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 Select Anthem Blue Cross and Blue Shield Plan Sites for Contract Years 2019 through 2021

Report Number 2023-CAAG-001
November 6, 2023

EXECUTIVE SUMMARY

Audit of Claims Processing and Payment Operations at Select Anthem Blue Cross and Blue Shield Plan Sites for Contract Years 2019 through 2021

Report No. 2023-CAAG-001 **November 6, 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 by four Anthem Blue Cross and Blue Shield (Plan) (plan codes 10,11, and 13) plan sites were in accordance with the terms of the Blue Cross and Blue Shield Association's contract with the U.S. Office of Personnel Management and the Service Benefit Plan brochures.

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 systems were sufficient to ensure that claims were properly processed and paid by the Plan 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?

We identified a significant system error for one of the Plan's sites, Anthem Blue Cross of California, which resulted in FEHBP overpayments of over $200 million. Apart from this system error, claim payment errors related to provider network status, and an identified procedural issue, we found that the Plan's internal controls over its claims processing system were generally effective in ensuring that health care claims were properly processed and paid.

For the areas reviewed, our audit identified net overpayments of $203,698,855 consisting of:

- $203,231,446 in program overcharges to the FEHBP due to a system error that caused Non-Participating outpatient facility non-emergency claims to pay at billed charges instead of the local plan allowance; and
- $467,409 in net program overcharges ($491,324 in overpayments and $23,915 in underpayments), due to claims paying at the incorrect provider network status.

Additionally, we identified a procedural finding involving debarment non-compliance:

- 25 enrollees were incorrectly notified that their provider was debarred from the FEHBP;
- 14 enrollees were not notified that they had received services from a debarred/suspended provider; and
- 61 claims were paid to a debarred billing provider.

ABBREVIATIONS

5 CFR 890	**Title 5, Code of Federal Regulations, Chapter 1, Part 890**
Act	**Federal Employees Health Benefits Act**
ASG	**Administrative Sanctions Group**
Association	**Blue Cross and Blue Shield Association**
BCBS	**Blue Cross and Blue Shield**
CAMT	**Claims Audit Monitoring Tool**
Contract	**Contract CS 1039 – The contract between the Blue Cross Blue and Shield Association and the U.S. Office of Personnel Management**
COVID-19	**Coronavirus Disease 2019**
DPF	**Debarred Provider File**
FAM	**Federal Administrative 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**
Guidelines	**Guidelines for Implementation of FEHBP Debarment and Suspension Orders**
HI	**Office of Healthcare and Insurance**
Med A	**Medicare Part A**
Med B	**Medicare Part B**
Non-Par	**Non-Participating**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
Par	**Participating**
Plan	**Four Anthem Plan Sites**
POS	**Place of Service**
SBP	**Service Benefit Plan**
SIU	**Special Investigations Unit**
U.S.C.	**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 four Anthem (Plan) (plan codes 10, 11, and 13) plan sites for contract years 2019 through 2021. The specific plan sites included in this audit were:

- Anthem Blue Cross and Blue Shield Colorado;
- Empire Blue Cross Blue Shield;
- Anthem Blue Cross of California; and
- Anthem Blue Cross and Blue Shield Nevada.

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 (U.S.C.), 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. sections 401 through 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 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 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

[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.

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 Association and the Plan are responsible for establishing and maintaining a system of internal controls.

The most recent audit report issued that covered claim payments for the Plan sites was report number 1A-99-00-10-013, dated March 17, 2011, which covered claim payments for contract years 2008 and 2009. 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 the Association and the Plan throughout the audit, including the issuance of three Notices of Findings and Recommendations, and at an exit conference on May 4, 2023. We issued a draft report, dated June 14, 2023, to solicit the Association's comments on 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.

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 and the SBP brochures.

