



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

Final Audit Report

Subject:

AUDIT OF CAREFIRST BLUECROSS BLUESHIELD OWINGS MILLS, MARYLAND

Report No. 1A-10-85-09-023

Date: May 21, 2010

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UNITED STATES OFFICE OF PERSONNEL MANAGEMENT

Washington, DC 20415

Office of the
Inspector General

AUDIT REPORT

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

CareFirst BlueCross BlueShield
Washington, D.C. and Maryland Service Areas and Overseas Claims
Plan Codes 080/081/082/190/580/582/690
Owings Mills, Maryland

REPORT NO. 1A-10-85-09-023

DATE: May 21, 2010

A handwritten signature in black ink, appearing to read "Michael R. Esser".

Michael R. Esser
Assistant Inspector General
for Audits



UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

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EXECUTIVE SUMMARY

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This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at CareFirst BlueCross BlueShield (Plan), which specifically included the Washington, D.C. and Maryland Service Areas and Overseas claims, questions \$1,304,034 in health benefit charges and \$60,561 in administrative expenses. The BlueCross BlueShield Association (Association) and/or Plan agreed (**A**) with \$1,333,921 and disagreed (**D**) with \$30,674 of the questioned charges. Lost investment income (LII) on the questioned charges amounts to \$1,554.

Our audit was conducted in accordance with Government Auditing Standards. The audit covered claim payments from January 1, 2006 through October 31, 2008, as well as miscellaneous payments and credits and administrative expenses from 2004 through 2008 as reported in the Annual Accounting Statements. In addition, we reviewed the Plan's cash management practices related to FEHBP funds for contract years 2004 through 2008. Due to certain errors identified during our review of claim payments, we expanded our audit scope to also include additional claims potentially paid incorrectly during various periods from January 1, 2006 through September 30, 2009.

Questioned items are summarized as follows:

HEALTH BENEFIT CHARGES

Claim Payments

- **Amounts Paid Greater than Covered Charges (A)** **\$684,657**

During our review of claims where the amounts paid were greater than the covered charges, we determined that the Plan incorrectly paid 164 claims, resulting in overcharges of \$684,657 to the FEHBP.

- **Inpatient Facility Claims - Duplicate or Overlapping Dates of Service** **\$297,735**

The Plan incorrectly paid 124 inpatient facility claims, resulting in net overcharges of \$297,735 to the FEHBP. Specifically, the Plan overpaid 120 claims by \$298,204 and underpaid 4 claims by \$469. The Association agreed with \$267,061 (A) and disagreed with \$30,674 (D) of the questioned charges.

- **Omnibus Budget Reconciliation Act of 1990 Review (A)** **\$169,397**

The Plan incorrectly paid 12 claims that were priced or potentially should have been priced under the Omnibus Budget Reconciliation Act of 1990 pricing guidelines, resulting in net overcharges of \$169,397 to the FEHBP. Specifically, the Plan overpaid 10 claims by \$220,139 and underpaid 2 claims by \$50,742.

- **Assistant Surgeon Review (A)** **\$116,348**

The Plan incorrectly paid 146 assistant surgeon claims, resulting in net overcharges of \$116,348 to the FEHBP. Specifically, the Plan overpaid 133 claims by \$127,100 and underpaid 13 claims by \$10,752.

- **Debarred Provider Payments (A)** **\$15,564**

The Plan made 205 claim payments, totaling \$15,564, to 3 debarred providers.

- **System Review (A)** **(\$52)**

Based on our review of judgmental samples of 301 claims, we determined that the Plan incorrectly paid 5 claims, resulting in net undercharges of \$52 to the FEHBP. Specifically, the Plan overpaid four claims by \$1,948 and underpaid one claim by \$2,000.

Miscellaneous Payments and Credits

- **Provider Audit Vendor Fees (A)** **\$15,249**

The Plan paid commission fees to a vendor for Federal Employee Program (FEP) recoveries that were not realized, resulting in overcharges of \$15,249 to the FEHBP.

- **Fraud Recovery Returned Untimely (A)** **\$5,136**

In one instance, the Plan did not timely return a fraud recovery to the FEHBP. As a result of this finding, the Plan credited the FEHBP \$5,136 for LII on this recovery.

ADMINISTRATIVE EXPENSES

- **BluesNet Charges (A)** **\$60,561**

The Plan charged the FEHBP for BluesNet expenses that had already been charged to the FEHBP by the FEP Operations Center. As a result, the FEHBP is due \$60,561, consisting of \$56,846 for duplicate BluesNet charges and \$3,715 for LII on these charges.

CASH MANAGEMENT

Overall, we concluded that the Plan handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and regulations, except for the findings pertaining to cash management noted in the "Miscellaneous Payments and Credits" section.

LOST INVESTMENT INCOME ON AUDIT FINDINGS

As a result of our audit findings presented in this audit report, the FEHBP is due LII of **\$1,554**, calculated through December 31, 2009.

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I. INTRODUCTION AND BACKGROUND

INTRODUCTION

This final audit report details the findings, conclusions, and recommendations resulting from our audit of the Federal Employees Health Benefits Program (FEHBP) operations at CareFirst BlueCross BlueShield (Plan), pertaining to the Washington, D.C. (DC) and Maryland Service Areas and Overseas claims. The Plan is located in Owings Mills, Maryland.

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 Retirement and Benefits 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 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 BlueCross and BlueShield plans throughout the United States to process the health benefit claims of its federal subscribers. The Plan is one of approximately 63 local BlueCross and BlueShield (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.

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.

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.

All findings from our previous audits of the Plan, pertaining to the DC and Maryland Service Areas and Overseas claims (Report No. 1A-10-85-03-103, dated August 19, 2005, and Report No. 1A-10-06-03-033, dated December 1, 2004), for contract years 1999 through 2002 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 report, dated December 3, 2009. 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 March 9, 2010, 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 as follows:

Health Benefit Charges

- To determine whether the Plan complied with contract provisions relative to benefit payments.
- To determine whether miscellaneous payments charged to the FEHBP were in compliance with the terms of the contract.
- To determine whether credits and miscellaneous income relating to FEHBP benefit payments were returned promptly to the FEHBP.

Administrative Expenses

- To determine whether administrative expenses charged to the contract were actual, allowable, necessary, and reasonable expenses incurred in accordance with the terms of the contract and applicable regulations.

Cash Management

- To determine whether the Plan handled FEHBP funds in accordance with applicable laws and regulations concerning cash management in the FEHBP.

SCOPE

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.

We reviewed the BlueCross and BlueShield FEHBP Annual Accounting Statements as they pertain to Plan codes 080, 081, 082, 190, 580, 582, and 690 for contract years 2004 through 2008. During this period, the Plan paid approximately \$6.8 billion in health benefit charges and \$412 million in administrative expenses for the DC and Maryland Service Areas and Overseas claims (See Figure 1 and Schedule A).

Specifically, we reviewed approximately \$54 million in claim payments made from January 1, 2006 through October 31, 2008 for proper adjudication, and from various periods from January 1, 2006 through September 30, 2009 for our expanded reviews of certain claim payment errors. In addition, we reviewed miscellaneous payments and credits, such as refunds and subrogation recoveries, administrative expenses, and cash management for 2004 through 2008.

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 operation. 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.

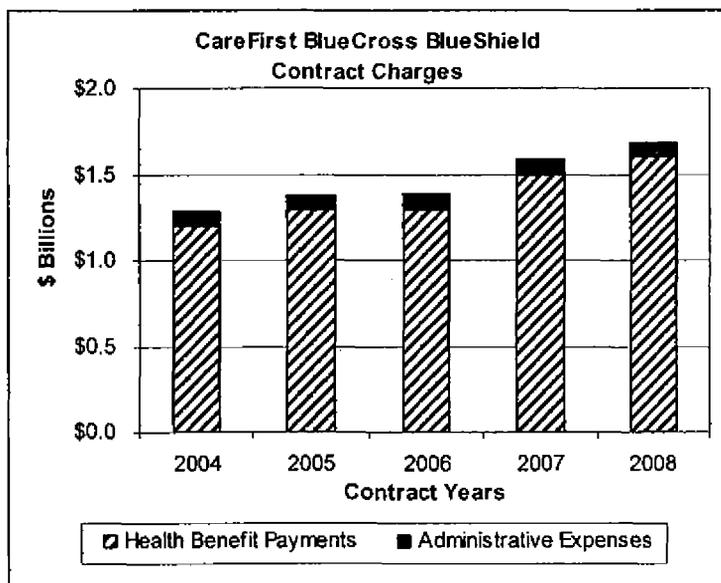


Figure 1 – Contract Charges

We also conducted tests to determine whether the Plan had complied with the contract, the applicable procurement regulations (i.e., Federal Acquisition Regulations (FAR) and Federal Employees Health Benefits Acquisition Regulations (FEHBAR), as appropriate), and the laws and regulations governing the FEHBP. The results of our tests indicate that, with respect to the items tested, the Plan did not comply with all provisions of the contract and federal procurement regulations. 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, the Plan, and the Centers for Medicare and Medicaid Services. Due to time constraints, we did not verify the reliability of the data generated by the various information systems involved. However, 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 Owings Mills, Maryland on various dates from May 4, 2009 through August 7, 2009. Audit fieldwork was also performed at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida.

METHODOLOGY

We obtained an understanding of the internal controls over the Plan's claims processing, financial, and cost accounting systems by inquiry of Plan officials.

