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

Final Audit Report

Audit of Claims Processing and Payment Operations as Administered by Blue Cross and Blue Shield of Florida for Contract Years 2020 through 2022

Report Number 2023-CAAG-022
March 6, 2024

EXECUTIVE SUMMARY

Audit of Claims Processing and Payment Operations as Administered by
Blue Cross and Blue Shield of Florida for Contract Years 2020 through 2022

Report No. 2023-CAAG-022 **March 6, 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 Blue Cross and Blue Shield of Florida (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 and the related Service Benefit Plan brochures.

What Did We Audit?

The Office of the Inspector General has completed a performance audit of the Plan's FEHBP claim operations. 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 2020 through 2022. Our audit work was remotely conducted by staff in our Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida offices.

Michael R. Esser
Assistant Inspector General
for Audits

What Did We Find?

Although our audit identified one finding, the overall claim lines impacted (660) and dollars in error ($66,962) lead us to believe that the Plan's internal controls over its claims processing system are generally effective in ensuring that health care claims were properly processed and paid.

We identified 660 claim lines, with potential overpayments of $66,962, 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

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**
FEHBP	**Federal Employees Health Benefits Program**
FEP	**Federal Employee Program**
OIG	**The Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
Plan	**Blue Cross and Blue Shield of Florida**

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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 as administered by Blue Cross and Blue Shield of Florida (Plan) [plan codes 10, 11, and 13] for contract years 2020 through 2022.

The audit was conducted pursuant to the provisions of contract CS 1039 (Contract) between the U.S. Office of Personnel Management (OPM) and the Blue Cross and Blue Shield Association (Association); Title 5, United States Code, Chapter 89; and Title 5, Code of Federal Regulations, Chapter 1, Part 890. The audit was performed by OPM's Office of the Inspector General (OIG), as authorized by the Inspector General Act of 1978, as amended (Title 5, United States Code sections 401 through 424).

The FEHBP was established by the Federal Employee Health Benefits 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 has overall responsibility for the administration of the FEHBP, including the publication of program regulations and agency guidance. As part of its administrative responsibilities, the Office of Healthcare and Insurance contracts with various health insurance carriers that provide service benefits, indemnity benefits, and/or comprehensive medical services. The provisions of the Federal Employees Health Benefits Act are implemented by OPM through regulations codified in Title 5, Code of Federal Regulations, Chapter 1, Part 890.

The Association, on behalf of participating local Blue Cross and Blue Shield (BCBS) plans, has entered a Government-wide Service Benefit Plan 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 Service Benefit Plan. The FEP Director's Office coordinates the administration of the Contract with the Association, member BCBS Plans, and OPM.

The Association has also established an FEP Operations Center. CareFirst BCBS, located in Owings Mills, Maryland, performs the activities of the FEP Operations Center. These activities include acting as fiscal intermediary between the Association and its member BCBS plans, verifying subscriber eligibility, approving, or denying the reimbursement of local plan payments of FEHBP claims (using computerized system edits), maintaining a history file of all FEHBP claims, and maintaining an accounting of all program funds.

[1] Throughout this report, when we refer to FEP, we are referring to the Service Benefit Plan lines of business at the local BCBS Plans. When we refer to the FEHBP, we are referring to the program that provides health benefits to Federal employees.

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

The most recent audit of claims processing and payment operations at the Plan was report number 1A-10-41-16-029, dated March 30, 2020, which covered the period January 1, 2012, through October 31, 2015. 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 one Notice of Findings and Recommendations, and at an exit conference on December 5, 2023. We issued a draft report, dated December 27, 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 Service Benefit Plan 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 2020 through 2022:

- **Place of Service Review**
  To determine if the claims were paid accurately according to the provider contract with the Plan and the Service Benefit Plan brochure.
- **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 is properly applying allowance adjustments for all procedure code modifiers requiring them when pricing FEHBP claims.
- **Unlisted Procedure Codes Review**
  To determine if claims that have unlisted, miscellaneous, or unclassified Current Procedural Terminology or Healthcare Common Procedure Coding System codes were priced and paid correctly in accordance with Plan policies and procedures.
- **Basic Option Non-Participating Provider Claim Review**
  To determine if Basic Option claims paid for Non-Participating providers met appropriate circumstances to pay and were not unallowable payments.
- **Non-Participating Outpatient Non-Emergency Claim Review**
  To determine if the Plan made allowance adjustments for a 2019 benefit change related to non-participating outpatient non-emergency claims.
- **Coronavirus Disease of 2019 Pandemic Claim Review**
  To determine if the Plan followed Association policy for cut-off dates on applying full Coronavirus Disease of 2019 Pandemic benefits for certain diagnosis codes.

- **Telehealth Claim Review**
  To determine if telehealth claim lines were paid for procedure codes that may be questionable as a telehealth service.
- **Fraud, Waste and Abuse Reporting Process Review**
  To determine if all possible fraud, waste, and abuse cases related to the FEHBP were properly reported to the OPM OIG Office of Investigations as stated by Carrier Letter Number 2017-13.

