U.S. Office of Personnel Management

Office of the Inspector General

Office of Audits

Final Audit Report

Audit of Claims Processed in Accordance with the Omnibus Budget Reconciliation Acts of 1990 and 1993 at All Blue Cross and Blue Shield Plans for Contract Years 2019 through 2021

Report Number 2022-CAAG-035
June 27, 2023

Executive Summary

Audit of Claims Processed in Accordance with the Omnibus Budget Reconciliation Acts of 1990 and 1993 at All Blue Cross and Blue Shield Plans for Contract Years 2019 through 2021

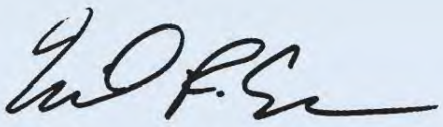
Report No. 2022-CAAG-035 **June 27, 2023**

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 FEHBP members were in accordance with the terms of the Blue Cross and Blue Shield Association's (Association) contract with the U.S. Office of Personnel Management, the Service Benefit Plan brochures, and the provisions related to the Omnibus Budget Reconciliation Acts of 1990 (OBRA 90) and 1993 (OBRA 93).

What Did We Audit?

The Office of the Inspector General has completed a performance audit of the FEHBP claim operations at all Blue Cross and Blue Shield (BCBS) Plans. Specifically, we reviewed claims that were subject to OBRA 90 or OBRA 93 provisions, to determine if the internal controls over the claims processing systems at local BCBS Plans were sufficient to ensure that claims were properly processed and paid during contract years 2019 through 2021. 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?

OBRA 90 and OBRA 93 contain provisions to limit the benefit payments for FEHBP annuitants who are not covered by Medicare parts A or B to what would have been paid by Medicare.

For claims subject to OBRA 90 provisions, our audit identified 447 improperly paid claims, totaling $22,482,081 in net overcharges to the FEHBP. Specifically, we identified the following:

- $14,974,275 in actual and estimated program overcharges, due to software sync errors;
- $7,069,824 in program net overcharges, due to a Centers for Medicare and Medicaid Services file format issue; and
- $437,982 in program overcharges, due to manual processor and system errors.

For claims subject to OBRA 93 provisions, our audit identified 10 claims with overcharges of $374,124 to the FEHBP. Specifically, we identified the following:

- $340,079 in program overcharges, due to claims with certain procedure code modifiers not being priced under OBRA 93 provisions; and
- $34,045 in program overcharges, due to manual processor errors.

While we identified a large dollar finding involving the processing of OBRA 90 claims, 97 percent of the amount questioned is related to a third-party software issue that was outside of the Association's control. Additionally, the overall questioned amount also represents less than one percent of the total OBRA 90 and OBRA 93 claims paid universe for the scope of the audit. For these reasons, we do not feel the issues identified are significant matters involving the Association's internal control structures and operations.

Abbreviations

5 CFR 890	**Title 5, Code of Federal Regulations, Chapter 1, Part 890**
Act	**Federal Employees Health Benefits Act**
ARC	**Audit Resolution and Compliance**
Association	**Blue Cross and Blue Shield Association**
BCBS	**Blue Cross and Blue Shield**
CMS	**Centers for Medicare and Medicaid Services**
Contract	**Contract CS 1039 – The contract between the Blue Cross and Blue Shield Association and the U.S. Office of Personnel Management**
DRG	**Diagnosis Related Group**
FAM	**Federal Administration Manual**
FEHBP	**Federal Employees Health Benefits Program**
FEP	**Federal Employee Program**
FEPDirect	**The Association's Nation-wide Claims Processing System**
FEPOC	**Federal Employee Program Operations Center**
FY	**Fiscal Year**
HI	**Office of Personnel Management's Office of Healthcare and Insurance**
ID	**Identification Number**
MPFS	**Medicare Physician Fee Schedule**
Non-Par	**Non-Participating**
NPBR	**Non-Par Balance Relief**
OBRA 90	**Omnibus Budget Reconciliation Act of 1990**
OBRA 93	**Omnibus Budget Reconciliation Act of 1993**
OIG	**The Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
SBP	**Service Benefit Plan**

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Report Fraud, Waste, and Mismanagement

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 all Blue Cross and Blue Shield (BCBS) Plans, as it relates to the Omnibus Budget Reconciliation Acts of 1990 (OBRA 90) and 1993 (OBRA 93), 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 U.S. 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, 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 (5 U.S.C. §§ 401-424).

