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

Final Audit Report

Subject:

AUDIT ON GLOBAL COORDINATION OF BENEFITS FOR BLUECROSS AND BLUESHIELD PLANS CONTRACT YEAR 2008

Report No. 1A-99-00-10-009

Date: March 31, 2010

--CAUTION--

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

Global Coordination of Benefits
BlueCross and BlueShield Plans

REPORT NO. 1A-99-00-10-009 DATE: March 31, 2010

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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 all BlueCross and BlueShield (BCBS) plans questions $7,417,178 in health benefit charges. The BlueCross BlueShield Association (Association) and/or BCBS plans agreed with $4,296,158 and disagreed with $3,121,020 of the questioned charges.

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covered health benefit payments for contract year 2008 as reported in the Annual Accounting Statement. Specifically, we reviewed claims incurred from October 1, 2007 through December 31, 2008 that were reimbursed in 2008 and potentially not coordinated with Medicare. We determined that the BCBS plans did not properly coordinate 14,773 claim line payments with Medicare as required by the FEHBP contract. As a result, the FEHBP was overcharged $7,417,178. When we notified the Association of these errors on October 1, 2009, the claims were within the Medicare timely filing requirement and could be filed with Medicare for coordination of benefits.

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I. INTRODUCTION AND BACKGROUND

INTRODUCTION

This final audit report details the findings, conclusions, and recommendations resulting from our limited scope audit of the Federal Employees Health Benefits Program (FEHBP) operations at all BlueCross and BlueShield (BCBS) plans.

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 BCBS plans, has entered into a Government-wide Service Benefit Plan contract (CS 1039) with OPM to provide a health benefit plan authorized by the FEHB Act. The Association delegates authority to participating local BCBS plans throughout the United States to process the health benefit claims of its federal subscribers. There are approximately 63 local BCBS plans participating in the FEHBP.

The Association has established a Federal Employee Program (FEP[1]) Director's Office in Washington, D.C. to provide centralized management for the Service Benefit Plan. The FEP Director's Office coordinates the administration of the contract with the Association, member BlueCross and BlueShield plans, and OPM.

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

Compliance with laws and regulations applicable to the FEHBP is the responsibility of the management for the Association and each BCBS plan. Also, management of each BCBS plan is responsible for establishing and maintaining a system of internal controls.

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

Findings from our previous global coordination of benefits audit of all BCBS plans (Report No. 1A-99-00-09-011, dated July 20, 2009) for contract year 2007 are in the process of being resolved.

Our preliminary results of the potential coordination of benefit errors were presented in detail in a draft report, dated October 1, 2009. The Association's comments offered in response to the draft report were considered in preparing our final report and are included as the Appendix to this report. Also, additional documentation provided by the Association and BCBS plans was considered in preparing our final report.

II. OBJECTIVE, SCOPE, AND METHODOLOGY

OBJECTIVE

The objective of this audit was to determine whether the BCBS plans complied with contract provisions relative to coordination of benefits with Medicare.

SCOPE

We conducted our limited scope performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient and appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

The audit covered health benefit payments for contract year 2008 as reported in the BlueCross and BlueShield FEHBP Annual Accounting Statement. Specifically, we reviewed claims incurred from October 1, 2007 through December 31, 2008 that were reimbursed in 2008 and potentially not coordinated with Medicare. Based on our claim error reports, we identified 565,331 claim lines, totaling $66,114,553 in payments, that potentially were not coordinated with Medicare. From this universe, we selected and reviewed 36,421 claim lines, totaling $24,000,153 in payments, for coordination of benefits with Medicare. When we notified the Association of these potential errors on October 1, 2009, the claims were within the Medicare timely filing requirement and could be filed with Medicare for coordination of benefits.

We did not consider each BCBS plan's internal control structure in planning and conducting our auditing procedures. Our audit approach consisted mainly of substantive tests of transactions and not tests of controls. Therefore, we do not express an opinion on each BCBS plan's system of internal controls taken as a whole.

We also conducted tests to determine whether the BCBS plans had complied with the contract and the laws and regulations governing the FEHBP as they relate to coordination of benefits. The results of our tests indicate that, with respect to the items tested, the BCBS plans did not fully comply with the provisions of the contract relative to coordination of benefits with Medicare. Exceptions noted in the areas reviewed are set forth in detail in the "Audit Finding and Recommendations" section of this report. With respect to the items not tested, nothing came to our attention that caused us to believe that the BCBS plans had not complied, in all material respects, with those provisions.

