U.S. OFFICE OF PERSONNEL MANAGEMENT
OFFICE OF THE INSPECTOR GENERAL
OFFICE OF AUDITS

Final Audit Report

Audit of the FEHBP Claims Processing and Payment Operations as Administered by Regence for Contract Years 2019 through 2021

Report Number 2023-CAAG-020
February 20, 2024

EXECUTIVE SUMMARY

Audit of the FEHBP Claims Processing and Payment Operations as Administered by Regence for Contract Years 2019 through 2021

Report No. 2023-CAAG-020 **February 20, 2024**

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 Regence (Plan) (plan codes 10,11, and 13) 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 (OPM) and the Service Benefit Plan brochures.

What Did We Audit?

The Office of the Inspector General (OIG) has completed a performance audit of the FEHBP claim operations at the Plan. Specifically, we performed various claim reviews to determine if the internal controls over the claims processing 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?

Apart from the procedural issues identified below, 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.

- We identified three claims where the Plan did not identify the provider as debarred; did not notify the member of the debarment; and the Association did not notify the OPM OIG of the provider's submission of claims after the effective date of debarment. This was due to Association policies and procedures conflicting with official guidance and additional information provided to the Association by the OPM OIG Debarring Official.

- We also identified 93 claim lines that were charged with either Current Procedural Terminology codes and/or procedure modifier codes classifying the service as telehealth when the service provided does not appear applicable to a telehealth setting.

ABBREVIATIONS

5 CFR 890	**Title 5, Code of Federal Regulations, Chapter 1, Part 890**
Act	**Federal Employees Health Benefits Act**
ASG	**Administrative Sanctions Group**
APM	**Association's FEP Administrative Procedures and Benefit Policy Manual**
Association	**Blue Cross and Blue Shield Association**
BCBS	**Blue Cross and Blue Shield**
Contract	**Contract CS 1039 – The contract between the Blue Cross and Blue Shield Association and the U.S. Office of Personnel Management**
CPT	**Current Procedural Terminology**
DPF	**Debarred Provider File**
FEHBP	**Federal Employees Health Benefits Program**
FEP	**Federal Employee Program**
FEPOC	**Federal Employee Program Operations Center**
Guidelines	**Guidelines for Implementation of FEHBP Debarment and Suspension Orders**
HI	**Office of Personnel Management's Office of Healthcare and Insurance**
Med A	**Medicare Part A**
Med B	**Medicare Part B**
Non-Par	**Non-Participating**
NPI	**National Provider Identifier**
OIG	**The Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
Plan	**Regence BlueCross BlueShield**
POS	**Place of Service**
SBP	**Service Benefit Plan**
SSN	**Social Security Number**
TIN	**Taxpayer Identification Number**
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's (FEHBP) claims processing and payment operations as administered by Regence (Plan) (plan codes 10, 11, and 13) plan sites for contract years 2019 through 2021.

The plan sites included in this audit were:

- Regence BlueShield of Idaho:
- Regence BlueCross BlueShield (Oregon);
- Regence BlueCross BlueShield (Utah); and
- Regence BlueShield (Washington).

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 eligible 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,

[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.

verifying subscriber eligibility, approving, or denying the reimbursement of local Plan payments of FEHBP claims (using computerized system edits), maintaining a history file of all FEHBP claims, and maintaining an accounting of all program funds.

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

The last audits of claims of the individual plan sites covered contract years 1998 through 2004. Due to their age, these audits were considered obsolete and were not considered as part of the planning of this audit.

The results of our audit were discussed with the Association and the Plan throughout the audit, including the issuance of two Notices of Findings and Recommendations, and at an exit conference on August 15, 2023. We issued a draft report, dated August 21, 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.

