



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

Final Audit Report

Subject:

AUDIT OF BLUECROSS BLUESHIELD OF TENNESSEE CHATTANOOGA, TENNESSEE

Report No. 1A-10-15-13-058

Date: June 6, 2014

--CAUTION--

This audit report has been distributed to Federal officials who are responsible for the administration of the audited program. This audit report may contain proprietary data that is protected by Federal law (18 U.S.C. 1905). Therefore, while this audit report is available under the Freedom of Information Act and made available to the public on the OIG webpage, caution needs to be exercised before releasing the report to the general public as it may contain proprietary information that was redacted from the publicly distributed copy.

AUDIT REPORT

Federal Employees Health Benefits Program
Service Benefit Plan Contract CS 1039
BlueCross BlueShield Association
Plan Code 10 and 11

BlueCross BlueShield of Tennessee
Plan Codes 390/890
Chattanooga, Tennessee

REPORT NO. 1A-10-15-13-058

DATE: June 6, 2014



Michael R. Esser
Assistant Inspector General
for Audits

--CAUTION--

This audit report has been distributed to Federal officials who are responsible for the administration of the audited program. This audit report may contain proprietary data that is protected by Federal law (18 U.S.C. 1905). Therefore, while this audit report is available under the Freedom of Information Act and made available to the public on the OIG webpage, caution needs to be exercised before releasing the report to the general public as it may contain proprietary information that was redacted from the publicly distributed copy.

EXECUTIVE SUMMARY

Federal Employees Health Benefits Program
Service Benefit Plan Contract CS 1039
BlueCross BlueShield Association
Plan Code 10 and 11

BlueCross BlueShield of Tennessee
Plan Codes 390/890
Chattanooga, Tennessee

REPORT NO. 1A-10-15-13-058 DATE: June 6, 2014

This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at BlueCross BlueShield of Tennessee (Plan), located in Chattanooga, Tennessee, questions \$3,618,301 in health benefit charges. The Plan agreed with \$937,069 of these questioned charges, disagreed with \$1,856,362, and did not respond to \$824,870.

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covered claim payments from January 1, 2010 through March 31, 2013 as reported in the Annual Accounting Statements.

The questioned health benefit charges are summarized as follows:

- **Retroactive Enrollment Report Review** **\$1,949,774**

The Plan did not initiate and/or complete the recovery process for payment errors related to 4,928 claims that were paid before the member's eligibility status was updated, resulting in overcharges of \$1,949,774 to the FEHBP.

- **Place of Service and Discount Review** **\$1,628,666**

Our review of a judgmental sample of claims paid by the Plan's local system determined that 1,088 claims were paid incorrectly, resulting in net overcharges of \$1,628,666 to the FEHBP. Specifically, the Plan overpaid 1,087 claims by \$1,630,096 and underpaid 1 claim by \$1,430.

- **Modifiers Review** **\$20,825**

The Plan incorrectly paid 62 claim lines containing procedure code modifiers, resulting in overcharges of \$20,825 to the FEHBP.

- **Omnibus Budget Reconciliation Act (OBRA) 90 Review** **\$15,366**

The Plan incorrectly paid 16 OBRA 90 claims, resulting in net overcharges of \$15,366 to the FEHBP. Specifically, the Plan overpaid 11 claims by \$18,549 and underpaid 5 claims by \$3,183.

- **Non-Covered Services Review** **\$3,670**

The Plan incorrectly paid five claims containing non-covered services, resulting in overcharges of \$3,670 to the FEHBP.

CONTENTS

	<u>PAGE</u>
EXECUTIVE SUMMARY	i
I. INTRODUCTION AND BACKGROUND	1
II. OBJECTIVES, SCOPE, AND METHODOLOGY	3
III. AUDIT FINDINGS AND RECOMMENDATIONS	5
HEALTH BENEFIT CHARGES	5
1. Retroactive Enrollment Report Review	5
2. Place of Service and Discount Review	8
3. Modifiers Review.....	12
4. Omnibus Budget Reconciliation Act (OBRA) 90 Review	14
5. Non-Covered Services Review	15
IV. MAJOR CONTRIBUTORS TO THIS REPORT	17
V. SCHEDULE A – HEALTH BENEFIT CHARGES AND AMOUNTS QUESTIONED	
APPENDIX: BlueCross BlueShield Association’s February 21, 2014 reply to the Draft Audit Report, issued December 17, 2013.	

I. INTRODUCTION AND BACKGROUND

INTRODUCTION

This final audit report details the findings, conclusions, and recommendations resulting from our limited scope audit of the Federal Employees Health Benefits Program (FEHBP) operations at BlueCross BlueShield of Tennessee (Plan). The Plan is located in Chattanooga, Tennessee.

The audit was performed by the Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as established by the Inspector General Act of 1978, as amended.

BACKGROUND

The FEHBP was established by the Federal Employees Health Benefits (FEHB) Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for federal employees, annuitants, and dependents. OPM's Healthcare and Insurance Office has overall responsibility for administration of the FEHBP. The provisions of the FEHB Act are implemented by OPM through regulations, which are codified in Title 5, Chapter 1, Part 890 of the Code of Federal Regulations (CFR). Health insurance coverage is made available through contracts with various health insurance carriers.

The BlueCross BlueShield Association (Association), on behalf of participating BlueCross and BlueShield (BCBS) plans, has entered into a Government-wide Service Benefit Plan contract (CS 1039) with OPM to provide a health benefit plan authorized by the FEHB Act. The Association delegates authority to participating local BCBS plans throughout the United States to process the health benefit claims of its federal subscribers. There are 64 BCBS plans participating in the FEHBP.

The Association has established a Federal Employee Program (FEP¹) 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. The activities of the FEP Operations Center are performed by CareFirst BlueCross BlueShield, located in Washington, D.C. These activities include acting as fiscal intermediary between the Association and member plans, verifying subscriber eligibility, approving or disapproving 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 Plan management. Also, management of the Plan is responsible for establishing and maintaining a system of internal controls.

¹ Throughout this report, when we refer to "FEP", we are referring to the Service Benefit Plan lines of business at the Plan. When we refer to the "FEHBP", we are referring to the program that provides health benefits to federal employees.

All findings from our prior audit of the Plan (Report No. 1A-10-15-09-009, dated June 16, 2009), which included claim payments from 2005 through 2007, have been satisfactorily resolved.

The results of this audit were provided to the Plan in written audit inquiries; were discussed with Plan and/or Association officials throughout the audit and at an exit conference; and were presented in detail in a draft audit report, dated December 17, 2013. 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. Also, additional documentation provided by the Association and Plan on various dates through April 9, 2014 was considered in preparing our final report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The objectives of our audit were to determine whether the Plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the contract. Specifically, our objectives were to determine whether the Plan complied with contract provisions relative to health benefit payments.

SCOPE

We conducted our limited scope 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.

We reviewed the BlueCross and BlueShield FEHBP Annual Accounting Statements as they pertain to Plan codes 390 and 890 for contract years 2010 through 2013. During this period, the Plan paid approximately \$1.6 billion in health benefit charges (See Figure 1 and Schedule A). Specifically, we reviewed approximately \$8.8 million in claim payments for the period January 1, 2010 through March 31, 2013 for proper adjudication.

