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

Final Audit Report

Subject:

AUDIT ON GLOBAL DUPLICATE CLAIM PAYMENTS FOR BLUECROSS AND BLUESHIELD PLANS

Report No. 1A-99-00-09-036

Date: October 14, 2009

--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 Duplicate Claim Payments
BlueCross and BlueShield Plans

REPORT NO. 1A-99-00-09-036 DATE: October 14, 2009

Michael R. Esser
Assistant Inspector General
for Audits

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

Office of the
Inspector General

EXECUTIVE SUMMARY

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

Global Duplicate Claim Payments
BlueCross and BlueShield Plans

REPORT NO. 1A-99-00-09-036 DATE: October 14, 2009

This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at all BlueCross and BlueShield (BCBS) plans questions $9,560,516 in duplicate claim payments. The BlueCross BlueShield Association (Association) and/or BCBS plans agreed with $8,620,458 and disagreed with $940,058 of the questioned charges.

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covered health benefit payments from 2006 through March 31, 2009 as reported in the Annual Accounting Statements. Specifically, we reviewed claims paid from January 1, 2006 through March 31, 2009 for duplicate payments charged to the FEHBP. We determined that the BCBS plans improperly charged the FEHBP for 15,294 duplicate claim payments during this period. These payments were unnecessary and unallowable charges, resulting in overcharges of $9,560,516 to the FEHBP.

CONTENTS

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 Center for Retirement and Insurance Services 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 duplicate claim payments audit of all BCBS plans (Report No. 1A-99-00-08-008, dated September 11, 2008) for contract years 2004 and 2005 are in the process of being resolved.

Our preliminary results of the potential duplicate claim payments were presented in detail in a draft report, dated May 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 duplicate claim payments.

SCOPE

We conducted our limited scope performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient and appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit 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 from 2006 through March 31, 2009 as reported in the Annual Accounting Statements. Specifically, we reviewed claims paid from January 1, 2006 through March 31, 2009 for duplicate payments charged to the FEHBP. Based on our claim error reports, we identified 1,791,693 groups, totaling $78,852,500 in potential duplicate claim payments. From this universe, we selected and reviewed 33,054 groups, totaling $27,335,369 in potential duplicate claim payments.

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 duplicate claim payments. 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 duplicate claim payments. 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 August 3, 2009 through September 11, 2009.

METHODOLOGY

To test each BCBS plan's compliance with the FEHBP health benefit provisions related to duplicate claim payments, we selected judgmental samples of potential duplicate claims that were identified in a computer search. Specifically, we selected for review 33,054 groups, totaling $27,335,369 (out of 1,791,693 groups, totaling $78,852,500) in potential duplicate claim payments.[2]

The samples were submitted to each applicable BCBS plan for their review and response. We then conducted a limited review of the plans' 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.

The determination of the questioned amount is based on the FEHBP contract, the Service Benefit Plan brochure, and the Association's FEP administrative manual.

[2] The sample selections included 17,126 groups, totaling $13,325,136 (out of 370,644 groups, totaling $24,778,433) in potential duplicate payments under our "best matches" criteria, and 15,928 groups, totaling $14,010,233 (out of 1,421,049 groups, totaling $54,074,067) in potential duplicate payments under our "near matches" criteria.

III. AUDIT FINDING AND RECOMMENDATIONS

Duplicate Claim Payments **$9,560,516**

The BCBS plans improperly charged the FEHBP $9,560,516 for 15,294 duplicate claim payments from January 1, 2006 through March 31, 2009. These payments were unnecessary and unallowable charges 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.

Section 6(h) of the FEHB Act provides that rates should reasonably and equitably reflect the costs of benefits provided.

We performed a computer search for potential duplicate payments on claims paid during the period January 1, 2006 through March 31, 2009. For all BCBS plans, we selected and reviewed 17,126 groups, totaling $13,325,136 (out of 370,644 groups, totaling $24,778,433) in potential duplicate payments, under our "best matches" criteria. We also selected and reviewed 15,928 groups, totaling $14,010,233 (out of 1,421,049 groups, totaling $54,074,067) in potential duplicate payments, under our "near matches" criteria. Our samples included all groups with potential duplicate payments of $250 or more under the "best matches" criteria and $400 or more under the "near matches" criteria.

Based on our review, we determined that 11,339 claim payments in our "best matches" sample were duplicates, resulting in overcharges of $6,738,616 to the FEHBP. Also, we determined that 3,955 claim payments in our "near matches" sample were duplicates, resulting in overcharges of $2,821,900 to the FEHBP. In total, 63 BCBS plans overcharged the FEHBP $9,560,516 for these 15,294 duplicate claim payments from January 1, 2006 through March 31, 2009 (See Schedule A for a summary of the questioned duplicate claim payments by BCBS plan and Schedule B for a breakdown of the questioned duplicate claim payments by "best matches" and "near matches").[3]

These duplicate claim payments resulted from the following:

- For 9,991 (65 percent) of the duplicate payments, the claims were not deferred on the claims system as potential duplicates for review by the processors.