Our audit fieldwork was remotely performed by staff located in our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida from August 24, 2023, through December 5, 2023.

We reviewed the Association's 2020 through 2022 annual accounting statements and determined that approximately $5.6 billion in health benefit payments were paid to the Plan during our audit scope.

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. Except for one area noted in the "Audit Finding and Recommendation" section of this audit report, we found that the Association and the Plan complied with the health benefit provisions of the Contract and the Service Benefit Plan brochures. 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 FEP Operations Center, the Association, and the Plan. Through the performance of audits and an in-house claims data reconciliation process, we have verified the reliability of the BCBS claims data in our data warehouse, which was used to identify areas to test and select our samples. The BCBS claims data is provided to the OPM OIG monthly by the FEP Operations Center, and after a series of internal steps, uploaded into our data warehouse. While utilizing the computer-generated data during our audit, nothing came to our attention to

cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

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 2020 through 2022):

- **Place of Service 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 2,119,949 claims, totaling $4,137,977,628, incurred during contract years 2020 through 2022, grouped by the claims' assigned place of service (the location where the service was performed).

  From the overall universe, we judgmentally selected all place of service groups with an amount paid percentage ***and*** claim line percentage of greater than 1 percent (resulting in 6 place of service groups). With a target sample of 85 claims, we judgmentally determined the number of claims to be reviewed from each place of service group selected based on its percentage of amount paid (with a minimum of 5 claims to be selected from each place of service group).

  Additionally, we judgmentally selected all place of service groups with ***either*** an amount paid percentage or a claim line percentage of greater than 1 percent (resulting in 3 place of service groups). From each place of service group selected in this manner, using a target sample of 15 claims, we judgmentally determined the number of claims to be reviewed from each place of service group selected based on its percentage of amount paid (with a minimum of 3 claims to be selected from each place of service group).

  We stratified each place of service group selected by 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 stratum based on the amount paid percentage.

  Based on our sampling methodology, we selected 106 claims with a total amount paid of $2,552,174.

- **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 or Part 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 Medicare A. If the BCBS plans indicated that Medicare A benefits were exhausted, we reviewed the claims to determine whether there were any inpatient services that were payable by Medicare B. For these categories Medicare 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 Medicare B. If the BCBS plans indicated that members had Medicare B only, we reviewed the claims to determine whether there were any inpatient services that were payable by Medicare B. For these categories, Medicare 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 Medicare B should have been the primary payer. For these categories, Medicare 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 of $100 or greater from January 1, 2020, through December 31, 2022, that potentially were not coordinated with Medicare. This search identified a universe of 17,875 patients, with potential COB overcharges totaling $13,223,263 in categories A, E and F. All other categories were determined to be immaterial.

- For Category A: We selected patients with a total amount paid equal to or greater than $25,000.

- For Category E: We selected patients with a total amount paid equal to or greater than $20,000.

- For Category F: We selected patients with a total amount paid equal to or greater than $50,000.

From this resulting subset, we then judgmentally selected the earliest claim incurred for each patient where the patient's Medicare information was available on the date of service and/or when that information was not available at the date of service. This resulted in a sample of 72 claims from 60 patients with a potential overpayment of $511,141.

- **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 1,109 claim lines, with a total amount paid of $3,226,939.

  From this universe we selected those procedure code modifiers with a total amount paid of $500,000 or greater. Using a target sample of 30 claims, we judgmentally determined the number of claims to be selected from each procedure code modifier (ensuring that no less than 5 claims were selected from each) based on the modifier's ratio of amount paid. We randomly selected 31 claims (resulting in 43 claim lines with procedure code modifiers that affect the claim's allowance), with a total amount paid of $65,780.

- **Unlisted Procedure Codes Review**

  From claim lines with procedure codes classified as "unlisted," "miscellaneous," and "unclassified" and with an amount paid greater than $0 and where the Plan was the primary payor, we identified a universe of 121 procedure codes with 24,547 claim lines and a total amount paid of $10,185,171.

From this universe we selected all procedure codes with a total amount paid of $100,000 or greater for review. From the 11 procedure codes selected, we randomly selected 4 claims lines from each, resulting in a sample of 44 claim lines with a total amount paid of $152,330.

- **Basic Option Non-Participating Provider Claim Review**

  We identified all claims that were paid where a member has the basic option and visited a non-participating provider for a service that is potentially not covered according to the FEHBP brochure. This resulted in a universe of 18,363 claims totaling $7,336,065.

  From this universe, we judgmentally selected the three highest paid claims from any place of service that had a total claims paid amount of $100,000 or more and the highest paid claim from any place of service that had a total claims paid amount between $30,000 and $99,999. In total, we selected 23 claims totaling $421,214.

- **Non-Participating Outpatient Non-Emergency Claim Review**

  We identified all claims that were paid to non-participating 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 85 claims from 30 providers totaling $113,866.