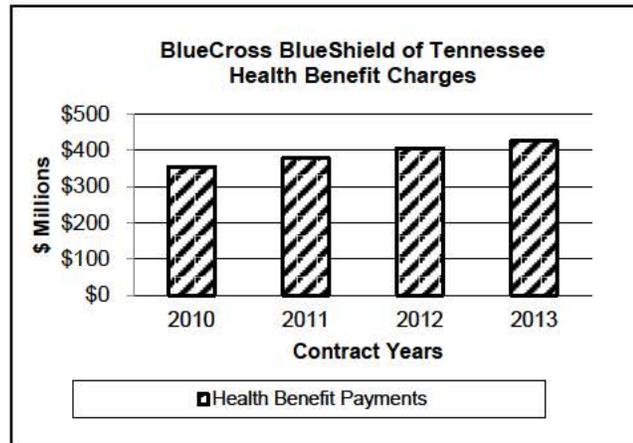


Figure 1 – Health Benefit Charges

In planning and conducting our audit, we obtained an understanding of the Plan’s internal control structure to help determine the nature, timing, and extent of our auditing procedures. This was determined to be the most effective approach to select areas of audit. For those areas selected, we primarily relied on 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 Plan’s system of internal controls taken as a whole.

We also conducted tests to determine whether the Plan had complied with the contract and the laws and regulations governing the FEHBP as they relate to claim payments. The results of our tests indicate that, with respect to the items tested, the Plan did not fully comply with the provisions of the contract relative to claim payments. Exceptions noted in the areas reviewed are set forth in detail in the “Audit Findings and Recommendations” section of this audit report.

With respect to the items not tested, nothing came to our attention that caused us to believe that the Plan had not complied, in all material respects, with those provisions.

In conducting our audit, we relied to varying degrees on computer-generated data provided by the FEP Director's Office, the FEP Operations Center, and the Plan. Through audits and a reconciliation process, we have verified the reliability of the BCBS claims data in our data warehouse, which was used to identify the universe of claims for each type of review. The BCBS claims data is provided to us on a monthly basis by the FEP Operations Center, and after a series of internal steps, uploaded into our data warehouse. However, due to time constraints, we did not verify the reliability of some of the data generated by the Plan's local claims system. While utilizing the computer-generated data during our audit testing, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

The audit was performed at the Plan's office in Chattanooga, Tennessee from August 19, 2013 through August 30, 2013. Audit fieldwork was also performed at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida through December 2013.

METHODOLOGY

We obtained an understanding of the internal controls over the Plan's claims processing system by inquiry of Plan officials.

To test the Plan's compliance with the FEHBP health benefit provisions, we selected and reviewed samples of 3,156 claims.² We used the FEHBP contract, the 2010 through 2013 Service Benefit Plan brochures, the Plan's provider agreements, and the Association's FEP Administrative Manual to determine the allowability of benefit payments. The results of these samples were not projected to the universe of claims.

² See the audit findings for "Retroactive Enrollment Review" (1), "Place of Service and Discount Review" (2), "Modifier Review" (3), "Omnibus Budget Reconciliation Act 90 Review" (4), and "Non-Covered Services" (5) on pages 5 through 16 for specific details of our sample selection methodologies.

III. AUDIT FINDINGS AND RECOMMENDATIONS

HEALTH BENEFIT CHARGES

1. Retroactive Enrollment Report Review

\$1,949,774

The retroactive enrollment report identifies paid claims that are potentially affected by enrollment changes (i.e., claims paid before the member's eligibility status is updated in the FEP Direct enrollment system). These potential overpayments require the Plan to determine if a refund should be initiated from the provider. The retroactive enrollment report consists of six categories: contract enrollment changes, other party liability coordination of benefits (COB), Medicare change, eligibility exception change, workers compensation, and no fault change. The report is generated by the FEP Operations Center and is distributed to the Plan on a daily basis.

We requested a walkthrough of the Plan's processing of the retroactive enrollment report to determine if the Plan was properly initiating recovery for claim payment errors charged to the FEHBP. During our walkthrough, we determined that the Plan was not reviewing claims listed on the retroactive enrollment report with incurred dates older than 90 days from the date of the report. Consequently, we requested the Plan to provide each daily retroactive enrollment report generated by the FEP Operations Center during the period of January 1, 2013 through March 31, 2013 to determine the potential impact on the FEHBP. These reports identified 2,505 claims, totaling \$1,045,632 in payments to the FEHBP, that were potentially paid in error. Of these claims, we selected 81 for review, totaling \$17,661 in payments, to determine if the Plan was properly reviewing these potential claim payment errors and initiating recovery from the providers. Specifically, we randomly selected claims from the top four high dollar categories (contract enrollment change, other party liability COB, Medicare change, and eligibility exception change) listed on the retroactive report.

Based on this initial review, we identified 56 claim payment errors, totaling \$15,490 in overcharges to the FEHBP (88 percent of the \$17,661 in payments we reviewed), where the Plan did not properly initiate recovery and/or return the overpayment to the FEHBP.

Since most of the claims from our initial sample were paid in error, we requested the Plan to perform an expanded review on all retroactive enrollment reports from January 1, 2012 through September 30, 2013. The expanded review identified an additional 11,578 claims, totaling \$2,822,443 in payments, that were potentially paid in error. This includes 9,090 claims, totaling \$2,358,108 in payments, for the period of January 1, 2012 through December 31, 2012, and 2,488 claims, totaling \$464,335 in payments, for the period of April 2013 through September 2013.

Our expanded review of these 11,578 claims identified an additional 4,872 claim payment errors, totaling \$1,934,284 in overcharges to the FEHBP, where the Plan did not properly initiate recovery and/or return the overpayment to the FEHBP.

Between our initial and expanded reviews, we determined the Plan did not initiate recovery and/or return 4,928 claim payment errors, resulting in overcharges of \$1,949,774 to the FEHBP.

These questioned charges consist of the following:

- \$824,870 represents 1,660 claim overpayments to the FEHBP where the Plan did not provide documentation to support that these claims were paid correctly. These claims appeared on the daily retroactive enrollment reports during the period of January 2013 through March 2013 with incurred dates older than 90 days from the date of each report.
- \$692,317 represents 2,443 claim overpayments where the Plan has initiated recovery efforts as a result of this audit.
- \$154,923 represents 284 claim overpayments where the Plan initiated recovery prior to the start of our audit; however, the recovery was not returned to the FEHBP. Although the Plan provided documentation, the support did not demonstrate why the funds have not been recovered and/or returned to the FEHBP.
- \$140,617 represents 122 claim overpayments identified as a result of the audit. Although the Plan provided documentation, the support did not demonstrate why the funds have not been recovered and/or returned to the FEHBP.
- \$127,092 represents 406 claim overpayments where recovery was not initiated because the overpayment was determined to be uncollectible according to the provider's contract. Although the Plan states the provider's contract deems the overpayments uncollectible due to time limitations, the Plan should make a prompt and diligent effort to recover these overpayments as specified in Contract CS 1039.
- \$9,955 represents 13 claim overpayments identified prior to the start of the audit; however, the recovery process was not initiated. Although the Plan provided documentation related to these claims, it did not adequately demonstrate why the recovery process has not been initiated.