To test the Plan's compliance with the FEHBP health benefit provisions, we selected and reviewed samples of 2,287 claims.² These claim samples include our expanded reviews of certain errors identified during our evaluation of claim payments. We used the FEHBP contract, the Service Benefit Plan brochure, 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.

We interviewed Plan personnel and reviewed the Plan's policies, procedures, and accounting records during our audit of miscellaneous payments and credits. We also judgmentally selected and reviewed 133 health benefit refunds, totaling \$10,602,342 (from a universe of 73,223 refunds, totaling \$42,448,024); 97 subrogation recoveries, totaling \$5,789,590 (from a universe of 5,636 subrogation recoveries, totaling \$13,939,217); 69 provider audit recoveries, totaling \$3,426,753 (from a universe of 1,751 provider audit recoveries, totaling \$10,445,902); 102 special plan invoices, totaling \$7,518,783 in net payments (from a universe of 2,212 special plan invoices, totaling \$65,126,329 in net payments); 80 provider advance adjustments and balances, totaling \$202,855,400 (from a universe of 614 provider advance adjustments and balances, totaling \$444,578,300); and 30 fraud recoveries, totaling \$3,060,473 (from a universe of 534 fraud recoveries, totaling \$4,555,776), to determine if refunds and recoveries were promptly returned to the FEHBP and if miscellaneous payments were properly charged to the FEHBP. The results of these samples were not projected to the universe of miscellaneous payments and credits.

We judgmentally reviewed administrative expenses charged to the FEHBP for contract years 2004 through 2008. Specifically, we reviewed administrative expenses relating to cost centers, natural accounts, out-of-system adjustments, prior period adjustments, pension, post-retirement, employee health benefits, executive compensation, Association dues, lobbying, return on investment, subcontracts, and Health Insurance Portability and Accountability Act of 1996 compliance. We used the FEHBP contract, the FAR, and the FEHBPBAR to determine the allowability, allocability, and reasonableness of charges. The results of the testing were not projected to the universe of administrative expenses.

We also reviewed the Plan's cash management to determine whether the Plan handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and regulations.

² See the audit findings for "Amounts Paid Greater than Covered Charges" (A1.a), "Inpatient Facility Claims - Duplicate or Overlapping Dates of Service" (A1.b), "Omnibus Budget Reconciliation Act of 1990 Review" (A1.c), "Assistant Surgeon Review" (A1.d), "Debarred Provider Payments" (A1.e), and "System Review" (A1.f) on pages 6 through 24 for specific details of our sample selection methodologies.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. HEALTH BENEFIT CHARGES

1. Claim Payments

a. Amounts Paid Greater than Covered Charges \$684,657

The Plan incorrectly paid 164 claims, resulting in overcharges of \$684,657 to the FEHBP.

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”

Contract CS 1039, Part II, section 2.6 states, “(a) The Carrier shall coordinate the payment of benefits under this contract with the payment of benefits under Medicare . . . (b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary carrier”

Contract CS 1039, Part III, section 3.8 states, “the Carrier will retain and make available all records applicable to a contract term”

The following summarizes our review of claims where amounts paid were greater than covered charges.

DC Service Area

For the period January 1, 2006 through October 31, 2008, we identified 14,163 claims where the amounts paid were greater than the covered charges by a total of \$18,524,241. From this universe, we selected and reviewed a judgmental sample of 192 claims with a total variance of \$6,419,838, and determined if the Plan paid these claims properly. Our sample included all claims where the amounts paid exceeded covered charges by \$15,000 or more. Based on our review, we determined that four of these claims were paid incorrectly, resulting in overcharges of \$596,153 to the FEHBP.

The claim payment errors resulted from the following reasons:

- In one instance, a claims processor entered incorrect pricing information when resolving a deferred claim, resulting in an overcharge of \$512,739 to the FEHBP.

- In one instance, a claims processor did not enter a year-end split claim override code, resulting in an overcharge of \$83,075 to the FEHBP.
- The Plan did not reject two claims with inaccurate information, resulting in overcharges of \$339 to the FEHBP. In each instance, the claim contained a claim line with revenue code 360 representing “operating room services” and procedure code 95991 representing “other procedures administered by a physician.” Since procedure 95991 is not an operating room service, these claims should have been rejected by the claims processors.

When we initially identified this error, we concluded that the error could have impacted more claims resulting in significant overcharges to the FEHBP. Therefore, we requested the Plan to identify all claims paid from January 1, 2006 through June 30, 2009 that were potentially processed with this type of error, and determine if the claims were paid correctly. The Plan identified 97 claims, totaling \$17,693 in payments, that were potentially processed with this type of error. We reviewed these claims and determined that 77 additional claims were paid incorrectly, resulting in overcharges of \$10,052 to the FEHBP.

Maryland Service Area

For the period January 1, 2006 through October 31, 2008, we identified 252 claims where the amounts paid were greater than the covered charges by a total of \$53,520. From this universe, we selected and reviewed a judgmental sample of 34 claims with a total variance of \$41,533, and determined if the Plan paid these claims properly. Our sample included all claims where the amounts paid exceeded covered charges by \$250 or more. Based on our review, we determined that 15 of these claims were paid incorrectly, resulting in overcharges of \$25,841 to the FEHBP.

The claim payment errors resulted from the following reasons:

- The Plan incorrectly paid five claims, resulting in overcharges of \$11,350 to the FEHBP. These errors occurred due to claims processors entering incorrect units or not correctly processing claims with occupational therapy services that were billed by a home health agency.
- In two instances, the Plan’s claims processing system did not deduct the Medicare payments, resulting in overcharges of \$6,665 to the FEHBP.

Because this is a claims system error, we requested the Plan to identify all claims paid from January 1, 2006 through June 30, 2009 that were potentially processed with this type of error and determine if these claims were paid correctly. The Plan identified 126 claims, totaling \$97,491 in payments, that were potentially processed with this type of error. We reviewed these claims and determined that 21 additional claims were paid incorrectly, resulting in overcharges of \$10,342 to

the FEHBP. As of October 9, 2009, the Plan is working to correct this system error.

- The Plan did not properly coordinate five claims with Medicare, resulting in overcharges of \$5,362 to the FEHBP.
- The Plan paid three claims using the 2006 non-participating (par) surgery allowances even though the billed charges were less, resulting in overcharges of \$2,464 to the FEHBP. These errors occurred because the FEP national claims system was programmed to pay the 2006 non-par surgery allowance rather than the lesser of the non-par surgery allowance or billed charges.

Since this system error potentially also affected the DC Service Area and Overseas claims, we expanded our review of this error to include the DC and Maryland Service Areas and Overseas claims (See “Expanded Review of the 2006 Non-Par Surgery Allowance” below). According to the FEP Director’s Office, this non-par system error has been corrected.

Overseas Claims

For the period January 1, 2006 through October 31, 2008, we identified 30 claims where the amounts paid were greater than the covered charges by a total of \$39,704. From this universe, we selected and reviewed a judgmental sample of eight claims with a total variance of \$32,599, and determined if the Plan paid these claims properly. Our sample included all claims where the amounts paid exceeded covered charges by \$1,000 or more. Based on our review, we determined that four of these claims were paid incorrectly, resulting in overcharges of \$11,881 to the FEHBP.

The claim payment errors resulted from the following reasons:

- The Plan processed three claims using the incorrect number of days, resulting in overcharges of \$7,501 to the FEHBP.
- The Plan paid one claim at the incorrect per diem rate, resulting in an overcharge of \$4,380 to the FEHBP.

Expanded Review of the 2006 Non-Par Surgery Allowance

Since additional claims may have been affected by the 2006 non-par surgery allowance error noted under the “Maryland Service Area”, we identified all claims for the DC and Maryland Service Areas and Overseas claims with dates of service from January 1, 2006 through December 31, 2006 that were subject to the 2006 non-par surgery pricing. We identified 153 claims, totaling \$520,920 in payments, that were potentially processed incorrectly. We requested the Plan to review these claims and determine if they were paid correctly. After reviewing the Plan’s response, we

determined that 43 additional claims were paid incorrectly, resulting in overcharges of \$30,388 to the FEHBP.

The following summarizes the overcharges:

- For the DC Service Area, the Plan incorrectly paid 12 claims, resulting in overcharges of \$2,772 to the FEHBP. The claim payment errors resulted from the following reasons:
 - The Plan paid eight claims using the 2006 non-par surgery allowances even though the billed charges were less, resulting in overcharges of \$1,624 to the FEHBP.
 - The Plan incorrectly priced four claims due to claims processor errors, resulting in overcharges of \$1,148 to the FEHBP.
- For the Maryland Service Area, the Plan incorrectly paid seven claims, resulting in overcharges of \$7,314 to the FEHBP. The claim payment errors resulted from the following reasons:
 - The Plan paid five claims using the 2006 non-par surgery allowances even though the billed charges were less, resulting in overcharges of \$3,090 to the FEHBP.
 - The Plan incorrectly priced two claims due to claims processor errors, resulting in overcharges of \$4,224 to the FEHBP.
- For the Overseas claims, the Plan incorrectly paid 24 claims, resulting in overcharges of \$20,302 to the FEHBP. The claim payment errors resulted from the following reasons:
 - The Plan did not provide a response or supporting documentation for five claims, resulting in unsupported charges of \$11,149 to the FEHBP.
 - The FEP national claims system did not calculate the appropriate co-insurance for 18 claims, resulting in overcharges of \$6,604 to the FEHBP. We expanded our review of this potential system error under the “System Review” (A1.f) audit finding.
 - The Plan incorrectly priced one claim due to a claims processor error, resulting in an overcharge of \$2,549 to the FEHBP.