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:

- **Place of service (POS) claims review**
  To determine if the claims were paid accurately according to the provider contract with the Plan and the SBP brochure;
- **Unlisted procedure code review**
  To determine if the claim lines with unlisted procedure codes were priced and paid accurately;
- **Potential duplicate claim payments review**
  To determine whether the claims identified were duplicate payments;
- **Provider network status claims review**
  To determine if claims were paid in accordance with the providers assigned network status;
- **Coordination of benefits with Medicare**
  To determine whether the claims identified required coordination with Medicare, and if so, were properly coordinated;
- **Basic option non-participating (Non-Par) claims review**
  To determine if the claims were for a covered service and appropriately paid;
- **Debarment policies and procedures review**
  To determine if the Plan has proper policies and procedures in place to prevent payments to debarred providers, and to properly notify enrollees if a provider used has been disbarred;
- **Procedure code modifier review**
  To determine if the Plan was properly applying procedure code modifier discounts;
- **Coronavirus Disease 2019 (COVID-19) claim payment policies and procedures review**
  To gain an understanding of the Association's COVID-19 policies, as well as any other COVID-19 regulations;

- **Claims Audit Monitoring Tool (CAMT) use review**
  To determine if the Association is monitoring the results of the CAMT reports and to assess the timeliness of their responses; and
- **Non-Par overpayments by Blue Cross of California Review**
  To assess the program impact related to the identified system error and to determine if the corrected allowed amounts were accurate.

Our audit fieldwork was remotely performed by staff located near our offices in Washington, D.C; Cranberry Township, Pennsylvania; and Jacksonville, Florida from December 6, 2022, through May 4, 2023.

We reviewed the Association's 2019 through 2021 annual accounting statements and determined that approximately $7.9 billion in health benefit payments were paid to the Plan for the sites under review.

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 identified a significant system error involving Non-Par outpatient facility non-emergency claims that caused the claims to pay at billed charges instead of the local plan allowance at Anthem Blue Cross California. 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 "Findings and Recommendations" section of this audit report, we found that the Association and the Plan 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 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 select our samples. The BCBS claims data is provided to the OPM OIG monthly by the FEPOC, 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 covered the full scope of the audit, contract years 2019 through 2021):

1. **POS Claims Review** – We identified all claims where the FEHBP paid as the primary insurer, the claim was not subject to the Omnibus Budget Reconciliation Acts of 1990 or 1993, or case management guidelines, and the total claim amount paid was $100 or greater. This resulted in an overall universe of 5,126,733 claim lines, totaling $7,147,257,786, grouped by the claims' assigned POS.

   From this universe, we judgmentally selected all POS groups where the total amount paid for all plan sites was greater than $50,000,000, resulting in 10 out of 44 POS groups being selected. With a target sample of 50 claims per each of the four plan sites, we determined how many claims to review for each POS group based on the ratio of total amount paid per POS group to the total amount paid of all POS groups for each site. In total, we selected 205 claims with a total amount paid of $8,167,772.

2. **Unlisted Procedure Code Review** – We identified a universe of 16,638 claim lines, with amounts paid totaling $4,612,007, where the procedure code utilized was either "unlisted," "miscellaneous," or "unclassified."

   From each plan site, we judgmentally selected all procedure codes with a total amount paid greater than $200,000. This resulted in a selection of seven procedure codes, with a total amount paid of $2,174,652.

   We then selected a random sample of 10 claim lines for each procedure code selected (all if there were less than 10 claim lines total). In total, we selected 68 claim lines, totaling $489,720.

3. **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 identified duplicate or overlapping dates of service.

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

Universe of Duplicate Claim Payments Identified

	Best Matches	Near Matches	Inpatient Facility Matches	Total
Duplicate Groups	92	166	25	283
Potential Overpayment	$456,531	$878,425	$271,984	$1,606,940

Using a target sample of 50 duplicate claim payment groups for "Best Matches" and "Near Matches" (we used a ratio of paid claims per site to total paid claims to determine the number of duplicate groups to select from each site) and all "Inpatient" duplicate claim payment groups, we randomly selected the following samples: (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	49	50	25	124
Potential Overpayment	$328,604	$567,758	$271,984	$1,168,346

4. **Provider Network Status Claims Review** – We identified all claims paid in which the Plan was the primary payer, the claims were not dental claims, and where a provider was paid as both a participating (Par) and Non-Par provider. This resulted in a universe of 6,215 providers with 3,339,569 claim lines, totaling $1,217,006,118.