Contract CS 1039, Part III, section 3.2 (b)(1) states, "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable." Part II, section 2.3(g) states, "If the Carrier or OPM determines that a Member's claim has been paid in error for any reason . . . the Carrier shall make a prompt and diligent effort to recover the erroneous payment . . . The recovery of any overpayment must be treated as an erroneous benefit payment, overpayment, or duplicate payment . . . regardless of any time period limitations in the written agreement with the provider."

BCBS of Tennessee's Response:

Based on the Plan's written response, the Plan agreed to \$208,164 of the questioned charges and states the Plan continues to show due diligence in its recovery effort. Additionally, the

Plan states, “These overpayments were caused by the untimely review of the retroactive enrollment reports and the Plan applying the provider agreement time limits to the overpayment recovery efforts in error.” For the contested items the Plan states, “[the claims] paid correctly because the member either had coverage under another contract id or payment was correct based on other insurance effective date and/or the overpayment was less than \$5.”

Regarding corrective actions, the Plan states that they will no longer apply the provider agreement time limits to overpayments, that procedures were enhanced to promote a timely review and the initiation of recoveries as appropriate, and that the audit staff will conduct random reviews of the retroactive enrollment reports to ensure that timely resolution is performed.

BCBS Association’s Response:

In response to the draft report the Association states, “[the Association] expects to enhance its on-line Claims Audit Monitoring Tool to include all daily retro-active enrollment transactions by July 31, 2014. Once these transactions are included in the on-line tool, [the Association] staff will review Plan processing for compliance with the FEP overpayment recovery requirements.”

OIG Comments:

Based on our review of the Association’s response and additional documentation provided by the Plan, we revised the amount questioned from the draft report to \$1,949,774. Although the Plan agrees with \$208,164 in its written response, the Plan’s additional documentation supports concurrence with \$827,821 of the revised questioned charges. This variance represents \$619,657 that was identified in the Plan’s expanded review of the retroactive enrollment reports. Due to the significant time the Plan needed to review the expanded sample, this amount was not included in the draft report questioned costs. Of the \$1,949,774 questioned in the final report, the Plan did not respond to \$824,870, which represents the claims that we questioned on the retroactive reports during the period of January 2013 through March 2013.

Recommendation 1

We recommend that the contracting officer disallow \$1,949,774 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 2

We recommend that the contracting officer ensure that the Association’s and Plan’s corrective actions for reviewing the daily retroactive enrollment reports are being implemented. These additional corrective actions are included in the Plan’s response to the draft report.

2. Place of Service and Discount Review

\$1,628,666

For health benefit claims reimbursed during the period January 1, 2012 through March 31, 2013 (excluding OBRA 90, OBRA 93, and case management claims), we identified 3,685,165 claim lines, totaling \$414,622,585 in payments, where the FEHBP paid as the primary insurer. We judgmentally selected and reviewed 135 claims (representing 947 claim lines), totaling \$1,446,193 in payments, to determine if the Plan adjudicated these claims properly and/or priced them according to the provider contract rates.³ As part of our review, we also selected 25 participating and preferred providers that were associated with the highest reimbursed claims in our sample for the purpose of verifying if these providers' contract rates were accurately and timely updated in the Plan's local network pricing system.

Our review determined that the Plan incorrectly paid 1,088 claims, resulting in net overcharges of \$1,628,666 to the FEHBP. Specifically, the Plan overpaid 1,087 claims by \$1,630,096 and underpaid 1 claim by \$1,430. Additionally, we identified three system issues requiring corrective actions. These claim payment errors resulted from the following:

- The Plan incorrectly paid 772 claims, totaling \$1,549,172 in overcharges to the FEHBP, due to provider billing errors. These claim payment errors were due to a provider(s) incorrectly billing two different types of dialysis procedures using revenue code 0851 (Continuous Cycling Peritoneal Dialysis) and procedure code 90999 (an unlisted inpatient or outpatient dialysis treatment) on the same claim line. For one claim from our sample, we requested the Plan to provide documentation to support the medical necessity of the procedures provided to the patient. The Plan was unable to provide supporting documentation for medical necessity, and we therefore questioned the entire claim payment amount, an overcharge of \$12,899 to the FEHBP for unsupported services.

Since the Plan's local system did not properly detect this billing inconsistency, we requested the Plan to perform an expanded review of an additional 771 claims that contained this type of billing discrepancy, totaling \$1,536,273 in payments, during the period of January 1, 2010 through September 30, 2013. The Plan did not provide documentation supporting the medical necessity of the actual procedures provided to the patients for any of these claims. As a result, we questioned all 771 claims. Of the total questioned charges, 615 claims, totaling \$1,105,014 in charges to the FEHBP, are part of an active litigation case between one billing provider and the Plan. The remaining questioned charges represent three providers that received payment for 157 claims, totaling \$444,158 in charges to the FEHBP.

The Plan's Provider Administrative Manual states that for these related dialysis services, "Presence of a fee is not a guarantee the procedure, service, or item will be eligible for reimbursement. Final reimbursement determinations are based on member eligibility on the date of service, medical necessity . . . authorization and referral requirements and

³ We selected our sample from an OIG-generated "Place of Service Report" that stratified the claims by place of service (POS), such as provider's office, and payment category, such as \$50 to \$99. We judgmentally determined the number of sample items to select from each POS stratum based on the stratum's total claim dollars paid.

BlueCross BlueShield of Tennessee medical policy.” Although the Plan’s policy and the FEP Brochure (previously cited) state medical necessity is required for reimbursement, we determined that the Plan inadvertently paid these 772 claims containing procedure discrepancies without determining the necessity.

- The Plan incorrectly paid two claims due to processors manually overriding the local Plan’s system bundling edits. Consequently, the Plan overpaid one claim by \$55,315 and underpaid one claim by \$1,430, resulting in net overcharges of \$53,885 FEHBP.
- The Plan incorrectly paid 93 claims, totaling \$13,223 in overcharges to the FEHBP, due to a systematic processing error. During our review, we identified one claim, resulting in an overcharge of \$108 to the FEHBP, where a provider incorrectly billed procedure code 88342 with procedure code 88361 simultaneously. Based on the American Medical Association’s (AMA) medical coding guidelines, procedure code 88342 is inclusive of procedure code 88361, and requires further review to substantiate an additional payment. Since the Plan’s local system did not defer the claim for additional review before payment, we requested the Plan to perform an expanded review of an additional 109 claims containing these procedure codes for the period of January 1, 2010 through September 30, 2013. This expanded review determined that the Plan incorrectly paid an additional 92 claims, totaling \$13,115 in overcharges to the FEHBP.
- The Plan incorrectly paid 221 claims due to a systematic processing error, resulting in overcharges of \$12,386 to the FEHBP. Specifically, these claim payment errors were due to providers billing the incorrect revenue code 0636 with the injection procedure codes of *J7030, J7040, J7042, J7050, J7060, J7070, J7100, J7110, J7120 or J7130*. Due to the provider billing the incorrect revenue code with the injection procedure code, the claim line paid as a separate service (unbundled).