Association's Response:

In response to the amount questioned in the draft report, the Association agrees with \$680,153 (\$605,925 + \$25,841 + \$10,342 + \$11,881 + \$2,772 + \$3,090 + \$20,302) and disagrees with \$105,127 (\$71,321 + \$2,492 + \$31,314).

The Association states that the Plan has initiated recovery efforts for the confirmed overpayments and has returned various amounts recovered to the FEHBP. To the extent that errors did occur, the Association also states that these payments were good faith erroneous benefit payments and fall within the context of CS 1039, Part II, section 2.3(g). Any payments the Plan is unable to recover are allowable charges to the FEHBP. As good faith erroneous payments, lost investment income (LII) does not apply to the claim payment errors identified in this finding.

In reference to the overpayments caused by claims processor errors, the Association states, "The overpayments were the results of Claims Examiner errors and were used as training tools in the recent re-fresher training session. In addition, the Plan has a quality review area that reviews claims and identifies payment errors. The identified payment errors are then discussed with the management in the Operations Areas. The objective is to determine whether individual examiners may need further training or if there is a pattern of inconsistency in the adjudication process for multiple Claims Examiners. The identified errors are used to determine the focus of the training for the group."

As part of its FEP overpayment recovery action plan, the Association states that "the FEP Director's Office sends the System-wide Claims Review Listing to the Plan which also includes an Amount Paid Greater Than Covered Charges Listing. The Plan . . . reviews and returns the results of its review to the FEP Director's Office as required. Where appropriate, refunds are initiated. However, there appears to be a difference in the claim selection criteria used to select these claims for OPM and the selection criteria used to generate the FEP Director's Office System-wide Claims Review Listing. We will re-evaluate our selection criteria to determine if any changes are required to bring it more in line with the OPM claim selection criteria."

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 \$684,657. Subsequent to receiving the Association's response, the Plan provided additional documentation supporting concurrence with the revised questioned amount.

Recommendation 1

We recommend that the contracting officer disallow \$684,657 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

b. Inpatient Facility Claims – Duplicate or Overlapping Dates of Service \$297,735

The Plan incorrectly paid 124 inpatient facility claims, resulting in net overcharges of \$297,735 to the FEHBP. Specifically, the Plan overpaid 120 claims by \$298,204 and underpaid 4 claims by \$469.

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 Carrier shall retain and make available all records applicable to a contract term. Also, the Plan must coordinate the payment of benefits with Medicare.

The following summarizes our review of inpatient facility claims with duplicate or overlapping dates of service.

Overseas Claims

We performed a computer search for potential duplicate payments on inpatient facility claims paid during the period January 1, 2006 through August 31, 2009. We identified 44 groups of claims with duplicate or overlapping dates of service. These 44 groups included 89 claims with total amounts paid of \$616,079. Based on our review, we determined that 29 of these claims were paid incorrectly, resulting in overcharges of \$166,965 to the FEHBP.

These claim payment errors resulted from the following:

- The Plan paid 21 duplicate claims, resulting in overcharges of \$98,238 to the FEHBP. These claims did not defer on the claims system as potential duplicates for review by the processors.
- The Plan reprocessed six claims with revised charges but did not adjust or void the previous claim payments, resulting in overcharges of \$33,497 to the FEHBP.
- In one instance, the Plan did not provide a complete response and/or documentation to support a claim payment of \$30,674. Specifically, the Plan could not locate the wire transfer documentation supporting the actual amount paid to the provider.
- In one instance, a claims processor keying error caused a duplicate claim not to defer on the claims system, resulting in an overcharge of \$4,556 to the FEHBP.

Due to the number of claim payment errors identified from this review of Overseas claims, we expanded our review to also include the DC and Maryland Service Areas. We also expanded our audit scope for these service areas to cover inpatient facility claims paid through September 30, 2009.

DC Service Area

We performed a computer search for potential duplicate payments on inpatient facility claims paid during the period January 1, 2006 through September 30, 2009. We identified 138 groups of claims with duplicate or overlapping dates of service. The 138 groups included 285 claims with total amounts paid of \$1,968,743. From this universe, we selected and reviewed a judgmental sample of 128 groups (representing 263 claims), totaling \$1,964,223 in payments, to determine if the Plan paid these claims properly. Our sample included all groups with potential duplicate claim payments of \$100 or more.

Based on our review, we determined that 61 of these claims were paid incorrectly, resulting in net overcharges of \$82,023 to the FEHBP. Specifically, the Plan overpaid 58 claims by \$82,323 and underpaid 3 claims by \$300. These claim payment errors resulted from the following:

- The Plan paid 16 duplicate claims, resulting in overcharges of \$35,729 to the FEHBP. Since the Plan processed these claims under different or incorrect provider identification numbers, the claims did not defer on the claims system as potential duplicates for review by the processors.
- The Plan processed 17 claims with unauthorized days of service, resulting in overcharges of \$18,031 to the FEHBP (non-duplicate errors).
- The Plan reprocessed eight claims with revised charges but did not adjust or void the previous claim payments, resulting in overcharges of \$13,285 to the FEHBP.
- The Plan paid eight duplicate claims, resulting in overcharges of \$7,039 to the FEHBP. Due to various claims processor keying errors, these claims did not defer on the claims system as potential duplicates for review by the processors.
- The Plan incorrectly paid six claims due to providers submitting claims with incorrect dates of service, resulting in overcharges of \$5,137 to the FEHBP (non-duplicate errors).
- The Plan paid three duplicate claims, resulting in overcharges of \$3,102 to the FEHBP. Since these claims were processed on the same day as the original claims, the claim system did not defer these claims as potential duplicates for review by the processors.

- The Plan paid three claims that contained other Plan payment errors, resulting in undercharges of \$300 to the FEHBP (non-duplicate errors).

Maryland Service Area

We performed a computer search for potential duplicate payments on inpatient facility claims paid during the period January 1, 2006 through September 30, 2009. We identified 61 groups with duplicate or overlapping dates of service. The 61 groups included 129 claims with total amounts paid of \$459,560. From this universe, we selected and reviewed a judgmental sample of 57 (representing 121 claims), totaling \$456,979 in payments, to determine if the Plan paid these claims properly. Our sample included all groups with potential duplicate claim payments of \$100 or more.

Based on our review, we determined that 34 of these claims were paid incorrectly, resulting in net overcharges of \$48,747 to the FEHBP. Specifically, the Plan overpaid 33 claims by \$48,916, and underpaid 1 claim by \$169. These claim payment errors resulted from the following:

- The Plan reprocessed nine claims with revised charges but did not adjust or void the previous claim payments, resulting in overcharges of \$20,000 to the FEHBP.
- The Plan paid 11 duplicate claims, resulting in overcharges of \$14,737 to the FEHBP. Since the Plan processed these claims under different or incorrect provider identification numbers, the claims did not defer on the claims system as potential duplicates for review by the processors.
- In six instances, the Plan reimbursed the State of Maryland (Medicaid program) for claims where Medicaid paid as the primary insurer when the FEHBP was the primary insurer. The Plan also paid the providers for these claims, resulting in duplicate charges of \$5,887 to the FEHBP.
- The Plan paid five duplicate claims, resulting in overcharges of \$5,220 to the FEHBP. Since these claims were processed on the same day as the original claims, the claim system did not defer these claims as potential duplicates for review by the processors.
- In one instance, the Plan incorrectly processed a case management claim, resulting in duplicate charges of \$1,020 to the FEHBP.
- The Plan did not properly coordinate two claims with Medicare, resulting in net overcharges of \$1,883 to the FEHBP (non-duplicate errors). Specifically, the Plan overpaid one claim by \$2,052 and underpaid one claim by \$169.

Association's Response:

In response to the amount questioned in the draft report, the Association agrees with \$250,299 (\$136,291 + \$82,023 + \$31,985), is reviewing \$11,541, and disagrees with the remaining questioned amount.

The Association states that the Plan has initiated recovery efforts for the confirmed overpayments and has returned various amounts recovered to the FEHBP. To the extent that errors did occur, the Association also states that these payments were good faith erroneous benefit payments and fall within the context of CS 1039, Part II, section 2.3(g). Any payments the Plan is unable to recover are allowable charges to the FEHBP. As good faith erroneous payments, LII does not apply to the claim payment errors identified in this finding.

The Association also states, "The FEP Claims System includes an edit that is designed to defer inpatient claims with overlapping dates of services. However, a review of this issue indicates that this edit only generates a deferral if the claims are from the same provider. As a result of this finding, the FEP Director's Office is modifying this edit to defer all inpatient claims with overlapping dates of service regardless of whether the Provider is the same or not. We expect this system enhancement to be implemented later in 2010.

In addition, the Plan has included the claims that were incorrectly coded as part of the training program for the Claims Examiners. Lastly, the Plan will provide additional training to all Claims Examiners by the second quarter of 2010 with an emphasis on the importance of coding claims correctly. The FEP Director's Office will also add these claim types to its System-wide claims listings that are sent to all Plans."

Regarding the contested overpayments, the Association states that the services were for different patients or coded incorrectly, or the dates of services were coded incorrectly.

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 \$297,735. Subsequent to receiving the Association's response, the Plan provided additional documentation supporting agreement with \$267,061 and disagreement with \$30,674 of the revised questioned amount. The contested amount pertains to an overseas claim where the Plan could not locate the wire transfer documentation supporting the actual amount paid to the provider. We will continue to question this claim until the Association or Plan provides adequate documentation supporting the amount paid to the provider.