[3] In addition, there were 2,062 duplicate claim payments, totaling $1,768,245, that were identified by the BCBS plans before the start of the audit (i.e., April 24, 2009) and adjusted or voided by the Association's response date (i.e., July 31, 2009) to the draft report. Since these duplicate claim payments were identified by the BCBS plans before the start of our audit and adjusted or voided by the Association's response to the draft report, we did not question these duplicate payments in the final report.

- For 5,303 (35 percent) of the duplicate payments, the claims were deferred as potential duplicates on the claims system, but were overridden by the processors.

Of the $9,560,516 in questioned duplicate payments, $930,034 (10 percent) were identified by the BCBS plans before the start of our audit (i.e., April 24, 2009). However, since the BCBS plans had not completed the recovery process and/or adjusted or voided these duplicate claims by the Association's response date (i.e., July 31, 2009) to the draft report, we are continuing to question these overcharges. The remaining questioned duplicate payments of $8,630,482 (90 percent) were identified as a result of our audit.

Association's Response:

The Association agrees with $8,542,354 of the questioned duplicate claim payments. The Associations states that the BCBS plans have recovered $1,470,162 of these duplicate payments as of July 24, 2009. The Association also states that the duplicate payments were good faith erroneous benefit payments and fall within the context of CS 1039, Part II, section 2.3(g). The BCBS plans will continue pursuing the overpayments as required by the FEHBP contract. Any duplicate payments the plans are unable to recover, where due diligence is demonstrated, are allowable charges to the FEHBP. As good faith erroneous payments, lost investment income does not apply to the duplicate payments identified in this finding.

The Association states, "Further analysis of the . . . two primary reasons for duplicate payments identified the following:

- Duplicate claim payments totaling $3,397,043 were made because the processor incorrectly overrode the duplicate deferral.
- Duplicate claim payments totaling $5,145,311 were made because the FEP claims system did not defer the claim for evaluation by processors."

Regarding the contested amount, the Association states that the recoveries of the duplicate payments were initiated prior to the start of the audit (i.e., April 24, 2009), but the recovery process has not been completed.

The Association states, "The FEP Director's Office continues to evaluate ways to improve the prevention and detection of duplicate claim payments. In order to reduce the number of duplicate payments, prior to this audit, the FEP Program implemented the following:

- Modified the FEPExpress System on January 1, 2009 to defer claims with the same modifier or modifiers that have similar meaning.
- Updated the FEP Administrative Manual on January 1, 2009 to provide additional instructions on the resolution of duplicate claim edits.

In addition, FEP will perform the following:

- Provide Plan training on the proper duplicate edit resolution process . . .
- Increase duplicates included on the FEP quarterly duplicate post-payment Plan reports by removing the criteria to match on allowed charges and match on all provider fields. . . .
- Modify our current duplicate reporting process to require Plans to submit the results of their review of the Quarterly Duplicate Claims Reports to the FEP Director's Office for review and analysis. . . .
- Expand the FEPExpress duplicate edit criteria to defer claims if there is a match on two of the five provider fields. Currently all provider fields must match in order for the claim to defer as a possible duplicate. . . .
- Expand the FEPExpress duplicate claim reporting to generate monthly summary reports of all duplicate claim edits overridden by processors for further Plan management review. The FEP Director's Office will also receive a copy of the Plans' monthly summary override reports for monitoring. . . .
- Remove the criteria for a match on covered charges from the duplicate edit criteria. . . .
- Modify the FEPExpress System to prevent Plan Approved claims from by-passing the duplicate edit logic."

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 $9,560,516. Based on the Association's response and the BCBS plans' additional documentation, we determined that the Association and/or plans agree with $8,620,458 and disagree with $940,058 of the questioned duplicate claim payments. Although the Association only agrees with $8,542,354 in its response, the BCBS plans' documentation supports concurrence with $8,620,458.

Based on the Association's response and/or the BCBS plans' documentation, the contested amount of $940,058 represents the following items:

- $930,034 of the contested amount represents 1,069 duplicate claim payments where recovery efforts were initiated by 31 BCBS plans before the audit started. However, the plans had not recovered these duplicate payments and adjusted or voided the claims by the Association's response date to the draft report. Since these duplicate payments had not been recovered and returned to the FEHBP by the Association's response date, we are continuing to question this amount in the final report.

- $10,024 of the contested amount represents 22 duplicate payments where the Alaska and Highmark BCBS plans did not provide sufficient documentation to support these contested items.

Recommendation 1

We recommend that the contracting officer disallow $9,560,516 for duplicate claim payments charged to the FEHBP, and have the BCBS plans return all amounts recovered to the FEHBP.