The Plan identified one claim payment error from our initial sample prior to the start of our audit, resulting in an overcharge of \$83 to the FEHBP. Although this claim payment error was identified and corrected during the Plan’s routine post-payment provider audit review process, we determined this error impacted multiple providers and claims. Subsequently, we requested the Plan to analyze 1,521 claims related to this issue, totaling \$140,480 in payments by the FEHBP during the period of January 1, 2012 through March 31, 2013. Based on this expanded review, the Plan incorrectly paid a total of 993 claims, resulting in net overcharges of \$102,308 to the FEHBP. Of the \$140,480 in payments, we determined that 73 percent was overcharged to the FEHBP and required a post-payment adjustment related to these provider billing errors. Specifically, 772 claims, totaling \$89,922 in net overcharges, were manually adjusted prior to the start of our audit and 221 claims, totaling \$12,386 in overcharges, were identified as a result of our audit. Since the Plan identified and recovered the \$89,922 in overcharges prior to the start of our audit, we only questioned \$12,386 in the final report.

As previously cited from CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent

effort to recover the overpayments. The contract also states that “the Carrier will retain and make available all records applicable to a contract term”

Carrier Letter (CL) 2008-14 states, “In accordance with FEHBAR 1652.246 – 70, the Office of Personnel Management’s (OPM) Contracting Office (CO), or authorized representative of the CO, has the right to examine and audit all books and records relating to the Federal Employees Health Benefits (FEHB) Contract.” The CL further states, “carriers . . . need to provide accurate, clear, comprehensive, and timely responses to all requests for information regarding, but not limited to . . . audit-related questions, information requests, and claim review samples, audit inquiries (findings or potential findings), draft audit reports, final audit reports and audit resolution. In responding to audit report recommendations, it is imperative carriers provide complete evidence supporting their position in responding to the draft report.”

The 2013 BCBS Service Benefit brochure states, “All benefits . . . are payable only when we determine that the criteria for medical necessity are met. Medical necessity shall mean health care services that a physician, hospital, or other covered professional or facility provider . . . would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms The fact that one of our covered physicians, hospitals, or other professional or facility providers has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary or covered under this Plan.”

BCBS of Tennessee’s Response:

Of the \$1,628,666 in questioned charges, the Plan agreed with \$81,186. In response to the claim payment errors questioned in the draft report, the Plan states the following:

- For the dialysis claims questioned in the draft report, the Plan states that documentation for claims that are considered part of an active case currently in litigation could jeopardize the current case and expose the Plan to significant litigation risk. The Association and Plan state “all documentation regarding the case will be provided to OPM as soon as the case has been resolved Also, due to the nature of the provider litigation on certain claims questioned in this finding, the Plan and [the Association] believes that it fully complied with the Carrier Letter 2008-14 [previously cited].” Additionally, the Plan disagrees with the dialysis claims that were questioned because the final payment is based on each provider’s contract. The Plan agrees to work with the Association to execute a feasibility study by second quarter 2014 to determine if the cost to the FEHBP to defer this type of claim for medical necessity review is appropriate.
- Regarding the claims questioned due to manual processing errors, the Plan states that claims examiners have been re-educated on the research required prior to overriding edits generated with the FEP Claims System and has included these types of claims in the “in-line quality process. ”

- For claims questioned due to incorrect bundling, the Plan states that corrective action was implemented on September 30, 2013 to ensure these codes bundled appropriately on all further claims.
- For claims questioned due to the improper billing of revenue code 0636, the Plan states that it is reviewing a pre-pay configuration in the local system that would “defer” or “pend” these types of claims for review prior to payment. However, consideration must be given to the time required to review each claim in a pre-pay environment and the affect this time lag will have on timely processing guidelines. The Plan and Association state that they will work together to complete a feasibility study by April 30, 2014, to defer this type of claim and determine the cost to the FEHBP for delaying member benefits.

OIG Comments:

Based on our review of the Association’s response and additional documentation provided by the Association and Plan, we revised the amount questioned from the draft report to \$1,628,666. Although the Plan agrees with \$81,186 in its written response, the Plan’s additional documentation supports concurrence with \$79,148 of the questioned charges. The active litigation case mentioned above accounts for the majority (\$1,105,014) of the charges contested by the Plan. However, the Plan has not provided us with any documentation to support the medical necessity of the procedures provided to the patients for these claims.

Recommendation 3

We recommend that the contracting officer disallow \$1,630,096 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 4

We recommend that the contracting officer allow the Plan to charge the FEHBP \$1,430 if an additional payment is made to the provider to correct the underpayment error. However, before making any additional payment(s) to the provider, the contracting officer should require the Plan to first recover any questioned overpayments from this provider.

Recommendation 5

Due to the amount of dialysis claims processed with billing discrepancies, we recommend that the contracting officer require the Plan to implement corrective actions in its local system to defer claims containing procedure code revenue code 0851 and procedure code 90999 for review prior to payment.

Recommendation 6

We recommend the contracting officer ensure that the Plan implemented corrective actions to its local system to properly bundle claims containing procedure codes 88342 and 88361. These additional corrective actions are included in the Plan's response to the draft report.

Recommendation 7

Due to the significant error rate of claims improperly billed and processed containing the previously cited "J-codes" and revenue code 0636, we recommend the contracting officer instruct the Plan to implement pre-payment edits in its local system for providers subject to these pricing terms.

3. Modifiers Review

\$20,825

For the period of January 1, 2010 through March 31, 2013, we identified 1,646,613 claim lines, totaling \$102,278,030 in payments, containing modifiers 22, 25, 26, 50, 51, 59, 62, 76, 77, 78 or TC. We selected for review 194 claims, representing 2,022 claim lines and totaling \$453,303 in payments, to determine if the Plan properly priced and charged claims containing these modifiers. We judgmentally selected claim lines with high dollar amounts paid and/or multiple procedure frequencies and also performed random sampling.

We determined that the Plan incorrectly paid an estimated 62 claim lines containing these procedure code modifiers, resulting in overcharges of \$20,825 to the FEHBP. The claim payment errors result from the following:

- For eight claim lines, totaling \$12,222 in claim payments, the Plan did not provide sufficient documentation to support the use of modifier 22. The AMA defines modifier 22 as an increased procedural service. In general, the Plan increases the procedure allowed amount by 30 percent when the provider bills modifier 22 as the primary modifier and documentation is provided to support medical necessity for the additional procedure performed. However, for these eight claim lines, the Plan was unable to obtain documentation from the providers to support medical necessity for the additional procedure and/or increased procedure performed.
- For 40 claim lines, the Plan did not provide sufficient documentation to support the medical necessity for additional and/or multiple procedures that were performed repeatedly. The AMA defines modifiers 76 and 77 as a repeated procedure or service by the same physician and a repeated procedure by another physician, respectively. Since we were unable to determine these additional and/or multiple procedures were medically necessary, we questioned the entire amount paid for these 40 claim lines, resulting in overcharges of \$5,224 to the FEHBP for unsupported services.
- For four claim lines, the Plan did not provide documentation to support the use of modifier 26 and TC on the same claim line. AMA defines the professional and technical portion for certain procedures by using modifiers 26 or TC, respectively. These

guidelines state that modifier 26 and TC should not be billed together for the same procedure. In addition, the Plan's local pricing guidelines state that when a procedure is billed with modifier 26 or TC, the reimbursement rate is potentially discounted. Since we were unable to determine which portion of the procedure was performed, we questioned the entire amount paid for these claim lines due to unsupported documentation, resulting in overcharges of \$1,909 to the FEHBP.