The FEHBP was established by the Federal Employee 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 Office of Healthcare and Insurance (HI) has overall responsibility for the administration of the FEHBP, including the publication of program regulations and agency guidance. As part of its administrative responsibilities, HI 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 local 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 member 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[1]) 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 (FEPOC). CareFirst BCBS, located in Owings Mills, Maryland, performs the activities of the FEPOC. 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 its member BCBS Plans. In addition, the Association and its member BCBS Plans are responsible for establishing and maintaining a system of internal controls.

Our most recent audit reports issued related to OBRA 90 and OBRA 93 were:

- OBRA 90 – Report no. 1A-99-00-15-047, dated June 17, 2016, which covered claims paid between January 1, 2012, and April 30, 2015; and

- OBRA 93 – Report no. 1A-99-00-12-001, dated July 16, 2012, which covered claims paid between August 1, 2008, and July 31, 2011.

All recommendations from the previously issued audit reports have been satisfactorily resolved and closed.

The results of our audit were discussed with the Association throughout the audit, including through the issuance of two Notices of Findings and Recommendations, and at an exit conference on March 8, 2023.

II. Objective, Scope, and Methodology

Objective

The objective of our audit was to determine whether the health benefit costs charged to the FEHBP and services provided to FEHBP members were in accordance with the terms of the Contract, the SBP brochures, and the provisions related to the OBRA 90 and OBRA 93.

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.

The focus of our performance audit was to ensure that the Association's claim processing controls were sufficient to identify and appropriately price claims that should be, or should have been, paid under the OBRA 90 or OBRA 93 provisions. Those provisions limit the benefit payments for FEHBP annuitants who are not covered by Medicare parts A or B to what would have been paid by Medicare.

Our audit fieldwork was remotely performed by staff located near our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida from July 28, 2022, through March 8, 2023.

In planning and conducting our audit, we obtained an understanding of the Association's internal control structure to help determine the nature, timing, and extent of our auditing procedures. Our audit approach consisted mainly of substantive tests of transactions and not tests of controls. While we identified a large dollar finding involving the processing of OBRA 90 claims, 97 percent of the amount questioned is related to a third-party software issue that was outside of the Association's control and was limited to the processing of OBRA 90 claims. The overall questioned amount also represents less than one percent of the total OBRA 90 and OBRA 93 claims paid universe for the scope of the audit. For these reasons, we do not feel the issues identified are significant matters involving the Association's internal control structures and operations. Furthermore, 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 system of internal controls taken as a whole.

We also conducted tests to determine whether the Association, and its member Plans, had complied with the Contract, the 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. Except for those areas noted in the "Findings and Recommendations" section of this audit report, we found that the Association, and its member Plans, complied 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 they 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 FEPOC, the Association, and the local BCBS Plans. Through the performance of audits and an in-house claims data reconciliation process, we have verified the reliability of the BCBS claims data in our data warehouse, which was used to identify claims paid under OBRA 90 and OBRA 93 provisions and claims that potentially should have been paid under these provisions. The BCBS claims data is provided to the OPM OIG monthly 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.

The following specific reviews were conducted during our audit (unless otherwise stated, the samples covered the full scope of the audit, contract years 2019 through 2021):

1. **OBRA 90 Paid Claims –** We identified all claims paid with an OBRA 90 pricing indicator and a total amount paid of $1,000 or greater. This resulted in a universe of 14,371 claims with a total amount paid of $226,271,058.

   From this universe, we judgmentally stratified the universe based on claim amount paid, and using an intended sample size of 50, selected a random sample of claims from each stratum based on the total amount paid ratio, ensuring there was at least 1 sample from each stratum. This resulted in a sample of 50 claims, totaling $1,000,384.

2. **Potential OBRA 90 Claims** – We identified all claims paid without an OBRA 90 pricing indicator, but which appeared to meet the required parameters. This resulted in a universe of 8,915 claims, totaling $111,870,669.

   From this universe, we selected all claims with a total amount paid of $50,000 or greater to review. This resulted in a sample of 345 claims with a total amount paid of $34,549,532.

3. **OBRA 93 Paid Claims –** We identified all claims paid with an OBRA 93 pricing indicator. This resulted in a universe of 175,377 claims with a total amount paid of $14,546,032.

   From this universe, we selected a random sample of 25 claims from claims with a total amount paid of $10,000 or greater. This resulted in a sample of 25 claims with a total amount paid of $626,874.