Recommendation 2

We recommend that the contracting officer ensure that the Association's corrective actions for improving the prevention and detection of duplicate claim payments are being implemented.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Experience-Rated Audits Group

[redacted] Auditor-In-Charge

[redacted] Auditor

[redacted], Auditor

[redacted] Auditor

[redacted] Chief [redacted]

Information Systems Audits Group

[redacted], Chief

[redacted] Senior Information Technology Specialist

GLOBAL DUPLICATE CLAIM PAYMENTS
BLUECROSS AND BLUESHIELD PLANS
January 1, 2006 - March 31, 2009

QUESTIONED DUPLICATE CLAIM PAYMENTS BY PLAN

Plan Site #	Plan Name	State	Number of DUPS	Number of Plan Agrees	Number of Plan Disagrees	Reasons for the Duplicate Payments					Amounts Questioned by Year				Total Questioned	Plan Agrees	Plan Disagrees
						Reason 1	Reason 2	Reason 3	Reason 4	Reason 5	2006	2007	2008	2009			
003	BCBS of New Mexico	NM	107	83	24	51	9	0	18	29	$ 54,474	$ 17,145	$ 33,797	$ 54,617	$ 160,032	$ 100,522	$ 59,510
005	WellPoint BCBS of Georgia	GA	109	98	11	43	17	0	0	49	$ 15,428	$ 22,915	$ 26,860	$ 11,742	$ 76,945	$ 66,965	$ 9,980
006	CareFirst BCBS (MD Service Area)	MD	636	636	0	374	11	4	0	247	$ 76,991	$ 83,289	$ 126,257	$ 38,241	$ 324,778	$ 324,778	$ -
007	BCBS of Louisiana	LA	503	503	0	372	18	0	0	113	$ 49,417	$ 60,036	$ 134,355	$ 15,931	$ 259,739	$ 259,739	$ -
009	BCBS of Alabama	AL	105	105	0	35	20	0	0	50	$ 25,910	$ 10,054	$ 13,022	$ 1,578	$ 50,563	$ 50,563	$ -
010	BCBS of Idaho Health Service	ID	26	24	2	2	0	0	0	24	$ -	$ 2,475	$ 9,902	$ -	$ 12,377	$ 11,681	$ 697
011	BCBS of Massachusetts	MA	30	30	0	13	17	0	0	0	$ 419	$ 2,984	$ 1,421	$ 10,351	$ 15,175	$ 15,175	$ -
012	BCBS of Western New York	NY	54	54	0	0	0	0	54	0	$ 4,563	$ 5,362	$ 4,808	$ -	$ 14,732	$ 14,732	$ -
013	Highmark BCBS	PA	266	248	18	36	43	4	0	183	$ 51,583	$ 73,376	$ 58,112	$ 16,117	$ 199,188	$ 196,532	$ 2,657
015	BCBS of Tennessee	TN	628	628	0	124	0	0	0	504	$ 54,399	$ 90,707	$ 177,614	$ 16,473	$ 339,193	$ 339,193	$ -
016	BCBS of Wyoming	WY	54	54	0	0	52	0	0	2	$ 1,295	$ 2,946	$ 67,289	$ 376	$ 71,906	$ 71,906	$ -
017	BCBS of Illinois	IL	493	354	139	250	3	0	0	240	$ 66,689	$ 103,213	$ 144,612	$ 12,481	$ 326,995	$ 213,854	$ 113,142
021	WellPoint BCBS of Ohio	OH	943	923	20	190	70	1	0	682	$ 91,101	$ 189,583	$ 236,846	$ 30,247	$ 547,777	$ 532,625	$ 15,152
024	BCBS of South Carolina	SC	37	37	0	9	14	10	0	4	$ 340	$ 2,779	$ 10,348	$ 5,045	$ 18,512	$ 18,512	$ -
027	WellPoint BCBS of New Hampshire	NH	132	125	7	56	0	0	0	76	$ 13,476	$ 22,806	$ 34,753	$ 2,497	$ 73,532	$ 68,860	$ 4,672
028	BCBS of Vermont	VT	33	29	4	26	3	0	0	4	$ 324	$ 3,995	$ 5,733	$ 4,064	$ 14,116	$ 11,796	$ 2,321
029	BCBS of Texas	TX	1,003	750	253	573	40	0	0	390	$ 116,988	$ 150,258	$ 357,520	$ 73,736	$ 698,502	$ 520,401	$ 178,101
030	WellPoint BCBS of Colorado	CO	566	439	127	153	8	0	228	177	$ 80,974	$ 146,092	$ 191,342	$ 26,180	$ 444,588	$ 358,150	$ 86,438
031	Wellmark BCBS of Iowa	IA	37	37	0	8	22	0	0	7	$ 48	$ 33,470	$ 1,684	$ 1,352	$ 36,554	$ 36,554	$ -
032	BCBS of Michigan	MI	255	246	9	119	12	1	91	32	$ 8,758	$ 19,562	$ 64,113	$ 7,166	$ 99,599	$ 94,977	$ 4,622
033	BCBS of North Carolina	NC	670	624	46	136	9	0	200	325	$ 30,546	$ 69,058	$ 216,702	$ 47,528	$ 363,834	$ 338,216	$ 25,618
034	BCBS of North Dakota	ND	4	4	0	0	0	0	0	4	$ 515	$ 1,069	$ -	$ -	$ 1,584	$ 1,584	$ -
036	Capital BC	PA	9	9	0	5	4	0	0	0	$ -	$ 479	$ 5,705	$ 2,870	$ 9,053	$ 9,053	$ -
037	BCBS of Montana	MT	3	3	0	1	0	0	0	2	$ 550	$ -	$ 265	$ 844	$ 1,659	$ 1,659	$ -
038	BCBS of Hawaii	HI	33	33	0	16	5	0	0	12	$ 1,739	$ 3,093	$ 9,506	$ 3,380	$ 17,719	$ 17,719	$ -
039	WellPoint BCBS of Indiana	IN	787	781	6	158	26	0	428	175	$ 75,281	$ 54,522	$ 170,632	$ 44,128	$ 344,563	$ 342,674	$ 1,889
040	BCBS of Mississippi	MS	247	241	6	116	57	0	0	74	$ 43,579	$ 264,061	$ 36,092	$ 3,137	$ 346,868	$ 344,088	$ 2,780
041	BCBS of Florida	FL	2,096	2,035	61	1,083	920	0	0	93	$ 111,382	$ 388,798	$ 383,681	$ 94,713	$ 978,575	$ 903,316	$ 75,259