In conducting our audit, we relied to varying degrees on computer-generated data provided by the FEP Director's Office, the FEP Operations Center, and the BCBS plans. 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 objective.

The audit was performed at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida from October 1, 2009 through March 5, 2010.

METHODOLOGY

To test each BCBS plan's compliance with the FEHBP health benefit provisions related to coordination of benefits with Medicare, we selected a judgmental sample of potential uncoordinated claim lines that were identified in a computer search. Specifically, we selected for review 36,421 claim lines, totaling $24,000,153 in payments, from a universe of 565,331 claim lines, totaling $66,114,553 in payments, that potentially were not coordinated with Medicare (See Schedule A for our sample selection methodology).

The claim samples were submitted to each applicable BCBS plan for their review and response. For each plan, we then conducted a limited review of their agreed responses and an expanded review of their disagreed responses to determine the appropriate questioned amount. We did not project the sample results to the universe of potential uncoordinated claim lines.

The determination of the questioned amount is based on the FEHBP contract, the Service Benefit Plan brochure, the Association's FEP administrative manual, and various manuals and other documents available from the Center for Medicare and Medicaid Services that explain Medicare benefits.

III. AUDIT FINDING AND RECOMMENDATIONS

Coordination of Benefits with Medicare **$7,417,178**

The BCBS plans did not properly coordinate 14,773 claim line payments, totaling $8,726,668, with Medicare as required by the FEHBP contract. As a result, the FEHBP paid as the primary insurer for these claims when Medicare was the primary insurer. Therefore, we estimate that the FEHBP was overcharged by $7,417,178 for these claim lines.

The 2008 BlueCross and BlueShield Service Benefit Plan brochure, page 113, Primary Payer Chart, illustrates when Medicare is the primary payer. In addition, page 23 of that brochure states, "We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), regardless of whether Medicare pays."

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 . . . ." Also, 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 . . . [and] on request, document and make available accounting support for the cost to justify that the cost is actual, reasonable and necessary; and (ii) determine the cost in accordance with: (A) the terms of this contract . . . ."

In addition, Contract CS 1039, 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 . . . ."

For claims incurred from October 1, 2007 through December 31, 2008 and reimbursed in 2008, we performed a computer search and identified 565,331 claim lines, totaling $66,114,553 in payments, that potentially were not coordinated with Medicare. From this universe, we selected for review a sample of 36,421 claim lines, totaling $24,000,153 in payments, to determine whether the BCBS plans complied with the contract provisions relative to coordination of benefits (COB) with Medicare. When we submitted our sample of potential COB errors to the Association on October 1, 2009, the claims were within the Medicare timely filing requirement and could be filed with Medicare for coordination of benefits.

Generally, Medicare Part A covers 100 percent of inpatient care in hospitals, skilled nursing facilities and hospice care. For each Medicare Benefit Period, there is a one-time deductible, followed by a daily copayment beginning with the 61st day. Beginning with the 91st day of the Medicare Benefit Period, Medicare Part A benefits may be exhausted, depending on whether the patient elects to use their Lifetime Reserve Days. For the uncoordinated Medicare Part A claims, we estimate that the FEHBP was overcharged for the total claim payment amounts. When applicable, we reduced the questioned amount by the Medicare deductible and/or Medicare copayment.

Medicare Part B pays 80 percent of most outpatient charges and professional claims after the calendar year deductible has been met. Also, Medicare Part B covers a portion of inpatient facility charges for ancillary services such as medical supplies, diagnostic tests, and clinical laboratory services. Based on our experience, ancillary items account for approximately 30 percent of the total inpatient claim payment. Therefore, we estimate that the FEHBP was overcharged 25 percent for these inpatient claim lines (0.30 x 0.80 = 0.24 ~ 25 percent).

We separated the uncoordinated claims into the following six categories based on the clinical setting and whether Medicare Part A or B should have been the primary payer.

- Categories A and B consist of inpatient claims that should have been coordinated with Medicare Part A. In a small number of instances where the BCBS plans indicated that Medicare Part A benefits were exhausted, we reviewed the claims to determine whether there were any inpatient services that were payable by Medicare Part B. For these claim lines, we only questioned the services covered by Medicare Part B.