4. **Potential OBRA 93 Claims** – We identified all claims paid without an OBRA 93 pricing indicator, but which appeared to meet the required parameters. This resulted in a universe of 14,396,832 claims with a total amount paid of $2,044,080,621.

From this universe, we selected all claims with a total amount paid of $25,000 or greater to review. This resulted in a sample of 250 claims with a total amount paid of $9,344,008.

During our review, we utilized the Contract, the 2019 through 2021 SBP brochures, the Association's FEP Procedures Administrative Manual (FAM), and various manuals and other documents provided by the local BCBS Plans and the Association, as well as applicable documents from the Center for Medicare and Medicaid Services (CMS) to determine compliance with program requirements, as well as deriving any amounts questioned. The samples selected 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. Findings and Recommendations

The objective of our audit was to determine whether the health benefit costs charged to the FEHBP and services provided to FEHBP members are in accordance with the terms of the contract, the SBP brochures, and the OBRA 90 and 93 provisions. Although we identified net overcharges of $22,856,205 to the FEHBP, the overall results of our audit indicated that the internal controls implemented by the Association regarding the pricing of OBRA 90 and OBRA 93 claims were generally working as intended.

1. OBRA 90 Claim Payment Errors: $22,482,081

Our review identified 447 claims, totaling $13,017,238 in net overpayments (overpayments of $13,114,022 and underpayments of $96,784), due to OBRA 90 pricing not being applied appropriately.

The FEHBP was overcharged a net amount of $22,482,081, due to software issues and processor and system errors.

Additionally, we have provided expanded samples of 638 claims, totaling $13,999,451, for the local BCBS Plans to review and begin recovery efforts on (if necessary). Of these expanded samples, we estimate the FEHBP was overcharged an additional $9,464,843.

The overpayments were a direct result of the following error categories:

- System and Processor Errors Leading to Incorrect OBRA 90 Pricing;
- CMS File Format Issue; and
- X52 Software Sync Errors.

5 CFR 890, Subpart I and Section 9 of the SBP brochure states that for retired enrolled individuals that are not enrolled in Medicare Part A, payments for inpatient hospital services are limited to those payments you would be entitled to if you had Medicare. Hospitals must follow Medicare rules and cannot bill the FEHBP plans or retired enrolled individuals for more than they could bill you if you had Medicare.

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

Additionally, Section 2.3 (g) (i) of the Contract states, “If the Carrier or OPM determines that a Member’s claim has been paid in error for any reason … , the Carrier shall make a prompt and diligent effort to recover the erroneous payment … the recovery of any overpayment must be treated as an erroneous benefit payment, overpayment or duplicate payment … regardless of any time period limitations in the written agreement with the provider.”

A. System and Processor Errors Leading to Incorrect OBRA 90 Pricing

Our review identified eight claims, totaling $437,982, that were not paid at the required OBRA 90 pricing, due to various system and processor errors. Specifically, we identified the following:

- Two claims were overpaid a total of $162,752 due to a system error. Specifically, FEPDirect (the Association's national claims system) did not defer claims with an edit code. This caused the claims to be processed as having "other insurance"; although there was no other insurance. We did not detect this error system wide.

- Four claims were overpaid a total of $160,961, due to processors incorrectly bypassing OBRA 90 pricing. A total of $32,314 has been recovered to date and $128,647 remains due to the FEHBP.

- Two claims were overpaid a total of $114,269, due to processors submitting the claims for pricing with either an incorrect or no Medicare provider identification number (ID). A total of $32,147 has been recovered to date and $82,122 remains due to the FEHBP.

Overall, we determined that eight claims were overpaid a total of $437,982 due to system and processor errors.

Recommendation 1:

We recommend that the contracting officer disallow $437,982 in overcharges to the FEHBP. To date, overpayments totaling $64,461 have been recovered, leaving a remaining amount of $373,521 due to the FEHBP.

Association's Response:

The Association stated it would work with the Plans to initiate recoveries on overpayments identified and return funds collected to the FEHBP. Additionally, it would also provide support of recovery efforts to OPM's Audit Resolution and Compliance (ARC) once the final report is issued.

OIG Comments:

The Association did not state specifically whether they agreed or disagreed with the recommendation. Based on the Association's response, we conclude it does not dispute that overcharges were made to the FEHBP. However, the amount recovered may ultimately be less than the amount questioned as long as carriers can show they met the due diligence requirements of the Contract's erroneous payments clause. Any amounts not recovered despite the carrier's due diligence efforts are deemed to be allowable uncollectible costs.