GLOBAL DUPLICATE CLAIM PAYMENTS
BLUECROSS AND BLUESHIELD PLANS
January 1, 2006 - March 31, 2009

QUESTIONED DUPLICATE CLAIM PAYMENTS BY PLAN

Plan Site #	Plan Name	State	Number of DUPS	Number of Plan Agrees	Number of Plan Disagrees	Reasons for the Duplicate Payments					Amounts Questioned by Year				Total Questioned	Plan Agrees	Plan Disagrees
						Reason 1	Reason 2	Reason 3	Reason 4	Reason 5	2006	2007	2008	2009			
042	BCBS of Kansas City	MO	119	119	0	17	32	0	70	0	$ 8,202	$ 14,119	$ 44,096	$ 19,774	$ 86,191	$ 86,191	$ -
043	Regence BS of Idaho	ID	1	1	0	1	0	0	0	0	$ -	$ -	$ -	$ 1,136	$ 1,136	$ 1,136	$ -
044	Arkansas BCBS	AR	149	149	0	0	0	0	0	149	$ 19,522	$ 16,649	$ 26,963	$ 13,832	$ 76,966	$ 76,966	$ -
045	WellPoint BCBS of Kentucky	KY	456	456	0	81	19	5	255	96	$ 68,645	$ 63,902	$ 106,616	$ 33,031	$ 272,194	$ 272,194	$ -
047	WellPoint BCBS of Wisconsin	WI	295	280	15	41	9	0	175	70	$ 16,090	$ 40,473	$ 113,227	$ 20,383	$ 190,174	$ 171,610	$ 18,564
048	Empire BCBS	NY	50	26	24	14	3	6	0	27	$ 7,761	$ 17,157	$ 35,625	$ 5,550	$ 66,093	$ 35,451	$ 30,643
049	Horizon BCBS of New Jersey	NJ	274	269	5	189	44	0	10	31	$ 85,717	$ 208,805	$ 130,192	$ 10,333	$ 435,048	$ 433,235	$ 1,813
050	WellPoint BCBS of Connecticut	CT	135	135	0	0	2	0	0	133	$ 13,905	$ 12,532	$ 40,544	$ 11,596	$ 78,577	$ 78,577	$ -
052	WellPoint BC of California	CA	62	56	6	12	2	0	42	6	$ 1,946	$ 19,399	$ 59,976	$ 13,092	$ 94,413	$ 43,166	$ 51,247
053	BCBS of Nebraska	NE	145	133	12	53	17	0	52	23	$ 16,299	$ 52,430	$ 30,460	$ 5,485	$ 104,674	$ 96,737	$ 7,936
054	Mountain State BCBS	WV	32	32	0	24	0	0	0	8	$ 12,121	$ 6,285	$ 3,834	$ -	$ 22,239	$ 22,239	$ -
055	Independence BC	PA	33	33	0	5	13	0	3	12	$ 21,860	$ 17,052	$ 2,844	$ 10,420	$ 52,177	$ 52,177	$ -
056	BCBS of Arizona	AZ	198	150	48	117	32	0	0	49	$ 20,602	$ 40,110	$ 50,569	$ 11,405	$ 122,687	$ 90,065	$ 32,622
058	Regence BCBS of Oregon	OR	92	92	0	36	29	1	5	21	$ 9,730	$ 22,957	$ 61,294	$ 9,915	$ 103,897	$ 103,897	$ -
059	WellPoint BCBS of Maine	ME	136	133	3	0	0	0	0	136	$ 6,143	$ 32,206	$ 55,938	$ 5,665	$ 99,953	$ 98,414	$ 1,539
060	BCBS of Rhode Island	RI	29	29	0	3	5	0	13	8	$ 6,564	$ 10,310	$ 3,766	$ 560	$ 21,200	$ 21,200	$ -
061	WellPoint BCBS of Nevada	NV	334	315	19	16	66	0	232	20	$ 11,084	$ 42,348	$ 63,453	$ 16,245	$ 133,130	$ 122,799	$ 10,331
062	WellPoint BCBS of Virginia	VA	686	671	15	27	436	0	1	222	$ 32,373	$ 87,703	$ 184,721	$ 37,545	$ 342,342	$ 334,839	$ 7,503