Recommendation 2

We recommend that the contracting officer disallow \$298,204 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 3

We recommend that the contracting officer allow the Plan to charge the FEHBP \$469 if additional payments are made to the providers to correct the underpayment errors.

Recommendation 4

We recommend that the contracting officer ensure that the Association and Plan have implemented corrective procedures to prevent these types of errors in the future.

c. Omnibus Budget Reconciliation Act of 1990 Review \$169,397

The Plan incorrectly paid 12 claims that were priced or potentially should have been priced under the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) pricing guidelines, resulting in net overcharges of \$169,397 to the FEHBP. Specifically, the Plan overpaid 10 claims by \$220,139 and underpaid 2 claims by \$50,742.

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, the Plan must coordinate the payment of benefits with Medicare.

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. However, the claims for the Maryland Service Area and Overseas are not subject to OBRA 90 pricing.

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.

The following summarizes our OBRA 90 review for the DC Service Area.

OBRA 90 Claim Pricing Errors

For the period January 1, 2006 through October 31, 2008, we identified 3,657 claims, totaling \$42,169,361 in payments, that were subject to OBRA 90 pricing guidelines. From this universe, we selected and reviewed a judgmental sample of 95 claims, totaling \$8,482,494 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 of \$40,000 or more.

Based on our review, we determined that eight of these claims were paid incorrectly, resulting in net overcharges of \$150,325 to the FEHBP. Specifically, the Plan overpaid seven claims by \$161,342 and underpaid one claim by \$11,017.

These claim payment errors resulted from the following:

- In two instances, the claims processors incorrectly priced split claims, resulting in net overcharges of \$80,818 to the FEHBP. Specifically, the Plan overpaid one claim by \$91,835 and underpaid one claim by \$11,017.
- The Plan did not properly coordinate six claims with Medicare, resulting in overcharges of \$69,507 to the FEHBP.

Claims Not Priced Under OBRA 90 (Possible OBRA 90 Claims)

For the period January 1, 2006 through October 31, 2008, we identified 7,414 claims, totaling \$27,093,377 in payments, that were potentially subject to OBRA 90 pricing guidelines but appeared to be paid under the Plan's standard pricing procedures. From this universe, we selected and reviewed a judgmental sample of 175 claims, totaling \$8,268,888 in payments, to determine if the Plan paid these claims properly. Our sample included all possible OBRA 90 claims with amounts paid of \$25,000 or more.

Based on our review, we determined that four of these claims were paid incorrectly, resulting in net overcharges of \$19,072 to the FEHBP. Specifically, the Plan overpaid three claims by \$58,797 and underpaid one claim by \$39,725.

These claim payment errors resulted from the following:

- In one instance, a claims processor inadvertently made an unnecessary claim adjustment, resulting in an overcharge of \$23,294 to the FEHBP.
- The Plan did not properly coordinate three claims with Medicare, resulting in net undercharges of \$4,222 to the FEHBP. Specifically, the Plan overpaid two claims by \$35,503 and underpaid one claim by \$39,725.

Association's Response:

The Association agrees with the finding. The Association states that the Plan has initiated recovery efforts for the confirmed overpayments, and as of February 1, 2010, the Plan had recovered and returned \$86,617 to the FEHBP. The Association also states that these payments were good faith erroneous benefit payments and fall within the context of CS 1039, Part II, section 2.3(g). Any payments the Plan is unable to

recover are allowable charges to the FEHBP. As good faith erroneous payments, LII does not apply to the claim payment errors identified in this finding.

The Association states, "When the claims were originally submitted to the Operations Center, there were coding discrepancies. These payment differences occurred because the examiners did not submit the correct information when the claims were initially manually processed. The claims were paid in error because Claims Examiners entered incorrect fields for Medicare Part B payment information; incorrectly coded split admission between two claims and adjusted an original OBRA 90 priced claim incorrectly. To reduce these types of pricing errors in the future, the Plan has implemented and updated its Policy & Procedure for OBRA '90 claim processing. . . . Also, the FEP Director's Office includes potential OBRA '90 priced claims in its periodic System-wide Claims Review to facilitate early identification and recovery of OBRA '90 claim payment errors. Completion of these periodic reports assists in the timely identification and recovery of OBRA '90 claim payment errors."

Recommendation 5

We recommend that the contracting officer disallow \$220,139 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 6

We recommend that the contracting officer allow the Plan to charge the FEHBP \$50,742 if additional payments are made to the providers to correct the underpayment errors.

d. Assistant Surgeon Review \$116,348

The Plan incorrectly paid 146 assistant surgeon claims, resulting in net overcharges of \$116,348 to the FEHBP. Specifically, the Plan overpaid 133 claims by \$127,100 and underpaid 13 claims by \$10,752.

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, the Plan must coordinate the payment of benefits with Medicare.

The following summarizes our review of potential assistant surgeon overpayments.

DC Service Area

For the period January 1, 2006 through October 31, 2008, we identified 1,170 assistant surgeon claim groups, totaling \$235,547 in potential overpayments, that may not have been paid in accordance with the Plan's assistant surgeon pricing procedures.

From this universe, we selected and reviewed a judgmental sample of 84 assistant surgeon claim groups, totaling \$77,781 in potential overpayments, to determine if the Plan paid these claims properly. Our sample included all assistant surgeon claim groups with potential overpayments of \$500 or more. The majority of these claim groups contained one primary surgeon and one assistant surgeon claim.

Based on our review, we determined that 40 claims were paid incorrectly, resulting in net overcharges of \$56,963 to the FEHBP. Specifically, the Plan overpaid 39 claims by \$57,332 and underpaid 1 claim by \$369.

The claim payment errors resulted from the following:

- The Plan incorrectly paid 29 claims that were subject to the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) pricing guidelines, resulting in overcharges of \$47,822.
 - Seventeen of the claims were paid in error due to Palmetto (OBRA 93 pricing vendor) not recognizing the physician assistant pricing modifier “AS” and erroneously calculating the physician assistant fee. These physician assistant claims should have been priced according to the Medicare fee schedule (13.6 percent of the primary surgeon fee). Consequently, the Plan overpaid these claims, resulting in overcharges of \$30,602 to the FEHBP.
 - Twelve of the claims were paid in error due to a Palmetto claims processing system error which caused an incorrect calculation of the assistant surgeon fee for claims containing assistant surgeon pricing modifiers 80, 81, or 82. These assistant surgeon claims should have been priced according to the Medicare fee schedule (16 percent of the primary surgeon fee). Consequently, the Plan overpaid these claims, resulting in overcharges of \$17,220 to the FEHBP.
- The Plan incorrectly paid five assistant surgeon claims, resulting in overcharges of \$3,901 to the FEHBP. These overcharges were due to the claim system’s incorrect calculation of the assistant surgeon or physician assistant fees, which should have been priced at 20 percent of the primary surgeon allowed amount.
- In three instances, the claims processors entered incorrect pricing information, resulting in overcharges of \$3,787 to the FEHBP.
- In three instances, the claims processors overrode system edits, resulting in net overcharges of \$1,453 to the FEHBP. Specifically, the Plan overpaid two claims by \$1,822 and underpaid one claim by \$369.

Maryland Service Area

For the period January 1, 2006 through October 31, 2008, we identified 2,938 assistant surgeon claim groups, totaling \$300,036 in potential overpayments, that may not have been paid in accordance with the Plan's assistant surgeon pricing procedures. From this universe, we selected and reviewed a judgmental sample of 68 assistant surgeon claim groups, totaling \$65,764 in potential overpayments, to determine if the Plan paid these claims properly. Our sample included all assistant surgeon claim groups with potential overpayments of \$500 or more. The majority of these claim groups contained one primary surgeon and one assistant surgeon claim.

Based on our review, we determined that 54 claims were paid incorrectly, resulting in net overcharges of \$53,501 to the FEHBP. Specifically, the Plan overpaid 51 claims by \$55,022 and underpaid 3 claims by \$1,521.

The claim payment errors resulted from the following:

- The Plan incorrectly paid 34 assistant surgeon claims, resulting in overcharges of \$38,068 to the FEHBP. These overcharges were due to the claim system's incorrect calculation of the assistant surgeon or physician assistant fees, which should have been priced at 20 percent of the primary surgeon allowed amount.
- The Plan incorrectly paid 15 claims that were subject to OBRA 93 pricing guidelines, resulting in overcharges of \$15,365.
 - Twelve of the claims were paid in error due to Palmetto not recognizing the physician assistant pricing modifier "AS" and erroneously calculating the physician assistant fee. These physician assistant claims should have been priced according to the Medicare fee schedule (13.6 percent of the primary surgeon fee). Consequently, the Plan overpaid these claims, resulting in overcharges of \$13,170 to the FEHBP.
 - Three of the claims were paid in error due to a Palmetto claims processing system error which caused an incorrect calculation of the assistant surgeon fee for claims containing assistant surgeon pricing modifiers 80, 81, or 82. These assistant surgeon claims should have been priced according to the Medicare fee schedule (16 percent of the primary surgeon fee). Consequently, the Plan overpaid these claims, resulting in overcharges of \$2,195 to the FEHBP.
- In one instance, the Plan did not properly coordinate a claim with Medicare, resulting in an overcharge of \$1,022 to the FEHBP.
- In one instance, the Plan used an incorrect rate to price a claim, resulting in an undercharge of \$426 to the FEHBP.