I. 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;
- **Debarment policies and procedures review**
  To determine if the Plan has proper policies and procedures in place to prevent payments to debarred or suspended providers, and to properly notify enrollees if a provider has been debarred or suspended;
- **Potential duplicate claim payments review**
  To determine whether the claims identified were duplicate payments;
- **Coordination of benefits with Medicare review**
  To determine whether the claims identified required coordination with Medicare, and if so, were properly coordinated;
- **Procedure code modifier review**
  To determine if the Plan was properly applying procedure code modifier discounts;
- **Unlisted procedure code review**
  To determine if the claim lines with unlisted procedure codes were priced and paid accurately;
- **Basic option non-participating (Non-Par) claims review**
  To determine if the claims were for a covered service and appropriately paid;
- **Non-Par outpatient non-emergency claims review**
  To determine if Non-Par outpatient non-emergency claims were paid in accordance with the SBP brochure; and
- **Telehealth claims review**
  To determine if claims identified with procedure codes that do not appear to be applicable to a telehealth setting underwent review prior to payment.

Our audit fieldwork was remotely performed by staff located in our offices in Washington, D.C; Cranberry Township, Pennsylvania; and Jacksonville, Florida from April 18, 2023, through August 15, 2023.

We reviewed the Association's 2019 through 2021 annual accounting statements and determined that approximately $2.4 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 did not identify any significant matters involving the Plan's internal control structure and its operations. However, since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on the 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 analytics 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 $250 or greater. This resulted in an overall universe of 1,173,631 claims, totaling $1,723,917,448, grouped by the claims' assigned POS (the location where the service was performed).

From the overall universe for each Plan site, we judgmentally selected all POS groups with an amount paid percentage and claim line percentage of greater than one percent (resulting in a sub-universe of 24 POS groups). With a target sample of 35 claims per Plan site, we judgmentally determined the number of claims to be reviewed from each POS group based on its percentage of amount paid (with a minimum of five claims to be selected from each POS group).

Additionally, we judgmentally selected all POS groups with either an amount paid percentage or a claim line percentage of greater than one percent (resulting in a sub-universe of 15 POS groups). From each POS group selected in this manner, we judgmentally determined to select three claims.

For both of the above selected sub-universes, we stratified each POS group by the total amount paid and judgmentally selected those strata where the amount paid percentage was greater than 10 percent. We randomly selected claims for review from each strata based on the amount paid percentage.

Based on our sampling methodology, we selected 232 claims with a total amount paid of $2,104,258.

2. **Debarment policies and procedures review** – We reviewed the universe of debarred and suspended FEHBP providers and identified all claims paid to debarred or suspended providers in the Plan's provider network to determine if any claims were improperly paid to those providers. We also reviewed the Plan's policies and procedures related to debarments and suspensions to determine if the Association and/or Plan properly followed its contractual requirements, as well as the OIG's Administrative Sanctions Group's (ASG) Guidelines for Implementation of FEHBP Debarment and Suspension Orders (Guidelines).

3. **Potential duplicate claim payments review** – Our search results of potential duplicate claim payments are separated into three categories – "best matches," "near matches," and "inpatient facility matches." The universe of potential duplicate claim groups was derived from the following search criteria:

   - Our "best match" logic identifies and groups unique claim numbers that contain most of the same claim data, including patient code, procedure code, diagnosis code, and sex code.
   - Our "near match" logic identifies and groups unique claim numbers that contain most of the same claim data, except for patient code, procedure code, diagnosis code, or sex code.

- Our "inpatient facility match" search criteria identifies duplicate or overlapping dates of service.

We identified a universe of 146 potential duplicate claim payment groups with potential duplicate overpayments of $1,000 or greater per group. Total potential overpayments for this grouping equaled $281,666, so we selected all groups for review to determine if the identified payments were duplicate payments.

4. **Coordination of benefits with Medicare review** – As part of our review, we separated the uncoordinated claims into six categories based on the POS 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 all paid claims with amounts paid $100 or greater that potentially were not coordinated with Medicare. This search identified a universe of 28,835 claims, totaling $6,545,641 in potential coordination of benefits overcharges.