   From this universe, we judgmentally selected all providers where the total amount paid was greater than $50,000 for plan sites 30 and 61 and $100,000 or greater for plan sites 48 and 52 and the claims amount paid percentage of Par and Non-Par claims was 10 percent or more of the total amount paid respectively. In total, we selected 50 providers, with 31,402 claim lines, totaling $31,078,478.

5. **Coordination of Benefits with Medicare 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	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. 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 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. 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 a universe of 47,571 claims, totaling $15,680,970 with potential coordination of benefits with Medicare errors.

From this universe, for each category and plan site we identified all claims with a total amount paid of $5,000 or greater and all other claims for those patients that had a total amount paid of $100 or greater. We then selected all categories by plan site that had a potential overcharge of $100,000 or greater. This resulted in a random sample selection of 1,271 claims, totaling $7,848,706.

6. **Basic Option Non-Par Provider Claims Review** – We identified all claims that were paid where a member has the basic option and visited a Non-Par provider for a service that is potentially not covered according to the FEHBP brochure. This resulted in a universe of 20,016 claims, totaling $43,429,570.

   From this universe, we judgmentally selected the three highest paid claims (split claims are considered one claim) from any POS 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 36 claims totaling $3,939,975.

7. **Debarment Policies and Procedures Review** – We selected all providers identified in the Plan's claims data as being debarred (eight providers total) and selected those providers with a total paid amount of $100,000 or greater to review for proper payment and member notifications. Specifically, we selected three out of eight providers to review.

   We also selected all performing and billing providers with multiple claims that were identified as debarred on OPM OIG's debarment listing, but not in the claims data to review for proper payment and member notifications. Specifically, we selected three out of nine providers to review.

8. **Procedure Code Modifier Review** – We identified a universe of 298,308 claim lines, totaling $82,898,232, with a procedure code modifier that requires Plan allowance discounts.

   From this universe, we selected all procedure code modifiers with a total amount paid of $300,000 or more; specifically, we selected 13 out of 18 procedure code modifiers. From the 13 selected procedure code modifiers, we randomly selected 10 claim lines from the modifier with the highest paid total amount and from the remaining 12 procedure code modifiers, we selected five claim lines each. In total, we selected 70 claim lines, totaling $101,294.

9. **COVID-19 Claim Payment Policies and Procedures Review** – We reviewed the Association's COVID-19 policies and procedures, OPM Carrier Letters, and other COVID-19 regulations to gain an understanding of how they affected claim adjudication.

10. **CAMT Use Review** – We reviewed the Association's FEP audit manual, the CAMT manual, the FEP Administrative Procedures Manual, the FEP Benefit Policy Manual, and Plan Performance Scorecards on system wide claims reviews to gain an understanding of

the Association's use of its CAMT (an audit monitoring tool used by the Association to communicate claims that may require adjustments and/or repricing to the local BCBS Plans) within FEPDirect (the Association's claims system).

11. **Non-Par Overpayments by Blue Cross of California Review** – We identified all claims that were affected by a system issue that caused Non-Par non-emergency outpatient facility claims in California to be paid at billed charges instead of the Plan's allowance. This resulted in a universe of 21,348 claims totaling $93,641,286.

    From this universe, we judgmentally selected eight procedure codes that occurred 50 or more times in our data and had an overpaid amount of $300,000 or more. In total, we selected 94 claims, totaling $1,196,495.

During our review, we utilized the Contract, the 2019 through 2021 SBP brochures, the Association's FEP Administrative Procedures and Benefit Policy Manual, and various manuals and other documents provided by the Plan and the Association 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. AUDIT 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 were in accordance with the terms of the contract and the SBP brochures. We identified a significant system error with Anthem Blue Cross of California which resulted in FEHBP overpayments of over $200 million. The audit also identified claim processing errors related to provider network status and a procedural issue related to the Plan's non-compliance with the program's debarment requirements. Except for these identified issues, we found that the Plan's internal controls over its claims processing system were generally effective in ensuring that health care claims were properly processed and paid.

