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

Final Audit Report

Subject:

SUPPLEMENTAL REPORT ON THE AUDIT OF GLOBAL NON-COVERED AMBULANCE CLAIMS FOR BLUECROSS AND BLUESHIELD PLANS

Report No. 1A-99-00-13-046

Date: April 17, 2014

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

Global Audit of Non-Covered Ambulance Claims
BlueCross and BlueShield Plans

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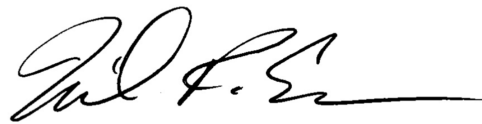

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EXECUTIVE SUMMARY

Federal Employees Health Benefits Program
Service Benefit Plan Contract CS 1039
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Global Audit of Non-Covered Ambulance Claims
BlueCross and BlueShield Plans

REPORT NO. 1A-99-00-13-046 DATE: April 17, 2014

This supplemental final report on the Federal Employees Health Benefits Program (FEHBP) operations at all BlueCross and BlueShield (BCBS) plans questions $1,423,823 in health benefit charges. The BlueCross BlueShield Association (Association) and/or BCBS plans agreed with $466,670 and disagreed with $957,153 of the questioned charges.

The audit report covers health benefit payments from June 1, 2011 through December 31, 2012 as reported on the plans' Annual Accounting Statements, and supplements our fiscal year 2012 Global Coordination of Benefits Audit (Report No. 1A-99-00-12-029) where we identified issues related to the processing of claims for ambulance services. Specifically, we requested the Association to identify all BCBS claims potentially containing non-covered ambulance services during the reporting period. We selected for review all 11,834 claims (representing 27,266 claim lines), totaling $2,953,809 in health benefit charges to the FEHBP, that the Association identified as potentially containing non-covered ambulance services. Based on our review of this sample, we determined that BCBS plans incorrectly paid 7,548 claims (representing 15,794 claim lines), resulting in $1,423,823 in overcharges to the FEHBP.

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I. INTRODUCTION AND BACKGROUND

INTRODUCTION

This supplemental 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 Healthcare and Insurance Office has overall responsibility for administration of the FEHBP. The provisions of the FEHB Act are implemented by OPM through regulations, which are codified in Title 5, Chapter 1, Part 890 of the Code of Federal Regulations (CFR). Health insurance coverage is made available through contracts with various health insurance carriers.

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

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

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[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.

This is our first global audit of non-covered ambulance claims for the BCBS plans. Our sample selections, instructions, and preliminary audit results were presented in detail in a formal information request, dated April 1, 2013, and discussed in detail with the Association and BCBS plan officials during the entrance conference on June 4, 2013. The Association's October 1, 2013 comments offered in response to our draft report, dated June 21, 2013, 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 on various dates through February 27, 2014 was considered in preparing our final report.

II. OBJECTIVE, SCOPE, AND METHODOLOGY

OBJECTIVE

The objectives of our audit were to determine whether the BCBS plans charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the contract. Specifically, our objectives were to determine whether the plans complied with contract provisions related to claims containing non-covered ambulance services.

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.

The audit covered health benefit payments from June 1, 2011 through December 31, 2012 as reported on the plans' Annual Accounting Statements. The scope of this audit was limited to the review of paid claims that potentially contained non-covered ambulance services related to an issue we identified during our fiscal year 2012 global coordination of benefits (COB) audit (Report No. 1A-99-00-12-029). We issued a formal information request to the Association on December 18, 2012, instructing the FEP Operations Center to identify all paid claims that potentially contained non-covered ambulance services during the period of June 1, 2011 through December 31, 2012. On April 25, 2013, the Association informed us that 11,834 claims, totaling $2,953,809 in charges to the FEHBP, potentially contained non-covered ambulance services. We selected for review all 11,834 claims (representing 27,266 claim lines).

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, laws, and regulations governing the FEHBP as they relate to non-covered ambulance claims. The results of our tests indicate that, with respect to claim payments that contained non-covered ambulance services, the BCBS plans did not fully comply with the provisions of the contract. Exceptions noted are explained 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 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 Operations Center and the BCBS plans. The BCBS claims data is provided to us on a monthly basis by the FEP Operations Center and is uploaded into our internal data warehouse. Through audits and a reconciliation process, we have verified the reliability of the claims data in

our data warehouse. However, due to time constraints, we did not verify the reliability of the data generated by the FEP Operations Center, which was used to identify the universe of claims within this review. 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 our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida from June 2013 through February 2014.