- In three instances, the claims processors entered incorrect pricing information, resulting in net undercharges of \$528 to the FEHBP. Specifically, the Plan overpaid one claim by \$567 and underpaid two claims by \$1,095.

Due to the high error rate, we selected for review an additional 340 assistant surgeon claim groups with potential overpayments totaling \$98,718. Our expanded sample included all assistant surgeon claim groups with potential overpayments equal to or greater than \$200 and less than \$500. Based on our review, we identified 52 additional claim payment errors, resulting in net overcharges of \$5,884 to the FEHBP. Specifically, the Plan overpaid 43 claims by \$14,746 and underpaid 9 claims by \$8,862. These overcharges were primarily due to errors in the calculation of the assistant surgeon fee, which should have been priced at either 13.6 percent, 16 percent, or 20 percent of the primary surgeon allowed amount.

Overseas Claims

For the period January 1, 2006 through October 31, 2008, we identified no assistant surgeon claim groups with potential overpayments.

Association's Response:

The Association agrees with this finding. The Association states that the Plan has initiated recovery efforts for the confirmed overpayments, and as of February 1, 2010, the Plan had recovered and returned \$95,450 (\$46,081 for the DC Service Area and \$49,369 for the Maryland Service Area) to the FEHBP.

The Association also states, "The overpayments related to the non-OBRA '93 assistant surgeon claims were the result of a local Plan system issue for both the Maryland and DC Plans. This system issue was identified by the Plan before the audit began and corrected in the second Quarter of 2009. The payments related to OBRA '93 priced Assistant Surgeon Claims were sent to the Plan as a part of the FEP Director's Office System-wide Claims Review Listing."

Recommendation 7

We recommend that the contracting officer disallow \$127,100 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 8

We recommend that the contracting officer allow the Plan to charge the FEHBP \$10,752 if additional payments are made to the providers to correct the underpayment errors.

Recommendation 9

We recommend that the contracting officer instruct the Association to ensure that the Plan corrected the local claim system issue of not applying the 20 percent reimbursement rate when pricing assistant surgeon and/or physician assistant claims.

e. Debarred Provider Payments \$15,564

The Plan made 205 claim payments, totaling \$15,564, to 3 debarred providers from January 1, 2006 through October 31, 2008.

Contract CS 1039, Part II, Section 2.7 states that if a provider has been barred from participating in the FEHBP under Title 5 of the U.S. Code, or the provider's services under the Code are excluded, the carrier agrees to withhold payments to that provider.

OPM periodically provides the FEP Director's Office with a list of debarred providers. According to the FEP Administrative Manual, the listing is forwarded to the FEP Operations Center. The FEP Operations Center will then provide these listings to the local Blue Cross and Blue Shield plans and request updates, such as provider identification numbers. Based on the updates received from the local plans, the FEP Operations Center updates the debarred provider file on the FEP national claims system.

For the period 2006 through October 31, 2008, we identified 44 DC and Maryland providers that were debarred. From this universe, we selected and reviewed a judgmental sample of 32 providers for the purpose of determining if the Plan paid any claims to these providers after the debarment dates. Based on our review, we determined that the Plan made 205 claim payments, totaling \$15,564, to 3 providers after their debarment dates. The Administrative Sanctions Branch confirmed that these three debarred providers were posted on OPM's debarred provider website and available to the FEP Operations Center to download and distribute to the BlueCross BlueShield plans on June 1, 2006, July 6, 2006, and October 2, 2008.

The Plan stated that the FEP Operations Center did not provide debarred information for one of the providers. Therefore, the Plan did not provide an updated provider file to the FEP Operations Center to reflect the debarment status, and the FEP Operations Center did not make the necessary system changes to the FEP national claims system to recognize this provider as debarred and suspend the claims. Consequently, the Plan paid 119 claims, totaling \$8,069, to this debarred provider.

In addition, the Plan stated that the FEP Operations Center provided debarred information for two of the providers; however, the Plan did not provide an updated provider file to the FEP Operations Center to reflect the debarment status. Therefore, the FEP Operations Center did not make the necessary system changes to the FEP national claims system to recognize these providers as debarred and suspend the

claims. Consequently, the Plan paid 86 claims, totaling \$7,495, to these debarred providers.

Association's Response:

The Association agrees with this finding. The Association states that these payments were good faith erroneous benefit payments and fall within the context of CS 1039, Part II, section 2.3(g). Any payments the Plan is unable to recover are allowable charges to the FEHBP. As good faith erroneous payments, LII does not apply to the claim payment errors identified in this finding.

For the two providers that were not updated on the debarred provider listings generated by the FEP Operations Center, the Association states, "As a result, no member notification was issued; therefore, the refund recovery effort cannot be initiated for the affected claims since the members did not receive the required notification. The Plan is currently validating the control changes necessary to prevent the updating of these providers on the FEP Claims System with a target completion date of first quarter 2010."

For the provider that was omitted in error from the debarred provider listing generated by the FEP Operations Center, the Association states, "The Plan updated its provider file as of October 2009 with the debarred status for the Provider in question. However, no member notification was issued; therefore, the refund recovery effort cannot be initiated for the affected claims since the members did not receive the required notification that the Provider was debarred as required by OPM."

The Association also states, "FEP has implemented additional controls at the Operations Center for the generation of the Debarred Provider Listings to Plans. Under the enhanced controls, when the listing is received from CMS and updated on the FEP System, it cannot be sent to Plans until the Plan's internal audit department has validated that all providers have been included on the listings. This control is being implemented during the first quarter 2010."

Recommendation 10

We recommend that the contracting officer disallow \$15,564 for payments made to three debarred providers.

Recommendation 11

We recommend that the contracting officer verify that corrective actions were implemented by the Association to prevent further payments to these or other debarred providers.

f. System Review

(\$52)

The Plan incorrectly paid five claims, resulting in net undercharges of \$52 to the FEHBP. Specifically, the Plan overpaid four claims by \$1,948 and underpaid one claim by \$2,000.

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 following summarizes our system review of claims.

DC Service Area

For health benefit claims reimbursed during the period January 1, 2008 through October 31, 2008, we identified 6,959,851 claim lines, totaling \$706,014,430 in payments, using a standard criteria based on our audit experience. From this universe, we selected and reviewed a judgmental sample of 151 claims (representing 1,536 claim lines), totaling \$7,730,798 in payments, to determine if the Plan adjudicated these claims properly.³ Our review identified one claim payment error, resulting in an undercharge of \$2,000 to the FEHBP. This error resulted from a claims processor incorrectly pricing the procedure code.

MD Service Area

For health benefit claims reimbursed during the period January 1, 2008 through October 31, 2008, we identified 4,836,420 claim lines, totaling \$436,108,524 in payments, using a standard criteria based on our audit experience. From this universe, we selected and reviewed a judgmental sample of 100 claims (representing 898 claim lines), totaling \$5,519,400 in payments, to determine if the Plan adjudicated these claims properly (see footnote 3). Based on our review, we determined the Plan properly paid these claims.

Overseas Claims

For health benefit claims reimbursed during the period January 1, 2008 through October 31, 2008, we identified 352,748 claim lines, totaling \$52,772,528 in payments, using a standard criteria based on our audit experience. From this universe, we selected and reviewed a judgmental sample of 50 claims (representing 364 claim lines), totaling \$3,065,582 in payments, to determine if the Plan adjudicated these claims properly (see footnote 3). Our review identified four claim

³ We selected our sample from an OIG-generated "Place of Service Report" (SAS application) that stratified the claims by place of service (POS), such as provider's office and payment category, such as \$50 to \$99.99. We judgmentally determined the number of sample items to select from each POS stratum based on the stratum's total claim dollars paid.

payment errors, resulting in overcharges of \$1,948 to the FEHBP. The claim payment errors resulted from the following:

- In one instance, the claims processor overrode the system edits when pricing the claim, resulting in an overcharge of \$1,663 to the FEHBP.
- The Plan did not apply the deductible when pricing two claims, resulting in overcharges of \$200 to the FEHBP.
- In one instance, the FEP national claims system did not calculate the appropriate co-insurance, resulting in an overcharge of \$85 to the FEHBP. We found that the FEP national claims system did not apply the correct co-insurance amount to outpatient facility claims with 2007 or 2008 dates of service, revenue codes 490 or 499 (ambulatory surgical care), and an alternate provider network status of "P1" (Preferred) or "P2" (Member) when the subscriber had standard option coverage and had not met the catastrophic maximum amount for the year.

Because this is a system error, we requested the Plan to identify all claims that were potentially affected by this type of error. Since the total amounts paid for the identified claims were immaterial, we did not select additional claims to review. Also, the Plan stated that this system error was corrected in June 2008.

Association's Response:

The Association agrees with this finding. The Association states that the Plan has initiated recovery efforts for the confirmed overpayments, and as of February 1, 2010, the Plan had recovered and returned \$1,748 to the FEHBP. The Association also states that these payments were good faith erroneous benefit payments and fall within the context of CS 1039, Part II, section 2.3(g). Any payments the Plan is unable to recover are allowable charges to the FEHBP. As good faith erroneous payments, LII does not apply to the claim payment errors identified in this finding.

In reference to the \$2,000 undercharge (DC Service Area), the Association states that the claim has been adjusted appropriately to pay the correct amount.

Recommendation 12

We recommend that the contracting officer disallow \$1,948 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 \$2,000 if an additional payment is made to the provider to correct the underpayment error.

