



**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
the Rural Carrier Benefit Plan
for Contract Years 2019 and 2020**

**Report Number 1B-38-00-21-033
August 19, 2022**

Executive Summary

Audit of Claims Processing and Payment Operations at the Rural Carrier Benefit Plan for Contract Years 2019 and 2020

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Why Did We Conduct the Audit?

The objective of our audit was to determine if the health benefit costs charged to the Federal Employees Health Benefits Program (FEHBP) and services provided to its members by the Rural Carrier Benefit Plan, as administered by the National Rural Letter Carriers' Association's and Aetna (Plan) were in accordance with the terms of its contract with the U.S. Office of Personnel Management (OPM).

What Did We Audit?

The Office of the Inspector General (OIG) has completed a performance audit of the FEHBP claim operations at the Plan. Specifically, we performed various claim reviews to determine if the internal controls over the claims processing system were sufficient to ensure that claims were properly processed and paid by the Plan for the period of January 1, 2019, through December 31, 2020. Our audit work was remotely conducted by staff in the Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida areas.



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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 one system error involving claims where an incorrect provider was identified and paid.

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

Abbreviations

5 CFR 980	Title 5, Code of Federal Regulations, Chapter 1, Part 890
Act	Federal Employees Health Benefits Act
Aetna	Claims Administration Corporation, an Aetna Company
ASG	Administrative Sanctions Group
CFR	Code of Federal Regulations
Contract	Contract CS 1073 – The contract between National Rural Letter Carriers’ Association (the Plan administrator) and the U.S. Office of Personnel Management
ECS	Emergency Care Services
FEHBP	Federal Employees Health Benefits Program
Guidelines	Guidelines for Implementation of FEHBP Debarment and Suspension Orders
HIO	OPM’s Healthcare and Insurance Office
NRLCA	National Rural Letter Carriers’ Association
OIG	Office of the Inspector General
OPM	Office of Personnel Management
PIN	Provider Identification Number
Plan	Aetna and NRLCA as administrators of RCBP
POS	Place of Service
RCBP	Rural Carrier Benefit Plan
TIN	Tax Identification Number
USC	United States Code

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I. Background

This final report details the results of our performance audit of the Federal Employees Health Benefits Program (FEHBP) claims processing and payment operations at Rural Carrier Benefit Plan (RCBP) for contract years 2019 and 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 1073 (Contract) between the Office of Personnel Management (OPM) and the National Rural Letter Carriers' Association (NRLCA); 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 RCBP is sponsored and administered by NRLCA. The NRLCA has contracted with Claims Administration Corporation, an Aetna company (Aetna), to further administer the claims processing and payment operations for RCBP. As both NRLCA and Aetna are joint administrators of RCBP, going forward we will refer to both jointly as the "Plan."

The Plan is a fee-for service experience-rated employee organization plan offering health care benefits to its subscribers. Enrollment in the Plan is open to eligible active and retired rural letter carriers of the United States Postal Service. To enroll in the Plan you must already be, or must immediately become, a member of the NRLCA.

Compliance with laws and regulations applicable to the FEHBP, as well as the terms and conditions of the Contract, is the responsibility of Plan management. 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 1B-38-07-02-104, dated December 23, 2003, which covered claim payments from January 1, 1999, through December 31, 2001. Any findings related to that audit were considered obsolete and not considered as part of planning for this audit.

The results of our audit were discussed with Plan officials throughout the audit and at an exit conference on March 8, 2022. We issued a draft report, dated March 16, 2022, to solicit the Plan's comments to the findings and recommendations. The Plan's comments offered in

response to the draft report were considered in preparing our final report and are included as an appendix to this report.

II. Objective, Scope, and Methodology

Objective

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

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 2019 and 2020:

- claims paid with unlisted procedure codes;
- policies and procedures for debarment;
- 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 September 2021 through March 2022.

We reviewed the Plan's annual accounting statements for contract years 2019 and 2020 and determined the Plan paid approximately \$634 million in health benefit payments over both years.

In planning and conducting our audit, we obtained an understanding of the 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 Plan's internal control structure and its operations. However, since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on the Plan's system of internal controls taken as a whole.