From this universe, for each category with potential overcharges of $400,000 or more, we judgmentally selected the highest paid claim from each member identification number with a total amount paid of $5,000 or greater. This resulted in a selection of 69 claims, totaling $606,846 in potential overcharges.

5. **Procedure code modifier review** – From claim lines with amounts paid $1,000 and greater and procedure code modifiers that affect the claim allowance, we identified a universe of 5,472 claim lines, with a total amount paid of $18,440,435.

   From this universe, we selected those procedure code modifiers with a total amount paid of $100,000 or greater. Using a target sample of 25 claims, from the 6 procedure code modifiers selected, we judgmentally determined the number of claims to be selected from each modifier (no more than 10 or less than 5) based on the modifier's ratio of amount paid. We randomly selected 35 claims (resulting in 79 claim lines with procedure code modifiers that affect the claim's allowance), with a total amount paid of $138,492.

6. **Unlisted procedure code review** – From claim lines with amounts paid of $1,000 and greater and "unlisted", "Miscellaneous", and "Not Otherwise Specified" procedure codes, we identified a universe of 5,369 claim lines, with a total amount paid of $9,760,551.

   From this universe, we selected those procedure codes identified with 100 or more claim lines for review. Using a target sample of 40 claim lines, from the 13 procedure codes selected, we randomly selected at least 3 claim lines based on the selected procedure code's ratio of amount paid. This resulted in a sample of 52 claim lines with a total amount paid of $165,660.

7. **Basic option Non-Par provider claims review** – We identified all claims that were paid where a member had 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 7,318 claims totaling $3,382,282.

   From this universe, we judgmentally selected the three highest paid claims from any POS that had a total claims paid amount of $100,000 or more and the highest paid claim from any POS that had a total claims paid amount between $30,000 and $99,999. In total, we selected 21 claims totaling $411,905.

8. **Non-Par outpatient non-emergency claims review** – We identified all claims that were paid to Non-Par outpatient facilities for non-emergency services where the Plan was the primary payor and the billed amount equaled the allowed amount. This resulted in a universe of 389 claims from 41 providers totaling $803,804.

   From this universe, we judgmentally selected the highest paid claim for the top 10 highest paid providers. In total, we selected 10 claims totaling $63,483.

9. **Telehealth claims review** – We identified a universe of 93 claim lines, with a total amount paid of $17,035, with procedure codes that do not appear to be applicable to a telehealth setting.

   From that universe we judgmentally selected two claim lines from each procedure code with four or more claim lines and a total amount paid of $400. This resulted in a sample of eight claim lines with a total amount paid of $2,529.

During our review, we utilized the Contract, the 2019 through 2021 SBP brochures, the Association's FEP Administrative Procedures and Benefit Policy Manual (APM), 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 universe taken as a whole.

II. 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. Except for the procedural issues identified, 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. Non-Compliance with Debarment Regulations — Procedural

We identified three claims where the Plan did not identify the FEHBP provider as debarred, notify the member of the debarment, and the Association did not notify OPM of the provider's submission of claims after the effective date of debarment. This was due to Association policies and procedures conflicting with official guidance and additional information provided to the Association by the OPM OIG's ASG.

The Plan did not identify claims paid to debarred providers due to policies and procedures conflicting with regulatory guidance provided by OPM OIG and the Association's reluctance to utilize all available matching criteria to identify claims paid to debarred and suspended providers.

Chapter 2, Part D, of the Guidelines states that carriers must notify enrollees who obtain services from a debarred provider about the provider's debarment status no matter if the claim payments were made to the provider or to the member. This notification should also inform the member that payments will not be made for services provided more than 15 days after the date of the notification.