2. **Miscellaneous Payments and Credits**

a. **Provider Audit Vendor Fees** **\$15,249**

The Plan paid commission fees to a vendor for FEP recoveries that were not realized, resulting in overcharges of \$15,249 to the FEHBP.

The provider audit services contract, effective November 20, 2001, between the Plan and AIM Healthcare Services, Inc. (vendor) states, "Fees shall be . . . for overpayments identified and recovered through the on-site credit balance review process"

As previously cited from CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable.

The Plan's vendor audit fees are calculated by applying a predetermined commission percentage to the overpayments identified and recovered. Therefore, the vendor should only charge the Plan for audits resulting in actual claim recoveries. If there are no claim overpayment recoveries, then there should be no charge to the Plan and no charge to the FEHBP. During our review of provider audit recoveries, we identified two audited FEP claims (from the DC Service Area) where the commission percentage was applied to the identified overpayments, however, no recovery or only a partial recovery occurred. Since there was no recovery or only a partial recovery for these two overpayments, the vendor charges of \$15,249 are not chargeable to the FEHBP.

Association's Response:

The Association agrees with this finding. The Association states, "The Plan has recovered the vendor overpayment. A Special Plan Invoice (SPI) was submitted on February 19, 2010. The funds were wired to the BCBSA Joint Operating Account on February 18, 2010."

Recommendation 14

We recommend that the contracting officer disallow \$15,249 for the provider audit vendor overcharges and verify that the Association returned these funds to the FEHBP.

b. Fraud Recovery Returned Untimely

\$5,136

In one instance, the Plan did not timely return a fraud recovery to the FEHBP. As a result of this finding, the Plan credited the FEHBP \$5,136 for LII on this recovery.

Based on an agreement between OPM and the Association, dated March 26, 1999, BlueCross and BlueShield plans have 30 days to return health benefit refunds and recoveries to the FEHBP if received after March 31, 1999.

48 CFR 52.232-17(a) states, “all amounts that become payable by the Contractor . . . shall bear simple interest from the date due . . . The interest rate shall be the interest rate established by the Secretary of the Treasury as provided in Section 611 of the Contract Disputes Act of 1978 (Public Law 95-563), which is applicable to the period in which the amount becomes due, as provided in paragraph (e) of this clause, and then at the rate applicable for each six-month period as fixed by the Secretary until the amount is paid.”

For the period 2004 through 2008, there were 534 fraud recoveries totaling \$4,555,776 for the DC and Maryland Service Areas and Overseas claims. From this universe, we judgmentally selected a sample of 30 fraud recoveries, totaling \$3,060,473, for the purpose of determining whether the Plan returned these recoveries to the FEHBP in a timely manner. Our sample included all fraud recoveries with recovery amounts of \$40,000 or more.

Based on our review, we determined that the Plan did not timely return one fraud recovery (from the Maryland Service Area) to the FEHBP. Specifically, although the Plan returned this fraud recovery to the FEHBP letter of credit account (LOCA), the funds were not timely deposited into the FEP investment account. Therefore, we calculated that the FEHBP is due \$5,136 for LII on this untimely returned fraud recovery.

Association’s Response:

The Association agrees with this finding. The Association states, “The Plan submitted a Special Plan Invoice (SPI) to BCBSA for the Lost Investment Income (LII) due the FEHBP. The funds were transferred to the Plan’s FEP investment account on June 25, 2009 and adjusted against the LOCA on July 7, 2009.”

Recommendation 15

Since we verified that the Plan credited the LOCA \$5,136 for LII on the untimely returned fraud recovery, no further action is required for this questioned amount.

B. ADMINISTRATIVE EXPENSES

1. BluesNet Charges

\$60,561

The Plan charged the FEHBP for BluesNet expenses that had already been charged to the FEHBP by the FEP Operations Center. As a result, the FEHBP is due \$60,561, consisting of \$56,846 for duplicate BluesNet charges and \$3,715 for LII on these charges.

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."

48 CFR 52.232-17(a) states, "all amounts that become payable by the Contractor . . . shall bear simple interest from the date due . . . The interest rate shall be the interest rate established by the Secretary of the Treasury as provided in Section 611 of the Contract Disputes Act of 1978 (Public Law 95-563), which is applicable to the period in which the amount becomes due, as provided in paragraph (e) of this clause, and then at the rate applicable for each six-month period as fixed by the Secretary until the amount is paid."

For the period 2004 through 2008, the Plan allocated administrative expenses of \$393,375,343 to the FEHBP from 1,834 cost centers. From this universe, we selected a judgmental sample of 58 cost centers to review, which totaled \$153,990,363 in expenses allocated to the FEHBP. We selected the cost centers based on high dollar amounts, our nomenclature review, and significant dollar amount fluctuations from year to year. We reviewed the expenses from these cost centers for allowability, allocability, and reasonableness. Based on our review, we identified one cost center that included BluesNet charges, totaling \$56,846 (\$37,677 for the DC Service Area and \$19,169 for the Maryland Service Area), that had already been charged to the FEHBP by the FEP Operations Center.

The Association operates a telecommunication system called BluesNet. BluesNet is a BlueCross BlueShield system-wide data communications network utility. The network uses data communication equipment and telecommunication carrier services to provide the physical connection and communication protocols necessary to exchange information among the local BCBS plans. The Association's expenses for maintaining the BluesNet system are allocated and charged to the FEP Operations Center through baseline charges.

From 2002 through 2006, the Association individually charged each Plan for BluesNet baseline charges. Effective January 2007, the Association began charging the FEP Operations Center for FEHBP's portion of the BluesNet baseline charges. Therefore, the BCBS plans may not allocate BluesNet baseline charges to the FEHBP after 2006. Through cost center 13133 (DC data hardware), the Plan charged the FEHBP \$27,808 and \$29,038 in years 2007 and 2008, respectively, for BluesNet base line charges.

As a result of this oversight, the Plan inappropriately charged the FEHBP \$56,846 for BluesNet base line charges that were already charged to the FEHBP by the FEP Operations Center. The Plan also determined that the FEHBP is due \$3,715 for LII on

these duplicate charges. Based on our review of the Plan's LII calculation, we agree with the amount determined by the Plan and will not assess additional LII.

Association's Response:

The Association agrees with this finding. The Association states, "The Plan submitted the necessary Prior Period Adjustments (PPA's) and SPI's for the LII due the FEHBP to BCBSA on September 29, 2009. The funds were wired to the BCBSA Joint Operating account on September 29, 2009."

Recommendation 16

We recommend that the contracting officer disallow \$56,846 for duplicate BluesNet charges and verify that the Association returned these funds to the FEHBP.

Recommendation 17

We recommend that the contracting officer verify that the Plan returned \$3,715 to the FEHBP for LII on the duplicate BluesNet charges.

C. CASH MANAGEMENT

Overall, we concluded that the Plan handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and regulations, except for the findings pertaining to cash management noted in the "Miscellaneous Payments and Credits" section.

D. LOST INVESTMENT INCOME ON AUDIT FINDINGS **\$1,554**

As a result of the audit findings presented in this report, the FEHBP is due LII of \$1,554 from January 1, 2008 through December 31, 2009.

48 CFR 52.232-17(a) states, "all amounts that become payable by the Contractor . . . shall bear simple interest from the date due . . . The interest rate shall be the interest rate established by the Secretary of the Treasury as provided in Section 611 of the Contract Disputes Act of 1978 (Public Law 95-563), which is applicable to the period in which the amount becomes due, as provided in paragraph (e) of this clause, and then at the rate applicable for each six-month period as fixed by the Secretary until the amount is paid."

We computed investment income that would have been earned using the semiannual rates specified by the Secretary of the Treasury. Our computations show that the FEHBP is due LII of \$1,554 from January 1, 2008 through December 31, 2009 on questioned costs for contract year 2007 (see Schedule C).

Association's Response:

The draft audit report did not include an audit finding for LII. Therefore, the Plan did not address this item in its reply.

Recommendation 18

We recommend that the contracting officer direct the Plan to credit \$1,554 (plus interest accruing after December 31, 2009) to the Special Reserve for LII on audit findings.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Experience-Rated Audits Group

