



**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
Health Care Service Corporation
for Contract Years 2018 through 2020**

**Report Number 1A-10-17-21-018
Original Issue Date: February 23, 2022
Corrected Report Issue Date: March 16, 2022**

Errata Page

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

Audit of Claims Processing & Payment Operations at Health Care Service Corporation for Contract Years 2018 through 2020

On March 7, 2022, the Blue Cross Blue Shield Association (Association) submitted a revised response to the draft report (Appendix A) that superseded its original response from October 11, 2021. This revised response resulted in edits to the previous response from Health Care Service Corporation and the OIG's comments to Recommendation 17 on page 29 of the report. However, these changes did not alter the conclusions and recommendations made in the final report.

Executive Summary

Audit of Claims Processing and Payment Operations at Health Care Service Corporation for Contract Years 2018 through 2020

Report No. 1A-10-17-21-018

march 16, 2022

Why Did We Conduct the Audit?

The objective of our audit was to determine whether the health benefit costs charged to the Federal Employees Health Benefits Program (FEHBP) and services provided to its members by the Health Care Service Corporation (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). Specifically, we performed various claim reviews to determine if the internal controls over the Plan's claims processing system were sufficient to ensure that claims were properly processed and paid by the Plan.

What Did We Audit?

The Office of the Inspector General (OIG) has completed a performance audit of the FEHBP claim operations at the Plan. Our audit consisted of specific reviews of claims reimbursed during contract years 2018 through 2020. Our audit work was remotely conducted by staff in the Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida areas.



Michael R. Esser
*Assistant Inspector General
for Audits*

What Did We Find?

Overall, we found that the Plan's internal controls over its claims processing system were effective in ensuring that healthcare claims were properly processed and paid. However, for the areas reviewed, our audit identified 2,175 incorrectly paid claims resulting in net overpayments of \$982,117 by the FEHBP. The claim payment errors identified indicate a need to strengthen procedures and controls related to:

- Claims with unlisted procedure codes;
- Claims requiring coordination of benefits with Medicare;
- Potential duplicate claim payments;
- Provider network status determinations; and
- Co-surgeon claims.

Additionally, we also found that the Association's debarment policies and procedures do not fully adhere to the requirements set forth by the Federal regulations and the OPM OIG's Administrative Sanctions Group's (ASG) debarment guidelines.

Finally, we found that the Plan incorrectly identified 17 providers as debarred from participation in the FEHBP. Members were then incorrectly notified of this because the Plan did not contact the OPM OIG's ASG for clarification when it found incomplete or partial matches to the debarment file.

Abbreviations

5 CFR 980	Title 5, Code of Federal Regulations, Chapter 1, Part 890
Act	Federal Employees Health Benefits Act
ASG	OPM OIG's Administrative Sanctions Group
Association	Blue Cross Blue Shield Association
BCBS	Blue Cross Blue Shield
CAMT	The Association's Claims Auditing Monitoring Tool
CFR	Code of Federal Regulations
COB	Coordination of Benefits
Contract	Contract CS 1039 – The contract between the Blue Cross Blue Shield Association and the U.S. Office of Personnel Management
CPT	Current Procedural Terminology
EOB	Explanation of Benefits
FEHBP	Federal Employees Health Benefits Program
FEP	Federal Employee Program
FEP Direct	The Association's nation-wide claims processing system
Guidelines	OMP OIG's Guidelines for Implementation of FEHBP Debarment and Suspension Orders
HCPCS	Healthcare Common Procedure Coding System
HIO	OPM's Healthcare and Insurance Office
ID	Identification
Med A	Medicare Part A
Med B	Medicare Part B
Non-PAR	Non-Participating Provider
OIG	The Office of the Inspector General
OPM	U.S. Office of Personnel Management
PAR	Participating Provider
Plan	Health Care Service Corporation
PNS	Provider Network Status
POS	Place of Service

SAR	Semiannual Report
SBP	Service Benefit Plan
SSN	Social Security Number
UPC	Unlisted Procedure Codes
USC	United States Code

Table of Contents

	Executive Summary	i
	Abbreviations	ii
I.	Background	1
II.	Objectives, Scope, and Methodology	3
III.	Audits Findings and Recommendations	10
	1. Claim Payment Errors.....	10
	2. Debarment Notifications Not in Compliance with Regulations	19
	3. Incorrect Notification of Debarment Status	26
	Appendix A: Blue Cross Blue Shield Association’s October 11, 2021, response to the draft report	
	Appendix B: Blue Cross Blue Shield Association’s February 10, 2022, response to new recommendations added following review of its comments to the draft report.	
	Report Fraud, Waste, and Mismangement	

I. Background

This final report details the results of our performance audit of the Federal Employees Health Benefits Program (FEHBP) claims processing and payment operations at Health Care Service Corporation (Plan) for contract years 2018 through 2020. The audit was remotely conducted in the Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida areas.

The audit was conducted pursuant to the provisions of contract CS 1039 (Contract) between the Office of Personnel Management (OPM) and the Blue Cross Blue Shield Association (Association); Title 5, United States Code (USC), Chapter 89; and Title 5, Code of Federal Regulations (CFR), Chapter 1, Part 890 (5 CFR 890). The audit was performed by OPM's Office of the Inspector General (OIG), as authorized by the Inspector General Act of 1978, as amended.

The FEHBP was established by the Federal Employees Health Benefits Act (Act), Public Law 86-382, enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for Federal employees, annuitants, and dependents. OPM's Healthcare and Insurance Office (HIO) has overall responsibility for administration of the FEHBP, including the publication of program regulations and agency guidance. 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 Act are implemented by OPM through regulations codified in 5 CFR 890.

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

The Association has established a Federal Employee Program (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 its member BCBS plans, verifying subscriber eligibility, approving or denying the reimbursement of local plan payments of FEHBP claims (using computerized system edits), maintaining a history file of all FEHBP claims, and maintaining an accounting of all program funds.

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

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

The most recent audit report issued that covered claim payments for the Plan was report number 1A-10-17-14-037, dated November 19, 2015, which covered claim payments from January 1, 2011, through January 31, 2014. All findings from the previous audit have been satisfactorily resolved and closed.

The results of our audit were discussed with Association and Plan officials throughout the audit and at an exit conference on August 3, 2021. We issued a draft report, dated September 9, 2021, to solicit the Association's comments to the findings and recommendations. The Association's comments offered in response to the draft report were considered in preparing our final report and are included as an appendix to this report. Additional documentation provided by the Association on various dates through November 4, 2021, 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 the Contract's provisions relative to health benefit payments.

Scope and Methodology

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

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

- claims paid with unlisted procedure codes;
- claims potentially charged with an incorrect provider network status;
- claims potentially uncoordinated with Medicare;
- co-surgeon claims potentially paid incorrectly;
- COVID-19 respiratory pathogen panel codes;
- debarred provider reviews:
 - accuracy of those reported as debarred;
 - review of Plan policies and procedures;
- place of service claims review; and
- potential duplicate claim payments.

Due to the COVID-19 pandemic we were unable to conduct site visits during the audit. Consequently, all audit fieldwork was remotely conducted by staff in the Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida areas from March 2021 through November 2021.

We reviewed the Association's annual accounting statements for contract years 2018 through 2020 and determined that the Plan paid approximately \$11.5 billion in health benefit payments as they pertain to the following BCBS plan codes and coverage areas:

- 121 and 621 – BCBS of Illinois;
- 400 and 900 – BCBS of Texas;
- 250 and 751 – BCBS of Montana;
- 290 and 790 – BCBS of New Mexico; and
- 340 and 840 – BCBS of Oklahoma.

In planning and conducting our audit, we obtained an understanding of both the Association's and Plan's internal control structures to help determine the nature, timing, and extent of our auditing procedures. Our audit approach consisted mainly of substantive tests of transactions and not tests of controls. Based on our testing, we did not identify any significant matters involving the Association's internal control structure and its operations. However, since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on the Association's or the Plan's system of internal controls taken as a whole.

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

In conducting our audit, we relied to varying degrees on computer-generated data provided by the FEP Director's Office, the FEP Operations Center, the Association and the Plan. Through the performance of audits and an in-house claims data reconciliation process, we have verified the reliability of the BCBS claims data in our data warehouse, which was used to identify areas to test and to select our samples. The BCBS claims data is provided to the OPM OIG on a monthly basis by the FEP Operations Center, and after a series of internal steps, uploaded into our data warehouse. While utilizing the computer-generated data during our audit, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

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

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

1. **Unlisted Procedure Code Review** – We identified a universe of 12,214 claim lines, totaling \$17,376,611, with either unlisted, miscellaneous, or unclassified procedure codes with an amount paid of \$100 or higher.