B. CMS File Format Issue

Our review identified 361 claims, with net overpayments of $7,069,824 (overpayments of $7,166,608 and underpayments of $96,784), that were paid incorrectly due to a CMS file format issue.

Additionally, we issued an expanded sample of which 11 claims, totaling $331,829, remain with the local BCBS Plans to review and begin recovery procedures on (if necessary). These claims were not included in the questioned claims mentioned above, because at the time of this report's issuance, actual overpayments related to these claims had not yet been determined. Any identified overpayments resulting from this expanded sample will be addressed during the resolution process.

FEPDirect uses the CMS Inpatient Facility Mainframe Pricer to price OBRA 90 claims. CMS provides the following to all FEHBP carriers:

- The Medicare Code Editor, which edits claims to identify incorrect billing data;
- The Medical Severity Diagnosis Related Group (DRG) Grouper, which "determines the DRG form data elements reported from the hospital";
- A Medicare pricer which determines the DRG allowance for the prospective payment; and
- Medicare provider information, such as the Medicare provider identification number.

CMS updates these files annually after the start of the Government fiscal year (FY) which begins on October 1. At the beginning of FY 2022, the FEPOC did not find updates on the CMS website. After inquiry, it was determined that CMS was rewriting the files and they would be released later in FY 2022. Once the files were available, the FEPOC discovered several issues and contacted CMS for assistance.

To modernize Medicare payment systems, CMS had converted its pricer application from COBOL programming language to Java. The FEPOC had not received formal advance notification from CMS about the change to a new programing language and had to implement a system update and test its system to accept the new files. In July of 2022, further issues were discovered with the provider files. The FEPOC had all its updates in place by the end of FY 2022. After October 1, 2022, the start of FY 2023, the local BCBS Plans reran all their potential OBRA 90 claims from FY 2022.

Our review of these claims, after being repriced, identified 361 claims that were overpaid a net amount of $7,069,824 (overpayments of $7,166,608 and underpayments of $96,784), due to OBRA 90 pricing not being available at the time of processing. It should be noted that this

audit only covered three months of FY 2022 and that the Association and the local BCBS Plans should continue recovery efforts for the remainder of the FY.

As mentioned above, we issued an expanded sample of claims impacted by this error, of which 11 claims, totaling $331,829, remain outstanding for review and potential recoveries (if necessary).

Recommendation 2:

We recommend that the contracting officer disallow $7,166,608 in overcharges to the FEHBP. To date, overpayments totaling $1,305,776 have been recovered, leaving a remaining amount of $5,860,832 due to the FEHBP.

Association's Response:

The Association stated it would work with the Plans to initiate recoveries on overpayments identified and return funds collected to the FEHBP. Additionally, it would also provide support of recovery efforts to OPM's ARC once the final report is issued.

OIG Comments:

The Association did not state specifically whether they agreed or disagreed with the recommendation. Based on the Association's response, we conclude it does not dispute that overcharges were made to the FEHBP. However, the amount recovered may ultimately be less than the amount questioned as long as carriers can show they met the due diligence requirements of the Contract's erroneous payments clause. Any amounts not recovered despite the carrier's due diligence efforts are deemed to be allowable uncollectible costs.

Recommendation 3:

We recommend that the contracting officer allow $96,784 in underpayments to the FEHBP and direct the Association to instruct the local BCBS Plans to make the necessary adjustments and issue payments to the providers and/or members.

Association's Response:

The Association concurs with our recommendation.

Recommendation 4:

We recommend that the contracting officer ensure that the Association continues recovery efforts and that the FEHBP is properly credited for all FY 2022 monies recovered for the nine months of FY 2022 not covered by this audit.

Association's Response:

The Association stated it would work with the Plans to initiate recoveries on overpayments identified and return funds collected to the FEHBP. Additionally, it would also provide support of recovery efforts to OPM's ARC once the final report is issued.

OIG Comments:

The Association did not state specifically whether they agreed or disagreed with the recommendation. Based on the Association's response, we conclude they do not dispute the recommendation. The Association will need to provide OPM's ARC with a list of claims from January through September 2022, for which overpayments or underpayments were identified.

C. X52 Software Sync Error

Our review identified 78 claims paid incorrectly due to OBRA 90 software sync problems with overpayments totaling $5,509,432.