064	Excellus BCBS of the Rochester	NY	10	10	0	2	0	0	8	0	$ 454	$ 1,518	$ 2,563	$ 1,002	$ 5,536	$ 5,536	$ -
066	Regence BCBS of Utah	UT	164	162	2	19	2	0	135	8	$ 18,372	$ 32,188	$ 45,537	$ 8,229	$ 104,326	$ 102,762	$ 1,564
067	BS of California	CA	123	73	50	62	0	0	4	57	$ 17,549	$ 31,267	$ 27,603	$ 17,333	$ 93,752	$ 51,064	$ 42,688
069	Regence BS of Washington	WA	125	124	1	120	1	0	0	4	$ 6,929	$ 13,027	$ 35,466	$ 13,111	$ 68,532	$ 67,004	$ 1,528
070	BCBS of Alaska	AK	78	74	4	18	0	0	25	35	$ 8,311	$ 15,592	$ 32,285	$ 5,421	$ 61,609	$ 54,242	$ 7,368
074	Wellmark BCBS of South Dakota	SD	13	13	0	8	1	0	3	1	$ -	$ 278	$ 9,861	$ 704	$ 10,842	$ 10,842	$ -
075	Premera BC of Washington	WA	107	105	2	2	0	0	7	98	$ 15,490	$ 9,555	$ 30,501	$ 10,013	$ 65,558	$ 59,446	$ 6,113
076	WellPoint BCBS of Missouri	MO	322	252	70	53	15	0	171	83	$ 3,496	$ 24,600	$ 150,154	$ 9,269	$ 187,519	$ 120,749	$ 66,770
078	BCBS of Minnesota	MN	26	26	0	0	0	0	0	26	$ 4,578	$ 314	$ 8,812	$ 6,306	$ 20,008	$ 20,008	$ -
079	Excellus BCBS of Central New York	NY	36	36	0	18	1	3	14	0	$ 16,868	$ 1,055	$ 7,856	$ 1,024	$ 26,802	$ 26,802	$ -

GLOBAL DUPLICATE CLAIM PAYMENTS
BLUECROSS AND BLUESHIELD PLANS
January 1, 2006 - March 31, 2009

QUESTIONED DUPLICATE CLAIM PAYMENTS BY PLAN

Plan Site #	Plan Name	State	Number of DUPS	Number of Plan Agrees	Number of Plan Disagrees	Reasons for the Duplicate Payments					Amounts Questioned by Year				Total Questioned	Plan Agrees	Plan Disagrees
						Reason 1	Reason 2	Reason 3	Reason 4	Reason 5	2006	2007	2008	2009			
082	BCBS of Kansas	KS	13	13	0	1	0	0	7	5	$ 2,327	$ 2,666	$ 3,581	$ 322	$ 8,896	$ 8,896	$ -
083	BCBS of Oklahoma	OK	351	285	66	207	10	0	5	129	$ 52,424	$ 74,946	$ 94,646	$ 34,613	$ 256,629	$ 203,175	$ 53,454
084	Excellus BCBS of Utica-Watertown	NY	32	32	0	11	2	6	11	2	$ 2,506	$ 5,345	$ 8,932	$ 810	$ 17,593	$ 17,593	$ -
085	CareFirst BCBS (DC Service Area)	DC	665	658	7	189	51	0	254	171	$ 100,531	$ 74,673	$ 130,721	$ 50,834	$ 356,760	$ 352,284	$ 4,476
088	BC of Northeastern Pennsylvania	PA	15	15	0	1	0	0	14	0	$ -	$ 5,486	$ 10,430	$ -	$ 15,916	$ 15,916	$ -
089	BCBS of Delaware	DE	19	19	0	5	10	0	0	4	$ 4,107	$ 2,842	$ 7,093	$ 1,954	$ 15,995	$ 15,995	$ -
09Z	CareFirst BCBS (Overseas)		103	94	9	2	9	0	75	17	$ 8,843	$ 34,461	$ 41,938	$ 7,248	$ 92,490	$ 81,428	$ 11,062
	Totals		15,294	14,203	1,091	5,303	2,191	41	2,610	5,149	$ 1,598,119	$ 2,858,377	$ 4,185,068	$ 918,952	$ 9,560,516	$ 8,620,458	$ 940,058