We sorted and quantified this universe by the applicable Current Procedural Technology (CPT) code and Healthcare Common Procedure Coding System (HCPCS) code categories and selected the top four by total amount paid. From these four CPT and

HCPCS code categories, we judgmentally selected all 12 procedure codes with a cumulative amount paid of \$170,000 or greater.

From each procedure code selected, we chose the top three claim lines by amount (and also included nine claim lines with like amounts) for review to determine if the claims underwent adequate review and were paid correctly. In total, we selected a total of 45 claim lines, with amounts paid totaling \$2,047,059.

2. **Provider Network Status Review** – We identified all claims paid where a provider was paid both as a participating (PAR) and a non-participating (Non-PAR) provider. This resulted in a universe of 79,069 providers, with 60,355,662 claim lines paid, totaling \$8,800,760,328.

From this universe, we judgmentally selected all providers where the total amount paid was greater than \$100,000 (for Texas we used a threshold of \$250,000) and the claims amount paid percentage of Non-Par and/or PAR claims were 10 percent or more of the total amount paid respectively. In total, we selected 164 providers, with 531,067 claim lines totaling \$106,643,718, to determine if the providers were assigned the correct network status.

3. **Claims Requiring Coordination of Benefits with Medicare (COB) Review** – As part of our review, we separated the uncoordinated claims into six categories based on the place of service and whether Medicare Part A (Med A) or Part B (Med B) should have been the primary payer, as follows:

Categories A and B	<p>Categories A and B consist of inpatient claims that should have been coordinated with Med A. If the BCBS plans indicated that Med A benefits were exhausted, we reviewed the claims to determine whether there were any inpatient services that were payable by Med B.</p> <p>For these categories Med A pays all covered costs (except for deductibles and coinsurance) for inpatient care in hospitals, skilled nursing facilities, and hospice care. Consequently, in determining potential overcharges for the claim lines improperly paid in these categories, we reduced the amount paid using the applicable Medicare deductible and/or copayment.</p>
Categories C and D	<p>Categories C and D include inpatient claims with ancillary items that should have been coordinated with Med B. If the BCBS plans indicated that members had Med B only, we reviewed the claims to determine whether there were any inpatient services that were payable by Med B.</p>

	For these categories, Med B covers a portion of inpatient facility charges for ancillary services such as medical supplies, diagnostic tests, and clinical laboratory services, and pays 80 percent for these services after the calendar year deductible has been met. Based on our experience, ancillary items account for approximately 30 percent of the total inpatient claim payment. Consequently, in determining potential overcharges for the claim lines improperly paid in these categories we estimated a 25 percent overcharge for the inpatient claim lines ($0.30 \times 0.80 = 0.24 \sim 25$ percent).
Categories E and F	Categories E and F include outpatient facility and professional claims where Med B should have been the primary payer. For these categories, Med B pays 80 percent of most outpatient charges and professional claims after the calendar year deductible has been met. Consequently, in determining potential overcharges for the claim lines improperly paid in these categories we used 80 percent of the amount paid as the amount overcharged.

We identified all paid claims from July 1, 2018, through December 31, 2020, that potentially were not coordinated with Medicare. This search identified a universe of 8,765 claims, totaling \$3,719,790 in potential COB overcharges.

From this universe, we judgmentally selected those categories with potential overcharges of \$500,000 or more. As a result, we eliminated categories B, C, and D from consideration. The remaining categories (A, E, and F) consisted of 8,678 claims, with potential COB overcharges totaling \$3,594,357.

From each of the remaining categories, we judgmentally selected the 20 claims with the highest potential overpayment. In total, we selected 60 claims, with potential COB overcharges totaling \$828,819, to determine if the claims were paid correctly.

4. **Co-Surgeon Claims Review** – The Plan’s typical process is to pay claims with procedure code modifiers of 62 (two surgeons) or 66 (surgical team) at a fraction of their allowance. Therefore, we queried the claims universe to identify all claims paid using those modifiers that paid more than expected. As a result, we identified a universe of 8,402 claim lines, with potential overpayments totaling \$1,232,638.

From the universe, we judgmentally selected the 25 claims with the highest potential overpayment amount. The resulting sample of 48 claim lines, with potential

overpayments totaling \$241,997, was reviewed to determine if the claims were paid correctly.

5. **COVID-19 Respiratory Pathogen Procedure Codes** – It came to our attention during the COVID-19 pandemic that two procedure codes, 87801 (a panel of lab tests) and 87633 (a single lab test), that were not normally billed together for the same patient on the same day (therefore a potential duplicate), were now being billed regularly for the same patient on the same day. To determine if there were any potential duplicates, we queried the claims data to identify all claims with procedure codes 87801 and 87633.

This resulted in a universe 369 claims, totaling \$506,367. The universe of claims consisted of 356 claims in Texas, 11 claims in Oklahoma, and two claims in Illinois. From this universe we judgmentally selected a subset of 20 claims for cursory review. From that subset, we then selected one claim from Oklahoma and Illinois for review. Additionally, from Texas we selected one claim each (first listed) from the three providers with the highest claims paid. In total, we selected five claims with a total amount paid of \$4,686 for review to determine if these were duplicate billings, to understand the Plan's processes for adjudicating the claims, and if those processes could be improved.

6. **Debarred Provider Reviews** – We compared the OPM OIG's Administrative Sanctions Group's (ASG) list of providers debarred from participation in the FEHBP to all claims paid to the providers listed, as well as all claims with a debarred provider code of "Y" in the claims data provided.

We then removed any claims that occurred before each providers debarment date which resulted in a universe of 28 debarred providers who submitted 233 claims with potential overpayments totaling \$61,022. Overall, this universe was determined to be immaterial, and we did not select a sample of claims for review.

However, our review of the universe found that there were several providers with a debarment code of "Y" that did not appear on the ASG debarred provider listing. Therefore, we reviewed those claims to determine if the providers were debarred or not and, if not debarred, whether FEHBP members were sent debarment notifications in error.

Lastly, we reviewed the Association's and Plan's debarment processes to determine if they followed the debarment regulations and the OPM OIG's Guidelines for Implementation of FEHBP Debarment and Suspension Orders (Guidelines).

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

67,612,066 claim lines, totaling \$10,252,841,725, grouped by the claims' assigned POS (the location where the service was performed).

From the universe, we judgmentally selected all POS groups in which the total amount paid represented five percent or more of the total claims paid. This narrowed our results to six POS groups. With a target of 150 samples, we judgmentally selected how many claims should be reviewed from each POS group based on a ratio of amount paid in each group compared to the total of all six groups. In total, we selected 152 claims whose total claim amount paid (all claim lines associated with the claim) was \$3,886,901. We reviewed each to determine if the claims were paid accurately according to the provider contract with the Plan and the SBP brochure.

8. **Potential Duplicate Claim Payments Review** – As part of our review, we categorized separate potential duplicate claim payments into three categories – “best matches,” “near matches,” and “inpatient facility matches.” The universe of potential duplicate claim groups was derived from the following search criteria:

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

From the period August 1, 2019, through December 31, 2020, we identified a universe of all duplicate claim groups with potential overpayments of \$1,000 or more. This resulted in the following universe:

Universe of Duplicate Claim Payments Identified

	Best Matches	Near Matches	Inpatient Facility Matches	Total
Duplicate Groups	201	381	6	588
Potential Overpayment	\$585,730	\$913,551	\$52,052	\$1,551,333

From the universe, we judgmentally selected the top 20 and 10 duplicate groups with the largest potential overpayment from “Best” and “Near” matches, respectively. Additionally, from the “Inpatient Facility Matches” we selected all duplicate groups identified. We reviewed the samples to determine if the claims identified were duplicate payments or not and to quantify any potential overpayment by the FEHBP. (See the table below for a summary of the total sample selected.)

Duplicate Claim Payment Samples Selected

	Best Matches	Near Matches	Inpatient Facility Matches	Total
Duplicate Groups	20	10	6	36
Potential Overpayment	\$245,700	\$237,174	\$52,052	\$534,926

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

III. Audit Findings and Recommendations

The objective of our audit was to determine if the internal controls over the Plan's claims processing system were sufficient to ensure that claims were properly processed and paid by the Plan. Although we do identify net overcharges of \$982,117 to the FEHBP, the overall results of our audit indicate that the internal controls implemented by the Association and the Plan are working as intended.