1. Claim Payment Errors — $203,698,855

Our review identified $203,698,855 in net health benefit overcharges to the FEHBP ($203,722,770 in overpayments and $23,915 in underpayments). The claim payment errors we found were a result of the following review areas which we cover in more detail below:

- Non-Par Provider Overpayment System Error; and
- Provider Network Status Errors.

Net overcharges to the FEHBP of $203,698,855 were incurred due to system and processor errors and untimely provider file updates.

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."

Section 2.3 (g) 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 … ."

A. Non-Par Provider Overpayment System Error

Due to a system error that occurred in addressing a benefit change in 2019, the FEHBP was overcharged $203,231,446. Specifically, a disconnect between the Plan's corporate claims system and the local plan's claims system incorrectly allowed Non-Par non-emergency claims provided at outpatient facilities to be paid at billed charges and not at the Plan's allowance. As a result of this error, we identified 59,487 claims from 803 providers, with overpayments totaling $203,231,446 to the FEHBP.

The Plan's special investigations unit (SIU) identified this system error during an investigation of an outpatient surgery center in California. During its investigation, the SIU realized FEHBP claims were paying at the full billed amount, which was higher than expected for these types of services for other commercial lines of business. A 2019 benefit change for non-emergency services at Non-Par outpatient facilities required claims to be paid at the local plan allowance. This benefit change required an update to the local plan's claim

system to accurately relay the allowance from the local plan system to Anthem's corporate claim system. After further investigation, it was determined that the local plan allowance for these types of claims in California was not being relayed to the Plan's corporate claim system properly, causing the claims to be paid at billed charges and resulting in significant FEHBP overpayments. The Plan reported the issue to the OIG Office of Investigations.

During our audit, we were informed that the system error was corrected on December 22, 2021. Following a cursory analysis of similar claims paid in 2022, it appears as if the claims are now pricing correctly at the local plan allowance.

The Plan initially identified 126 providers who overcharged the FEHBP $85,099,502 on 21,339 claims. We used the Plan's logic for identifying these claims to develop our own queries to identify additional claims and providers that were potentially overpaid. These queries identified an additional 677 providers and an additional $118,131,944 in overcharges to the FEHBP on 38,148 claims.

Due to the enormity of the overpayments, the Association should make every effort to ensure that the FEHBP funds are recovered. While recovery efforts (letters issued notifying providers they owe monies) for the FEHBP overpayments have begun, as of the date of this report the Plan indicates only $213,420 has been recovered and $37,623,603 has been sent to collections. We did not receive any supporting documentation to verify that any amounts had been recovered.

Fortunately, Non-Par providers in California are required by state law to directly bill insurance plans. This allows the Plan to potentially offset payments owed for future FEHBP member claims. As previously mentioned in one of our Management Advisory Reports (report number 4A-HI-00-18-026, issued on April 1, 2021), we continue to suggest that OPM amend the Contract to require carriers to set up benefit offsets after receiving no response to the first recovery letter rather than waiting until all four letters have been sent (up to 120 days later). If a payment offset is not effective for a provider, the Plan and Association should utilize a collection agency or any legal means to attempt recovery of the total amount owed.

As a result of a system error causing Non-Par non-emergency services provided by outpatient facilities to be paid at billed charges and not at the Plan allowance, the FEHBP was overcharged $203,231,446.

Recommendation 1

We recommend that the Contracting Officer disallow $203,231,446 in overcharges to the FEHBP.

Association's Response:

The Association disagrees that the overcharges should be disallowed due to its efforts in discovering the error, notifying the OIG, and initiating recovery efforts. [redacted]

OIG Comments:

The Contract states carriers may only charge costs that are "actual, allowable, allocable, and reasonable." As such, when there are charges to the FEHBP that are not "allowable," then these charges must be disallowed (questioned) which we are recommending the Contracting Officer to do. The Plan does not dispute the amount of the overcharges.