- The Plan applied the incorrect Veteran Affairs (VA) pricing allowance to nine claim lines, resulting in overcharges of \$1,304 to the FEHBP. The FEP Administration Procedures Manual indicates the Plan should reimburse the lower of the VA's reasonable charge or the local Plan's allowance. For these nine claim lines, the Plan did not apply the local Plan's modifier discount when determining the proper VA pricing allowance, which caused the incorrect allowance to be applied.
- The Plan incorrectly paid one claim for an unallowable investigative procedure (i.e., modifier Q0), resulting in an overcharge of \$166 to the FEHBP. The Plan did not provide documentation to support that the investigative services were considered medically necessary or covered as defined on page 111 of the 2011 FEHBP Benefit Brochure. Although Medicare reimbursed the claim as primary, the FEP portion of the amount paid was for a FEHBP non-covered service.

As previously cited from CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments. Also, as previously cited from Contract CS 1039 and CL 2008 -14, the Carrier should retain and make records available.

BCBS of Tennessee's Response:

Based on the Plan's written response, the Plan agreed that \$11,782 of the questioned charges were due to manual processing errors, and has initiated recovery on the confirmed overpayments. For the contested items, the Plan states additional documentation has been provided. The Plan also states that it has "implemented additional procedures that require peer review of any manual priced claims prior to the submission to the FEP claims system for adjudication. The confirmed payment errors were used as training tools during the recent Re-fresher Training Sessions." The Plan and Association state they will work together to complete a feasibility study by April 30, 2014, to determine the cost to the FEHBP to defer modifier Q0.

OIG Comments:

Based on our review of the Association's response and additional documentation provided by the Plan, we revised the amount questioned from the draft report to \$20,825. While the Plans written response agrees with \$11,782, supporting documentation supports concurrence with \$11,064.

Recommendation 8

We recommend that the contracting officer disallow \$20,825 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 9

We recommend the contracting officer require the Plan to identify and review all claims for the period of January 1, 2011 through December 31, 2013 that contain modifier 22, and determine if the procedure and/or additional procedure was medically necessary. If overcharges are identified, the Plan should return all amounts recovered to the FEHBP. Additionally, we recommend the contracting officer require the Plan to provide evidence or supporting documentation ensuring that the Plan implemented the corrective actions as stated in the draft report.

Recommendation 10

We recommend that the contracting officer require the Association to provide education and/or detailed training to the Plan related to FEHBP's pricing of VA claims. Also, we recommend that the contracting officer require the Association to provide evidence or supporting documentation ensuring that the Association implemented the corrective actions.

Recommendation 11

We recommend that the contracting officer provide evidence or supporting documentation ensuring the Association and Plan complete a feasibility study by April 30, 2014 to defer modifier Q0. If the study results in savings to the FEHBP, we recommend the contracting officer ensure edits to the FEP Direct system are implemented to defer these claims.

4. Omnibus Budget Reconciliation Act (OBRA) 90 Review **\$15,366**

OBRA 90 limits the benefit payments for certain inpatient hospital services provided to annuitants age 65 or older who are not covered under Medicare Part A. The FEHBP fee-for-service plans are required to limit the claim payment to the amount equivalent to the Medicare Part A payment.

Using a program developed by the Centers for Medicare and Medicaid Services to price OBRA 90 claims, we recalculated the claim payment amounts for the claims in our samples that were subject to and/or processed as OBRA 90.

For the period January 1, 2010 through March 31, 2013, we identified 750 claims, totaling \$6,635,383 in payments, that were subject to OBRA 90 pricing guidelines. From this universe, we selected and reviewed a judgmental sample of 40 claims, totaling \$1,080,987 in payments, to determine if these claims were correctly priced by the FEP Operations Center

and paid by the Plan. Our sample included all OBRA 90 claims with amounts paid greater of \$10,000 or more.

We determined that these claim payment errors were due to local Plan processors providing the incorrect provider information to the FEP Direct System during pricing. As a result, the Plan incorrectly paid 16 claims, resulting in net overcharges of \$15,366 to the FEHBP. Specifically, the Plan overpaid 11 claims by \$18,549 and underpaid 5 claims by \$3,183.

As previously cited from CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments.

BCBS of Tennessee's Response:

The Plan agreed to this finding. The Plan states that refresher training has been conducted for claims examiners to help minimize the occurrences for these types of errors in the future. Additionally, procedures have been implemented to assign more experienced claims processors to handle OBRA 90 claim deferral resolutions.

Recommendation 12

We recommend that the contracting officer disallow \$18,549 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 13

We recommend that the contracting officer allow the Plan to charge the FEHBP \$3,183 if an additional payment is made to the provider to correct the underpayment error.

Recommendation 14

We recommend the contracting officer ensure that the Plan provides sufficient documentation to ensure an OBRA 90 refresher training for claims processors has been conducted and the Plan has fully implemented the procedures for handling OBRA 90 claim deferral resolutions.

5. Non-Covered Services Review

\$3,670

For the period January 1, 2010 through March 31, 2013, we identified 3,119 claims, totaling \$3,898,535 in payments, that potentially contained non-covered services. From this universe, we selected and reviewed a judgmental sample of 171 claims, representing 497 claim lines and totaling \$277,401 in payments, to determine if these claims were correctly priced and paid by the Plan.

Based on our review, we determined that five claims were paid incorrectly due to manual processing errors, resulting in overcharges of \$3,670 to the FEHBP. Specifically, the local

Plan processors overrode local system edits on four claims where the procedure code billed on the claim was inconsistent with the gender of the patient and for one claim where an injection was not properly reviewed for medical necessity.

As previously cited from CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments.

BCBS of Tennessee's Response:

The Plan agreed with this finding. The Plan states refresher training has been conducted for claims examiners to help minimize the occurrences of these types of errors in the future.

Recommendation 15

We recommend that the contracting officer disallow \$3,670 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 16

We recommend the contracting officer ensure that the Plan provides sufficient documentation to ensure the Plan provided refresher training to claims processors to minimize these types of errors in the future.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Information Systems Audits Group