1. Claim Payment Errors: \$982,117

Our claim reviews found that the Plan incorrectly paid 2,175 claims, resulting in net overpayments by the FEHBP of \$982,117 (overpayments of \$1,184,715 and underpayments of \$202,598). The claim payment errors we found were a result of the following review areas which we cover in more detail below:

- Claims with unlisted procedure codes (UPC);
- Claims requiring COB with Medicare;
- Potential duplicate claim payments;
- Provider network status (PNS) determinations; and
- Co-surgeon claims.

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

Additionally, Section 2.3 (g) of the Contract states that if the Plan identifies a claim payment error that it "shall make a prompt and diligent effort to recover the erroneous payment".

A. Claims with Unlisted Procedure Codes

Our review of claims with UPCs identified nine incorrectly paid claims totaling \$203,817 in health benefit overcharges to the FEHBP.

Unlisted CPT and/or HCPCS codes are used by providers when, in their determination, there is no specific code that would apply for the procedure performed. The Plan's regular procedure is to send claims with UPCs to medical review to determine if the billed procedure is allowable and whether there is a more appropriate alternate CPT/HCPCS code based on a review of claim and physician notes. The claim is then processed based on the directions received from medical review.

We selected a sample of claim lines with UPCs and provided them to the Plan to review and determine if they were paid correctly. We then reviewed their responses to determine if the processors followed the direction provided by medical review.

Medical review instructions were not followed, and claims were paid incorrectly as a result.

Our review identified nine claims, totaling \$203,817, where the processor either misinterpreted or failed to follow the direction provided by medical review for the claim lines sampled.

Discussion with the Plan found that it has no process in place for a secondary/supervisory review of claims with UPCs. Instead, as part of its daily procedures, it conducts audits of processed claims, of which unlisted procedure code claims could be included. However, claims where manual intervention by a processor is necessary involve an increased risk of error, due to the manual intervention. This is especially so in claims such as these where the payment amount is often not determined by the system, but manually input by the processor. Consequently, claims requiring this type of intervention should require a secondary/supervisory review before they are processed and paid.

As a result of Plan processors not consistently following medical review directives on claims with UPCs, as well as a lack of secondary review, the FEHBP was overcharged \$203,817. A total of \$18,763 has been recovered to date, so a total of \$185,054 remains due to the FEHBP.

Recommendation 1: We recommend that the contracting officer direct the Association to institute procedures at the Plan to require a secondary review of claims with UPCs or to ensure that the medical review guidance is followed in their processing.

Association's Response: The Association agrees with the recommendation and has requested the Plan to implement the recommendation and provide documentation supporting the implementation once completed.

B. Claims requiring Coordination of Benefits with Medicare

Our review identified eight claims, with overpayments totaling \$170,594, that were not properly coordinated with Medicare.

Section 2.6 of the Contract 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”

Also, the 2020 BCBS SBP brochure Primary Payer Chart illustrates whether Medicare or the Plan should be the primary payer (based on employment status and other factors determined by Medicare). In addition, the SBP brochure states that for those persons with Medicare, the Plan will limit its “payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), regardless of whether Medicare pays.”

We selected a sample of claims where the patients had Medicare coverage, but the claims did not appear to be coordinated with Medicare. We provided the samples to the Plan and asked it to review them and provide a determination. We then reviewed their responses to determine if the claims were paid correctly. Our review identified eight claims with overpayments totaling \$170,594. These claim payment errors are comprised of the following:

- Two claims were overpaid \$126,160 due to Medicare becoming primary during an extended inpatient stay but the claims were paid as primary by the FEP for the entire stay. When this occurs, the Plan should split the claim and the portion related to Medicare should be submitted to it for payment (according to chapter 31 of the FEP Administrative Procedures Manual). At the time the claims were paid, the Plan's procedures for these types of claims were incorrect and required the claim to be paid as FEP primary. The Plan states that the procedures have been updated since and now require coordination with Medicare. The Plan has recovered the full amount.

Medicare became primary in the middle of an inpatient stay, but FEHBP paid primary for the entire stay.

Recommendation 2: We recommend that the contracting officer ensure that the Plan's updated procedures properly identify and coordinate with Medicare claims when Medicare becomes primary during the covered dates of service.

Association's Response: The Association agrees with the recommendation and "will work with the Plan to evaluate and implement ... the recommendation and provide documentation to support the updated protocols and the effective dates once they have been implemented."

Additionally, the Plan stated that it has implemented updates to its Medicare claim procedures in June 2020 and that it will conduct focused audits to ensure enrollments appearing on the Retroactive Enrollment Reports are processed correctly.

OIG Comments: Based on the information provided by the Association and the Plan, we could not verify the updates initiated by the Plan at the time this report was prepared.

Recommendation 3: We recommend that the contracting officer direct the Association to identify and correct all FEHBP claims where COB did not occur when Medicare became effective during a hospital stay and return any FEHBP funds overpaid as a result.

Association's Response: The Association agrees with the recommendation and will work with the Plan to identify claims where the member's COB information changed in the middle of a hospital stay and return any overpaid funds to the FEHBP.

- Three claims were overpaid by \$27,495 because the members' Medicare enrollment information was not known at the date of service. The Plan initiated recoveries timely on the claims and has recovered \$7,884 to date.
- Three claims were overpaid by \$16,939 due to Plan processor errors. These claim payment errors are comprised of the following:
 - One claim was overpaid by \$11,189 after it was retroactively reviewed and determined that Medicare should be the primary payor. The Plan requested and received a refund for the full amount it paid as primary payor and will pay the correct allowance as secondary payor.
 - One claim was overpaid by \$3,175 because a processor did not apply the Medicare savings amount that was provided on the claim from the provider and instead used the Plan allowance amount. The Plan has initiated recovery and has recovered \$389 to date.
 - One claim was overpaid by \$2,575 because a processor overrode the system and submitted the claim to Medicaid in error when it should have been submitted to Medicare for payment. The Plan has initiated recovery but has not recovered any of the overpayment.

Recommendation 4: We recommend that the contracting officer direct the Association to ensure that Plan processors are properly reviewing and adjusting deferred Medicare claims and ensure that they are paying claims using appropriate Medicare pricing allowances.

Association's Response: The Association agrees with the recommendation and will work with the Plan to support implementation of procedures requiring processors to properly review and adjust deferred Medicare claims and to ensure that Medicare claims are paid at the correct allowance.

C. Potential Duplicate Claim Payments

Our review identified 11 duplicate claim payments that resulted in FEHBP overpayments totaling \$137,718.

As part of the Association's internal controls, it has implemented a Claims Auditing Monitoring Tool (CAMT) that it utilizes monthly to identify potential duplicate claim payments. When potential duplicate payments are identified, they are provided to the local plan for review and, if confirmed, the local plan is expected to begin the recovery process on the claims.

Improper submission of re-issued claims by providers led to duplicate claim payments.

We reviewed a sample of claim groupings that we identified as potential duplicates and provided those claim groupings to the Association for their review and supporting documentation. Our review identified the following errors:

- **Provider Billing Errors – Reissued Claims**

We identified 10 claims, with overpayments totaling \$129,415, that were paid as duplicate claims due to various errors, which will be covered in more detail below.

The specific errors identified are as follows:

- **Claims Submitted Without Reissue Identifier**

We identified seven duplicate claims, totaling \$99,989 in overpayments, that were caused by the provider not properly resubmitting claims.

In these cases, the provider submitted a corrected claim after determining that a mistake was made in the original billing. However, the provider did not properly identify the claim as a reissue of a prior claim when it was resubmitted. Without the reissued claim identifier, the Plan's local claims system treated the claims as new claims (assigning them new claim numbers). The resulting claims would not be exact matches. Therefore, the Plan's local claims system and the Association's nation-wide claims processing system (FEP Direct) did not identify the claims at the time of adjudication as potential duplicates. However, the claims were later identified by the Association through its CAMT and the Plan has begun the recovery process on each claim.

As a result of providers reissuing claims without the proper reissue identifier, the FEHBP was overcharged \$99,989 (of which the Plan has recovered \$48,725).

- **Claims Where an Incorrect Provider was Initially Paid**

We identified three duplicate claims, with overpayments totaling \$29,426, where the wrong provider was initially paid, which caused the actual provider to resubmit the claim to seek payment. However, like the previous issue, when the

provider resubmitted the claim for payment, they neglected to include the reissued claim identifier, causing the claims to be paid as duplicates.

We determined that the incorrect providers were selected for payment as the result of the following errors:

i. Claims System Changed the Provider

We identified two duplicate claims, with \$14,948 in overpayments, where the claims system overrode the provider chosen by the claims processor.