It is also our position that it is very early in the recovery process to be raising a due diligence argument, especially in light of the enormity of the overcharges to the program. [redacted]. It is incumbent on the Association and Plan to exhaust all avenues to recover these overpayments, which resulted from a significant claims system error, before a determination can be made on the allowability of the overcharges.

B. Provider Network Status Errors

Our review identified 57 claims, related to nine providers, paid incorrectly due to provider network status errors. As a result, we identified net FEHBP overpayments totaling $467,409 (overpayments of $491,324 and underpayments of $23,915).

According to the SBP brochure, the Plan enters contracts with facilities and physician providers (often referred to as "preferred" or "participating" providers) to provide its members with covered services at negotiated rates as payment in full. Facilities and physicians without contracts (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.

Therefore, amounts paid to Non-Par providers, both by the Plan and FEHBP members, often dramatically exceed the amounts paid to preferred or Par providers because of the Plan's ability to negotiate allowances that are lower than the Non-Par provider's billing rate.

Our review of the network status of providers who were identified as having claims paid as both a Par and Non-Par provider identified 57 claims paid improperly. Specifically, we identified the following:

- We found 44 claims, related to seven providers, were overpaid a net amount of $388,319 (overpayments of $403,260 and underpayments of $14,941) due to retroactive provider file updates. This occasionally happens when provider contract negotiations extend beyond the prior contract's termination, requiring the new contract to be backdated and not entered into the claim's system timely.

  The Plan stated that when a retroactive provider file update is made, it submits an ad hoc report request to identify claims paid during the time affected by the retroactive update. When the report is returned, the Plan compares the payment to the new contract terms to determine the correct amount to pay. If identified, overpaid claims are sent to the recovery department and underpaid claims are sent to adjustments. However, our review determined that 30 of the 44 payment errors identified due to retroactive updates to the provider files (68 percent) were identified after the beginning of our audit. The Plan stated that the provider networks team did not provide the file updates, so the ad hoc reports were not requested to identify the claim payment errors. The Plan has made the provider networks team aware of the situation to prevent future occurrences.

- Additionally, 11 claims for one provider overpaid $88,064 due to untimely local provider contract updates.

  The Plan stated that an error occurred when a provider was incorrectly terminated from its provider file. When this was identified and the provider file reactivated, an audit was performed on the impacted claims. The Plan stated it received a claim listing from the provider network team for adjustment; however, the payment error occurred because the claims were adjusted before the update to the provider file went into effect. Additionally, the processor did not identify the claims paid incorrectly as part of their review.

- Lastly, two claims for one provider underpaid $8,974 due to processors entering the wrong provider National Provider Identifier. This error resulted in the claim system assigning the network status of the incorrect provider that was entered.

Due to retroactive and/or untimely provider file updates and processor errors, the FEHBP was overcharged $467,409 (net).

Recommendation 2

We recommend that the Contracting Officer disallow $491,324 in FEHBP overcharges due to provider network status errors. To date, $16,933 has been recovered and $474,391 remains due to the FEHBP.

Association's Response:

The Association disagrees that the overcharges should be disallowed due to its efforts in initiating recovery and states that $296,427 has been recovered to date.

OIG Comments:

The Contract states carriers may only charge costs that are "actual, allowable, allocable, and reasonable". As such, when there are charges to the FEHBP that are not "allowable", then these charges must be disallowed (questioned) which we are recommending the Contracting Officer to do. The Plan does not dispute the amount of the overcharges. The Plan also did not provide any support for the additional amounts recovered for verification.

Recommendation 3

We recommend that the Contracting Officer allow $23,915 in undercharges to the FEHBP due to provider network status errors. To date, all adjustments to providers/members have been made; as such, we consider this recommendation closed.

Association's Response:

The Association agrees with our recommendation.

2. Non-Compliance with Debarment Regulations — Procedural

Processor overrides and errors led to incorrect debarment notifications and payments to debarred providers.

Our review of the Plan's debarment policies and procedures identified three areas of non-compliance with the debarment regulations. Specifically, we identified several instances where the Plan incorrectly notified members that their provider was debarred from the FEHBP, where members were not notified they had received services from a debarred provider, and where the Plan incorrectly paid a debarred billing provider directly.