Additionally, we issued an expanded sample of 627 claims, totaling $13,667,662, for the local BCBS Plans to review and begin recovery procedures on (if necessary). The Association stated that its review of this expanded sample will not be completed prior to issuance of the final report. The **estimated** overpayment of the expanded sample is $9,464,843 (based on error rates identified in other similar claims).

Section 2.3 (g) of the Contract states, "It is the Carrier's responsibility to proactively identify overpayments through comprehensive, statistically valid reviews and a robust internal control program."

When a claim is processed through the OBRA 90 pricer and something is incorrect with the pricing, an X52 error code, indicating an OBRA 90 software sync problem, populates in the DRG field. The local BCBS Plans then price the claim based on their local pricing.

This error code happens frequently at the start of each FY until the new FY pricing files are downloaded from CMS. Once the new CMS pricing files are downloaded, programmers run a report to identify all claims with the X52 error code from October 1 through the date of the software update and send the report to the local BCBS Plans for review, adjustment, and recovery initiation if needed.

The Association indicated that it only looks for X52 errors each year that occur from October 1 through the date of the CMS file pricing update. It does not run any other reports to identify these claims throughout the year, even when mid-year software updates happen.

The Association stated that this error is also sometimes for legitimate reasons that would exclude the claim from OBRA 90 pricing.

We determined that 78 claims were overpaid by $5,509,432 due to the local BCBS Plans not identifying and repricing claims with an X52 error that were not captured on the report run after the annual CMS software update or occurred after the report was run.

As mentioned above, we also issued an expanded sample of 627 claims, totaling $13,667,622, to the local BCBS Plans for review. This expanded sample had error attributes similar to the 78 claims originally identified as being paid in error. The Association informed us they would be unable to reprice these claims until mid-May 2023 because it needs to reinstall older versions of the DRG grouper to properly price the claims. Given this time frame, we did not have the actual overpayments from this expanded sample back in time for us to include them in this final report. However, using the overpayment error rate of the claims we have reviewed; we **estimate** additional potential overpayments related to the expanded sample to be $9,464,843.

Recommendation 5:

We recommend that the contracting officer disallow $5,509,432 in overcharges to the FEHBP. To date, overpayments totaling $2,266,366 have been recovered, leaving a remaining amount of $3,243,066 due to the FEHBP.

Association's Response:

The Association stated it would work with the Plans to initiate recoveries on overpayments identified and return funds collected to the FEHBP. Additionally, it would also provide support of recovery efforts to OPM's ARC once the final report is issued.

OIG Comments:

The Association did not state specifically whether they agreed or disagreed with the recommendation. Based on the Association's response, we conclude it does not dispute that overcharges were made to the FEHBP. However, the amount recovered may ultimately be less than the amount questioned due as long as carriers can show they met the due diligence requirements of the Contract's erroneous payments clause. Any amounts not recovered despite the carrier's due diligence efforts are deemed to be allowable uncollectible costs.

Recommendation 6:

We recommend that the contracting officer direct the Association to institute policies and procedures to run reports of claims with the X52 errors within 30 days of any software update effecting pricing, to issue to its local BCBS Plans for review and repricing.

Association's Response:

The Association stated that they implemented this policy on September 30, 2022, and have provided the policy with its draft response.

OIG Comments:

The Association did not state specifically whether they agreed or disagreed with the recommendation. Based on the receipt of the updated policy the OIG concludes it does not dispute the recommendation. The updated policy discusses how to process claims with the X52 error and the process for claims to be reprocessed based on the recent software updates. However, the policy fails to state that this process should be followed each time there is a software update that affects pricing (even for mid-year updates) and within 30 days after these updates.

Recommendation 7:

We recommend that the contracting officer disallow $9,464,843 in overpayments estimated from our expanded sample. In addition, we recommend the contracting officer direct the Association to complete its review of the expanded sample and the appropriate amounts to be paid to determine the actual overpayment to the FEHBP.

Association's Response:

The Association stated they will complete the repricing of the expanded sample when the OBRA 90 mainframe pricer is updated on May 12, 2023, but they have determined that claims that do not qualify for OBRA 90 pricing will continue to receive the X52 error.

OIG Comments:

The Association did not state specifically whether they agreed or disagreed with the recommendation. Based on its response, we conclude it does not dispute the recommendation. The OIG acknowledges that some of the claims, which do not qualify for OBRA 90 pricing, will continue to receive the X52 error.