Plan Sites Reviewed = 63

Plan Sites with Duplicate Claim Payments = 63

	Overridden	Incorrect Claim Info	Keying Error	Not Deferred or Pended	Other
Reason 1 =	5,303				
	35%				
Reasons 2, 3, 4, and 5 =	9,991				
	65%				

GLOBAL DUPLICATE CLAIM PAYMENTS
BLUECROSS AND BLUESHIELD PLANS
January 1, 2006 - March 31, 2009

QUESTIONED DUPLICATE CLAIM PAYMENTS BY PLAN - BREAKDOWN BY BEST AND NEAR MATCHES

			Best Matches Questioned		Near Matches Questioned		Total	
Plan Site #	Plan Name	State	Number of DUPS	Questioned Charges	Number of DUPS	Questioned Charges	Number of DUPS	Questioned Charges
003	BCBS of New Mexico	NM	90	$ 121,270	17	$ 38,762	107	$ 160,032
005	WellPoint BCBS of Georgia	GA	72	$ 43,991	37	$ 32,954	109	$ 76,945
006	CareFirst BCBS (MD Service Area)	MD	469	$ 201,357	167	$ 123,422	636	$ 324,779
007	BCBS of Louisiana	LA	471	$ 214,258	32	$ 45,482	503	$ 259,740
009	BCBS of Alabama	AL	59	$ 31,053	46	$ 19,511	105	$ 50,564
010	BCBS of Idaho Health Service	ID	24	$ 10,725	2	$ 1,652	26	$ 12,377
011	BCBS of Massachusetts	MA	26	$ 13,186	4	$ 1,989	30	$ 15,175
012	BCBS of Western New York	NY	47	$ 8,906	7	$ 5,826	54	$ 14,732
013	Highmark BCBS	PA	129	$ 74,428	137	$ 124,760	266	$ 199,188
015	BCBS of Tennessee	TN	501	$ 227,928	127	$ 111,265	628	$ 339,193
016	BCBS of Wyoming	WY	7	$ 4,524	47	$ 67,383	54	$ 71,907
017	BCBS of Illinois	IL	389	$ 243,479	104	$ 83,516	493	$ 326,995
021	WellPoint BCBS of Ohio	OH	827	$ 434,065	116	$ 113,712	943	$ 547,777
024	BCBS of South Carolina	SC	29	$ 15,247	8	$ 3,265	37	$ 18,512
027	WellPoint BCBS of New Hampshire	NH	122	$ 68,095	10	$ 5,437	132	$ 73,532
028	BCBS of Vermont	VT	28	$ 11,129	5	$ 2,987	33	$ 14,116
029	BCBS of Texas	TX	674	$ 426,087	329	$ 272,415	1,003	$ 698,502
030	WellPoint BCBS of Colorado	CO	471	$ 375,115	95	$ 69,473	566	$ 444,588
031	Wellmark BCBS of Iowa	IA	24	$ 20,390	13	$ 16,164	37	$ 36,554
032	BCBS of Michigan	MI	228	$ 67,910	27	$ 31,690	255	$ 99,600
033	BCBS of North Carolina	NC	632	$ 336,759	38	$ 27,075	670	$ 363,834
034	BCBS of North Dakota	ND	4	$ 1,584	0	$ -	4	$ 1,584