5 CFR 890 section 890.1001-1072 implements 5 U.S.C, 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. Providers may be debarred due to loss of professional license, conviction related to delivery of or payment for health care services, violation of a Federal program's provisions; or being debarred or suspended by another Federal agency. 5 U.S.C 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, the OIG Administrative Sanctions Group (ASG) issued Guidelines for Implementation of FEHBP Debarment and Suspension Orders (Guidelines) to supplement the regulations and to provide comprehensive instructions on all aspects of carriers' responsibilities.

5 U.S.C 8902a (j), 5 CFR 890.1045 and Chapter 2D of the Guidelines require the FEHBP carriers to notify enrollees who have obtained services from a debarred/suspended provider about

the status of the providers sanctions, that payments to debarred/suspended providers are prohibited, and that payments will not be made for services rendered from the provider after 15 days from date of the notice.

Additionally, Chapter 2E of the Guidelines states that OPM provides debarment/suspension data to carriers in an automated format and that carriers should use their database of debarred/suspended providers to make reasonable efforts to prevent payment of claims for items or services rendered after the date of debarment or suspension. It is further recommended that carriers use the entire OIG cumulative file of debarred/suspended providers.

A. Incorrect Notification of Debarment Status

Our review identified 25 enrollees that were incorrectly notified that their provider was debarred from the FEHBP.

We identified seven providers in the Plan's claim data where the debarment field indicated "Y" for yes. A comparison of these providers to the OIG Debarment Listing indicated that none were debarred or suspended. The Plan indicated that a processor had manually marked the debarment field as "Y," which triggered the notification to the enrollee in error.

When there is a discrepancy in the debarred/suspended status of a provider between the Plan's claim processing system and FEPDirect, a deferral edit code is issued. The Association provides instructions for claim processors to follow to clear the edit code. In these instances, the claims processors incorrectly determined that the providers were debarred/suspended and applied a payment reason code indicating that the claim was within the 15-day grace period for payments to debarred/suspended providers to allow the claims to pay.

Due to claims processors not following proper edit resolutions, 25 members were incorrectly notified that their provider was debarred/suspended.

Recommendation 4

We recommend that the Contracting Officer direct the Association to require the Plan to notify enrollees of the erroneous notification.

Association's Response:

The Association agrees with our recommendation and states that it has already provided notifications to the enrollees.

OIG Comments:

The Association will need to provide OPM's Audit Resolution Group with support to show the enrollees have been notified to close out the recommendation.

B. Enrollees Not Notified of Provider Debarment/Suspension

Our review identified 14 enrollees that were not notified they had received services from a debarred/suspended provider.

To determine if claims were paid to debarred/suspended providers we compared the providers from the OIG Debarment Listing to the providers in the Plan's claims data to determine if any claims were paid to those providers. We found 14 enrollees, in total, where the Plan had not identified the provider as debarred/suspended or made a notification to the enrollee of the provider's status, which the Plan verified.

On a monthly basis, the OPM OIG provides the FEPOC with a listing of debarred, suspended, and reinstated providers. The OIG's ASG indicates that the files available to Plans each month include a cumulative debarred/suspended listing, a monthly debarment/suspension listing, a monthly debarment termination listing, and monthly updates. While the Guidelines state that a monthly update file is provided, it does recommend the use of the cumulative debarred/suspended provider file.

According to the Association's Federal Administrative Manual (FAM), the FEPOC maintains an online National Debarred Provider File (DPF). The FEPOC notifies Plans that the DPF has been updated so the Plans can make the debarment status updates to its provider files, to include the debarment indicator, which will flag the debarment status on incoming claims. The FAM also reminds Plans that since updates are only provided monthly, it is important to download every file to avoid missing relevant information.