After the claims processor selected the correct performing provider, at some point in the adjudication process the Plan's claims system overrode the selection and chose a different provider to receive the payment. The Plan had already identified this error in its system prior to our audit and has initiated a system enhancement to correct the issue.

Of the \$14,948 questioned due to this error, \$13,286 has been recovered.

Recommendation 5: We recommend that the contracting officer direct the Association to submit the Plan's documentation that supports this system error correction and the date it was effective.

Association's Response: The Association agrees with the recommendation and will work with the Plan to implement it.

Recommendation 6: We recommend that the contracting officer direct the Association to identify and correct all FEHBP claims affected by this system error and return any FEHBP funds overpaid as a result.

Association's Response: The Association agrees with the recommendation and will work with the Plan to identify and correct claims affected by the system error.

Recommendation 7: We recommend that the contracting officer direct the Association to require the Plan to send communication to providers on the proper way to re-submit claims.

Association's Response: The Association agrees with the recommendation and will work with the Plan to implement it.

ii. Processor Selected the Wrong Performing Provider

We identified one duplicate claim, with an overpayment of \$14,478, where the claims processor selected the wrong performing provider.

During the claim adjudication process, the Plan stated that its claims processor inadvertently selected the wrong performing provider. The Plan has recovered the entire overcharge.

Due to the nature of the identified error, we are not making a recommendation in this report to address it.

- **Plan did not Return FEHBP Monies Due to Settlement**

We found one duplicate claim, with an overpayment of \$8,303, that was identified by the Plan's claim system as a duplicate. However, the Plan did not begin the recovery process due to a legal settlement with the provider.

The Plan mistakenly included FEP claims in a provider settlement and did not attempt recovery of monies owed to the FEHBP.

The Plan did not attempt recovery because there was a provider settlement in place that capped the amount owed by the provider. The claim in question was one that exceeded the cap set by the settlement. However, in discussion with the Plan it acknowledged that FEHBP claims should not be subject to settlements and that the Plan should return the monies.

As a result of misunderstanding the applicability of provider settlements to FEHBP claims, the FEHBP was overcharged \$8,303 (which has been returned by the Plan).

Recommendation 8: We recommend that the contracting officer direct the Association to review all other Plan legal settlements to ensure that any FEHBP payments overlooked by the settlement are properly returned.

Association's Response: The Association agrees with the recommendation and will work with the Plan to review all legal settlements that involve FEP claims to ensure that settlements are returned to the FEHBP.

As a result of errors found during the duplicate claims review, the FEHBP was overcharged \$137,718. To date, \$84,792 has been recovered, leaving a remaining amount due of \$52,926.

D. Provider Network Status Determinations

Our review identified 2,142 claims, related to 37 providers, that were paid incorrectly due to an incorrect provider network status (PNS). This resulted in net FEHBP overpayments totaling \$370,707 (overpayments of \$573,305 and underpayments of \$202,598).

According to the SBP brochure, the Plan contracts with PAR providers to provide its members with covered services at negotiated rates as payment in full. Non-PAR providers may or may not accept Plan set allowances for covered services. If a Non-PAR provider is utilized, the member is responsible not only for applicable copayment or coinsurance amounts, but also for any amount exceeding the Plan's allowance.

2,142 claims were paid under the wrong network status due to processor errors.

Amounts paid to Non-PAR providers, both by the Plan and FEHBP members, often dramatically exceed the amounts paid to PAR providers as a result of the Plan's ability to negotiate allowances that are lower than the Non-PAR provider's billing rate.

We identified a universe of providers who had both PAR and Non-PAR paid claims and provided the Plan with a sample of 128 providers to determine if the correct provider network status was associated with the claims. From our review, we determined that 37 providers (**approximately 29 percent of those reviewed**) had claims with the incorrect PNS. Specifically, we identified 2,142 improperly paid claims with net overpayments of \$370,707.

We previously requested the Plan to provide us with a detailed description for the cause of each error, but we did not receive that information. However, the Plan indicated that a significant portion of the PNS errors could be classified under one of the following processor error circumstances:

- When a claim is received from a Government provider that is not in the claims system, the processor must add the provider manually. Occasionally, when this occurs the provider type associated with Government providers is not being entered correctly in FEP Direct. When this happens, it prevents the system from identifying the claims as being from Veterans Affairs or Department of Defense providers, for example. However, the Plan did not provide an explanation as to how this provider type effects the provider status.
- For claims received from a provider group with multiple providers within it, processors occasionally select the wrong provider.
- When system deferrals related to the provider's contract status (Non-PAR or PAR) are resolved, processors occasionally input the PNS into the wrong field in FEP Direct.

As a result of the Plan not applying the correct PNS, the FEHBP was overcharged \$370,707 (net). To date, the Plan has not recovered any of the overpayments.

Recommendation 9: We recommend that the contracting officer direct the Association to institute procedures at the Plan to require a secondary review of claims that fit the common errors identified in the finding to ensure that the correct provider network status is reflected prior to final processing of the claim. Additionally, the Association should ensure that its processors are adequately trained on these specific error types to prevent them.

Association’s Response: The Association agrees with this recommendation and will work with the Plan to institute new procedures “to ensure that the correct provider network status is reflected prior to final processing of the claim and support training of Plan’s processors”

E. Co-Surgeon Claims

Our review determined that the Plan overpaid five co-surgeon claims by a total of \$99,281.

Manual pricing errors by claim processors led to \$99,281 in overpayments.

Claim lines with a co-surgeon modifier code (62 or 66) should pay at a fraction of the primary surgeon’s allowance for the procedure. Specifically, New Mexico and Oklahoma claims should pay at 62.5 percent and Texas, Illinois and Montana claims should pay at 60 percent of the primary surgeon’s allowance.

We identified a universe of claims with co-surgeon modifier codes where the reduced allowance did not appear to be applied correctly and provided a sample to the Plan for it to determine if the claims were paid properly. We reviewed the Plan’s responses and identified five claims with overcharges of \$99,281.

The claims identified were paid incorrectly for the following reasons:

- Four claims were overpaid by \$66,541 as a result of the processor not following system guidance and applying an incorrect ratio for the co-surgeon procedures.

As with the claims questioned in our UPC review, these claims required manual intervention to process, but did not have a secondary level of review in place. While claims with co-surgeon modifier codes are typically processed by the system correctly without intervention, when manual intervention is necessary, at least a second level of review should be performed prior to final adjudication.

- One claim, with an overcharge of \$32,740, was deferred by the system for manual pricing due to an unlisted procedure code found on the claim. The processor reviewed the claim and manually applied an incorrect pricing allowance instead of applying the appropriate Non-PAR Medicare plan allowance.

As a result of processor errors involving the misapplication of provider allowances, the FEHBP was overcharged \$99,281. To date, \$66,541 has been recovered, leaving a remaining amount due of \$32,740.

Recommendation 10: We recommend that the contracting officer direct the Association to institute procedures at the Plan to require a secondary review of co-surgeon claims that require manual intervention to ensure that system guidance is being followed and the correct ratio is applied.

Association's Response: The Association “agrees with the recommendation and has requested the Plan to implement the recommendation.”

As a result of claim payment errors related to the above five review areas, we identified net overpayments of \$982,117.

Recommendation 11: We recommend that the contracting officer disallow \$1,184,715 in overcharges to the FEHBP. To date, overpayments totaling \$315,718 have been recovered, leaving a remaining amount due of \$868,997.

Association's Response: The Association agrees with the amount originally questioned in the draft report (\$890,024) and stated that it will work with the Plan to ensure recoveries are initiated. However, it did not have an opportunity to respond to the additional questioned amount of \$294,691 based on our review of the documentation provided in response to the draft report.

Recommendation 12: We recommend that the contracting officer direct the Association to have the Plan make claim adjustments and pay claim underpayments totaling \$202,598 to the appropriate providers.

Association's Response: The Association agrees with \$176,976 of the underpayments identified in our draft report and requested the Plan to initiate claim adjustments. However, it did not have an opportunity to respond to the additional \$25,622 in underpayments identified as a result of its response to our draft report.

2. Debarment Notifications Not in Compliance with Regulations: Procedural

Our review of the Association's debarment policies and procedures found that they do not fully adhere to the requirements set forth in the Federal regulations and OPM OIG's Guidelines for Implementation of FEHBP Debarment and Suspension Orders (Guidelines).

The Association has not followed the Debarment regulations since their revision in 2004.