██████████ Lead Auditor

██████████ Auditor

██████████ Auditor

██████████ Auditor

██████████ Auditor

██████████ Auditor

██████████ Auditor

██████████ Chief ██████████

██████████ Senior Team Leader

V. SCHEDULES

CAREFIRST BLUECROSS BLUESHIELD
WASHINGTON, D.C. AND MARYLAND SERVICE AREAS AND OVERSEAS CLAIMS
OWINGS MILLS, MARYLAND

CONTRACT CHARGES

CONTRACT CHARGES	2004	2005	2006	2007	2008	TOTAL
A. HEALTH BENEFIT CHARGES*						
<u>DC SERVICE AREA:</u>						
PLAN CODES 080/081/580/582	\$723,239,877	\$779,156,681	\$808,539,914	\$881,811,033	\$950,884,620	\$4,143,632,125
MISCELLANEOUS PAYMENTS	4,601,943	6,559,136	3,660,507	5,187,558	7,841,131	27,850,275
TOTAL	\$727,841,820	\$785,715,817	\$812,200,421	\$886,998,591	\$958,725,751	\$4,171,482,400
<u>MARYLAND SERVICE AREA:</u>						
PLAN CODES 190/690	388,749,424	434,921,166	467,856,613	523,890,148	572,976,865	2,388,394,216
MISCELLANEOUS PAYMENTS	2,742,835	4,096,714	4,195,539	3,741,464	5,311,391	20,087,943
TOTAL	\$391,492,259	\$439,017,880	\$472,052,152	\$527,631,612	\$578,288,256	\$2,408,482,159
<u>OVERSEAS CLAIMS:</u>						
PLAN CODE 082	35,003,937	40,389,347	44,181,062	52,104,727	58,486,709	230,165,782
MISCELLANEOUS PAYMENTS	0	0	(1,656)	0	0	(1,656)
TOTAL	\$35,003,937	\$40,389,347	\$44,179,406	\$52,104,727	\$58,486,709	\$230,164,126
TOTAL HEALTH BENEFIT CHARGES	\$1,154,338,016	\$1,265,123,044	\$1,328,431,979	\$1,466,734,930	\$1,595,500,716	\$6,810,128,685
B. ADMINISTRATIVE EXPENSE CHARGES						
PLAN CODES 080/190**	\$77,280,430	\$76,912,687	\$81,196,640	\$85,345,703	\$83,697,824	\$404,433,284
PRIOR PERIOD ADJUSTMENTS	(96,125)	(310,308)	9,805,212	0	(244,413)	9,154,366
BUDGET SETTLEMENT REDUCTION	0	(1,960,193)	(1,557,054)	0	0	(3,517,247)
BUDGET SETTLEMENT REVISION	0	(817,406)	3,067,585	0	0	2,250,179
TOTAL ADMINISTRATIVE EXPENSE CHARGES	\$77,184,305	\$73,824,780	\$92,512,383	\$85,345,703	\$83,453,411	\$412,320,582
TOTAL CONTRACT CHARGES	\$1,231,522,321	\$1,338,947,824	\$1,420,944,362	\$1,552,080,633	\$1,678,954,127	\$7,222,449,267

* We reviewed claim payments from January 1, 2006 through October 31, 2008 (through September 30, 2009 for expanded claim reviews).

** Plan code 080 includes administrative expense charges for the DC Service Area and Overseas Claims; and Plan code 190 only includes the Maryland Service Area.

CAREFIRST BLUECROSS BLUESHIELD
 WASHINGTON, D.C. AND MARYLAND SERVICE AREAS AND OVERSEAS CLAIMS
 OWINGS MILLS, MARYLAND

QUESTIONED CHARGES

AUDIT FINDINGS	2004	2005	2006	2007	2008	2009	TOTAL
A. HEALTH BENEFIT CHARGES							
1. Claim Payments							
a. Amounts Paid Greater than Covered Charges	\$0	\$0	\$38,395	\$32,453	\$612,649	\$1,160	\$684,657
b. Inpatient Facility Payments - Duplicate or Overlapping Dates of Service	0	0	39,618	64,698	141,558	51,861	297,735
c. Omnibus Budget Reconciliation Act of 1990 Review	0	0	73,596	49,747	46,054	0	169,397
d. Assistant Surgeon Review	0	0	19,083	44,292	52,973	0	116,348
e. Debarred Provider Payments	0	0	8,706	3,647	2,999	212	15,564
f. System Review	0	0	0	0	(52)	0	(52)
Total Claim Payments	\$0	\$0	\$179,398	\$194,837	\$856,181	\$53,233	\$1,283,649
2. Miscellaneous Payments and Credits							
a. Provider Audit Vendor Fees*	\$0	\$0	\$0	\$15,249	\$0	\$0	\$15,249
b. Fraud Recovery Returned Untimely**	0	0	0	3,407	1,729	0	5,136
Total Miscellaneous Payments and Credits	\$0	\$0	\$0	\$18,656	\$1,729	\$0	\$20,385
TOTAL HEALTH BENEFIT CHARGES	\$0	\$0	\$179,398	\$213,493	\$857,910	\$53,233	\$1,304,034
B. ADMINISTRATIVE EXPENSES							
1. BluesNet Charges***	\$0	\$0	\$0	\$27,808	\$30,430	\$2,323	\$60,561
TOTAL ADMINISTRATIVE EXPENSES	\$0	\$0	\$0	\$27,808	\$30,430	\$2,323	\$60,561
C. CASH MANAGEMENT							
	\$0	\$0	\$0	\$0	\$0	\$0	\$0
D. LOST INVESTMENT INCOME ON AUDIT FINDINGS							
	\$0	\$0	\$0	\$0	\$753	\$801	\$1,554
TOTAL QUESTIONED CHARGES	\$0	\$0	\$179,398	\$241,301	\$889,093	\$56,357	\$1,366,149

* This audit finding is subject to lost investment income (LII).

** No additional LII is applicable for this audit finding.

*** This audit finding also includes LII of \$3,715.

CAREFIRST BLUECROSS BLUESHIELD
 WASHINGTON, D.C. AND MARYLAND SERVICE AREAS AND OVERSEAS CLAIMS
 OWINGS MILLS, MARYLAND

LOST INVESTMENT INCOME CALCULATION

	2004	2005	2006	2007	2008	2009	TOTAL
A. QUESTIONED CHARGES (Subject to Lost Investment Income)							
Provider Audit Vendor Fees	\$0	\$0	\$0	\$15,249	\$0	\$0	\$15,249
B. LOST INVESTMENT INCOME CALCULATION							
a. Prior Years Total Questioned (Principal)	\$0	\$0	\$0	\$0	\$15,249	\$0	
b. Cumulative Total	0	0	0	0	0	15,249	
c. Total	\$0	\$0	\$0	\$0	\$15,249	\$15,249	
d. Treasury Rate: January 1 - June 30	4.000%	4.250%	5.125%	5.250%	4.750%	5.625%	
e. Interest (d * c)	\$0	\$0	\$0	\$0	\$362	\$429	\$791
f. Treasury Rate: July 1 - December 31	4.500%	4.500%	5.750%	5.750%	5.125%	4.875%	
g. Interest (f * c)	\$0	\$0	\$0	\$0	\$391	\$372	\$763
Total Interest By Year (e + g)	\$0	\$0	\$0	\$0	\$753	\$801	\$1,554



**BlueCross BlueShield
Association**

An Association of Independent
Blue Cross and Blue Shield Plans

February 19, 2010

██████████ Group Chief
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**Reference: OPM DRAFT AUDIT REPORT
Carefirst Blue Cross Blue Shield
Audit Report Number 1A-10-85-09-023
(Dated December 3, 2009 and Received December 4, 2009)**

Dear ██████████

This is our response to the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report covering the Federal Employees' Health Benefits Program (FEHBP) concerning CareFirst BlueCross BlueShield. Our comments concerning the findings in the report are as follows:

General Plan Comment:

OPM questioned a total of \$1,585,661 as incorrect charges to the FEHBP. These charges relate to (1) health benefit payments covering 2006-09, and (2) miscellaneous payments and administrative charges covering 2004-08. These questioned charges equate to 0.0113% of the total claims payments/administrative charges during the audit period.

A. HEALTH BENEFIT CHARGES

1) Claim Payment Errors

a) **Amount Paid Greater than Covered Charges** **\$785,280**

DC Service Area

The Plan contests \$71,321 of the questioned amount but does not contest \$605,925. There were two claims that comprised the total questioned dollar amount. The Plan contests a portion of the questioned overpayment amount for the following reasons: (1) on the first claim, the OIG auditors questioned billed charges (\$583,780) instead of the Plan's DRG allowance (\$512,739) for this admission. This resulted in a variance of \$71,041. (2) The second incorrect dollar amount was cited as \$83,075 instead of the Plan's DRG allowance. This resulted in a variance of \$280. The total variance equals \$71,321 (\$71,041 + \$280).

The confirmed overpayment of \$605,925 has been adjusted and credited to the Program.

The overpayments were the results of Claims Examiner errors and were used as training tools in the recent re-fresher training session. In addition, the Plan has a quality review area that reviews claims and identifies payment errors. The identified payment errors are then discussed with the management in the Operations Areas. The objective is to determine whether individual examiners may need further training or if there is a pattern of inconsistency in the adjudication process for multiple Claim Examiners. The identified errors are used to determine the focus of the training for the group.

In addition, the FEP Director's Office sends the System-wide Claims Review Listing to the Plan which also includes an Amount Paid Greater Than Covered Charges Listing. The Plan in compliance with the "FEP Overpayment Recovery Action Plan," reviews the listing and returns the results of its review to the FEP Director's Office as required. Where appropriate, refunds are initiated. However, there appears to be a difference in the claim selection criteria used to select these claims for OPM and the criteria used to generate the System-wide Claims Listing. We will re-evaluate our selection criteria to determine if any changes are required to bring it more in line with the OPM claim selection criteria.

Maryland Service Area

The Plan does not contest \$25,841 from the original sample and \$10,342 from the expanded Medicare Claims Review. The Plan has initiated Refund recovery efforts where appropriate for the confirmed overpayments. As of February 1, 2010, the Plan has recovered and returned \$14,000 to the Program from the original sample and \$1,386 from the expanded claims review.

Overseas Claims

The Plan does not contest this finding. The Plan has initiated Refund recovery efforts where appropriate for the confirmed overpayments. The overpayments were the result of Claims Examiner error and were used as training tools in the recent re-fresher training session. In addition, the Plan has a quality review area that reviews claims and identifies payment errors. The identified payment errors are then discussed with the management in the Operations Areas. The objective is to determine whether individual examiners may need further training or if there is a pattern of inconsistency in the adjudication process for multiple Claims Examiners. The identified errors are used to determine the focus of the training for the group.