  From the universe, we judgmentally selected the highest paid claim for the top 10 highest paid providers. In total, we selected 10 claims totaling $86,870.

- **Coronavirus Disease of 2019 Pandemic Claim Review**

  The Association updated its Coronavirus Disease of 2019 Pandemic policies and procedures (effective for claims processed on or after January 22, 2021) to end provisions for full benefits (100 percent of Plan allowance/charges, with no member cost-share regardless of the provider's network status) for six diagnosis codes starting January 1, 2021. We identified all claims with the six diagnosis codes that were incurred on or after January 1, 2021, and had no member cost-share applied. This resulted in a universe of 3,203 claims totaling $322,536.

  From that universe, we used a target sample of 12 claims and calculated a ratio of the amount paid for each diagnosis code and applied the ratio to our target sample to determine a sample size for each diagnosis code with each diagnosis code having at least one claim selected regardless of the ratio. This resulted in a sample of 16 claims with a total amount paid of $51,403.

- **Telehealth Claim Review**

  We identified a universe of 689 claim lines, with a total amount paid of $74,909, with procedure codes that do not appear to be applicable to a telehealth setting and either a place of service group or procedure code modifier that reference telehealth, audio, or telecommunications (place of service groups 02 or 10 and/or procedure code modifiers of either 95, GQ, GT, or G0).

  From that universe, we judgmentally selected the highest paid claim line from each procedure code with four or more claim lines and a total amount paid of $400 or greater. This resulted in a sample of 11 claim lines with a total amount paid of $11,169.

- **Fraud, Waste and Abuse Reporting Process Review**

  We reviewed all 48 legal and/or fraud cases identified by the Plan that were not reported to the OPM OIG Office of Investigations.

During our review, we utilized the Contract, the 2020 through 2022 Service Benefit Plan 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 FINDING AND RECOMMENDATION

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 Service Benefit Plan brochures. Although our audit identified one finding, the overall claim lines impacted (660) and dollars in error ($66,962) lead us to believe that the Plan's internal controls over its claims processing system are generally effective in ensuring that health care claims were properly processed and paid.

1. No System Edits to Defer Potential Telehealth Claim Errors $66,962

We identified 660 claim lines, with potential overpayments of $66,962, 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. These claim lines were processed through the Plan's claims processing system without deferring for medical review prior to payment.

There are no edits in the claims system to catch payments made for services that cannot be performed in a telehealth setting.

We initially reviewed 11 claim lines and requested that the Plan explain if the claim lines with the telehealth component of the claims, which don't traditionally align with the assigned procedure codes, 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. Based on the Plan's response, we issued a Notice of Findings and Recommendations to the Plan requesting that it review the remaining claim lines in our sample universe. Our review of the Plan's response found that, in total, 660 claim lines were paid without intervention.

While telehealth services are not new to the FEHBP, the number and variety of services has drastically increased since the 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 2022-CAAG-0014) we issued to OPM on March 6, 2023. 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 place of service, Current Procedural Terminology code, and procedure code modifiers, the Plan did not review them for appropriateness, which allowed 660 claim lines to pay incorrectly, totaling $66,962 in potential overpayments to the FEHBP.

Recommendation 1

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 and procedure code modifiers suspend prior to payment for review.

Association's Response:

The Association stated that it agrees with the recommendation and that it is "in the process of implementing a telehealth place of service (POS) and telehealth modifier edit in FEPDirect to defer claims for review before processing. The new edit is expected to be implemented by June 2024."

Recommendation 2

We recommend that the Contracting Officer require the Association to reprocess the identified claims with its updated claim edits to determine if they were properly paid and if not, to return any identified overpayments to the FEHBP.

OIG Comments:

While the Association did not have an opportunity to respond to this recommendation, it is aware of the potential overpayments and of its responsibility to attempt recovery of any amounts identified as program overcharges.

APPENDIX

BlueCross BlueShield Association
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January 23, 2024

Stephanie Oliver
Group Chief, Claims 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
Blue Cross Blue Shield of Florida
Audit Report Number 2023-CAAG-022
December 27, 2023

Dear Ms. Oliver:

This is the Blue Cross and Blue Shield of Florida, response to the above referenced U.S. Office of Personnel Management OPM) Draft Audit Report covering the Federal Employees Programs Claims Processing and Payment Operations. Our comments concerning the findings in the report are as follows:

1. **No System Edits to Defer Potential Telehealth Claim Errors** **Procedural**

Recommendation 1

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 procedure code modifiers suspend prior to payment for review.

BCBSA Response

BCBSA agrees with this recommendation as stated and is actively in the process of implementing a telehealth place of service (POS) and telehealth modifier edit in FEPDirect to defer claims for review before processing. The new edit is expected to be implemented by June 2024.

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

Sincerely,

Redacted by the OPM-OIG
Managing Director, FEP Program Assurance

Redacted by the OPM-OIG

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