Chapter 2, Part E 2 of the Guidelines states that at a **minimum** the carrier should flag the following in their claim system (emphasis added):

- Any debarred or suspended provider that has been paid FEHBP funds directly or indirectly within the year preceding their debarment;
- Any debarred or suspended provider located in the carrier's service area, even if they have **not previously received FEHBP payments; and**
- Any debarred or suspended provider that is affiliated with the carrier's preferred provider network.

Chapter 2, Part E 6 of the Guidelines additionally states that the carrier should furnish the OIG with documentation of all claims submitted by a debarred provider after the effective date of the provider's debarment.

Lastly, the OPM OIG's ASG, which monitors providers debarred or suspended from the FEHBP, produces both a cumulative list of all debarred providers and a monthly update of changes to the cumulative listing (listing of newly debarred providers or those with changes to their debarment

status). These are both available with a history going back several months, along with all debarment regulations and the Guidelines document, on OPM's Secure Debarment website (www.opm.gov/debar).

We identified three claims related to one Non-Par debarred provider where the Plan did not properly identify the provider as debarred. Consequently, the members were not notified properly of the provider's status and that claims after 15 days would not be paid. The OPM OIG was also not made aware of the claims submitted by the provider after its debarment.

The claims we identified included an exact match on the provider's National Provider Identifier (NPI) number, name, and address. As a result, the claims properly suspended on FEPDirect (the Association's national claims system) for the Plan to manually confirm if the provider was debarred or not. However, Plan review determined it was not a match, as the provider was not flagged as debarred within its provider database, and as a result, it did not follow the required debarment notification steps.

According to the Association, when the debarment notice was received by the Plan in 2019, the provider in question was not located within the Plan's provider system due to its Non-Par status. The Association stated that the debarment status was not correctly populated for FEHBP claims once the provider was added to the Plan's provider database in 2020.

It is not surprising that the Plan did not identify the provider in question for two reasons. First, the provider was at that point Non-Par and would therefore not be in the Plan's local provider file for it to identify in accordance with the APM (which provides procedures for all local Plans to follow for FEHBP lines of business). Second, the only required matching criteria referred to in the APM is the Social Security Number (SSN), which most local Plans do not maintain for contracted providers. As Non-Par providers do not contract with the local plans, the Plan would also not have maintained SSNs for these providers.

The fact that the provider was not on the Plan's local provider file caused the first error in 2019. Per the Association, its APM states that "Plans must compare their local provider files to the Debarred Provider File (DPF) to identify those providers who match the providers on their local Plan provider files." The APM further states, "Plans should routinely flag providers on local provider files. If a Plan does not have the capability to flag provider names and identification numbers, manual procedures must be implemented." The APM Update to the DPF section states, "Important! Plans must compare the entire listing to their local provider files for a match on SSN, regardless of the state listed. Do not sort and run only those providers in the Plan's service area."

However, the Guidelines require the local plans to update their systems to flag providers in their local service area as debarred, even if they have not received FEHBP payments previously, and not just providers on its local provider file. Because the Association's APM makes no mention of providers that do not exist on the local provider files, providers in the Plan's local service area

and not on its local provider files (which would almost exclusively be Non-Par providers) were not flagged and identified by the Plan as potentially debarred or suspended providers.

The APM's limitation of matching only on SSN led to the second error in 2020. While the Guidelines state that SSN is the best method of matching, it does not limit other forms of matching. NPI's, Taxpayer Identification Numbers (TIN), names, or addresses are all available on the debarment listing provided by the OPM OIG. However, the Association's APM states, "At this time, provider Social Security Numbers (SSNs) are the only provider identification numbers that appear on the [OPM] listings." The Association's APM is incorrect in this statement. As mentioned above, other potential matching criteria (TIN and NPI) has been provided for 53 percent of all providers debarred or suspended on the OPM OIG ASG listings since 2009.