METHODOLOGY

To test each BCBS plan's compliance with the FEHBP health benefit provisions, we selected for review all 11,834 non-covered ambulance claims paid during the period of June 1, 2011 through December 31, 2012 that were potentially not priced in accordance with the Service Benefit Plan brochure. See Schedule A for a summary of the selections of potentially non-covered ambulance claims by BCBS plan.

The sample selections were submitted to each BCBS plan for their review and response. We then conducted a limited review of the plans' "paid incorrectly" responses and an expanded review of the plans' "paid correctly" responses. Specifically, we verified the supporting documentation, the accuracy and completeness of the plans' responses, determined if the claims were paid correctly, and/or calculated the appropriate questioned amounts for the claim payment errors. Additionally, we reviewed the status of corrective actions that have been implemented by the Association, FEP Operations Center and/or the BCBS plans. We did not project the sample results to the universe of claims potentially containing non-covered ambulance services.

The determination of the questioned amount is based on the FEHBP contract, the 2011 and 2012 Service Benefit Plan brochures, and the Association's FEP Administrative Manual.

III. AUDIT FINDING AND RECOMMENDATIONS

Non-Covered Ambulance Services **$1,423,823**

During our FY 2012 global COB audit, we determined the FEP Direct system (which processes and approves all FEP claim payments) and/or BCBS plan local systems were incorrectly processing claims containing non-covered ambulance services. Based on our expanded review of this error, we determined that the BCBS plans incorrectly paid an additional 7,548 claims (representing 15,794 claim lines), resulting in net overcharges of $1,423,823 to the FEHBP.[2]

The 2012 BCBS Service Benefit Plan brochure states that ambulance transport services are covered under the following circumstances: "when medically appropriate and related to medical emergency or accidental injury; or associated with inpatient hospital care or covered hospice." Additionally, non-covered services are defined as, "ambulance and any other modes of transportation to or from services including but not limited to physician appointments, dialysis, or diagnostic tests not associated with covered inpatient hospital care."

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

While reviewing the claims for the 2012 global COB audit, we identified a system error in the FEP Direct claims processing system that allows payment for non-covered ambulance services as defined by the Service Benefit Plan brochure. According to the Association, this system error was identified in May 2011, and corrective actions to enhance FEP Direct to defer claims containing non-covered ambulance services were implemented on April 1, 2012. Although corrective actions were implemented to fix the FEP Direct system, the Association did not instruct the BCBS plans to identify, review and/or adjust the claims that were potentially affected by this error, or to initiate recoveries for the actual overpayments until after the start of our FY 2012 global COB audit.

On December 18, 2012, we issued a formal information request to the Association instructing the FEP Operations Center to identify all claims paid during the period of June 1, 2011 through December 31, 2012 that potentially contained non-covered ambulance services. Specifically, we requested the FEP Operations Center to identify all paid claims containing procedure codes A0021, A0080, A0090, A0100, A0110, A0120, A0130, A0140, A0160, A0170, A0180, A0190, A0200, A0210, A0420, A0426, or A0428 that did not meet the Service Benefit Plan brochure's criteria for covered ambulance services. On April 25, 2013, the Association informed us that 11,834 claims (representing 27,266 claim lines), totaling $2,953,809 in charges to the FEHBP, potentially contained non-covered ambulance services. Due to the possible significant impact to the

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[2] During our 2012 global COB audit, we questioned 558 claim lines, totaling $221,439 in overcharges to the FEHBP. These overcharges are not included in the questioned costs of this supplemental final report.

FEHBP, we expanded our review and requested each BCBS plan to identify and/or review claims that were potentially processed and paid incorrectly. We submitted these additional 11,834 claims for their review and response.

Based on our expanded review, we determined that 62 of the 64 BCBS plans incorrectly paid an additional 15,794 claim lines, totaling $1,423,823 in overcharges to the FEHBP (See Schedule B for a summary of questioned charges by BCBS plan).