We also conducted tests to determine whether the Plan had complied with the Contract, the applicable procurement regulations (i.e., Federal Acquisition Regulations and Federal Employees Health Benefits Acquisition Regulations, as appropriate), and the laws and regulations governing the FEHBP as they relate to claim payments. With the exception of those areas noted in the "Audit Findings" section of this audit report, we found that the Plan was 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 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 Plan. Through the performance of audits and an in-house claims data reconciliation process, we have verified the reliability of the Plan's claims data in our data warehouse, which was used to identify areas to test and to select our samples. The Plan's claims data is provided to the OPM OIG on a monthly basis by the Plan, 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 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 2019 and 2020):

1. **Unlisted Procedure Code Review** – We identified a universe of 3,521 claim lines, totaling \$2,220,804 from all Current Procedural Technology codes and Healthcare Common Procedure Coding System codes containing unlisted, miscellaneous, or unclassified procedures.

From each procedure code which accumulated \$50,000 or more in paid claims (four) during our audit scope, we randomly selected five claim lines to review. In total, we selected 20 claim lines, totaling \$32,831, to determine if the claims underwent adequate review and were paid correctly.

2. **Debarment Policies and Procedures Review** – We reviewed the 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).
3. **Place of Service (POS) Review** – We identified a universe of 2,819,506 claim lines, totaling \$641,943,109, by summarizing the claims data for our scope by POS (the location where the service was performed).

From this universe, we selected a total of 125 claims, with 1,462 claim lines, totaling \$336,228, to determine if the claims were paid accurately according to the provider contract with the Plan and the Plan benefit brochure. Specifically, we randomly selected:

- 25 claims from each of the three POS groupings with five percent or more of the total claim lines. We selected 75 claims, with 908 claim lines, totaling \$260,098; and
- 50 claims from the remaining POS groups with amounts paid greater than \$1 million. We selected 50 claims, with 554 claim lines, totaling \$76,130.

4. **Potential Duplicate Claim Payment 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 identified duplicate or overlapping dates of service.

For each of the duplicate claim groups we identified the following universes:

Universe of Duplicate Claim Payments Identified

	Best Matches	Near Matches	Inpatient Facility Matches	Total
Duplicate Groups	585	156	778	1,519
Potential Overpayment	\$3,119,612	\$494,914	\$25,075,856	\$28,690,382

From these universes, we judgmentally selected all duplicate groups with the total potential duplicate payments of \$25,000 or greater for “Best” matches and \$10,000 or greater for “Near” matches. Additionally, from the “Inpatient Facility Matches” we randomly selected five duplicate groups with total potential duplicate payments of \$100,000 or greater. We reviewed the samples to determine if the claims identified were duplicate payments or not and to quantify any potential FEHBP overpayments. (See the table below for a summary of the total samples selected.)

Duplicate Claim Payment Samples Selected

	Best Matches	Near Matches	Inpatient Facility Matches	Total
Duplicate Groups	30	7	5	42
Potential Overpayment	\$1,311,198	\$124,038	\$956,628	\$2,391,864

During our reviews, we utilized the Contract, the 2019 and 2020 Plan benefit brochures, 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

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 identified two procedural findings, the overall results of our audit indicate that the internal controls implemented by the Plan are generally working as intended.

1. Incorrect Provider Identified and Paid: Procedural

Our review found 18 claims where the Plan incorrectly identified and paid the wrong facility provider due to a system error.

A system error caused claims to be paid to the wrong facility.

According to the Plan brochures, the Plan reimburses participating providers according to an agreed-upon fee schedule. To pay a provider with the agreed-upon fee schedule, the correct provider needs to be identified by the Plan's claim system. The claim system, using unique identifying information (provider and facility identifiers), should routinely assign claims to the correct provider or facility based on the information provided in the claim data.

If the wrong provider or facility is chosen by the claims system, then the provider is not paid according to the agreed-upon fee schedule, which could lead to an incorrect payment to the provider.

Our review identified a claim from an organization that operates both an emergency care service (ECS) and a rehabilitation center. These are separate facilities and have separate contracts and pricing structures with the Plan; however, they have the same parent organization. Although the facilities have different but similar physical addresses and unique, Plan created provider identification numbers (PIN), they do fall under the same tax identification number (TIN).