The Guidelines state that "We expect that you will use SSNs as the principle basis for matching providers on our suspended/debarred providers list against your systems. We believe the SSN is the best available data element because it is definitive and constant for individuals." The current Guidelines, being a 2004 document, are dated and indicate that TIN, EIN (employee identification number), and NPI, by omission, were generally not provided. That changed in 2009 for NPI and TIN as stated earlier. However, regarding only matching on SSN, the Association states that because it had not received any correspondence indicating that other identifiers should be used as matching criteria that it continued its sole matching on SSN. While the Guidelines state that SSNs are the "best" matching criteria, it does not state that SSNs are the "only" matching criteria. It would be expected that the Association, in its fiduciary responsibilities to the FEHBP, would strive to do more than the minimum to prevent improper payments to potential debarred or suspended providers. More should be done, therefore, than only attempting matches on SSN when other matchable criteria are available. Especially considering that, as was previously mentioned, most local Plans do not maintain SSNs for their contracted providers, making matching on SSN rather difficult.

The Association limits the possibility of matching debarred providers by other identifiers available on the OPM OIG listing by incorrectly stating that SSNs are the only identification information on the OPM OIG debarment or suspension listings and only requiring local Plans to match on SSN,. Any matches made using a method other than an SSN should be considered, at a minimum, a partial match and would need to be verified by the OPM OIG ASG before the provider is flagged.

As a result of the Association's APM's lack of direction regarding providers not on the local plan's provider file and its sole focus on matching debarred providers based on SSN, the Plan did not identify the provider as debarred for these three claims; did not notify the member of the debarment; and the Association did not notify the OPM OIG's ASG of the provider's submission of claims after the effective date of debarment.

Recommendation 1:

We recommend that the Contracting Officer require the Association to update its APM to direct local plans to ensure that all debarred and suspended providers in its local area are added to their local provider databases and flagged as debarred or suspended, even if the providers have not previously submitted FEHBP claims (including adding Non-Par providers on the OPM OIG listing, if necessary) so claims paid to them will be flagged if presented to the local Plans as required by the Guidelines.

Auditee's Response:

The Association disagrees with the recommendation and states that its APM already has guidance included within its FEP policies. Additionally, because it does not require its local BCBS plans to code provider identification numbers on claims submitted from Non-Par providers, those local plans should implement their own measures to ensure that claims from Non-Par providers can be identified. The Association also stated that it is evaluating its existing claim system edits to determine if enhancements should be made to ensure debarred providers are not paid.

OIG Comments:

The Association's response only focuses on measures taken when a claim is received. However, the focus of the finding and the recommendation is on when the local plan is notified of a newly debarred provider that is not on its local provider file.

While the Association's FEP policies require the local plan to implement their own measures to ensure that claims from Non-Par debarred providers are identified, the Plan does not do anything to flag said providers not in its local provider file. Additionally, there is no language that covers this situation in the Association's FEP procedures as is required by the Guidelines. Therefore, the Association's procedures need to be updated to account for this situation going forward to further ensure that claims for debarred or suspended providers are identifiable and not erroneously paid.

Recommendation 2:

We recommend that the Contracting Officer require the Association to update its APM to include other (non-SSN) matching criteria available on the OPM OIG debarred or suspended provider listing for potential partial matches for flagging purposes in its DPF and local plan provider databases. The Association should also provide training to its local plans to ensure that they understand the importance of these additional matching criteria.

Auditee's Response:

The Association disagrees with the recommendation and states that it has not received any direction or guidance from the OPM OIG to use other identifiers (other than SSN and date of birth) as criteria to identify claims paid to debarred providers.

OIG Comments:

The Association's response fails to consider its responsibility under the regulations as well as the additional information provided to it that could prevent unallowable program charges. Additionally, the Plan has chosen this course of action instead of seeking clarification on how the additional information could be utilized to identify and prevent improper payments to these providers.

The Guidelines require the identification of potential matches in addition to matches based on the SSN or date of birth. If there is not sufficient information to make an authoritative match, the Association will need to confirm a match with the OPM OIG's ASG.