- Categories C and D include inpatient claims with ancillary items that should have been coordinated with Medicare Part B. When we could not reasonably determine the actual overcharge for a claim line, we questioned 25 percent of the amount paid for these inpatient claim lines. In a small number of instances where the BCBS plans indicated that members had Medicare Part B only and priced the claims according to the Omnibus Budget Reconciliation Act of 1990 pricing guidelines, we reviewed the claims to determine whether there were any inpatient services that were payable by Medicare Part B.

- Categories E and F include outpatient and professional claims where Medicare Part B should have been the primary payer. When we could not reasonably determine the actual overcharge for a claim line, we questioned 80 percent of the amount paid for these claim lines.

From these six categories, we selected for review a sample of claim lines that potentially were not coordinated with Medicare (See Schedule A for our sample selection methodology). Based on our review, we identified 14,773 claim lines, totaling $8,726,668 in payments, where the FEHBP paid as the primary insurer when Medicare was the primary insurer. We estimate that the FEHBP was overcharged $7,417,178 for these claim line payments.[2]

[2] In addition, there were 7,128 claim lines, totaling $3,980,789 in payments, with COB errors that were identified by the BCBS plans before the start of our audit (i.e., October 1, 2009) and adjusted on or before the plans' response due date (i.e., December 31, 2009) to our audit information request. Since these COB errors were identified by the BCBS plans before the start of our audit and adjusted by the plans' response due date to our audit request, we did not question these COB errors in the final report.

The following table details the six categories of questioned uncoordinated claim lines:

Category	Claim Lines	Amount Paid	Amount Questioned
Category A: Medicare Part A Primary for Inpatient (I/P) Facility	234	$4,296,846	$4,296,846
Category B: Medicare Part A Primary for Skilled Nursing/Home Health Care (HHC)/ Hospice Care	4,937	$901,072	$901,072
Category C: Medicare Part B Primary for Certain I/P Facility Charges	102	$858,328	$217,875
Category D: Medicare Part B Primary for Skilled Nursing/HHC/Hospice Care	65	$280,882	$77,717
Category E: Medicare Part B Primary for Outpatient (O/P) Facility and Professional	7,688	$1,548,594	$1,246,056
Category F: Medicare Part B Primary for O/P Facility and Professional (Participation Code F)	1,747	$840,946	$677,612
Total	14,773	$8,726,668	$7,417,178

Our audit disclosed the following for the COB errors:

- For 11,205 (76 percent) of the claim lines questioned, there was no special information on the FEP national claims system to identify Medicare as the primary payer when the claims were paid. However, when the Medicare information was subsequently added to the FEP national claims system, the BCBS plans did not review and/or adjust the patient's prior claims back to the Medicare effective dates.

- For 3,568 (24 percent) of the claim lines questioned, there was special information present on the FEP national claims system to identify Medicare as the primary payer when the claims were paid. An incorrect Medicare Payment Disposition Code was used for 90 percent of these claims. The Medicare Payment Disposition Code identifies Medicare's responsibility for payment on each charge line of a claim. Per the FEP Administrative Manual, the completion of this field is required on all claims for patients who are age 65 or older. We found that codes E, F, and N were incorrectly used. An incorrect entry in this field causes the claim line to be excluded from coordination of benefits with Medicare.

Of the $7,417,178 in questioned charges, $3,121,020 (42 percent) were identified by the BCBS plans before the start of our audit (i.e., October 1, 2009). However, since the BCBS plans had not completed the recovery process and/or adjusted these claims by the plans' response due date (i.e., December 31, 2009) to the audit information request, we are continuing to question these COB errors. The remaining questioned charges of $4,296,158 (58 percent) were identified as a result of our audit.

Association's Response:

In response to the draft audit report, the Association states, "After reviewing the OIG Draft Audit Report and listing of potentially uncoordinated Medicare COB claims . . . there was a total of $4,610,894 . . . of the questioned amount that was not coordinated with Medicare. Of this amount, $2,520,614 in claim payments were made correctly when the claim was initially paid; however, the claim was not adjusted upon subsequent processing of Medicare coverage information. To date Plans have received $1,238,256 in claim payment errors. Recovery has been initiated on the remaining overpayments and the Plans will continue to pursue these overpayments . . .

To the extent that claim payment errors did occur or were not identified, these payments were good faith erroneous benefit payments and fall within the context of CS 1039, Section 2.3 (g). Any benefit payments the Plans are unable to recover are allowable charges to the Program. In addition, as good faith erroneous payments, lost investment income does not apply to the payments identified in the finding.