██████████, Chief

██████████, Senior Team Leader

██████████, Auditor-In-Charge

██████████, Auditor

██████████, Auditor

██████████, Auditor

Experience-Rated Audits Group

██████████, Chief

Office of Management

██████████, Senior Information Technology Specialist

██████████, Senior Information Technology Specialist

██████████, Information Technology Specialist

V. SCHEDULE A

BLUECROSS BLUESHIELD OF TENNESSEE CHATTANOOGA, TENNESSEE HEALTH BENEFIT CHARGES AND AMOUNTS QUESTIONED					
HEALTH BENEFIT CHARGES	2010	2011	2012	2013	TOTAL
PLAN CODE 390:					
CLAIM PAYMENTS	\$347,655,153	\$372,828,523	\$394,993,588	\$414,456,083	\$1,529,933,347
MISCELLANEOUS PAYMENTS AND CREDITS	7,921,181	7,038,032	9,728,466	11,273,890	35,961,569
PLAN CODE 890:					
PLAN CODE CLAIM PAYMENTS	0	0	67,888	89,281	157,169
MISCELLANEOUS PAYMENTS AND CREDITS	0	0	0	0	0
TOTAL	\$355,576,334	\$379,866,555	\$404,789,942	\$425,819,254	\$1,566,052,085
AMOUNTS QUESTIONED	2010	2011	2012	2013	TOTAL
1. RETROACTIVE ENROLLMENT REVIEW	\$293,495	\$688,120	\$909,959	\$58,200	\$1,949,774
2. PLACE OF SERVICE AND DISCOUNT REVIEW	46,252	442,904	526,148	613,362	1,628,666
3. MODIFIERS	1,503	6,392	8,678	4,252	20,825
4. OMNIBUS BUDGET RECONCILIATION ACT OF 1990	(365)	18,209	(2,478)	0	15,366
5. NON-COVERED SERVICE CHARGES	0	1,492	2,178	0	3,670
TOTAL QUESTIONED CHARGES	\$340,885	\$1,157,117	\$1,444,485	\$675,814	\$3,618,301

APPENDIX



BlueCross BlueShield Association

An Association of Independent
Blue Cross and Blue Shield Plans

Federal Employee Program
1310 G Street, N.W.
Washington, D.C. 20005
Phone # 202.942.1000
Fax 202.942.1125

February 21, 2014

██████████ Group Chief,
Claims & IT Audits Group,
U.S. Office of Personnel Management
1900 E Street, Room 6400
Washington, D.C. 20415-1100

**Reference: OPM FINAL AUDIT REPORT
Blue Cross and Blue Shield of Tennessee
Audit Report Number 1A-10-15-13-058
(Dated December 17, 2013 and Received December 17, 2013)**

Dear ██████████:

This is our response to the above referenced U.S. Office of Personnel Management (OPM) Final Audit Report covering the Federal Employees' Health Benefits Program (FEHBP) for Blue Cross and Blue Shield of Tennessee. Our comments concerning the findings in this report are as follows:

HEALTH BENEFIT CHARGES

In summary the Plan disagrees that 976 claims totaling \$1,578,725 were paid incorrectly and agrees to 748 claims totaling \$321,598 which excludes the additional review of J-codes listed in the Place of Service Discount Review. These totals equate to a financial impact of 0.166% and .028% error rate based on the total amount paid of \$1,140,232,831 for this audit. The Plan diligently worked to provide OPM with supporting documentation throughout the audit.

1. Place of Service and Discount Review \$1,631,412

Recommendations 1, 2 and 3

We recommend that the contracting officer disallow \$1,632,842 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

We recommend that the contracting officer allow the Plan to charge the FEHBP \$1,430 if an additional payment is made to the provider to correct the underpayment error. However, before making any additional payment(s) to the provider, the contracting

officer should require the Plan to first recover any questioned overpayments from this provider.

We recommend the contracting officer require the Plan to review all claims paid from January 1, 2010 through September 30, 2013 containing revenue code 0851 and procedure code 90999 to determine if these claims were priced correctly and charged to the FEHBP. If a claim payment error is identified the Plan should initiate recovery as soon as possible. The Plan should provide detailed documentation to support the review of each claim. Additionally, we recommend the contracting officer ensure that the Plan provides sufficient documentation to ensure the Plan implemented corrective actions to defer these claims for review prior to payment in Facets for claims containing procedure code revenue code 0851 and procedure code 90999.

Plan Response:

The Plan disagrees that 925 claims totaling \$1,550,226 were paid incorrectly and does agree that 106 claims payments totaling \$81,186 were paid incorrectly. The Plan also completed the review of the audit regarding J-code claims and agrees to 1,108 claims totaling \$91,954 and disagrees to 414 claims totaling \$49,890 for a total review of 1,522 claims totaling \$141,844 which was not included in the \$1,631,412 total.

Both FEP and the Plan would like to make clarifications to some of the wording of this finding totaling \$1,631,412. The questioned amount is discussed up as follows:

- Dialysis Review totaling \$1,549,499
- Manual Overrides Reviews totaling \$55,315
- Bundling Review totaling \$28,028.

Dialysis – Review total \$1,549,499

The Plan disagrees with respect to \$1,549,499 for 915 claims noted as a result of a system error and disagrees with the OIG auditor comments that after multiple requests, insufficient documentation was provided to support the Plan's position. Of the \$1,549,499 a total of \$574,851 (360 claims) are considered part of an active case currently in litigation. A total of \$974,648 (555-claims) was processed according to both the provider contract and the Plan's Provider Administrative Manual and FEBHP contract. The questioned costs of \$1,549,499 are explained below.

During both the original review and expanded review, the Plan was open and transparent regarding the circumstances related to the selected sample and related dollar amounts. The initial sample selected, totaling \$12,899, is part of an active case currently in litigation. The Plan communicated to both BCBSA and OPM during the audit that providing any documentation could jeopardize the current case and expose the Plan to significant litigation risk. BCBSA and the Plan indicated that all documentation regarding the case will be provided to OPM as soon as the case has been resolved. All other details regarding questioned processes and claims were provided as requested. Thus, to state insufficient documentation was provided is not clear. As a result, the Plan requests that the statement should be changed to reflect the facts and that documentation is not available at this time and the Plan will be providing documentation at the close of the case. Also, due to the nature of the provider litigation on certain claims questioned in this finding, the Plan and BCBSA believes that it fully complied with the Carrier Letter 2008-14, which requires that, "Carriers need to provide accurate, clear, comprehensive, and timely responses to all requests for information regarding, but not limited to, audit-related questions, information requests, and claim review samples, audit inquiries (findings or potential findings), draft audit reports, final audit reports and audit resolution. In responding to audit report recommendations, it is imperative carriers provide complete evidence supporting their positions in responding to the draft report."

- \$574,851 in questioned costs: The Plan identified the original sample claim totaling \$12,899, as incorrectly processed through internal controls and processes. Based on medical records an overpayment was identified resulting in an expanded post payment review by the Plan which resulted in the identification of additional overpayments. These overpayments totaling \$561,952 (359-claims) are currently included in the above mentioned litigation case. As previously stated, all documentation will be provided at the resolution of the case.
- \$530,163 in questioned costs: Changes to the provider contract on September 1, 2012 resolved the overpayment/billing finding identified by the Plan's expanded review by reducing and matching allowable charges for both hemo- and peritoneal-dialysis. The Plan's Provider Administrative Manual instructs the provider to "bill using HCPCS/CPT® when appropriate. HCPCS/CPT code does NOT affect reimbursement. Reimbursement is based upon the provider contract and pricing for the revenue code billed." This means that even though the provider billed with CPT code 90999, as long as the appropriate revenue code 851, 821 is billed on the

claim, reimbursement is based on the provider contract. This provider contract uses the same base price for both hemo- and peritoneal-dialysis procedures resulting in no change of payment. Therefore, a total of \$530,163 (374-claims) was processed according to both the provider contract and FEHBP contract which does not require medical necessity review for this type of service. The Plan would be glad to engage in a webinar with the OPM OIG to view this provider contract for validation of this statement.