The Association's responsibility under the FEHBP regulations is to ensure that debarred and suspended providers are appropriately identified and improper payments to these providers are precluded beyond any allowable grace periods. The Guidelines supplement these regulations and are required to be followed. While the current Guidelines emphasize the use of the SSN and date of birth as the best available criteria for matching purposes, they do not preclude the use of other available identifiers. These other identifiers are required to be used in order to flag potential matches. The OIG's monthly debarment listings include identifiers such as NPIs, TINs, and other relevant data elements that must be used to identify potential matches. When a potential match is identified based on other identifiers, the Association must confirm the match with the OPM OIG's ASG.

The Plan should utilize the additional matching criteria it has had available for over a decade and work with the OPM OIG's ASG to confirm provider matches.

2. No Edits to Defer Potential Telehealth Claim Errors — Procedural

We identified 93 claim lines that were charged with either Current Procedural Terminology (CPT) codes and/or procedure modifier codes classifying the service as telehealth when the service provided does not appear applicable to a telehealth setting. These claim lines were processed through the Plan's claims processing system without deferring for medical review prior to payment.

Claims for telehealth related CPT and/or procedure modifier codes were paid for services inconsistent with telehealth settings without review prior to payment.

The claim lines identified focused on lines with POS groups 02 (Telehealth Provided Other than in Patient's Home) or 10 (Telehealth Provided in Patient's

Home) with either modifier codes 95, GQ, GT, or G0 (all of which reference telehealth, audio, or telecommunications) and a telehealth CPT code. The descriptions of these POS codes, modifier codes, and CPT codes indicate that some sort of medical review is required to determine if the services would be performable via telehealth prior to payment.

We specifically reviewed eight claim lines and requested that the Plan explain if these types of claim lines, which do not traditionally align with telehealth-type services, undergo any sort of pre-payment review. In response, the Plan stated that there were no edits in place for this and that the claims processed without intervention.

While telehealth services are not new to the FEHBP, the number and variety of services has drastically increased since the Coronavirus Disease of 2019 pandemic. As such, we believe increased scrutiny by the Plan is necessary to determine if telehealth claims are correct prior to payment.

This area was brought to the forefront in a recent Data Brief (brief number 022-CAAG-0014) issued to OPM. Continued identification of questionable claims in this audit suggests that these types of claims should require increased scrutiny prior to payment, rather than paying the claims and hopefully catching them after the fact or not at all. Additionally, pre-payment review of these types of claims would assist in preventing erroneous payments before they happen.

As a result of the Association's lack of edits for claim lines with telehealth-related POS and modifier codes, the Plan did not review them for appropriateness, which potentially allowed 93 claim lines to pay incorrectly.

Recommendation 3:

We recommend that the Contracting Officer require the Association to update its claims processing system with edits to ensure that claim lines with telehealth-related POS and modifier codes suspend for review prior to payment.

Auditee's Response:

"The Association agrees with this recommendation."

APPENDIX

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

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September 27, 2023

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Office of the Inspector General
U.S. Office of Personnel Management
1900 E. Street, Room 6400
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Reference: OPM Regence Draft Audit Report
Audit Report Number 2023-CAAG-020
August 21, 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. Debarment Regulations

Recommendation 1

We recommend that the Contracting Officer require the Association to update its Administrative Procedure Manual (APM) to direct local Plans to ensure that all debarred providers in its local area are added to their local provider databases and flagged as debarred even if the providers have not previously submitted FEHBP claims (including adding Non-PAR providers on the OPM listing) so claims paid to them will be flagged if presented to the local Plans as required by the Guidelines.