Our analysis of payment errors indicated the following:

- Claims were processed incorrectly because the claims examiner failed to use the Medicare Summary Notice (MSN) submitted by the provider to process the claim correctly. This resulted in claims being paid as 'not covered by Medicare' when the MSN indicated that Medicare had made payments on the claims.

- Claims were processed incorrectly because the claims examiner processed a claim submitted by the provider that did not include the MSN which documents whether Medicare denied the services. This also resulted in claims being paid as 'not covered by Medicare' or 'provider not covered by Medicare' when the MSN indicated that Medicare had made payments on the claims.

- Claims that were provided to the Plans on either the retroactive enrollment reports, the FEP Director's Office on-line Uncoordinated Medicare application or the FEP Operations Center generated Ad-Hoc review reports were not worked before the start of the audit.

- The FEP Operations Center Ad-Hoc reports used to identify various uncoordinated Medicare claims . . . did not identify all of the appropriate claims for Plans to review and adjust.

In order to continue to improve the FEP Program's Medicare COB processing, FEP will continue with our current COB Action Plan, with modification as necessary . . . ."

Regarding the contested amount, the Association states that "the claims were paid correctly as discussed below:

- Claims totaling $2,805,889 are contested because recovery had been initiated in accordance with CS 1039, 2.3 (g) but not completed or were uncollectible at the time the Draft Audit Report response was provided. The majority of these claims were also paid correctly based upon the Medicare information that was on file at the time of initial payment. . . .

Documentation to support the contested amounts and the initiation of overpayment recovery before the audit has been provided."

OIG Comments:

After reviewing the Association's response and additional documentation provided by the BCBS plans, we revised the questioned charges from our draft report to $7,417,178. Based on the Association's response and the BCBS plans' additional documentation, we determined that the Association and/or plans agree with $4,296,158 and disagree with $3,121,020.

Although the Association agrees with $4,610,894 in its response, the BCBS plans' documentation only supports concurrence with $4,296,158. For these uncontested COB errors, we disagree with the Association's comments that the payments were good faith erroneous benefit payments. When the Medicare information was subsequently added to the claims system, the BCBS plans did not review and/or adjust the patients' prior claims back to the Medicare effective dates. Since the BCBS plans did not take the proper action to immediately correct the overpayments, we do not believe the BCBS plans acted in good faith to recover these overpayments.

Based on the Association's response and/or the BCBS plans' documentation, $3,121,020 of the contested amount represents COB errors where recovery efforts were initiated by the plans before the audit started. However, the BCBS plans had not recovered these overpayments and adjusted the claims by the plans' response due date to our audit information request. Since these overpayments had not been recovered and returned to the FEHBP by the plans' response due date, we are continuing to question this amount in the final report.

Recommendation 1

We recommend that the contracting officer disallow $7,417,178 for uncoordinated claim payments and verify that the BCBS plans return all amounts recovered to the FEHBP.

Recommendation 2

Although the Association has developed a corrective action plan to reduce COB findings, we recommend that the contracting officer instruct the Association to ensure that all BCBS plans are following the corrective action plan.

Recommendation 3

We recommend that the contracting officer require the Association to ensure that the BCBS plans have procedures in place to review all claims incurred back to the Medicare effective dates when updated, other party liability information is added to the FEP national claims system. When Medicare eligibility is subsequently reported, the plans are expected to immediately determine if already paid claims are affected and, if so, to initiate the recovery process within 30 days.

Recommendation 4

We recommend that the contracting officer require the Association to revise and correct the procedures regarding the input of Medicare Payment Disposition Codes. We also recommend that the software used for handling claims received electronically be reviewed to verify that it creates the appropriate value for Medicare Payment Disposition Codes. These corrective actions should ensure that the FEP system will utilize the special information when it is present to properly coordinate these claims.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

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SCHEDULE A

V. SCHEDULES

Coordination of Benefits with Medicare
BlueCross and BlueShield Plans
Claims Reimbursed in 2008

