U.S. Office of Personnel Management

Office of the Inspector General

Office of Audits

Final Audit Report

Audit of Claims Processing and Payment Operations at Blue Cross Blue Shield of Arizona for Contract Years 2019 through 2021

Report Number 2022-CAAG-028
February 16, 2023

Executive Summary

Audit of Claims Processing and Payment Operations at
Blue Cross Blue Shield of Arizona for Contract Years 2019 through 2021

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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 Blue Cross Blue Shield of Arizona (Plan) (plan codes 10, 11, and 13) were in accordance with the terms of the Blue Cross and Blue Shield Association's contract with the U.S. Office of Personnel Management.

What Did We Audit?

The Office of the Inspector General 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 healthcare claims were properly processed and paid by the Plan. 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. Therefore, we have no recommendations for the Plan as a result of our audit.

Abbreviations

5 CFR 980	**Title 5, Code of Federal Regulations, Chapter 1, Part 890**
Act	**Federal Employees Health Benefits Act**
Association	**Blue Cross and Blue Shield Association**
BCBS	**Blue Cross and Blue Shield**
CFR	**Code of Federal Regulations**
Contract	**Contract CS 1039 – The contract between the Blue Cross and Blue Shield Association and the U.S. Office of Personnel Management**
FEHBP	**Federal Employees Health Benefits Program**
FEP	**Federal Employee Program**
HIO	**OPM's Healthcare and Insurance Office**
Med A	**Medicare Part A**
Med B	**Medicare Part B**
OIG	**The Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
Plan	**Blue Cross Blue Shield of Arizona**
POS	**Place of Service**
SBP	**Service Benefit Plan**

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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 Blue Cross Blue Shield of Arizona (Plan) (plan codes 10, 11, and 13) for contract years 2019 through 2021. 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 and Blue Shield Association (Association); Title 5, United States Code, 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 and 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 (FEP) 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.

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-10-56-07-024, dated April 4, 2008, which covered claim payments for contract years 2004 through 2006. 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 Association officials throughout the audit, through the issuance of a Notice of Finding and Recommendation, and via an exit conference on November 7, 2022. As all identified findings were resolved, we did not issue a draft 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 through 2021:

- **Basic option non-participating provider claims**
  To determine if the non-participating basic option claims identified met appropriate circumstances to pay and were not unallowable payments;

- **Claims with procedure modifier codes**
  To determine if the plan allowance for claim lines with procedure modifier codes were appropriately adjusted prior to payment;

- **Claims with override codes**
  To determine if claims should have been overridden in the first place and to determine if the processors correctly priced and paid the claims manually;

- **Coordination of benefits with Medicare**
  To determine whether the claims identified required coordination;

- **Place of service review**
  To determine if the claims were paid accurately according to the provider contract with the Plan and the SBP; and

- **Potential duplicate claim payments**
  To determine whether the claims identified were duplicate 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 July 2022 through November 2022.

We reviewed the Association's annual accounting statements for contract years 2019 through 2021 and determined that the Plan paid approximately $1.4 billion in health benefit payments.

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. 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 2019 through 2021).

Basic Option Non-Participating Provider Claims

We identified all claims that were paid where a member had basic option and visited a non-participating provider for a service that was potentially not covered according to the SBP brochure. This resulted in a universe of 22,510 claims with a total amount paid of $10,351,200.

From this universe, we judgmentally selected the three highest paid claims from any place of service (POS – the location where the service was performed) that had an amount paid of

$200,000 or more and the highest paid claim from any POS that had an amount paid between $5,000 and $199,999. In total, we selected 14 claims totaling $524,608.

Claims with Procedure Modifier Codes

We identified a universe of 23,660 claim lines, totaling $10,465,505, with amounts paid greater than or equal to $100 and procedure modifier codes that either require Plan allowance discounts when certain modifiers are present or modifier codes that have been identified as potential problems in prior audits.

From that universe, we further judgmentally selected only those procedure modifier codes which had amounts paid of more than $250,000 during our audit scope. This resulted in 10 procedure modifier codes, with 23,190 claim lines totaling $10,285,992.

For each procedure modifier code selected we calculated its percentage of amount paid to total amount paid and then, using 50 as our target sample, determined what ratio of samples should be pulled from each modifier. In total, we selected 50 claim line samples, totaling $80,660.

Claims with Override Codes

We identified all claims that were deferred with a manual pricing override code of E4B, E27, or 6FM (those identified by the Plan as the three most utilized override codes). This resulted in a universe of 31,485 claims totaling $11,219,329.

From this universe, we focused on claims that had an amount paid of $5,000 or more during our audit scope for each override code. We then randomly selected 10 claims from override codes E4B and E27 and five claims from override code 6FM. In total, we selected 25 claims totaling $354,601.

Coordination of Benefits with Medicare

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	Categories A and B consist of inpatient claims that should have been coordinated with Med A. If the Plan 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. 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.
Categories C and D	Categories C and D include inpatient claims with ancillary items that should have been coordinated with Med B. If the Plan 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. 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 x 0.80 = 0.24 ~ 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, 2019, through December 31, 2021, that potentially were not coordinated with Medicare. This search identified a universe of 1,568 claims, totaling $274,534 in potential coordination of benefits overcharges.

From this universe, we judgmentally selected all claims from category F with total amounts paid of $2,500 or greater (all other categories were determined to be immaterial). This resulted in a sample of 94 claims for review with potential coordination of benefits overcharges $79,126.

Place of Service 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 8,655,456 claim lines, totaling $1,228,280,294, grouped by the claims' assigned POS.

From the universe, we judgmentally selected all POS groups in which the total amount paid represented four percent or more of the total claims paid. This narrowed our results to seven 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 seven groups. In total, we selected 148 claims whose total claim amount paid (all claim lines associated with the claim) was $3,150,480.

Potential Duplicate Claim Payments

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.

From each of the duplicate categories, we identified all duplicate claim payment groups with potential overpayments of $250 or greater. This resulted in a universe of 109 potential duplicate claim payment groups (with potential overpayments of $370,955), and we selected all duplicate groups with potential overpayments totaling $1,500 or more for review. This resulted in a sample of 74 duplicate groups with potential overpayments of $327,684.

During our review, we utilized the Contract, the 2019 through 2021 SBP brochures, the Association's FEP Procedures Administrative Manual, and various other manuals and documents provided by the Association and/or 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 Results

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. Therefore, we have no recommendations for the Plan as a result of our audit.

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