Of the 14 enrollees not properly notified of their provider's debarment status, 10 were not notified because the Plan's provider file was not updated to include the debarment status of the provider. The Plan stated it had not been notified of the provider's debarment status. However, the Association stated that all of the providers show as debarred in FEPDirect and the Plan had overridden FEP edits and processed the claims in error. The remaining four enrollees were not notified because the Plan's processors made an incorrect determination of the debarment status and overrode the debarment deferral code. To address this issue and improve debarred provider claim processing results, the Association indicated that it intended to provide debarred provider training to all BCBS Plans in July 2023.

By not properly identifying debarred/suspended providers, enrollees were not notified of the sanctioned status of these providers, and the Plan risks payment to a provider that has potentially lost its professional license, been convicted of a crime related to delivery of or payment for health care services, previously violated provisions of a Federal program, or been debarred/suspended by another Federal agency. Additionally, members receiving treatment from debarred/suspended providers could potentially be putting their lives and health at risk, depending upon the nature of the provider's sanction.

Recommendation 5

We recommend that the Contracting Officer direct the Association to instruct the Plan to make the required notifications to all enrollees that have had claims paid from the previously unidentified debarred/suspended providers.

Association's Response:

The Association agrees with our recommendation and states that it has provided notifications to the enrollees.

OIG Comments:

The Association will need to provide OPM's Audit Resolution Group with support to show the enrollees have been notified to close out the recommendation.

Recommendation 6

We recommend that the Contracting Officer direct the Association to instruct the Plan to institute a secondary review process whenever a processor overrides an FEP debarment edit.

Association's Response:

The Association did not state whether it agreed or disagreed with the recommendation. Additionally, it stated that it is currently evaluating the existing FEPDirect debarred provider edits to determine whether enhancements should be made to the current functionality.

OIG Comments:

While enhancements to FEPDirect are welcome, this does not address when processors at the local plans override the edits in place. We continue to recommend that there be a secondary review when debarment edit codes are overridden by processors.

C. Payments Made to Debarred Billing Providers

Our review identified 61 claims that were paid to a debarred billing provider.

5 CFR 890.1043 (a) states, "A debarred provider is not eligible to receive payment directly or indirectly, from FEHBP funds for items or services furnished to a covered individual on or after the effective date of the debarment. Also, a provider shall not accept an assignment of a claim for items or services furnished to a covered individual during the period of debarment."

Chapter 3F of the Guidelines and Section 15.6 of the FAM state that if a claim is submitted by a debarred/suspended group or clinic, the claim is payable if it can be verified that the

provider that provided the service is not debarred or suspended. Payment may only be made directly to the non-debarred/suspended provider.

Our review of debarred providers identified 61 claims paid where the billing provider was debarred. The Plan stated that since the provider performing the service was not debarred, the claims were paid to the billing provider. However, the regulations state that in these circumstances, the claim may be paid, but only directly to the non-debarred/suspended provider (in this case to the performing provider as opposed to the billing provider). We reviewed the Association's written policies and procedures in its FAM, and while those appear to be correct, they were not followed. The Plan stated that the debarred provider's information was not completely loaded into the local system due to a processor error and that this prevented the claims from deferring and paying directly to the non-debarred, performing provider.

By not following guidelines for claims submitted by a debarred/suspended group or clinic, 61 claims were paid to a debarred billing provider in violation of Federal regulations.

Recommendation 7

We recommend that the Contracting Officer direct the Association to instruct the Plan to institute edits to prevent claims paying to providers with incomplete files.

Association's Response:

The Association did not state whether it agreed or disagreed with the recommendation. Additionally, it stated that it is currently evaluating the existing FEPDirect debarred provider edits to determine whether enhancements should be made to the current functionality.

OIG Comments:

While enhancements to FEPDirect are welcomed, this does not address processor errors that happen at the local plan level. We continue to recommend that the local plans also institute edits to prevent payments being made to debarred billing providers.

APPENDIX

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

July 18, 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 AUDIT REPORT**
Audit of Claims Processing and Payment Operations at Select Anthem Blue Cross and Blue Shield Plan Sites
Report No. 2023-CAAG-001
Dated June 14, 2023

Dear Ms. Oliver:

This is the Blue Cross and Blue Shield 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:

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

A. Non-Par Provider Overpayment System Error

Recommendation 1

We recommend the Contracting Officer disallow $203,231,446 in overcharges to the FEHBP.