BCBSA Response:

The Association disagrees with this recommendation. Guidance is already included in APM Section 15.6 FEP Special Administrative Guidelines (FEP Guidelines) and states, "Plans must compare their local provider files to the debarred provider file (DPF) to identify those providers who match the providers on their Local Plan provider files Plans should routinely flag providers on local provider files. If a Plan does not have the capability to flag provider names and identification numbers, manual procedures must be implemented." The FEP Guidelines also state "The FEP Claims Processing System does not require Plans to code provider identification numbers on member (non-par provider) submitted claims. Therefore, Plans should implement their own measures to ensure that debarred or suspended providers are

identified on member submitted claims. Provider Identification Numbers must be entered so that Debarred Provider processing can occur at the FEP Operations Center. Again, it is important to enter the debarred or suspended provider's appropriate identification number(s) exactly as it appears on the Operations Center file record, before submitting the claim to the Operations Center".

To reduce incorrect payment of debarred provider claims (including non-par provider claims), the Association is currently evaluating the existing FEPDirect debarred provider edits to determine if enhancements should be made to the current functionality to ensure claims for debarred providers are not erroneously paid.

The Association will also evaluate updating the current Claims Audit Monitoring Tool (CAMT) Debarred Provider post payment report to include claims with debarred provider indicator "N". Inclusion of these claims will identify debarred provider claims where the debarred provider edit was incorrectly overridden and paid by the Plan. A status of this activity will be provided to OPM Audit Resolution and Compliance (ARC) once the final report is issued.

Recommendation 2:

We recommend that the Contracting Officer require the Association to update its APM to include other (non-SSN) matching criteria available on the OPM debarred provider listing for potential partial matches for flagging purposes in its DPF and local Plan provider databases. The Association should also provide training to its local Plans to ensure that they understand the importance of these additional matching criteria.

BCBSA Response:

The Association disagrees with this recommendation. APM Section 15.6 states, "Plans must compare the entire listing to the local provider files for a match on social security number (SSN). If there is not a reasonable assurance that the Plan has identified the correct debarred, suspended, or reinstated provider, Plans should send the provider's name, date of birth (DOB) and SSN to the FEP Special Investigation Unit (FEP SIU), and FEP SIU will send the information to the OIG Administrative Sanction Group (ASG) for determination." The Guidelines for Implementation of Federal Employees Health Benefits Program Debarment and Suspension Orders (Guidelines) state "We believe the SSN is the best available data element because it is definitive and constant for individuals. The provider's DOB may be used as a secondary matching element. Generally, we do not maintain or disseminate records on providers' tax identification numbers (TIN) or employee identification numbers (EIN) because a person and/or a health care practice may have several different ones, and therefore they are not definitive for matching purposes." The Association has not received correspondence indicating that other identifiers should be used as a "matching" criteria and the DOB is already used as a secondary matching criteria.

On March 22, 2023, the Association requested a provider verification from the OPM ASG. The response was for the Association to provide "the DOB and SSN of the provider in question". There was no mention of any other identifier (i.e., NPI, EIN, etc.) for this provider verification.

Debarred provider training was provided to all Plans on July 27, 2023.

2. Telehealth Claims Errors

Recommendation 3:

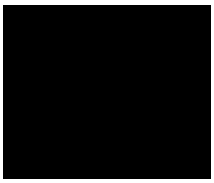
We recommend that the Contracting Officer require the Association to update its claims processing system with edits to ensure that claim lines with telehealth related Place of Service (POS) and modifier codes suspend prior to payment for review.

BCBSA Response:

The Association agrees with this recommendation. In response to OIG Brief 022-CAAG-0014, the Association implemented a workplan to evaluate the current FEPDirect telehealth adjudication process to either defer or deny procedure codes that may be incorrectly billed as a telehealth service (either based upon POS 02 or with use of modifier 95, GQ or GT). The expected completion date is September 30, 2024. The Association is also developing a CAMT post payment report that will target all incorrectly billed telehealth services for Plan review by January 2, 2024. A status of these activities will be provided to OPM ARC once the final report is issued.

Thank you for this opportunity to respond to the recommendations included in this draft report. If you have any questions, please contact me at [redacted] or [redacted] at [redacted].

Sincerely,



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