Specifically, we found the following areas of deficiency:

- The Association's notifications to enrollees are not proactive;
- The Association's notifications to enrollees are incomplete; and
- The Association does not notify the OPM OIG's Administrative Sanctions Group (ASG) promptly when debarred providers submit claims.

Title 5 CFR section 890.1001-1072 implements Title 5 USC section 8902a, which establishes a system of administrative sanctions that OPM may, or in some cases, must, apply to health care providers who have committed certain violations. 5 USC 8902a (j) gives OPM the authority to prescribe regulations with regards to services or supplies furnished by debarred providers.

The OPM OIG operates the administrative sanctions as applicable to the FEHBP under delegation from the OPM Director. In March 2004, ASG issued Guidelines to supplement the regulations and to provide comprehensive instructions on all aspects of carriers' responsibilities.

According to 48 CFR 1609-7001(a) carriers are required to meet the requirements of 5 USC 8902a and 5 CFR 890.1045, upon which the Guidelines are based. Additionally, 48 CFR 1609-7001(b)(3) states that the carriers must comply with the terms of the FEHBP contract, regulations, and statutes.

A. Proactive Notification to Members

The Association does not proactively identify enrollees that previously utilized a newly debarred provider and notify them of the provider's debarment status as required by the Federal regulations and the Guidelines. On its Semiannual Report (SAR) to the OPM OIG the Association states that it "does not proactively notify enrollees. BCBS pays the first claim, then notifies the enrollee that no further claims will be paid."

5 USC 8902a (j) states, "the carrier involved shall take appropriate measures to ensure that the individual is informed of the debarment and the minimum period of time remaining under the terms of the debarment."

5 CFR 890.1045 requires carriers to notify covered individuals who have obtained items or services from a debarred or suspended provider within one year of the date of the debarment or suspension.

The Guidelines chapter 2 B.3 states that, at a minimum, the Plan's debarment procedures should identify debarred or suspended providers utilized by FEHBP enrollees and issue notices to those enrollees of the provider's status.

Additionally, the Guidelines chapter 2 E.2 states that, at a minimum, the Plan's claim system should identify any "debarred or suspended providers who have been paid FEHBP funds directly or indirectly" within the year preceding their debarment. Then, according to

chapter 2 D, the Plan should identify those enrollees associated with the provider and notify them of their suspension.

Discussion with and documentation provided by the Association indicate that it has never proactively notified enrollees of a provider's debarment status (beyond a one-time mass mailing in 1994). Prior to the complete revision of the debarment regulations (5 CFR 890 Subpart J) in 2004 there were no specific regulations regarding enrollee notification by the carriers. As a result of the revised regulations, the ASG issued the March 2004 Guidelines to supplement the regulations and provide specific instructions for the carriers to follow going forward.

The Association's failure to proactively notify enrollees of a previously utilized provider's debarment not only affect the FEHBP financially, but it can also have ramifications to the patient's medical care. Financially, the FEHBP is impacted because claims that would not be paid following the 15-day grace period would be incurred and paid. Patients could also be adversely affected because, without proper and clear notification of a provider's debarment, they could be subjected to medical care from providers who have been debarred because of criminal activity or, because of their debarment, lost their medical license.

Recommendation 13: We recommend that the contracting officer direct the Association to update its debarment procedures to include the Guidelines' proactive notification requirements.

Association's Response: The Association disagrees with the recommendation and states that during the time that guidance was initially issued, it met with the OIG and that the OIG was satisfied with its process. The Association provided documentation supporting communications with the OIG between March 1994 and December 1998 to support its position. As it relates to proactive notifications, the Association stated that guidance provided to it in April 1994 allowed it to make proactive notifications then as a one-time procedure.

OIG Comments: The Association's response is concerning as it does not take into consideration that the regulations governing payments to debarred providers were updated in their entirety in 2003. Additionally, it does not consider updated OIG guidance (the Guidelines) to carriers outlining their responsibilities and duties in response to those new regulations that was issued in March 2004. The new regulations and Guidelines issued in March 2004 required all FEHBP carriers to issue proactive notifications to enrollees beginning at that time.

Any guidance provided prior to 2003 to the Association regarding the debarment process was null and void when the regulations were updated, and the new guidance was issued by the OIG in March 2004. The Association should immediately begin updating its debarment processes to ensure that it is following the OIG guidance and begin notifying enrollees if they have previously utilized a debarred provider on a proactive basis.

B. Incomplete Enrollee Notification

The Association's enrollee notification of a provider's debarment status on the Explanation of Benefits (EOB) does not include all the required information to be communicated to the enrollee. Additionally, notification via the EOB is not the clearest way to communicate this type of important information to the enrollees.

The Guidelines supplement 5 CFR 890.1045 and provide suggested text (Appendices 9, 10, and 11) for notifying enrollees of a provider's debarment status. Additionally, the Guidelines provide what information must be included in the enrollee notification (chapter 2 D.2 and chapter 2 D.3):

- that the enrollee has obtained services from a debarred provider;
- that payments to an OPM-debarred provider are prohibited;
- that payments will not be made for items or services rendered more than 15 days after the date of the notice to the enrollee; and
- that exceptions may be approved by OPM on a limited and individual basis.

According to its debarment procedures, the Association includes remarks on its EOBs to enrollees when a claim is paid to a debarred provider. Those remarks, according to chapter 17 of the Association's FEP Administrative Procedures Manual, are as follows: "We have been informed by the U.S. Office of Personnel Management that this provider has been debarred or suspended from participation in the Federal Employees Health Benefits Program. Federal regulations prohibit us from paying claims for services given by debarred or suspended providers. We will provide benefits for these services and for care given by this provider up to 15 days after the date of this notification. However, you will be responsible for any charges received after that date. Please refer to your BCBS SBP brochure."

Additionally, all EOBs include language in respect to the enrollee's right to dispute claims. However, the disputed claim notice in the EOB does not mention debarment or refer to the enrollee's right to seek an exception as explicitly stated in the letter included in the Guidelines. Furthermore, the SBP brochure, Section 6 – General Exclusions section only mentions that services from providers "barred or suspended from the FEHBP Program" are not covered and does not include any further direction to enrollees or indicate their right to seek an exception.

The combined messaging of the EOB and SBP brochure are incomplete, because neither of them clearly nor directly communicates the enrollees' right to seek an exception from OPM. Therefore, we do not find it surprising that the Association continually indicates on its SAR to the OIG that no appeals have been requested, because the enrollees are not made aware of their right to do so.

As in the proactive notification issue above, there were no specific enrollee notification directives in the regulations prior to February 2004. However, with the issuance of the revised regulations and Guidelines, the notification requirements were made known to all FEHBP carriers.

Additionally, the messaging to the enrollee on the EOB is not clearly stated. Instead, it is cryptically stated via a code and definition. Enrollees receive EOBs throughout the year and the codes and messages are not easily understood by all. The Guidelines provide example letter notifications to the enrollee that are much easier to understand.

As a result of not including all information required in the enrollee notification, the enrollees are not informed of their right to seek an exception to the debarment decision on an individual basis. Additionally, by including the debarment message as a code on the EOB, the Association is not making the debarment notification clear for the enrollees.

Recommendation 14: We recommend that the contracting officer direct the Association to include all required enrollee notifications as stated in the Guidelines in the messaging to enrollees for debarred providers.

Association's Response: The Association disagrees with the recommendation and provided a copy of its debarment policies (dated December 1993) and current EOB's to support its position that all information required is imparted to the enrollee regarding their right to appeal. According to the Association, "The EOB states under Subscriber Appeals, 'The process states that the Plan Appeals or Customer Service Department questions the denial of payment for services rendered by a debarred or excluded provider, the Plan should verify the provider's status, and advise them to review the Exclusions Section 6 – General Exclusions of the FEP Service Benefit Brochure If the members persist in appealing the denial, the Plan is instructed to pursue the usual appeal process for a review of the claim by OPM. Once the Plan receives the medical documentation, the Plan initiates its review process, send it to the FEP SIU, and then BCBSA FEP SIU sends to OPM for final approval'" Additionally, the Association states that it has not submitted any exceptions to the OIG's ASG directly or its SAR and that therefore they are compliant.

OIG Comments: As stated previously, the Association is relying upon outdated policies and procedures for its debarment processes as demonstrated by its reliance on policies from December 1993.