In addition, the FEP Director's Office sends the System-wide Claims Review Listing to the Plan which also includes an Amount Paid Greater Than Covered Charges Listing. The Plan reviews and returns the results of its review to the FEP Director's Office as required. Where appropriate, refunds are initiated. However, there appears to be a difference in the claim selection criteria used to select these claims for OPM and the selection criteria used to generate the FEP Director's Office System-wide Claims Review Listing. We will re-evaluate our selection criteria to determine if any changes are required to bring it more in line with the OPM claim selection criteria.

Accordingly, to the extent that errors did occur, the payments are good faith erroneous benefits payments and fall within the context of CS 1039, Section 2.3(g). Any benefit payments the Plan is unable to recover are allowable charges to the Program. In addition, as good faith payments, the Plan continues to initiate recovery in a timely manner for confirmed overpayments. Because these are good faith erroneous payments, they are not subject to lost investment income.

1a All Service Areas – Expanded Review of 2006 Non-Par Provider

Maryland Service Area

The Plan contests \$31,314 of the questioned amount as one claim was for an inpatient admission that was coded incorrectly (\$31,314). The necessary documentation to support the Plan's position was provided to the OPM auditors with the overlapping Spreadsheet on February 9, 2010.

The Plan does not contest \$3,090. The Plan has initiated and recovered the confirmed overpayment. As of February 1, 2010, the funds have been returned to the Program

Overseas Claims

The Plan does not contest this finding. The Plan has initiated refund recovery efforts where appropriate for the confirmed overpayment. As of February 1, 2010, the Plan has recovered and returned \$2,772 to the Program.

DC Service Area

The Plan contests one claim totaling \$2,492 because this is a claim for service in the Maryland designated service area. It was also included in the Maryland listing. However, the Plan does not contest that 12 claims totaling \$2,772 for the DC service area were overpaid. The Plan has initiated recovery efforts for the overpayments. As of February 1, 2010, \$1,615 has been recovered and returned to the Program.

whether the Provider is the same or not. We expect this system enhancement to be implemented later in 2010.

In addition, the Plan has included the claims that were incorrectly coded as part of the training program for the Claims Examiners. Lastly, the Plan will provide additional training to all Claims Examiners by the second quarter of 2010 with an emphasis on the importance of coding claims correctly. The FEP Director's Office will also add these claim types to its System-wide claims listings that are sent to all Plans.

Accordingly, to the extent that errors did occur, the payments are good faith erroneous benefits payments and fall within the context of CS 1039, Section 2.3(g). Any benefit payments the Plan is unable to recover are allowable charges to the Program. In addition, as good faith payments, the Plan continues to initiate recovery in a timely manner for confirmed overpayments. Because these are good faith erroneous payments, they are not subject to lost investment income.

c) Omnibus Budget Reconciliation Act of 1990 Review \$169,397

DC Service Area

The Plan does not contest this finding and refund recovery efforts have been initiated where appropriate for confirmed overpayments. As of February 1, 2010, the Plan had recovered and returned \$86,617 to the Program.

When the claims were originally submitted to the Operations Center, there were coding discrepancies. These payment differences occurred because the examiners did not submit the correct information when the claims were initially manually processed. The claims were paid in error because Claims Examiners entered incorrect fields for Medicare Part B payment information; incorrectly coded split admission between two claims and adjusted an original OBRA '90 priced claim incorrectly. To reduce these types of pricing errors in the future, the Plan has implemented and updated its Policy & Procedure for OBRA '90 claim processing. Request for refunds have been initiated to recover payment errors and any amounts recovered will be returned to the Program. Also, the FEP Director's Office includes potential OBRA '90 priced claims in its periodic System-wide Claims Review to facilitate early identification and recovery of OBRA '90 claim payment errors. Completion of these periodic reports assists in the timely identification and recovery of OBRA '90 claim payment errors. Accordingly, to the extent that errors did occur, the payments are good faith erroneous benefits payments and fall within the context of CS 1039, Section 2.3(g). Any benefit payments the Plan is unable to recover are allowable charges to the Program. In addition, as good faith payments, the

Plan continues to initiate recovery in a timely manner for confirmed overpayments. Because these are good faith erroneous payments, they are not subject to lost investment income.

d) Assistant Surgeon Review \$116,926

DC Service Area

The Plan does not contest this finding. Refund recovery efforts have been initiated where appropriate for the confirmed overpayments. As of February 1, 2010, the Plan had recovered and returned \$46,081 to the Program.

Maryland Service Area

The Plan contests \$578 based on the fact that a different claim was adjusted. The spreadsheet to support the Plan's position is included as Attachment I. However, the Plan does not contest \$59,385. Refund recovery efforts have been initiated where appropriate for the confirmed overpayments. As of February 1, 2010, the Plan had recovered and returned \$49,369 to the Program.

The overpayments related to the non-OBRA '93 Assistant Surgeon claims were the result of a local Plan system issue for both the Maryland and DC Plans. This system issue was identified by the Plan before the audit began and corrected in the second quarter of 2009. The payments related to OBRA '93 priced Assistant Surgeon claims were sent to the Plan as a part of the FEP Director's Office System-wide Claims Review Listing. Refund recovery efforts have been initiated where appropriate for the confirmed overpayments.

e) Debarred Provider Payments \$15,564

DC Service Area

The Plan does not contest this finding. The Plan has updated the Provider Files with the debarred status of the two providers for which the incorrect payments were made.

Upon investigation, it was determined that the two debarred providers were not updated on the Debarred Provider Listing generated by the Operations Center. As a result, no member notification was issued; therefore, the refund recovery effort cannot be initiated for the affected claims since the members did not receive the required notification. The Plan is currently validating the control changes necessary to prevent the updating of these providers on the FEP Claims System with a target completion date of first quarter 2010.

Maryland Service Area

The Plan does not contest this finding. The Provider in question for this finding was omitted in error from the Debarred Provider Listing generated by the FEP Operations Center. The Plan updated its provider file as of October 2009 with the debarred status for the Provider in question. However, no member notification was issued; therefore, the refund recovery effort cannot be initiated for the affected claims since the members did not receive the required notification that the Provider was debarred as required by OPM.

FEP has implemented additional controls at the Operations Center for the generation of the Debarred Provider Listings to Plans. Under the enhanced controls, when the listing is received from CMS and updated on the FEP System, it cannot be sent to Plans until the Plan's internal audit department has validated that all providers have been included on the listings. This control is being implemented during the first quarter 2010.

Accordingly, to the extent that errors did occur, the payments are good faith erroneous benefits payments and fall within the context of CS 1039, Section 2.3(g). Any benefit payments the Plan is unable to recover are allowable charges to the Program. In addition, as good faith payments, the Plan continues to initiate recovery in a timely manner for confirmed overpayments. Because these are good faith erroneous payments, they are not subject to lost investment income.

f) System Review

(\$52)

The Plan does not contest this finding which is a net of an Overseas claim and a DC Plan claim.

Overseas Claims

The Plan has initiated recovery efforts for the confirmed overpayments. As of February 1, 2010, the Plan had recovered and returned \$1,748 of the \$1,948 questioned amount to the Program

DC Service Area

The Plan does not contest the \$2,000 undercharge for this finding. This claim has been adjusted appropriately to pay the correct amount. The errors were the result of the Claims Examiners incorrectly coding the claims. The Plan has provided additional training to Claims Examiners in an effort to reduce future errors.

Accordingly, to the extent that errors did occur, for findings 1a - 1f, the payments are good faith erroneous benefit payments and fall within the context of CS 1039, Section 2.3(g). Any benefit payments the Plan is unable to recover are allowable charges to the Program. In addition, as good faith payments, the Plan continues to initiate recovery in a timely manner for confirmed overpayments. Because these are good faith erroneous payments, they are not subject to lost investment income.

Accordingly, to the extent that errors did occur, the payments are good faith erroneous benefits payments and fall within the context of CS 1039, Section 2.3(g). Any benefit payments the Plan is unable to recover are allowable charges to the Program. In addition, as good faith payments, the Plan continues to initiate recovery in a timely manner for confirmed overpayments. Because these are good faith erroneous payments, they are not subject to lost investment income.

2) Miscellaneous Payments and Credits

a) Provider Audit Vendor Fees \$15,249

The Plan does not contest this finding. The Plan has recovered the vendor overpayment. A Special Plan Invoice (SPI) was submitted on February 19, 2010. The funds were wired to the BCBSA Joint Operating Account on February 18, 2010.

b) Fraud Recovery Returned Untimely \$5,136

The Plan does not contest this finding. The Plan submitted a Special Plan Invoice (SPI) to BCBSA for the Lost Investment Income (LII) due the FEHBP. The funds were transferred to the Plan's FEP investment account on June 25, 2009 and adjusted against the LOCA on July 7, 2009. The documentation that supports the transfer of the funds is included as Attachment II.

B. ADMINISTRATIVE EXPENSES

1) BluesNet Charges \$56,846

The Plan does not contest this finding. The Plan submitted the necessary Prior Period Adjustments (PPA's) and SPI's for the LII due the FEHBP to BCBSA on September 29, 2009. The funds were wired to the BCBSA Joint Operating account on September 29, 2009. The supporting documentation relating to this finding is included as Attachment III.

[REDACTED] Group Chief

February 19, 2010
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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.

[REDACTED]
Executive Director
Program Integrity

Attachments

[REDACTED]