UNIVERSE AND SAMPLE OF POTENTIALLY UNCOORDINATED CLAIM LINES

	UNIVERSE				SAMPLE						
CATEGORY	Number of Claims	Number of Claim Lines	Number of Patients	COB Universe Total Payments	Sample Selection Methodology	Number of Claims	Number of Claim Lines	Number of Patients	Amounts Paid	Estimated Overcharge Percentage	Potential Overcharge
Category A: Medicare Part A Primary for I/P Facility	725	726	562	$11,220,055	all patients	725	726	562	$11,220,055	100%	$11,220,055
Category B: Medicare Part A Primary for Skilled Nursing/HHC/Hospice Care	4,523	14,525	1,473	$2,835,753	patients with cumulative claims of $1,000 or more	2,578	9,924	482	$2,467,972	100%	$2,467,972
Category C: Medicare Part B Primary for Certain I/P Facility Charges	179	180	152	$1,844,266	patients with cumulative claims of $2,500 or more	170	171	143	$1,825,968	25%	$456,492
Category D: Medicare Part B Primary for Skilled Nursing/HHC/Hospice Care	268	413	170	$854,099	patients with cumulative claims of $2,500 or more	167	186	110	$777,718	25%	$194,430
Category E: Medicare Part B Primary for Outpatient Facility and Professional	13,966	25,598	3,767	$4,288,791	patients with cumulative claims of $1,000 or more	7,375	16,016	787	$3,513,361	80%	$2,810,689
Category F: Medicare Part B Primary for Outpatient Facility and Professional (Participation Code F)	402,918	523,889	218,624	$45,071,589	patients with cumulative claims of $5,000 or more	4,704	9,398	415	$4,195,080	80%	$3,356,064
Totals	**422,579**	**565,331**		**$66,114,553**		**15,719**	**36,421**		**$24,000,153**		**$20,505,701**

Coordination of Benefits with Medicare
BlueCross and BlueShield Plans
Claims Reimbursed in 2008

SUMMARY OF QUESTIONED CHARGES

			COB Category A		COB Category B		COB Category C		COB Category D		COB Category E		COB Category F		ALL COB Categories	
Plan Site #	Plan State	Plan Name	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned
003	NM	BCBS of New Mexico	4	$24,458	1	$77	0	$0	0	$0	75	$7,810	4	$2,054	84	$34,399
005	GA	WellPoint BCBS of Georgia	4	$47,972	118	$11,771	1	$768	0	$0	198	$67,451	3	$122	324	$128,084
006	MD	CareFirst BCBS	3	$47,494	113	$44,418	2	$2,828	0	$0	88	$16,301	19	$9,499	225	$120,540
007	LA	BCBS of Louisiana	5	$51,976	105	$8,590	0	$0	0	$0	182	$17,208	115	$56,516	407	$134,290
009	AL	BCBS of Alabama	5	$50,195	1	$5,490	8	$12,489	0	$0	165	$104,977	330	$56,576	509	$229,727
010	ID	BC of Idaho Health Service	1	$2,262	19	$2,901	0	$0	1	$978	0	$0	0	$0	21	$6,141
011	MA	BCBS of Massachusetts	1	$19,059	42	$3,741	1	$914	0	$0	0	$0	1	$964	45	$24,678
012	NY	BCBS of Western New York	0	$0	0	$0	0	$0	0	$0	12	$1,649	0	$0	12	$1,649
013	PA	Highmark BCBS	0	$0	0	$0	0	$0	0	$0	175	$46,634	0	$0	175	$46,634
015	TN	BCBS of Tennessee	0	$0	202	$33,547	0	$0	4	$7,102	175	$32,987	30	$2,759	411	$76,395
016	WY	BCBS of Wyoming	1	$86,450	0	$0	0	$0	0	$0	0	$0	0	$0	1	$86,450
017	IL	BCBS of Illinois	18	$462,561	146	$14,754	2	$4,673	0	$0	251	$29,286	164	$28,491	581	$539,765
021	OH	Ohio WellPoint BCBS	11	$442,481	115	$48,539	7	$11,864	13	$17,356	13	$7,517	36	$8,775	195	$536,532
024	SC	BCBS of South Carolina	0	$0	254	$39,064	0	$0	0	$0	33	$4,735	0	$0	287	$43,799
027	NH	New Hampshire WellPoint BCBS	0	$0	5	$10,154	0	$0	1	$1,050	0	$0	0	$0	6	$11,204
028	VT	BCBS of Vermont	0	$0	0	$0	0	$0	0	$0	1	$173	5	$3,154	6	$3,327
029	TX	BCBS of Texas	9	$94,672	308	$35,599	10	$18,425	0	$0	725	$111,531	83	$47,523	1,135	$307,750
030	CO	Colorado WellPoint BCBS	8	$364,721	208	$19,672	2	$8,947	1	$1,668	174	$65,125	6	$12,188	399	$472,321
031	IA	Wellmark BCBS of Iowa	6	$85,354	0	$0	0	$0	0	$0	2	$2,686	0	$0	8	$88,040
032	MI	BCBS of Michigan	3	$1,758	12	$1,918	3	$1,986	0	$0	2	$1,189	11	$5,865	31	$12,716
033	NC	BCBS of North Carolina	17	$226,657	583	$61,072	9	$19,514	0	$0	592	$76,021	0	$0	1,201	$383,264
034	ND	BCBS of North Dakota	0	$0	1	$4,654	0	$0	0	$0	0	$0	0	$0	1	$4,654
036	PA	Capital BC	2	$8,292	0	$0	1	$967	1	$1,197	12	$631	0	$0	16	$11,087
037	MT	BCBS of Montana	1	$5,912	7	$1,159	0	$0	0	$0	0	$0	1	$81	9	$7,152
038	HI	BCBS of Hawaii	0	$0	0	$0	0	$0	0	$0	3	$243	0	$0	3	$243
039	IN	Indiana WellPoint BCBS	1	$13,424	14	$2,131	7	$8,659	4	$5,117	135	$57,241	9	$7,506	170	$94,078
040	MS	BCBS of Mississippi	2	$21,410	73	$68,759	0	$0	0	$0	478	$30,336	11	$357	564	$120,862