GLOBAL DUPLICATE CLAIM PAYMENTS
BLUECROSS AND BLUESHIELD PLANS
January 1, 2006 - March 31, 2009

QUESTIONED DUPLICATE CLAIM PAYMENTS BY PLAN - BREAKDOWN BY BEST AND NEAR MATCHES

Plan Site #	Plan Name	State	Best Matches Questioned		Near Matches Questioned		Total	
			Number of DUPS	Questioned Charges	Number of DUPS	Questioned Charges	Number of DUPS	Questioned Charges
036	Capital BC	PA	5	$ 4,678	4	$ 4,376	9	$ 9,054
037	BCBS of Montana	MT	3	$ 1,659	0	$ -	3	$ 1,659
038	BCBS of Hawaii	HI	22	$ 11,129	11	$ 6,590	33	$ 17,719
039	WellPoint BCBS of Indiana	IN	669	$ 229,985	118	$ 114,578	787	$ 344,563
040	BCBS of Mississippi	MS	202	$ 312,131	45	$ 34,737	247	$ 346,868
041	BCBS of Florida	FL	894	$ 546,993	1,202	$ 431,582	2,096	$ 978,575
042	BCBS of Kansas City	MO	78	$ 38,797	41	$ 47,394	119	$ 86,191
043	Regence BS of Idaho	ID	1	$ 1,136	0	$ -	1	$ 1,136
044	Arkansas BCBS	AR	129	$ 62,475	20	$ 14,491	149	$ 76,966
045	WellPoint BCBS of Kentucky	KY	376	$ 202,866	80	$ 69,328	456	$ 272,194
047	WellPoint BCBS of Wisconsin	WI	252	$ 143,534	43	$ 46,640	295	$ 190,174
048	Empire BCBS	NY	22	$ 18,254	28	$ 47,840	50	$ 66,094
049	Horizon BCBS of New Jersey	NJ	204	$ 368,726	70	$ 66,321	274	$ 435,047
050	WellPoint BCBS of Connecticut	CT	116	$ 59,979	19	$ 18,598	135	$ 78,577
052	WellPoint BC of California	CA	53	$ 83,141	9	$ 11,272	62	$ 94,413
053	BCBS of Nebraska	NE	118	$ 83,114	27	$ 21,559	145	$ 104,673
054	Mountain State BCBS	WV	15	$ 8,392	17	$ 13,847	32	$ 22,239
055	Independence BC	PA	22	$ 40,936	11	$ 11,240	33	$ 52,176
056	BCBS of Arizona	AZ	161	$ 94,169	37	$ 28,518	198	$ 122,687
058	Regence BCBS of Oregon	OR	64	$ 82,178	28	$ 21,718	92	$ 103,896
059	WellPoint BCBS of Maine	ME	109	$ 77,747	27	$ 22,206	136	$ 99,953
060	BCBS of Rhode Island	RI	22	$ 13,374	7	$ 7,827	29	$ 21,201

GLOBAL DUPLICATE CLAIM PAYMENTS
BLUECROSS AND BLUESHIELD PLANS
January 1, 2006 - March 31, 2009

QUESTIONED DUPLICATE CLAIM PAYMENTS BY PLAN - BREAKDOWN BY BEST AND NEAR MATCHES

			Best Matches Questioned		Near Matches Questioned		Total	
Plan Site #	Plan Name	State	Number of DUPS	Questioned Charges	Number of DUPS	Questioned Charges	Number of DUPS	Questioned Charges
061	WellPoint BCBS of Nevada	NV	297	$ 107,650	37	$ 25,481	334	$ 133,131
062	WellPoint BCBS of Virginia	VA	577	$ 287,101	109	$ 55,241	686	$ 342,342
064	Excellus BCBS of the Rochester	NY	5	$ 3,150	5	$ 2,386	10	$ 5,536
066	Regence BCBS of Utah	UT	117	$ 66,038	47	$ 38,289	164	$ 104,327
067	BS of California	CA	90	$ 66,036	33	$ 27,716	123	$ 93,752
069	Regence BS of Washington	WA	111	$ 54,406	14	$ 14,126	125	$ 68,532
070	BCBS of Alaska	AK	54	$ 43,298	24	$ 18,312	78	$ 61,610
074	Wellmark BCBS of South Dakota	SD	8	$ 4,312	5	$ 6,530	13	$ 10,842
075	Premera BC of Washington	WA	98	$ 60,411	9	$ 5,147	107	$ 65,558
076	WellPoint BCBS of Missouri	MO	273	$ 149,681	49	$ 37,838	322	$ 187,519
078	BCBS of Minnesota	MN	26	$ 20,008	0	$ -	26	$ 20,008
079	Excellus BCBS of Central New York	NY	31	$ 23,472	5	$ 3,331	36	$ 26,803
082	BCBS of Kansas	KS	2	$ 786	11	$ 8,110	13	$ 8,896
083	BCBS of Oklahoma	OK	218	$ 141,724	133	$ 114,904	351	$ 256,628
084	Excellus BCBS of Utica-Watertown	NY	26	$ 11,510	6	$ 6,084	32	$ 17,594
085	CareFirst BCBS (DC Service Area)	DC	497	$ 228,082	168	$ 128,678	665	$ 356,760
088	BC of Northeastern Pennsylvania	PA	9	$ 6,004	6	$ 9,912	15	$ 15,916
089	BCBS of Delaware	DE	6	$ 3,978	13	$ 12,017	19	$ 15,995
092	CareFirst BCBS (Overseas)		34	$ 24,089	69	$ 68,396	103	$ 92,485
	Totals		**11,339**	**$ 6,738,616**	**3,955**	**$ 2,821,900**	**15,294**	**$ 9,560,516**

APPENDIX

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

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

July 31, 2009

[redacted]
Group Chief
Experience-Rated Audits Group
Office of the Inspector General
U.S. Office of Personnel Management
1900 E. Street, N.W., Room 6400
Washington, D.C. 20415