The EOBs provided by the Association are much the same as we've previously reviewed and, as the finding indicates, do not include all the information required by the Guidelines to be in its debarment notifications. The information specifically missing in its debarment notifications is the right of an enrollee to appeal to OPM. The EOB does include a generic catch-all final statement that includes, "If you disagree with the decision on your claim or request for services, and wish to have the decision reconsidered, you must notify your Plan

in writing within 6 months from the date of this decision.” However, unlike as described by the Association, this catch-all statement is not labeled as “Subscriber Appeals,” nor does it mention anything about debarment.

The enrollee’s right to appeal a debarment decision should be included in the statement notifying them of the provider’s debarment status and not separated, to ensure the enrollee fully understands their rights. Separating and not specifying the appeals process as it relates to the debarment action makes it appear as if the other dispute process in the EOB is unrelated to debarment and that the enrollee has no other course of action. Additionally, although “suggested” language, Appendix 11 of the Guidelines provides appeals criteria that should be included in the messaging to the enrollee to further explain the process that is not included by the Association.

The Association also mentions that enrollees should be directed to the “Exclusions Section 6 – General Exclusions of the FEP Service Benefit Brochure.” However, there is no information anywhere in the Exclusions Section 6 – General Exclusions section of the FEP SBP that refers to the enrollee’s appeals process. So, referring the enrollee to that section would not provide them any useful information.

We would like to be clear that we found no problem with the Association’s process for handling appeals once submitted. Rather, our concern is that no appeals are being submitted because enrollees are not being made aware of the debarment-specific reasons for which they may request an exception.

C. Notification to the OIG

The Association does not notify the OIG of debarred providers who submit claims for services following the effective date of their debarments. Additionally, the Association’s SAR to the OIG, which occasionally includes a listing of debarred claims paid by providers, appears to be incomplete.

Although the regulations do not contain these specific instructions, they do authorize OPM to administer OPM’s sanctions program. As mentioned above, OPM has delegated this authority to the ASG who developed the Guidelines as supplemental guidance to the carriers. Guidelines chapter 2 Section E.6 states, “If a suspended/debarred provider continues to submit claims for services rendered after the effective date of his/her suspension/debarment, you should furnish the OIG with documentation of all claims for services received after the effective date of the provider’s suspension/debarment.”

Discussions with the Association found that it only notifies the OIG of claims paid to debarred providers on the SAR and does not separately notify the OIG if providers continue to submit claims for services after the effective dates of their debarments.

The Association feels that it is following the Guideline requirements by including this information on the SAR. However, the SAR is a summary of the carrier's debarment activities from the previous six months and does not serve as a tool to notify OPM of an issue which it may need to act upon immediately, such as notifying a provider of the violation of their debarment terms. All carriers must notify the OIG upon knowledge of the provider's actions and provide all claims documentation for items or services rendered after the effective debarment date, then report a summary of these notices in its SAR.

Furthermore, a review of the Association's SARs for the period October 1, 2019, through September 30, 2020, (two reporting periods) showed that they only reported four claims totaling \$74 as paid to debarred providers over that year long period. The SAR covers all BCBS plans nationwide which, over contract years 2018 through 2020, averaged approximately \$26 billion in claims paid (roughly 94 million claims) per year, so it seems unlikely that only four claims totaling \$74 were paid to debarred providers during the time frame of the SARs. This was confirmed when we reviewed claims from this same period. Our review consisted of claims paid with a debarment indicator of "Y" and identified 330 total claims, with amounts paid of \$332,395.

Recommendation 15: We recommend that the contracting officer direct the Association to notify OIG monthly of all claims submitted by debarred providers after the effective date of their debarments.

Association's Response: The Association disagrees with this recommendation. It is the Association's position that it has complied with the Guidelines through its SAR that quantifies claims paid to debarred providers. In reference to Carrier Letter 1993-20 (issued July 1993) it states that the SAR will require reporting on the "number and amounts of claims paid (or services provided) and denied involving debarred providers" In addition, the Association pointed out that the Guidelines do not explicitly state that the documentation should be sent once the claims have been incurred, as opposed to only on the SAR.

OIG Comments: As stated previously, the Association is relying upon outdated guidance from OPM as demonstrated by its reliance upon Carrier Letter 1993-20 which has since been superseded.

The Association is also incorrect in its assertion that its submission of the SAR (required in the Guidelines in Chapter 2 F.1) meets the requirement noted in the finding outlined in Guidelines Chapter 2 E.6. These are included in separate sections of the Guidelines and therefore, these are separate requirements and are not an either/or scenario.

Chapter 2 E.6 of the Guidelines specifically states, "If a suspended/debarred provider continues to submit claims for services rendered after the effective date of his/her suspension/debarment, you *should* (emphasis added) furnish OIG with documentation of all claims for services received after the effective date of the provider's

suspension/debarment.” It is our position that the simple roll-up count of these instances requested for the SAR does not constitute furnishing the “OIG with documentation of all claims for services received after the effective date of a provider's suspension/debarment.” Additionally, waiting every six months to submit a roll-up summary of debarred claims paid does not allow the OIG to contact the provider in a timely manner if necessary.

Recommendation 16: We recommend that the contracting officer direct the Association to review its reporting practices to ensure that all claims paid to debarred providers are reported to the OIG on its SAR.

Association’s Response: The Association disagrees with this recommendation and states that it is following the Guidelines through its SAR submission.

OIG Comments: The Association did not provide any supporting documentation to dispute the claims identified as not reported to the OIG during the October 1, 2019, through September 30, 2020, SAR reporting periods.

As a result of only notifying the OIG of claims paid to debarred providers on its SAR and not when providers are continuing to submit claims for services after the effective date of their debarments, the Association is not giving the OIG the opportunity to contact the providers and address the issue. Delays in notifications can lead to more claims being paid to debarred providers as a result. Additionally, by not accurately reporting debarment activities on its SAR to the OIG, the Association is not providing the ASG with a clear picture of the scope of overall debarments.

3. Incorrect Notification of Debarment Status: Procedural

Our review identified 18 claims (related to 17 providers) where the enrollees were incorrectly notified that their provider was debarred from the FEHBP.

The Association incorrectly informed FEHBP members that their provider was debarred because it did not seek clarification from the OIG on partial matches.

5 CFR 890.1045 requires FEHBP carriers to notify enrollees utilizing a debarred provider of the provider’s debarred status and that the provider may not receive FEHBP funds while debarred.

Chapter 2 E.4 of the Guidelines states that the best matching criterion for debarred providers is the social security number (SSN) of the provider that is included in the listing provided by the OIG. Additionally, chapter 2 E.3 further states that if there is a partial match that the OIG should be contacted for clarification.

To determine if the Plan’s claims processing system had proper edits in place to identify debarred providers, we reviewed a sample of claim lines that had a “Y” debarment indicator, but the provider’s name did not appear on our debarment listing. The results of our review showed

that the Plan's claims processing system did not have sufficient information to make this determination. Consequently, enrollees were sent EOB notifications that their provider was debarred when that was not the case.

All 18 claims identified as suspended on FEP Direct with deferral codes indicated that while there was a match on the performing provider identification (ID) number, there was a mismatch on provider name. This would then be classified as an incomplete or partial match.

When the processor reviewed the claim deferral, they did not verify whether the performing provider's name appeared on the Debarred/Suspended Provider file, nor did they reach out to the OIG for clarification on the partial match. Therefore, the processor worked the resolution incorrectly by manually labeling the provider as debarred in FEP Direct. This prompted the claims system to include the debarred provider remarks on the enrollee's EOB, stating that the provider was debarred, and the members had a 15-day grace period for any further claims to be covered under the FEHBP.

Discussion with the Plan found that it does its initial debarment matching on SSN. However, it does not always have that information in its records to confirm a match. Consequently, it matches secondarily on performing provider National Provider Identifier number or performing provider ID number.

We do not understand how the Plan does not have access to the providers' SSNs. While this may be the case for providers not in the Plan's local network(s), it should have obtained its networked provider's SSNs at some point in the contracting and credentialing process. Once that information is obtained it should be maintained within its systems to enable the Plan to perform a debarment match when needed.

The Plan stated that it has updated its local procedures to forward documentation to OPM (via the FEP Special Investigation Unit) for clarification when it does not have "reasonable assurance" that it has identified the correct provider.

Although the identified claims were paid correctly, the consequences of these errors could inconvenience FEHBP members by unnecessarily requiring them to find other providers. It could also lead to potential member harm by requiring members to unnecessarily stop needed treatment from a provider. For the provider, the errors could cause negative financial consequences if they are falsely deemed debarred to their FEHBP patients.

Recommendation 17: We recommend that the contracting officer direct the Association to provide the Plan's updated procedures and the effective date of their implementation.