Coordination of Benefits with Medicare
BlueCross and BlueShield Plans
Claims Reimbursed in 2008

SUMMARY OF QUESTIONED CHARGES

			COB Category A		COB Category B		COB Category C		COB Category D		COB Category E		COB Category F		ALL COB Categories	
Plan Site #	Plan State	Plan Name	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned
041	FL	BCBS of Florida	52	$503,283	685	$125,124	5	$7,671	2	$1,555	897	$104,025	397	$231,635	2,038	$973,293
042	MO	BCBS of Kansas City	1	$935	4	$11,899	1	$2,432	1	$655	0	$0	34	$16,186	41	$32,107
044	AR	Arkansas BCBS	0	$0	0	$0	0	$0	0	$0	82	$8,422	0	$0	82	$8,422
045	KY	Kentucky WellPoint BCBS	2	$12,621	63	$4,544	2	$2,569	4	$4,975	25	$3,096	0	$0	96	$27,805
047	WI	WellPoint BCBS United of Wisconsin	0	$0	0	$0	0	$0	7	$2,274	70	$11,400	35	$21,386	112	$35,060
048	NY	Empire BCBS	11	$71,328	73	$8,287	0	$0	0	$0	920	$84,786	0	$0	1,004	$164,401
049	NJ	Horizon BCBS of New Jersey	1	$52,395	249	$33,146	8	$7,971	0	$0	296	$47,909	0	$0	554	$141,421
050	CT	Connecticut WellPoint BCBS	1	$937	6	$519	1	$1,883	1	$1,050	0	$0	5	$268	14	$4,657
052	CA	WellPoint BC of California	17	$889,649	167	$23,678	9	$38,428	2	$3,294	272	$61,013	16	$32,404	483	$1,048,466
053	NE	BCBS of Nebraska	1	$66,394	0	$0	0	$0	0	$0	18	$5,263	0	$0	19	$71,657
054	WV	Mountain State BCBS	0	$0	137	$17,399	0	$0	1	$439	0	$0	0	$0	138	$17,838
055	PA	Independence BC	5	$61,195	85	$9,313	5	$35,794	5	$6,103	0	$0	0	$0	100	$112,404
056	AZ	BCBS of Arizona	2	$27,637	18	$2,607	0	$0	0	$0	77	$15,240	60	$28,506	157	$73,990
058	OR	Regence BCBS of Oregon	3	$35,642	149	$26,190	0	$0	4	$4,895	22	$1,674	0	$0	178	$68,401
059	ME	Maine WellPoint BCBS	0	$0	27	$3,570	0	$0	2	$6,405	6	$1,674	24	$13,503	59	$25,152
060	RI	BCBS of Rhode Island	0	$0	48	$11,067	0	$0	0	$0	0	$0	0	$0	48	$11,067
061	NV	Nevada WellPoint BCBS	3	$103,276	3	$2,835	0	$0	2	$2,250	39	$4,828	0	$0	47	$113,189
062	VA	Virginia WellPoint BCBS	0	$0	48	$29,448	0	$0	4	$3,120	34	$23,583	234	$32,918	320	$89,069
066	UT	Regence BCBS of Utah	2	$28,096	147	$14,146	2	$1,535	2	$478	11	$794	0	$0	164	$45,049
067	CA	BS of California	0	$0	0	$0	0	$0	0	$0	789	$60,271	6	$641	795	$60,912
069	WA	Regence BS of Washington	0	$0	0	$0	0	$0	0	$0	16	$1,751	0	$0	16	$1,751
070	AK	BCBS of Alaska	1	$54,743	0	$0	0	$0	0	$0	14	$5,042	34	$18,646	49	$78,431
075	WA	Premera BC	9	$143,944	3	$5,920	0	$0	0	$0	25	$4,701	35	$16,355	72	$170,920
076	MO	WellPoint BCBS of Missouri	4	$46,802	21	$38,365	14	$25,070	0	$0	197	$38,495	0	$0	236	$148,732
078	MN	BCBS of Minnesota	5	$40,534	0	$0	0	$0	0	$0	77	$31,370	18	$2,983	100	$74,887
079	NY	BCBS of Central NY	4	$32,718	0	$0	0	$0	0	$0	45	$3,240	0	$0	49	$35,958
082	KS	BCBS of Kansas	1	$6,541	30	$3,298	0	$0	0	$0	2	$318	0	$0	33	$10,157
083	OK	BCBS of Oklahoma	2	$25,134	15	$1,632	0	$0	0	$0	108	$21,323	3	$4,762	128	$52,851