Our audit disclosed the following for these overpayments:

- The BCBS plans incorrectly paid 10,733 claim lines because the BCBS plans' local systems and/or FEP Direct system did not defer these claims for review. This resulted in overcharges of $1,023,160 to the FEHBP. In most instances, we determined these claims did not contain an emergency diagnosis code <u>and</u> the plans did not provide sufficient documentation to support payment for these services as described in the Service Benefit Plan brochure. <u>Additionally, we determined that 30 percent of the claim payment errors were processed after April 1, 2012 (i.e., the date FEP Direct enhancements were implemented) and were related to a systematic processing error.</u>

- The BCBS plans incorrectly paid 4,425 claim lines due to manual processing errors, resulting in overcharges of $310,109 to the FEHBP. For 3,946 of these claim lines (89 percent), the local plan processors overrode the non-emergency ambulance system deferral "C3P" in FEP Direct and allowed payment for these services. The plans did not provide sufficient documentation to support payment for these services as described in the Service Benefit Plan brochure.

- The BCBS plans incorrectly paid 636 claim lines due to provider billing errors (e.g., the incorrect use of modifiers and procedure codes), resulting in overcharges of $90,554 to the FEHBP.

<u>Association's Response:</u>

The Association agrees with $399,231 of the questioned charges. The Association states the plans will continue to pursue these overpayments as required by CS 1039, Part II, section 2.3(g)(l).

Regarding the contested amount, the Association disagrees with these questioned charges for the following reasons:

- Claims were for covered accidental injury transport, medical emergency transport, medically necessary hospital, skilled nursing home, or hospice transport, or were reviewed and approved for medically necessary ambulance transport.

- Claims were paid incorrectly; however, recovery was not initiated due to the threshold of recovery (less than $100) or the plans were unable to initiate recovery as a result of provider contract limitations.

Regarding corrective actions to reduce claim payment errors, the Association states, "The FEP Direct claim system was updated on April 1, 2012 to include a system edit to prevent certain non-emergency ambulance transport claims from paying without plan medical review. However, [the Association] expects to evaluate the results of this audit to identify additional corrective actions that will further reduce the occurrence of the overpayments in the future. We expect to have this activity completed by November 30, 2013."

OIG Comments:

After reviewing the Association's response and additional documentation provided by the BCBS plans, we determined that 62 BCBS plans incorrectly paid 7,548 claims, resulting in overcharges of $1,423,823 to the FEHBP. Based on the Association's response and the BCBS plans' additional documentation, we determined that the Association and/or plans agree with $466,670 and disagree with $957,153 of these questioned overcharges. Although the Association only agrees with $399,231 of these questioned overcharges in its response, the BCBS plans' documentation supports concurrence with $466,670.

Based on the Association's response and/or the BCBS plans' documentation, the contested amount of $957,153 is comprised of the following items:

- $746,154 represents 6,673 claim line overpayments where the BCBS plans' local system and/or FEP Direct did not defer these claims for review and the plans did not provide sufficient documentation to support payment for these services as described in the Service Benefit Plan brochure.

- $210,999 represents 2,932 claim line overpayments where the BCBS local plan processors overrode the non-emergency ambulance deferral in FEP Direct and the plans did not provide sufficient documentation to support payment for these services as described in the Service Benefit Plan brochure.

Recommendation 1

We recommend that the contracting officer disallow $1,423,823 for claim overcharges and verify that the BCBS plans return all amounts recovered to the FEHBP.

Recommendation 2

Due to the volume of claims identified after FEP Direct enhancements for non-covered ambulance services were implemented, we recommend that the contracting officer require the Association to have the FEP Operations Center identify the reason(s) why FEP Direct continues to allow non-covered ambulance claims to process and pay. Also, we recommend that the contracting officer require the Association to provide evidence or supporting documentation ensuring that the FEP Operations Center implemented the appropriate system modifications.

Recommendation 3

We recommend that the contracting officer require the Association to consider discontinuing the use of modifiers as a source of edits on non-covered ambulance claims that allow the claims to process and pay. Instead, the FEP Operations Center should develop programming enhancements that rely on the patient's history to evaluate compliance with the Service Benefit Plan brochure criteria (i.e., when medically appropriate and related to medical emergency or accidental injury; or associated with inpatient hospital care or covered hospice care) before processing the claim payment.

Recommendation 4

Due to the volume of claims where the local plan processors overrode the FEP Direct system edits for non-covered ambulance claims, we recommend that the contracting officer require the Association to provide education and/or detailed training to the local BCBS plans related to FEHBP coverage for non-covered ambulance services. Also, we recommend that the contracting officer require the Association to provide evidence or supporting documentation ensuring that the Association implemented the corrective actions.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

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