Association's Response: The Association "agrees with this recommendation and requested the Plan provide updated procedures once completed."

Additionally, the Plan agrees with the recommendation and states that procedures have been updated as of June 2021.

OIG Comments: We accept the Association's response.

Recommendation 18: We recommend that the contracting officer direct the Association to require its member plans to obtain and maintain provider SSNs and ensure that their claim databases can search and match providers using SSNs to determine if they are debarred.

Association's Response: The Association does not agree with this recommendation and feels that it is compliant with OPM's Guidelines, "as stated in Carrier Letter [19]93-20." The Association's Administrative Policy Manual states that when a partial match is made, the local plan may update the provider information if there is reasonable assurance that the Plan has identified the correct provider. If there is not reasonable assurance, OPM will make the determination.

OIG Comments: Again, the Association is relying upon OPM guidance that has since been superseded, updated, and expanded upon with direct guidance of the rules that must be followed for debarment. The regulations that must be followed are those that were issued in 2004 and clarified with specific guidance in the OPM-OIG Guidelines issued in March 2004. Chapter 2 E.4 of those Guidelines specifically says, "We *expect that you will use SSNs as the principal basis for matching* providers on our suspended/debarred providers list against providers in your systems. We believe the SSN is the best available data element because it is definitive and constant for individuals." (Emphasis added.)

In its response the Association makes no reference to its ability to match against SSNs. It refers to its own partial match procedures instead and therefore has provided no reasonable basis for its disagreement. As the Guidelines state, the SSN is "definitive and constant for individuals" and is the best matching identifier available.

As stated in our finding, the initial match is made against the provider's SSN. While, the provider's SSN may not always be available, it is obtainable by the local plans during the provider credentialing and contracting process. If that information is not currently maintained, the local plans can easily begin to compile that information for the Association to set up a database to eventually match against SSNs.

However, to disagree with a finding because the Association feels that nearly 30-year-old superseded guidance applies is no reason to begin efforts to use the “best available data element” for matching purposes. We also don’t understand why the Association is against obtaining information that will help it do its job more efficiently. Not making the effort to comply with the Guidance will only permit unidentified debarred providers to be unlawfully paid with FEHBP funds.

Additional OIG Comments: We would like to reiterate our previous comments regarding debarment guidance issued by OPM and, more importantly, the federal regulations governing debarment that *all* FEHBP carriers must follow. As regulations are updated and if new guidance is issued, the updated regulations and guidance are what carriers participating in the FEHBP **must** follow.

In relation to debarment or otherwise, the Association should not assume discussions made in decades past exempt it from complying with new regulations, carrier letters, and guidelines. It should be noted that the Association has updated its policies and procedures to comply with some of the updated regulations. For example, while the Association consistently referenced Carrier Letter 1993-20 as the basis for its compliance with OPM guidance, this carrier letter states that the grace period for payment of claims for services rendered by a debarred provider is 10 days. However, when the debarment regulation was updated in 2003, a grace period of 15 days was specified. The Association’s procedures follow this updated grace period, demonstrating that it is aware of the updated regulations, yet continues to rely on outdated guidance for other procedures. This gives the appearance that the Association has been picking the sections of the federal regulations (as they relate to debarment) with which it would like to comply, based on convenience, for nearly two decades.

The Association should immediately update its policies and procedures based on the most current federal regulations and OPM guidance as they relate to debarment. Additionally, the Association should implement all debarment recommendations so that it follows the program’s requirements.

Appendix A



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

October 11, 2021
March 7, 2022 Update

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

VIA E-mail

Reference: OPM Draft Audit Report 1A-10-17-21-018
Issued: September 9, 2021, Received September 9, 2021

Dear Ms. Oliver:

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

1. Claim Payment Errors: \$713,048

A. Unlisted Procedure Codes (UPC)

Recommendation 1: We recommend that the contracting officer direct the Association to institute procedures at the Plan to require a secondary review of claims with UPCs or to ensure that the medical review guidance is followed in their processing.

BCBSA Response: BCBSA has requested the Plan implement the recommendation and provide documentation to support implementation once completed.

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

B. Claims requiring Coordination of Benefits with Medicare (COB)

Recommendation 2: We recommend the contracting officer direct the Association to submit the Plan's updated protocols and the dates effective to ensure that they have been implemented.

BCBSA Response: BCBSA will work with the Plan to evaluate and implement (if appropriate) the recommendation and provide documentation to support the updated protocols and the effective dates once they have been implemented.

Plan Response: The Plan agrees with this recommendation. The Plan implemented updates to its Medicare Facility Claim Procedure Flow in June 2020. The Plan conducts audits pertaining to Medicare COB throughout the year to ensure that enrollments in Medicare are identified and processed accurately and timely. The Plan will also continue to conduct focused audits to ensure enrollments appearing on the Retro Enrollment Report (RER) are processed correctly.

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

C. Potential Duplicate Claim Payments

Recommendation 4: We recommend that the contracting officer direct the Association to submit the Plan's documentation that supports this system error correction and the date it was effective.

BCBSA Response: BCBSA will work with the Plan to implement the recommendation and if necessary, obtain documentation to support that the system error has been corrected.

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

Recommendation 5: We recommend that the contracting officer direct the Association to require the Plan to send communication to providers on the proper way to re-submit claims.

BCBSA Response: BCBSA will work with the Plan to implement the recommendation and if necessary, obtain documentation to support that the recommendation has been implemented.

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

Recommendation 6: We recommend that the contracting officer direct the Association to review all other Plan legal settlements to ensure that any FEHBP payments overlooked by the settlement are properly returned.

BCBSA Response: BCBSA will work with the Plan to review all FEHB Plan legal settlements to ensure that the settlements are returned to FEP.

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

E. Co-Surgeon Claims

Recommendation 9: We recommend that the contracting officer direct the Association to institute procedures at the Plan to require a secondary review of co-surgeon claims that require manual intervention to ensure that system guidance is being followed and the correct ratio is applied.

BCBSA Response: BCBSA agrees with this recommendation and has requested the Plan implement the recommendation.

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

Recommendation 10: We recommend that the contracting officer disallow \$890,024 in overcharges to the FEHBP. To date, overpayments totaling \$299,126 have been recovered, leaving a remaining amount due of \$590,898.

BCBSA Response: BCBSA agrees with this recommendation and will work with the Plan to ensure that overpayment recovery is initiated in accordance with CS1039.

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

Recommendation 11: We recommend that the contracting officer direct the Association to have the Plan make claim adjustments and pay claim underpayments totaling \$176,976 to the appropriate providers. To date, we are unaware of any adjustments to the claim underpayments identified.

BCBSA Response: BCBSA agrees with this recommendation and has requested the Plan initiate claim adjustments and provide support the adjustments have been initiated.

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

2. Debarment Notifications Not in Compliance with Regulations

A. Proactive Notification to Members

Recommendation 12: We recommend that the contracting officer direct the Association to update its debarment procedures to include the Guidelines' proactive notification requirements.

BCBSA Response: BCBS Association does not agree with this recommendation(s).

During the time the guidance was initially issued, BCBSA met with OPM Sanctions and shared the procedures that ensure compliance with the Common Rule guidance as it relates to proactively notifying members. The following meetings, attachments and approvals support FEP compliance:

[Note: The attachments referenced in the Association's response to draft report recommendations 12, 13, and 17 are not included in this report. The Association's comments provide all necessary context.]

- On March 25, 1994, the OPM Debarring Official issued a letter Attachment 10, to BCBSA requesting a copy of the implementation of the FEP Debarment Program.
- Attachment 11, dated April 21, 1994, provides BCBSA procedures as requested. In the BCBSA Prohibition Benefit Payment to Debarment Providers policy Attachment 12, page 4-5 dated August 19, 1994, the enrollee notification procedure indicated that the "Plans will notify all subscribers who have received services from a provider appearing on the initial listing. This initial notification, by letter, will be a one- time procedure. Subsequent notifications of the listing of the debarred or excluded providers will be accomplished through the Explanation of Benefits (EOB) form as discussed below."
- Attachment 13, dated August 26th, 1994, identifies an approval letter received from the OPM Debarring Official stating that "the program described in your submission demonstrates a reasonable assurance of compliance".
- Attachment 14, dated November 29, 1994, reiterates FEP's member notification procedure.
- Attachment 15, dated December 3, 1998, documents a conference call conducted with the OPM Debarment Official, FEP SIU, and FEPOC to discuss the debarment process. The notes from this meeting indicated that the OPM Debarment Official "was satisfied with the FEP process".