2. OBRA 93 Claim Payment Errors: $374,124

Our review identified 10 claims, including 44 claim lines, with FEHBP overpayments totaling $374,124, due to OBRA 93 pricing not being applied either because of processor errors or incorrect procedure code modifier pricing.

5 CFR 890, Subpart I and Section 9 of the SBP brochure states that for retired enrolled individuals that are not enrolled in Medicare Part B, payments for physician services are limited to those payments you would be entitled to if you had Medicare. Physicians must follow Medicare rules and cannot bill the FEHBP plans or retired enrolled individuals for more than they could bill you if you had Medicare.

The FEHBP was overcharged $374,124 due to processor errors and claims with certain procedure code modifiers not being priced according to OBRA 93 provisions.

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

Additionally, Section 2.3 (g) (i) of the Contract states, "If the Carrier or OPM determines that a Member's claim has been paid in error for any reason … , the Carrier shall make a prompt and diligent effort to recover the erroneous payment … the recovery of any overpayment must be treated as an erroneous benefit payment, overpayment or duplicate payment … regardless of any time period limitations in the written agreement with the provider."

A. Claim Lines with Procedure Code Modifiers Requiring Medical Review/Approval not Priced in Accordance with OBRA 93

Our review identified three claims, with 24 claim lines and overpayments totaling $340,079, due to incorrect Association instructions to its local BCBS Plans regarding OBRA 93 eligible claim lines containing certain procedure code modifiers requiring medical review/approval.

5 CFR Part 890 section 904, states that the FEHBP's benefit payments for physician services are limited to the lower of billed charges or the equivalent Medicare part B payment under the Medicare Participating or Non-Participating (Non-Par) Fee Schedule for Medicare providers. It also states that Medicare providers may not collect from the FEHBP and retired enrolled individuals more than the equivalent Medicare part B payment for physician services.

The Association's SBP Brochure states that in certain circumstances, when a subscriber receives professional services from a Non-Par provider during an emergency room visit, an outpatient visit, or a hospital admission, their responsibility will be limited to $5,000 plus the applicable deductible, copay, or coinsurance when the difference between the Non-Par provider's billed amount and the local BCBS Plan's covered amount is greater than $5,000. This is also referred to as Non-Par Balance Relief (NPBR).

Our review identified three claims, with 24 claim lines, that were not priced under the required OBRA 93 regulations, because they included modifier 62 (co-surgeons). The Association's contract with its OBRA 93 pricing vendor indicates the vendor does not price claims with special discount pricing for procedure code modifiers 51 (multiple surgical

procedures), 62, or 66 (surgical team). Claims that include these modifiers often require medical review and approval which the vendor does not provide.

For claim lines that include modifier 62, the Association's FAM, Chapter 18 instructs local BCBS Plans to perform a medical necessity review and, if approved, to price the claim line at the local Plan allowance with the appropriate modifier discount. The Association stipulates that this protocol is also to be followed with OBRA 93 claims since their OBRA 93 pricing vendor does not price the claims with modifiers 51, 62, and 66. However, the OBRA 93 regulations have no pricing exceptions for claims with modifiers or requiring medical review/approval.

Additionally, the Medicare Physician Fee Schedule (MPFS) look-up tool, which the auditors used to price claims during the audit, provides instruction for the pricing of modifier 62. If the Association chooses to not have its OBRA 93 pricing vendor return a Medicare price for claims with modifiers or requiring medical review/approval, then it should instruct the local BCBS Plans to manually price those claims to the required Medicare provision and apply the modifier discount after their medical review/approval. The MPFS look-up tool is available online for pricing these claims. The three claims identified were overpaid a total of $298,146.

In addition, because the above claims were priced at the local Plan allowance, instead of the required OBRA 93 pricing, one of the claims was also overpaid an additional $41,933, due to NPBR being applied to the claim. If the claim had been appropriately priced under OBRA 93 pricing, NPBR would not have applied because Medicare providers are prevented from charging any amount over the Medicare Part B amount, regardless of their contracting status with the local BCBS Plans.

Overall, the FEHBP was overcharged $340,079 for three claims, due to the local BCBS Plans not using the required OBRA 93 pricing.

Recommendation 8:

We recommend that the contracting officer disallow $340,079 in overcharges to the FEHBP.

