, we used Medicare allowances and compared what the Plan used to price and pay these claims to calculate potential overcharges to the FEHBP. The professional claims we are questioning paid at a higher reimbursement rate than Medicare allowances.

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We respectfully request a meeting with the OPM OIG and OPM's Office of Special Investigations to fully discuss these issues.

Sincerely,



Derek Butler
Director, FEP Audit & Advisory Services | Corporate Audit & Assurance Services



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