Plan Response

The Plan respectfully disagrees that the overcharges should be disallowed. As noted in the draft audit report, this issue was initially discovered and brought to the attention of the OPM, Office of Inspector General (OIG) by the Plan's Special Investigation Unit. This discovery by the Plan and subsequent notification to OPM OIG complied with the Plan's obligations with respect to reporting potential fraud, waste, and abuse under section1.9(a) Detection of Fraud and Abuse) and with respect to its recovery efforts under 2.3(g) Erroneous Payments.

The draft report acknowledges that the plan's overpayment recovery efforts are well under way.

As noted in the draft audit report, the systems issue was discovered by the Plan's own due diligence and was fixed once it had been discovered. Exhibit 1 shows the current status of $96 million recovery efforts against the providers who have not disputed the debt. [redacted]

Redacted by the OPM-OIG
Draft Report Recommendations 2 -4 Were Dropped For the Final Report

B. Provider Network Status Errors

Recommendation 5 (Recommendation 2 in the Final Report)

We recommend the Contracting Officer disallow $491,324 in FEHBP overcharges due to provider network status errors. To date, $16,933 has been recovered and $474,391 remains due to the FEHBP.

Plan Response:

The Plan respectfully disagrees with Recommendation 5 for the same reasons set forth under Recommendation 1. The Plan has complied with its contractual obligations under 2.3(g) in pursuing recovery of these overpayments and, as evidenced in the Exhibit 2, more than $296,427 has been recovered, to date.

Recommendation 6 (Recommendation 3 in the Final Report)

We recommend that the Contracting Officer allow $23,915 in undercharges to the FEHBP due to provider network status errors. To date, all adjustments to providers/members have been made; as such, we consider this recommendation closed.

Plan Response:

The Plan agrees with this recommendation.

Non-Compliance with Debarment Regulations **Procedural**

A. Incorrect Notification of Debarment Status

Recommendation 7 (Recommendation 4 in the Final Report)

We recommend the Contracting Officer direct the Association to require the Plan to notify enrollees of the erroneous notification.

Plan Response

The Plan agrees with this recommendation. The Plan has already provided notifications to enrollees.

B. Enrollees Not Notified of Provider Debarment/Suspension

Recommendation 8 (Recommendation 5 in the Final Report)

We recommend the Contracting Officer direct the Association to instruct the Plan to make the required notifications to all enrollees that have had paid claims from the previously unidentified debarred/suspended providers.

Plan Response

The Plan agrees to this recommendation. The Plan has already provided notifications to enrollees.

Recommendation 9 (Recommendation 6 in the Final Report)

We recommend that the Contracting Officer direct the Association to instruct the Plan to institute a secondary review process whenever a processor overrides a FEP debarment edit.

BCBSA Response

BCBSA is currently evaluating the existing FEPDirect debarred provider edits to determine if enhancements should be made to the current functionality to ensure the following:

- Claims submitted by debarred providers are not erroneously paid outside of the 15-day grace period.
- Claims for providers that are not debarred are not being erroneously denied by Plans as having a debarred provider status.

C. Payments Made to Debarred Billing Provider

Recommendation 10 (Recommendation 7 in the Final Report)

We recommend the Contracting Officer direct the Association to instruct the Plan to institute edits to prevent claims paying to providers with incomplete files.

BCBSA Response

BCBSA is currently evaluating the existing FEPDirect debarred provider edits to determine if enhancements should be made to the current functionality to ensure the following:

- Claims submitted by debarred providers are not erroneously paid outside of the 15-day grace period (by September 30, 2024).
- Claims for providers that are not debarred are not being erroneously denied by Plans as having a debarred provider status (implemented by December 31, 2024).

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]
Managing Director, FEP Program Assurance

Attachments

cc: Barbara Hansen, Contracting Officer, FEHB 1
Angela Calarco, Program Manager, Audit Resolution and Compliance
[redacted]

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