Association's Response:

The Association states its calculations show an overpayment of $156,459 for two claims and no overpayment on the third claim. The Association indicates that it uses a vendor to price OBRA 93 claims and the vendor does not provide pricing or provider Medicare status for claims that include a procedure code modifier 62.

The Association stated it would work with the Plans to initiate recoveries on overpayments identified and return funds collected to the FEHBP. Additionally, it

would also provide support of recovery efforts to OPM's ARC once the final report is issued.

OIG Comments:

While the Association did not state specifically whether they agreed or disagreed with the recommendation, based on their response it appears they agree with overpayments of $156,459 which were due to modifier discounts not being applied on two of the claims in question. The Association appears to disagree with the remaining amount of $183,620, which is associated with the OBRA 93 pricing of the three claims and the NPBR that was applied to one claim. As previously stated, procedure code modifiers do not exempt a claim from OBRA 93 pricing regulations. Therefore, the Association's internal policies and the vendor's lack of pricing of claims containing procedure code modifiers are contributing factors to the error identified.

Finally, while the Association states above that it will work with the Plans to initiate recoveries and report on the status of recovery efforts, the amount recovered may ultimately be less than the amount questioned as long as carriers can show they met the due diligence requirements of the Contract's erroneous payments clause. Any amounts not recovered despite the carrier's due diligence efforts are deemed to be allowable uncollectible costs.

Recommendation 9:

We recommend that the contracting officer direct the Association to update its FAM to instruct local BCBS Plans to manually price claim lines with modifiers requiring medical review/approval at the appropriate Medicare amount with applicable modifier price adjustments.

Association's Response:

The Association states that the Plans are unable to manually price these claims because the OBRA 93 vendor determines the provider locality and whether they participate in Medicare, so manual pricing would result in inaccurate pricing.

OIG Comments:

The Association did not state specifically whether they agree or disagree with the recommendation. Based on its response, we conclude it does not agree. Throughout the course of this audit, OIG auditors manually repriced all of the sampled claims using provider information and pricing tools available on the CMS website. In absence of vendor pricing, it is possible to manually reprice claims.

Recommendation 10:

We recommend the contracting officer direct the Association to consider requiring its OBRA vendor to return a price for all claims initially, even if the claims require medical review/approval, to ensure that a price is available following the review.

Association's Response:

The Association stated it will work with the OBRA 93 vendor to determine if this can be implemented.

OIG Comments:

The Association did not state specifically whether they agree or disagree with the recommendation. Based on its response, we conclude it is not opposed to the recommendation. We strongly encourage the Association to have the vendor provide pricing, even if they must suspend the claims for medical review and approval. That way, if approved, processors could then apply the vendor pricing and applicable modifier discounts to maintain compliance with Federal regulations.

B. OBRA 93 Processor Errors

Our review identified seven claims, with 20 claim lines, that were not paid at the required OBRA 93 pricing due to processor errors. These errors resulted in FEHBP overpayments of $34,045.

Our review identified seven claims that were assigned an invalid Medicare provider ID by claims processors before submitting the claims to the vendor utilized for OBRA 93 pricing. As a result, the vendor was unable to return Medicare pricing and the claims were incorrectly priced at the local Plan allowance. This processor error was isolated to one local BCBS Plan and the Association has indicated that in 2022, a system edit has been implemented to defer such claims.

The FEHBP was overcharged a total of $34,045, due to processors using an invalid Medicare provider ID on seven claims.

Recommendation 11:

We recommend that the contracting officer disallow $34,045 in overcharges to the FEHBP.

Association's Response:

The Association stated it would provide documentation to support recovery efforts to OPM's ARC once the final report is issued.

OIG Comments:

The Association did not state specifically whether they agreed or disagreed with the recommendation. Based on the Association's response, we conclude it does not dispute that overcharges were made to the FEHBP. However, the amount recovered may ultimately be less than the amount questioned due as long as carriers can show they met the due diligence requirements of the Contract's erroneous payments clause. Any amounts not recovered despite the carrier's due diligence efforts are deemed to be allowable uncollectible costs.

Appendix A

BlueCross BlueShield Association
An Association of Independent Blue Cross and Blue Shield Plans
1310 G Street, N.W.
Washington, D.C. 20005
202.626.4800
www.BCBS.com

April 27, 2023

Ms. Stephanie M. Oliver
Group Chief, Claim Audits and Analytics Group
Office of the Inspector General
U.S. Office of Personnel Management
1900 E. Street, Room 6400
Washington, D.C. 20415-1100

Reference: OPM Draft Global AUDIT REPORT
Omnibus Budget Reconciliation Acts (OBRA) of 1990 and 1993
Report No. 2022-CAAG-035
Dated March 23, 2023

Dear Ms. Oliver:

This is the OBRA 90'/93' response to the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report covering the Federal Employees Health Benefits Program (FEHBP).