B. Incomplete Enrollee Notifications

Recommendation 13: We recommend that the contracting officer direct the Association to include all required enrollee notifications as stated in the Guidelines in the messaging to enrollees for debarred providers.

BCBSA Response: BCBSA does not agree with this recommendation.

The appeal language in Attachment 12 pg. 7, on the Explanation of Benefit (EOB) indicates the member's right to appeal a decision. The EOB states under Subscriber Appeals, "The process states that the Plan Appeals or Customer Service Department questions the denial of payment for services rendered by a debarred or excluded provider, the Plan should verify the provider's status, and advise them to review the Exclusions Section 6 - General Exclusions of the FEP Service Benefit Brochure (Attachment 17). If the members persist in appealing the denial, the Plan is instructed to pursue the usual appeal process for a review of the claim by OPM. Once the Plan receives the medical documentation, the Plan initiates its review process, sends it to the FEP SIU, and then BCBSA FEP SIU sends to OPM for final approval (Attachment 12). This process was approved by OPM (Attachment 14). In Attachment (16), on page 4, it further expands on the member's appeal process. Samples of an EOB sent to a member who received services from a debarred provider can be found in Attachment 18 and 19. The AS Semi-Annual Report template Attachment 22 in Section D pg.2, requests that the Plan provide information regarding Debarment/Suspension notifications to OPM Sanctions Group. To the best of our

knowledge, BCBSA FEP SIU has not submitted an exception to OPM Sanctions, therefore we are compliant with this exceptions' procedure.

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

C. Notification to the OIG

Recommendation 15: We recommend that the contracting officer direct the Association to notify OIG monthly of all claims submitted by debarred providers after the effective date of their debarments.

BCBSA Response: BCBSA does not agree with this recommendation.

Since the March 2004 OPM Guidelines for Implementation of FEHBP Debarment and Suspension Orders Chapter 2, A.1, F.1 and F.2 were issued for Semi-Annual Reporting, BCBSA has implemented procedures to comply with these guidelines. In Carrier Letter 93-20, Question and Answer section, question 10 states, "Reports (see enclosure) will be required on the number and amounts of claims paid (or services provided) and denied involving debarred providers, i.e., claims incurred before notice and the number of claims denied. Semi-annual reports are required for 1993 and annual reports thereafter. The first of the two 1993 reports will be due September 30, 1993, for the period January 1 (or date your program was put in place) through June 30, 1993; the second 1993 report will be due March 31, 1994, for the period July 1 through December 31, 1993. The annual reports for 1994 and thereafter will be due each March 31st for the period January 1 through December 31 of the prior year. Reports will be required indefinitely." BCBSA complies with this requirement.

The OPM Guidelines for Implementation of March 2004 FEHBP Debarment and Suspension Orders E.6 page 11 states "if a suspended/debarred provider continues to submit claims for services rendered after the effective date of his/her suspension/debarment, you should furnish OIG with documentation of all claims for services received after the effective date of the provider's suspension/debarment. If the circumstances warrant, we will inform the provider about the consequences of submitting further claims, including an additional debarment period and/or civil monetary penalties." Therefore, it is BCBSA's position that FEP has complied with the guidelines stated above to semi-annually report claims paid to debarred providers. Also, the OPM Guidelines do not state that the documentation should be sent once the claims have been incurred, and not only on the Semi-Annual Debarment Report.

Historically, the Semi-Annual Reports of Debarment activity have reported at a minimum two to three claims on average due to the proactive method of the FEHBP Debarment Program.

Recommendation 16: We recommend that the contracting officer direct the Association to review its reporting practices to ensure that all claims paid to debarred providers are reported to the OIG on its Semi-Annual Report (SAR).

BCBSA Response: BCBSA does not agree with this recommendation. FEP is compliant with the guidance in reporting practices to ensure that all claims paid to debarred providers are reported to the OIG on the SAR.

3. Incorrect Notification of Debarment Status

Recommendation 17: We recommend that the contracting officer direct the Association to provide the Plan's updated procedures and the effective date of their implementation.

BCBSA Response: BCBSA agrees with this recommendation and requested the Plan provide updated procedures once completed.

Plan Response: The Plan agrees with the recommendation. Procedures governing debarment have been updated, and implementation was completed March of 2021 and June of 2021.

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

Recommendation 18: We recommend that the contracting officer direct the Association to require its member plans to obtain and maintain provider SSNs and ensure that their claim databases can search and match providers using SSNs to determine if they are debarred.

BCBSA Response: BCBSA does not agree with this recommendation. FEP is compliant with this guidance and following the OPM's Guidelines as stated in Carrier Letter 93-20. If a provider record in the payment system is a possible match with an OPM suspended/debarred provider, but there is not sufficient information to make an authoritative match, the OIG Administrative Sanctions Team should be notified. The BCBSA Administrative Policy Manual, page 3 and 4, states "When Information Doesn't Match, if the Plan identifies a provider who is not an exact match and the Plan's local provider file contains different, more current, or more accurate information, the Plan may update the "Alternate Name" and "Address" fields if there is reasonable assurance that the Plan has identified the correct debarred, suspended, or reinstated provider. If there is not reasonable assurance that the Plan has identified the correct debarred, suspended, or reinstated provider, OPM will make the determination.

To facilitate this, Plans should send the following information regarding the provider in question to the FEP Special Investigations Unit (FEP SIU) at the FEP Director's Office:

1. Provider's full name,
2. Provider's Social Security Number, and
3. Provider's date of birth as it appears on the Plan's file via secure email to FEPSIU@bcbsa.com

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].

Sincerely,

[REDACTED]

[REDACTED]

[REDACTED], FEP Program Assurance

cc: Sylvia Pulley, OPM Contracting Officer
Denise Caddick, Health Care Service Corporation

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

Appendix B



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

February 10, 2022

Mr. Michael Weaver
Senior Team Leader
Office of Personnel Management – Office of the Inspector General Office of
Audits - Claim Audits and Analytic Group
1900 E Street, Room 6400
Washington, DC 20415-11000

Reference: OPM Draft Audit Report 1A-10-17-21-018
Issued: January 31, 2022

Dear Mr. Weaver:

This is the Blue Cross and Blue Shield Association's (BCBSA) 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 additional recommendations included in the report are as follows:

1. Claim Payment Errors: \$982,117

Recommendation 3: We recommend that the contracting officer direct the Association to identify and correct all FEHBP claims where COB did not occur when Medicare became effective during a hospital stay and return any FEHBP funds overpaid as a result.

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

BCBSA Response: BCBSA will work with HCSC to identify and correct HCSC claims where COB did not occur when Medicare became effective during a hospital stay and have HCSC return any FEHBP funds overpaid, once the final report is issued.

Recommendation 4: We recommend that the contracting officer direct the Association to ensure that Plan processors are properly reviewing and adjusting deferred Medicare claims and ensure that they are paying claims using appropriate Medicare pricing allowances.

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

BCBSA Response: BCBSA will work with the Plan to provide evidence that the Plan has implemented procedures to ensure that processors are properly reviewing and adjusting deferred Medicare claims and that the claims are paid at the correct allowance, once the final report is issued.

Recommendation 6: We recommend that the contracting officer direct the Association to identify and correct all FEHBP claims affected by this system error and return any FEHBP funds overpaid as a result.

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

BCBSA Response: BCBSA will work with the Plan to identify and correct the HCSC claims affected by the Plan system error, once the final report is issued.

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

Recommendation 10: We recommend that the contracting officer direct the Association to institute procedures at the Plan to require a secondary review of claims that fit the common errors identified in the finding to ensure that the correct provider network status is reflected prior to final processing of the claim. Additionally, the Association should ensure that its processors are adequately trained on these specific error types to prevent them.

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

BCBSA Response: BCBSA will work with HCSC to provide the Plan's new procedures to ensure that the correct provider network status is reflected prior to final processing of the claim, and support training of Plan's processors, once the final report is issued. BCBSA does not have any processors to train.

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].

Sincerely,

[REDACTED]

[REDACTED], FEP Program Assurance

cc: Denise Caddick, Health Care Service Corporation



Report Fraud, Waste, and Mismanagement

Fraud, waste, and mismanagement in Government concerns everyone: Office of the Inspector General staff, agency employees, and the general public. We actively solicit allegations of any inefficient and wasteful practices, fraud, and mismanagement related to OPM programs and operations. You can report allegations to us in several ways:

By Internet: <http://www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse>

By Phone: Toll Free Number: (877) 499-7295
Washington Metro Area (202) 606-2423

By Mail: Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, NW
Room 6400
Washington, DC 20415-1100