- The remaining questioned amount totaling \$444,485 (181 claims) were processed correctly based on the information provided by the provider, FEHBP contract, the Plan's provider contract and Provider Administration Manual. FEHBP benefits do not require medical necessity reviews or limits for hemo- and peritoneal-dialysis. The Plan's Provider Administrative Manual instructs the provider to "bill using HCPCS/CPT® when appropriate. HCPCS/CPT code does NOT affect reimbursement. Reimbursement is based upon the provider contract." For this provider the allowable is the same for all types of dialysis, thus resulting in no change of reimbursement.

The Plan disagrees that the claims in this audit finding were paid incorrectly because the final payment is based on each provider contract. The Plan does agree that its current use of proactive post-payment reports to review these types of billing practices identifies potential overpayments for review and investigation. The Plan will work with BCBSA to execute a feasibility study by second quarter 2014, to determine if the cost to the Program to defer this type of claim for medical necessity review is appropriate. The Plan provided its Plan's Provider Administrative Manual to support its position that claims totaling \$1,549,499 were paid correctly. The Plan would be glad to engage in a webinar with BCBSA and OPM to view the provider contracts for validation.

Manual Overrides – Review total \$55,315

The FEP Direct Claims System does not have bundling program edits as stated in the finding write-up. BCBSA would like for this statement to be removed from the report.

The Plan does agree that two claims totaling \$55,315 were processed incorrectly due to manual overriding the FEP Direct System by the processor resulting in one claim overpaid by \$53,885 and one underpayment in the amount of \$1,430.

- The overpaid funds were returned to FEP on April 17, 2013 and the underpayment was adjusted on June 19, 2013. The Plan believes the provided documentation of the Plan's processing screen and provider remittances indicating the adjusted amounts suffice for supporting documentation. OPM should notify the Plan if any additional documentation is required. The Plan re-educated the examiners on the research required prior to overriding edits generated within the FEP Claims System and has included these types of claims in the "in-line quality process."

Bundling – Review total \$28,028

The Plan does agree to 104 claims totaling \$27,301 and disagrees to six claims totaling \$727 stated as incorrectly paid due to unbundling codes by the provider.

- The Plan disagreed to the six claims totaling \$727 because the claims disposition codes were either "3" or "4". According to OPM's instructions the Plan should not review claims with disposition codes either a "3" or "4." The six claims are listed on lines 12, 48, 156, 183, 264 and 266 of the excel file and highlighted for reference.
- The Plan initiated overpayment recovery efforts for \$27,301 (104 claims) confirmed as overpayments and has provided a copy of each refund request as supporting documentation to OPM. As soon as the overpayment is received the funds will be returned to the FEP Program.
- Corrective action was implemented on September 30, 2013 to ensure these codes bundled appropriately on all further claims. The Plan provided a copy of the code editing update for supporting documentation of this corrective action.

Recommendation 4

We recommend the contracting officer require the Plan to review all claims paid January 1, 2010 through September 30, 2013 containing procedure code 88342 and 88361 to determine if these claims were priced correctly and charged to the FEHBP. If a claim payment error is identified the Plan should initiate recovery as soon as possible. The Plan should provide detailed documentation to support the review of each claim. Additionally, we recommend the contracting officer ensure that the Plan provides sufficient documentation to ensure the Plan implemented corrective actions to defer these claims for review prior to payment in Facets for claims containing procedure code 88342 and 88361.

Plan Response

The Plan completed the review of all claims paid January 1, 2010 through September 30, 2013 containing procedure code 88342 and 88361 to determine if these claims were priced correctly and charged to the FEHBP. The Plan provided refund letters as supporting documentation to the OIG auditors. The Plan has also provided documentation from the Plan's processing system online help that documents the implementation of clinical editing which will bundle these codes. Reference attachment titled Clinical Editing Implemented.

The Plan would also like to state that it already conducts a post payment review of claim payments to identify potential overpayments. The Plan will also work with FEPDO to complete a feasibility analysis on deferring claims billed with procedure codes 88342 and 88361 as well as working with Plan management to see if this can be configured. We expect to provide an update on the feasibility of implementing this type of deferral in Facets by April 30, 2014.

Recommendation 5

We recommend the contracting officer require the Plan to perform an analysis on all acute facility providers for claims paid from January 1, 2012 through March 31, 2013 containing procedure codes J7030, J7040, J7042, J7050, J7060, J7070, J7100, J7110, J7120 and J7130 and where revenue code 0636, and develop pre-payment local system edits for providers subject to these pricing terms. Additionally, for the remaining 750 claims (representing 964 claim lines), totaling \$51,922 in potential overpayments identified in our expanded review and has not received a post-payment adjustment, we recommend the contracting officer require the Plan to review these claims to determine if these claims were correctly priced and charged to the FEHBP. If a claim payment error is identified the Plan should initiate recovery as soon as possible. The Plan should provide detailed documentation to support the review of each claim.

Plan Response

J-Code – Review total \$141,844

The Plan disagrees to 414 claims totaling \$49,890 and agrees to 1,108 claims totaling \$91,954 for a procedural finding regarding the processing of specific J-codes where the

Plan's post-payment adjustments (initiates the claim review process) were initiated for 1,522 claims totaling \$141,844.

- The Plan disagrees to 414 claims totaling \$49,890. Of the 414 claims totaling \$49,890 no change in payment occurred when the revenue code was changed for the J-code billed on 314 claims totaling \$41,193. The remaining 100 claims totaling \$8,697 were not overpaid but resulted in an underpayment in the amount of \$4,137. Adjustments have been completed for these claims concluding in statistical adjustment for the claims with no change in payment and additional benefits provided for all the underpayments.
- Of the agreed to amount of \$91,954, a total of \$89,922 has been returned to the FEP Program and refunds have been requested on \$2,032. The Plan continues to show due diligent in its recovery efforts. As soon as the monies have been received the funds will be returned to the FEP Program.

The Plan would also like to state that it identified the original sample claim as incorrectly processed through internal controls and processes. Based on medical records an overpayment was identified resulting in an overpayment in the amount of \$83 which was recovered and returned to the Plan prior to the notification of the claims audit. The Plan also has a variety of provider contract provisions which preclude the Plan from incorporating some pre-paid corrections. The Plan currently uses an auditing tool during post payment review to determine if certain procedure codes are billed to the appropriate revenue code for outpatient acute care facilities. If errors are detected adjustments are processed.

The Plan is currently reviewing a pre-pay configuration that would "defer/pend" these types of claims for review prior to payment. However, consideration must be given to the time required to review each claim in a pre-pay environment and the affect this time lag will have on timely processing guidelines. The Plan expects to complete this review by April 30, 2014. The Plan will also work with FEPDO to request a feasibility analysis be performed on pending this type of claim and determine the cost to the program for delaying member benefits. The Plan and BCBSA expect to complete the feasibility study by April 30, 2014 and will provide the OIG auditors with the results of the review.

Supporting documentation provided includes a copy of the pricing for both revenue codes 636 and 258, which identifies whether a change in pricing occurred and if so,

how much and the appropriate refund letters. The Plan asks that OPM or FEPDO notify us if any additional information or documentation is needed.

2. Retroactive Enrollment Report Review

\$222,730

Recommendation 6

We recommend that the contracting officer disallow \$222,730 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Plan Response

The Plan disagrees to 27 claims totaling \$14,566 and agrees to 604 claims totaling \$208,164 as a result of the Retroactive Enrollment Report review.