According to the Plan, a claim for an ECS visit was incorrectly assigned to the rehabilitation center. This caused the claim to be paid at the wrong pricing and to the wrong facility.

The Plan stated the rehabilitation center was set up with the same identifiers as the ECS with only the provider's name and PIN being different. However, the PIN for the rehabilitation center was set up with the incorrect provider type, identifying it incorrectly as a hospital.

When matching a provider on a claim to the provider database, the claims system uses the following criteria in order: type of provider (facility or physician), TIN, physical location, and billing location. Once a match is found, the system does not look any further.

In this case, the first provider record that matched the identifiers happened to be the rehabilitation center instead of the ECS, so the claim was paid to the rehabilitation center at the rehabilitation center's contracted rates, resulting in an underpayment to the FEHBP. This underpayment was reimbursed to the provider during our audit. The Plan identified an additional 17 claims that were affected by the system error. The overall over/under payments were

immaterial and not questioned. While the monetary error is immaterial, the Plan should still make efforts to correct the additional 17 claims.

As a result of incorrect coding in the set-up of the rehabilitation center, 18 claims were priced incorrectly and were paid to the wrong facility.

OIG Comments: The Plan has updated its system with the necessary corrections and provided supporting documentation as evidence that the system correction is working properly. Therefore, we did not issue a recommendation for this finding.

2. Debarred Claims Notification Process: Procedural

The Plan did not have procedures in place to notify the OPM OIG when claims are submitted by providers debarred from the FEHBP as required by the OPM OIG's Guidelines.

The Plan was unaware of the requirement to notify the OPM OIG of claims submitted by debarred providers.

Title 5 CFR section 890 Sub-Part J 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 regarding services or supplies furnished by debarred providers.

The OPM OIG operates administrative sanctions as applicable to the FEHBP under delegation from the OPM Director. In March 2004, the Administrative Sanctions Group (ASG) issued the 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 89 and 5 CFR 890 upon which the Guidelines are based. Additionally, 48 CFR 1609-7001(b)(3) states that the carriers must comply with the terms of the FEHB Contract, regulations, and statutes.

Chapter 2 Section E.6 of the Guidelines 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." This reporting is in addition to the reporting the Plan is already required to do as part of its Semi-Annual Report to ASG.

The Plan was unaware of the requirement to notify the OPM OIG of claims submitted by debarred providers after the effective date of their debarments. As a result, the OPM OIG was not made aware and was not given the opportunity to contact the providers to address the issue.

In October 2021, the ASG notified the Plan of its non-compliance with this requirement and the Plan updated its debarment policies and procedures to comply.

OIG Comments: The Plan has implemented a process to notify the ASG monthly of claims paid to debarred providers, and we were able to verify a submission of claims related to debarred providers was sent to ASG in April 2022. As a result, we did not issue a recommendation for this finding.

Appendix



Aetna Management Response to OPM OIG Draft Audit Report No. 1B-45-00-21-033

April 18, 2022

I. *Audit Findings and Recommendations*

**Redacted by the OIG
Not Relevant to the Final Report**

1. *Incorrect Provider Identified and Paid: Procedural*

**Redacted by the OIG
Not Relevant to the Final Report**

Recommendation 2: *We recommend that the contracting officer direct the Plan to provide verification that the system updates made are working properly and claims from these facilities are properly adjudicated.*

Aetna Response: As Aetna advised the OPM OIG auditors during the course of their field work, it has implemented the necessary system update to correct this issue. Since that update was performed, the provider in issue has submitted two (2) claims. Screen prints demonstrating that the system update is working properly are appended to this response.

For these reasons, Recommendation 2 should be withdrawn.

2. *Debarred Claims Notification Process: Procedural*

**Redacted by the OIG
Not Relevant to the Final Report**

Recommendation 3: *We recommend that the contracting officer verify that the Plan's corrective action plan is in place and that it has begun to notify the OPM OIG when claims from debarred providers are submitted to it.*

Aetna Response: A copy of the monthly transmittal e-mail submitted to the OPM OIG's Administrative Sanctions Branch containing the additional reporting referenced above is appended to this response. Accordingly, Recommendation 3 should be withdrawn.



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