Our comments concerning the findings in the report are as follows:

OBRA 90 Claim Payment Errors — **Amount Redacted by the OPM-OIG As amount questioned has changed**

Recommendation 1

Redacted by the OPM-OIG

BCBSA Response

BCBSA will work with Plans to initiate recovery on identified overpayments and return any funds collected to the FEHB Program. Documentation to support due diligence recovery efforts will be provided to OPM Audit Resolution and Compliance (ARC), once the final report is issued.

Recommendation 2

Redacted by the OPM-OIG

BCBSA Response

BCBSA will work with Plans to initiate recovery on identified overpayments and return any funds collected to the FEHB Program. Documentation to support due diligence recovery efforts will be provided to OPM ARC, once the final report is issued.

Recommendation 3

Redacted by the OPM-OIG

BCBSA Response

BCBSA will work with Plans to initiate recovery on identified overpayments and return any funds collected to the FEHB Program. Documentation to support due diligence recovery efforts will be provided to OPM ARC, once the final report is issued.

Recommendation 4

Redacted by the OPM-OIG

BCBSA Response

BCBSA will continue to work with Plans to initiate recovery on identified overpayments and return any funds collected to the FEHB Program. Documentation to support due diligence recovery efforts will be provided to OPM ARC, once the final report is issued.

Recommendation 5

Redacted by the OPM-OIG

BCBSA Response

BCSA implemented this policy on September 30, 2022. Documentation to support implementation of this policy is attached (Attachment 4)

Recommendation 6

Redacted by the OPM-OIG

BCBSA Response

We have determined that some claims in the sample when repriced still received the X52 error or the claims were for providers who did not qualify for OBRA 90 pricing (i.e., Long Term Care Provider, Rehabilitation Facility). See attached support. We will

complete the repricing when the FEP Direct OBRA 90 mainframe pricer is updated on May 12, 2023.

1. **OBRA 93 Claim Payment Errors** **$374,124**

Recommendation 7

Redacted by the OPM-OIG

BCBSA Response

BCBS Plans' calculation shows an overpayment amount of $156,459

Redacted by the OPM-OIG

Carriers in the FEHBP use a vendor to price OBRA 93 claims. The OBRA vendor does not provide pricing or provider Medicare status for any procedure code that includes modifier 62.

BCBSA will work with Plans to initiate recovery on identified overpayments and return any funds collected to the FEHB Program. Documentation to support due diligence recovery efforts will be provided to OPM ARC, once the final report is issued.

Recommendation 8

Redacted by the OPM-OIG

BCBSA Response

Plans are unable to manually price these claims. By doing so, the correct pricing would not be obtained. The OBRA vendor determines not only the Provider locality but if the provider participates with Medicare. Manually pricing these claims would result in incorrect pricing and payment of claims.

Recommendation 9

Redacted by the OPM-OIG

BCBSA Response

BCBSA will work with the OBRA vendor to determine if this is something that can be implemented.

Recommendation 10

Redacted by the OPM-OIG

BCBSA Response

Documentation to support due diligence recovery efforts will be provided to OPM ARC, once the final report is issued.

Redacted by the OPM-OIG

We appreciate the opportunity to provide our response to this Draft Audit Report and request that our comments be included in their entirety as an amendment to the Final Audit Report.

Sincerely,

[redacted]
Managing Director, FEP Program Assurance

cc: [redacted], FEP Program Assurance
[redacted] FEP Program Assurance
[redacted] FEP Program Assurance

Appendix B

As part of our review of OBRA 90 claims, we issued two expanded samples, which were not received before issuance of the draft report. One of the expanded samples was received after the Association's response to the draft report. Upon review, it was determined that an additional recommendation, to address underpayments identified in the expanded sample, was needed. We emailed the new recommendation (below) to the Association for its comment on May 3, 2023.

Recommendation:

We recommend the contracting officer allow $96,784 in underpayments to the FEHBP and direct the Association to instruct the Plans to make the necessary adjustments and issue payments to the providers and/or members.

The Association responded via email on May 3, 2023, stating that "We agree with this Recommendation."

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