Coordination of Benefits with Medicare
BlueCross and BlueShield Plans
Claims Reimbursed in 2008

SUMMARY OF QUESTIONED CHARGES

			COB Category A		COB Category B		COB Category C		COB Category D		COB Category E		COB Category F		ALL COB Categories	
Plan Site #	Plan State	Plan Name	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned
084	NY	BCBS of Utica-Watertown	0	$0	7	$679	0	$0	0	$0	44	$3,053	0	$0	51	$3,732
085	DC	CareFirst BCBS	5	$35,934	595	$104,882	1	$1,222	3	$5,756	59	$9,173	17	$14,956	680	$171,923
088	PA	BC of Northeastern Pennsylvania	0	$0	0	$0	1	$1,266	0	$0	0	$0	0	$0	1	$1,266
089	DE	BCBS of Delaware	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
092	DC	CareFirst BCBS (Overseas)	0	$0	30	$4,515	0	$0	0	$0	52	$11,881	1	$33	83	$16,429
		Totals	**234**	**$4,296,846**	**4,937**	**$901,072**	**102**	**$217,875**	**65**	**$77,717**	**7,688**	**$1,246,056**	**1,747**	**$677,612**	**14,773**	**$7,417,178**

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

Federal Employee Program
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January 22, 2010

[redacted] Group Chief
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Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, Room 6400
Washington, DC 20415-1100

Reference: **OPM DRAFT AUDIT REPORT**
Tier VIII Global Coordination of Benefits
Audit Report #1A-99-00-10-009
(Report dated and received 10/1/09)

Dear [redacted]

This is in response to the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report concerning the Global Coordination of Benefits Audit for claims paid in 2008. Our comments concerning the findings in the report are as follows:

A11. Coordination of Benefits with Medicare
Questioned Amount - $20,505,701

The OPM OIG submitted their sample of potential Medicate Coordination of Benefits errors to the Blue Cross Blue Shield Association (BCBS) on October 1, 2009. The BCBS Association and/or the BCBS Plans were requested to review these potential errors and provide responses by January 15, 2010. These listings included claims incurred from October 1, 2007 through December 31, 2008 but reimbursed in 2008. OPM OIG identified 565,331 claim lines totaling $66,114,553 in potential uncoordinated claims. From this universe OPM OIG selected a sample of 36,421 claim lines with a potential overcharge of $20,505,701 to the Federal Employee Health Benefit Program.

Blue Cross Blue Shield Association Preliminary Response:

After reviewing the OIG Draft Audit Report and listing of potentially uncoordinated Medicare COB claims totaling $20,505,701, there was a total of $4,610,894 or 23 percent of the questioned amount that was not coordinated with Medicare. Of this amount, $2,520,614 in claim payments were made correctly when the claim was initially paid; however, the claim

was not adjusted upon subsequent processing of Medicare coverage information. To date Plans have recovered $1,238,256 in claim payment errors. Recovery has been initiated on the remaining overpayments and the Plans will continue to pursue these overpayments as required by CS 1039, Section 2.3 (g)(l).