- 27 claims totaling \$14,566 were paid correctly because the member either had coverage under another contract id or payment was correct based on other insurance effective date and/or overpayment was less than \$5.
- A total of 604 incorrect payments were identified and refunds were initiated. As of January 31, 2014, the Plan has collected \$3,068.06 and returned to the FEP. The Plan continues to show due diligence in its recovery efforts.

These overpayments were caused by the untimely review of the Retroactive Enrollment Reports and the Plan applying the provider agreement time limits to overpayment recovery efforts in error.

Recommendation 7

We recommend that the contracting officer ensure that the Plan provides sufficient documentation to ensure the Plan has implemented corrective actions to initiate recovery as soon as possible when a claim payment error is identified. Additionally, we recommend that the contracting officer require the Association to ensure on an ongoing basis that the Plan is identifying and properly returning claim payment errors identified on the FEP Operations Center daily retroactive reports.

Plan Response

The Plan has taken the following actions to minimize these types of errors in the future:

- The Plan will no longer apply the provider agreement time limits to overpayments. See Policy update for Retro Procedures for supporting documentation on the Policy update for Retro Reviews.
- Procedures were enhanced to promote the timely review completion and the initiation of recoveries as appropriate.
- Plan audit staff will conduct random reviews of the Retroactive Enrollment Reports to ensure that timely resolution is performed.

BCBSA Response

BCBSA expects to enhance its on-line Claims Audit Monitoring Tool to include all daily retro-active enrollment transactions by July 31, 2014. Once these transactions are included in the on-line tool, BCBSA staff will review Plan processing for compliance with the FEP overpayment recovery requirements.

3. Modifier Review

\$25,715

Recommendation 8

We recommend that the contracting officer disallow \$25,715 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Plan Response

The Plan disagrees to \$13,933 for 28 claims and agrees that \$11,782 for 13 claims were paid incorrectly.

Modifier – Review total \$14,061

The Plan disagrees to an overpayment totaling \$2,279 and agrees to \$11,782 for 13 claims. Refund recovery has been initiated on the confirmed over payments. As of January 31, 2014, the Plan has collected \$41 and returned these monies to the Program. The Plan continues to pursue these refunds diligently.

- The Plan disagrees to an overpayment totaling \$2,279 because benefits for the modifier were processed correctly according to the Plan's Provider Administrative Manual and the modifier billed by the provider. The Plan provided supporting documentation representing the allowable and the Provider Administrative Manual.

- The agreed to 13 claims totaling \$11,782 were the results of manual pricing errors. The Plan has implemented additional procedures that require peer review of any manual priced claims prior to the submission to the FEP Claims System for adjudication. The confirmed payment errors were used as training tools during the recent Re-fresher Training Sessions. Refund recovery was initiated upon review and overpayments will be returned to the program.

Modifier – Review total \$10,942 (\$8,828 + \$2,114)

The Plan disagrees to a finding of \$10,942 for 25 claims.

- The Plan has provided additional documentation to support the payments for modifiers 26 or TC or the combination of both modifiers. The support provided consist of the Plan's processing system and demonstrates the appropriate allowable for the billed modifier(s). The Plan will be glad to work with FEPDO should OPM require a webinar to view the provider contract.

Modifier – Review total \$546

The Plan disagrees to a duplicate payment in the amount of \$546 for one claim.

- This claim was billed by both the surgery center and the physician performing the procedure. Supporting documentation from the Plan supports the procedure was billed by both the facility and rendering physician correctly. Reimbursements were based on both a facility "All Inclusive Rate" and a physician "Relative Unit Value x Conversion Factor rate."

Modifier – Review total \$166

The Plan disagrees to a total of \$166 for an investigative procedure.

- The Plan provided secondary to Medicare benefits for the FEHBP member. One of the procedures included a Q0 modifier which indicates an investigative procedure. The Plan provided documentation of current processing guidelines from both FEPDO and the Plan for this procedure which allowed benefit payment. The Plan will work with FEPDO to complete a feasibility study by April 30, 2014 to determine the cost to the program to defer this modifier.

Recommendation 9

We recommend that the contracting officer ensure that Facets is properly identifying and pricing all four modifier fields billed on the providers claim and ensure that Facets is properly deferring and/or pricing claims containing modifiers 22, 26, 76, 77 and TC.

Plan Response

As stated in the response above, modifier 22 is already configured to defer; however, modifier 26, 76, 77 and TC do not have a deferral. Current Plan policy is to allow these charges as billed. BCBST does a number of post-payment analysis which looks for any oddities in billing, which the Plan feels is adequate to identify these types of payment errors.

4. Omnibus Budget Reconciliation Act (OBRA '90) \$15,366

Recommendations 10 and 11

We recommend that the contracting officer disallow \$18,549 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

We recommend that the contracting officer allow the Plan to charge the FEHBP \$3,183 if an additional payment is made to the provider to correct the underpayment error.

Plan Response

The Plan agrees 16 claims with a net overpayment totaling \$15,366 were not priced correctly using the OBRA '90 price.

- The Plan agrees 11 claims were overpaid totaling \$18,549 and 5 claims totaling \$3,183 were underpaid due to the examiners providing the FEP Claims System with incorrect provider information. Using the incorrect provider information caused coding errors resulting in incorrect allowable or pricing.
- The Plan had initiated recovery for the overpayments and as of January 31, 2014, the Plan has collected all \$15,366 and returned the monies to the Program. The Plan has also made an additional payment to the provider for all identified underpayments. These adjustments resolve all findings for this category.

- In an effort to prevent these types of errors in the future, the Plan has conducted re-fresher training on the proper method to code FEP claims that defer for possible OBRA '90 pricing. In addition, the more experienced claims examiners have been assigned to the deferral resolution for all claims that hit any of the OBRA '90 edits.

5. Non- Covered Service

\$3,670

Recommendation 12

We recommend that the contracting officer disallow \$3,670 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Plan Response

The Plan agrees that five claims totaling \$3,670 out of a 171 claims totaling \$277,401 were paid incorrectly.

- The incorrect payments were the result of manual overrides by the process and one claim that was not sent for review by the processor. The Plan has initiated recoveries on these confirmed overpayments. As of January 31, 2014, the Plan has collected \$173 and returned these funds the Program. The Plan continues to pursue these refunds diligently.
- In an effort to minimize the occurrence of these types of errors in the future, the Plan has conducted re-fresher training for the claims examiners on the confirmed errors.
- Re-educated the examiners on the research required prior to overriding edits generated within the FEP Claims System.

[REDACTED]

Tennessee BCBS Draft Report
February 21, 2014
Page 13 of 13

We appreciate the opportunity to provide our response to each of the findings in this report and request that our comments be included in their entirety and are made a part of the Final Audit Report. If you have any questions, please contact me at 202.942.1285 or Connie Woodard at 202.942.1159.

Sincerely,

[REDACTED]

[REDACTED], CRMA, CISA
Managing Director, Program Assurance

cc: [REDACTED], OPM
[REDACTED], OPM
[REDACTED], OPM
[REDACTED], BCBSTN
[REDACTED], BCBSTN
[REDACTED], FEP
[REDACTED], FEP