Reference: **OPM DRAFT AUDIT REPORT**
Global Duplicate Claim Payments Audit
Audit Report 1A-99-00-09-036

Dear [redacted]:

This is our preliminary response to the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report concerning the Global Duplicate Claim Payments Audit. Our final draft response will be submitted to your office by July 31, 2009. Our comments concerning the findings in the report are as follows:

Duplicate Claim Payments **$27,335,369**

The OPM Office of Inspector General (OIG) conducted the Duplicate Claims Payment Audit in May 2009 through June 31, 2009. For the period January 1, 2006 through March 31, 2009, OPM OIG selected and reviewed 17,126 groups, totaling $13,325,136 (out of 370,644 groups, totaling $24,778,433) in potential duplicate payments, under its "best matches" criteria. OPM OIG also selected and reviewed 15,928 groups, totaling $14,010,233 (out of 1,421,049 groups, totaling $54,074,067) in potential duplicate payments, under its "near matches" criteria. OPM OIG samples included all groups with potential duplicate payments of $250 or more under the "best matches" criteria and $400 or more under the "near matches" criteria.

We do not contest that $ 8,542,354 in duplicate claim payments may have been made in error. The overpayment represents .0002 percent of total medical claims paid for the period under audit (for the period of January 1, 2006 through March 31, 2009, the FEP Program paid $45,708,183,006 in medical claims). As of July 24, 2009, we have recovered $1,470,162. Attachment A identifies total confirmed duplicates and the amount recovered by each Plan location.

Further analysis of the Plan's two primary reasons for duplicate payments identified the following:

- Duplicate claim payments totaling $3,397,043 were made because the processor incorrectly overrode the duplicate deferral.

- Duplicate claim payments totaling $5,145,311 were made because the FEP claims system did not defer the claim for evaluation by processors.

We contest $18,793,015 in duplicate claim payments for the following reasons:

- The duplicate claim was voided or adjusted prior to April 24, 2009 (the start of the audit).

- Recovery of the duplicate claim was initiated prior to April 24, 2009 and the claim was adjusted or voided on or after April 24, 2009.

- Recovery of the duplicate claim was initiated prior to April 24, 2009 but the recovery process has not been completed.

- The claims were for a provider who provided different multiple procedures to the same patient.

- The claims were for confirmed repeated procedures, multiple births, round trip ambulance services, team surgery and medication doses more than once a day.

- The claims were for procedures preformed on different body parts or on different family members.

- The claims were for additional payments necessary to correct a prior payment.

The FEP Director's Office continues to evaluate ways to improve the prevention and detection of duplicate claim payments. In order to reduce the number of duplicate payments, prior to this audit, the FEP Program implemented the following:

- Modified the FEPExpress System on January 1, 2009 to defer claims with the same modifier or modifiers that have similar meaning.

- Updated the FEP Administrative Manual on January 1, 2009 to provide additional instructions on the resolution of duplicate claim edits.

In addition, FEP will perform the following:

- Provide Plan training on the proper duplicate edit resolution process by the end of 4th quarter 2009.

- Increase duplicates included on the FEP quarterly duplicate post-payment Plan reports by removing the criteria to match on allowed charges and match on all provider fields. This change will be implemented by the end of 4th Quarter 2009.

- Modify our current duplicate reporting process to require Plans to submit the results of their review of the Quarterly Duplicate Claims Reports to the FEP Director's Office for review and analysis. This change will be implemented with the 4th Quarter 2009 reports.

- Expand the FEPExpress duplicate edit criteria to defer claims if there is a match on two of the five provider fields. Currently all provider fields must match in order for the claim to defer as a possible duplicate. This modification will be implemented by the end of 2nd Quarter 2010.

- Expand the FEPExpress duplicate claim reporting to generate monthly summary reports of all duplicate claim edits overridden by processors for further Plan management review. The FEP Directors Office will also receive a copy of the Plans' monthly summary override reports for monitoring. This modification will be implemented by the end of 2nd Quarter 2010.

- Remove the criteria for a match on covered charges from the duplicate edit criteria. This modification will be implemented by the end of 2nd Quarter 2010.

- Modify the FEPExpress System to prevent Plan Approved claims from by-passing the duplicate edit logic. This modification will be implemented by the end of 2nd Quarter 2010.

To the extent that there were duplicate payment errors, the payments were good faith erroneous benefit payments and fall within the context of CS 1039, Section 2.3 (g). The Plans will continue to pursue the overpayment amounts as required by CS 1039, Section 2.3 (g)(l). Any benefit payments the Plans are unable to recover and where due diligence was demonstrated 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 the finding and request that our comments be included in their entirety as part of the Final Audit Report.

[redacted]
Executive Director
Program Integrity

Attachment

cc: [redacted]