To the extent that claim payment errors did occur or were not identified, these payments were good faith erroneous benefit payments and fall within the context of CS 1039, Section 2.3 (g). Any benefit payments the Plans are unable to recover are allowable charges to the Program. In addition, as good faith erroneous payments, lost investment income does not apply to the payments identified in the finding.

Our analysis of payment errors indicated the following:

- Claims were processed incorrectly because the claims examiner failed to use the Medicare Summary Notice (MSN) submitted by the provider to process the claim correctly. This resulted in claims being paid as "not covered by Medicare" when the MSN indicated that Medicare had made payments on the claims.
- Claims were processed incorrectly because the claims examiner processed a claim submitted by the provider that did not include the MSN which documents whether Medicare denied the services. This also resulted in claims being paid as "not covered by Medicare" or "provider not covered by Medicare" when the MSN indicated that Medicare had made payments on the claims.
- Claims that were provided to the Plans on either the retroactive enrollment reports, the FEP Director's Office on-line Uncoordinated Medicare application or the FEP Operations Center generated Ad-Hoc review reports were not worked before the start of the audit.
- The FEP Operations Center Ad-Hoc reports used to identify various uncoordinated Medicare claims (i.e., home health, skilled nursing, claims with incurred dates prior to the start of the member's coverage but in effect at the time the member was discharged or claims that were coordinated as non-covered services) did not identify all of the appropriate claims for Plans to review and adjust.

In order to continue to improve the FEP Program's Medicare COB processing, FEP will continue with our current COB Action Plan, with modification as necessary, to include the following:

- Additional monitoring of Medicare COB activity for the 15 Plans with the highest COB Medicare audit finding.
- Modification of the FEP Administrative Manual to provide better guidance on when the Medicare Participation "F" code should be used

as well as when certain home health, skilled nursing and hospice claims should be coordinated.

- Causal analysis of the confirmed overpayments to identify enhancements to improve the current Medicare edits.
- Request a re-evaluation by the FEP Administrative Policy Group of the development of an edit that would defer inpatient facility claims for members with Medicare Part A when the Medicare Participation Code "F" is used and the amount payable is above a specific dollar threshold for all but Veterans Administration or Department of Defense Facility claims.
- Evaluation of the requirement to have all Plans' claims from the Uncoordinated Medicare on-line application reported as part of their overpayment recovery claims inventory. This will allow closer monitoring of Plans activity by the FEP Director's Office.
- Evaluation of a new deferral that would require all claims processed as non-covered by Medicare or as a non-covered Medicare provider to be reviewed to ensure that the claim is only processed when the provider has included a MSN substantiating that the service was not covered or that the provider is not a covered provider.
- Evaluation of the current Operations Center Ad Hoc reports to determine where improvements can be made.

With respect to the remaining $15,866,781, our review indicated that the claims were paid correctly as discussed below:

- Claims totaling $2,805,889 are contested because recovery had been initiated in accordance with CS1039, 2.3 (g) but not completed or were uncollectible at the time the Draft Audit Report response was provided. The majority of these claims were also paid correctly based upon the Medicare information that was on file at the time of initial payment.
- Claims totaling $3,660,482 are contested because the claims were adjusted before the response to the Draft Audit Report was submitted.
- Claims totaling $222,903 were contested because Medicare A or B is secondary or there were no Part B charges.
- Claims totaling $226,743 did not require coordination because the Medicare benefits were exhausted at the time of payment or Medicare was secondary.
- Claims totaling $4,151,274 were services not covered by Medicare or Medicare denied these charges.
- Claims totaling $465,285 are contested because the services were provided by a non Medicare approved provider.
- Claims totaling $4,184,302 are contested for "other" reasons, including but not limited to the fact that claim was coordinated correctly when originally paid and no adjustment was required.

Documentation to support the contested amounts and the initiation of overpayment recovery before the audit has been provided. In addition, we have attached a schedule listed as Attachment A that shows the amount questioned, contested, reason contested and amount recovered by each Plan location. The Plans will continue to pursue the remaining amounts as required by CS 1039, Section 2.3 (g)(l). Any benefit payments the Plan is unable to recover are allowable charges to the Program. In addition, as good faith erroneous payments, lost investment income does not apply to the payments identified in the finding.

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

Sincerely,

[redacted]

Attachment

cc: [redacted]