



US OFFICE OF PERSONNEL MANAGEMENT
OFFICE OF THE INSPECTOR GENERAL
OFFICE OF AUDITS

Final Audit Report

Subject:

AUDIT OF WELLPOINT SOUTHEAST MASON, OHIO

Report No. 1A-10-63-08-044

Date: March 3, 2009

--CAUTION--

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Office of the
Inspector General

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

AUDIT REPORT

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

Wellpoint Southeast
Plan Codes 060/560 (Connecticut), 180/680 (Maine),
270/770 (New Hampshire), and 423/923 (Virginia)
Mason, Ohio

REPORT NO. 1A-10-63-08-044 DATE: March 3, 2009

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

Michael R. Esser
Assistant Inspector General
for Audits



Office of the
Inspector General

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

EXECUTIVE SUMMARY

Federal Employees Health Benefits Program
Service Benefit Plan Contract CS 1039
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Plan Codes 060/560 (Connecticut), 180/680 (Maine),
270/770 (New Hampshire), and 423/923 (Virginia)
Mason, Ohio

REPORT NO. 1A-10-63-08-044

DATE: March 3, 2009

This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at WellPoint Southeast (Plan) in Mason, Ohio, questions \$693,795 in health benefit charges. The BlueCross BlueShield Association (Association) agreed (*A*) with \$679,256 and disagreed (*D*) with \$14,539 of the questioned charges.

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covered claim payments from 2005 through 2007 as reported in the Annual Accounting Statements.

Questioned health benefit charges are summarized as follows:

- **Amounts Paid Greater than Covered Charges (A)** **\$314,993**

During our review of claims where the amounts paid were greater than the covered charges, we determined that the Plan incorrectly paid 20 claims, resulting in net overcharges of \$314,993 to the FEHBP. Specifically, the Plan overpaid 17 claims by \$317,383 and underpaid 3 claims by \$2,390.

- **Assistant Surgeon Review (A)** **\$170,820**

The Plan incorrectly paid 185 assistant surgeon claims.

- **System Review (A)** **\$117,354**

Based on our review of a judgmental sample of 290 claims, we determined that the Plan incorrectly paid five claims, resulting in net overcharges of \$117,354 to the FEHBP. Specifically, the Plan overpaid four claims by \$118,617 and underpaid one claim by \$1,263.

- **Omnibus Budget Reconciliation Act of 1990 Review** **\$90,628**

The Plan incorrectly paid 18 claims that were priced or potentially should have been priced under the Omnibus Budget Reconciliation Act of 1990 pricing guidelines. Specifically, the Plan overpaid 13 claims by \$120,647 and underpaid 5 claims by \$30,019, resulting in net overcharges of \$90,628 to the FEHBP. The Association agreed with \$76,089 (A) and disagreed with \$14,539 (D) of the questioned charges.

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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 WellPoint Southeast (Plan). The Plan includes the Connecticut, Maine, New Hampshire and Virginia BlueCross and BlueShield plans. The Plan's central office is located in Mason, Ohio.

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

The Association has established a Federal Employee Program (FEP¹) Director's Office in Washington, D.C. to provide centralized management for the Service Benefit Plan. The FEP Director's Office coordinates the administration of the contract with the Association, member 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 BlueCross BlueShield, located in Washington, D.C. These activities include acting as fiscal intermediary between the Association and member plans, verifying subscriber eligibility, approving or disapproving the reimbursement of local plan payments of FEHBP claims (using computerized system edits), maintaining a history file of all FEHBP claims, and maintaining an accounting of all program funds.

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

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

All findings from our previous audits of the Plan (Report No. 1A-10-59-01-022 for Maine, dated May 14, 2001; Report No. 1A-10-27-02-022 for New Hampshire, dated February 14, 2003; Report No. 1A-10-50-03-021 for Connecticut, dated June 24, 2004; and Report No. 1A-10-62-04-003 for Virginia, dated January 4, 2005), covering various contract years during the period 1997 through 2002, have been satisfactorily resolved.

The results of our audit were provided to the Plan in written audit inquiries; were discussed with Plan and/or Association officials throughout the audit and at an exit conference; and were presented in detail in a draft report, dated November 18, 2008. The Association's comments offered in response to the draft report were considered in preparing our final report and are included as an Appendix to this report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

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

SCOPE

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

We reviewed the BlueCross and BlueShield FEHBP Annual Accounting Statements as they pertain to Plan codes 060/560 (Connecticut), 180/680 (Maine), 270/770 (New Hampshire), and 423/923 (Virginia). During this period, the Plan paid approximately \$2.6 billion in health benefit charges (See Schedule A). Specifically, we reviewed approximately \$74 million in claim payments made from 2005 through 2007 for proper adjudication.

In planning and conducting our audit, we obtained an understanding of the Plan's internal control structure to help determine the nature, timing, and extent of our auditing procedures. This was determined to be the most effective approach to select areas of audit. For those areas selected, we primarily relied on substantive tests of transactions and not tests of controls. Based on our testing, we did not identify any significant matters involving the Plan's internal control structure and its operation. However, since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on the Plan's system of internal controls taken as a whole.

We also conducted tests to determine whether the Plan had complied with the contract, the applicable procurement regulations (i.e., Federal Acquisition Regulations and Federal Employees Health Benefits Acquisition Regulations, as appropriate), and the laws and regulations governing the FEHBP. The results of our tests indicate that, with respect to the items tested, the Plan did not comply with all provisions of the contract and federal procurement regulations. Exceptions noted in the areas reviewed are set forth in detail in the "Audit Findings and Recommendations" section of this audit report. With respect to the items not tested, nothing came to our attention that caused us to believe that the Plan had not complied, in all material respects, with those provisions.

In conducting our audit, we relied to varying degrees on computer-generated data provided by the FEP Director's Office, the FEP Operations Center, the Plan, and the Centers for Medicare and Medicaid Services. Due to time constraints, we did not verify the reliability of the data generated

by the various information systems involved. However, while utilizing the computer-generated data during our audit testing, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

The audit was performed at our offices in Cranberry Township, Pennsylvania and Jacksonville, Florida from August 5 through November 19, 2008.

METHODOLOGY

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

To test the Plan's compliance with the FEHBP health benefit provisions, we selected and reviewed samples of 1,536 claims.² We used the FEHBP contract, the Service Benefit Plan brochure, the Plan's provider agreements, and the Association's FEP administrative manual to determine the allowability of benefit payments. The results of these samples were not projected to the universe of claims.

² See the audit findings for "Amounts Paid Greater than Covered Charges" (A1), "Assistant Surgeon Review" (A2), "System Review" (A3), and "Omnibus Budget Reconciliation Act of 1990 Review" (A4) on pages 5 through 12 for specific details of our sample selection methodologies.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. HEALTH BENEFIT CHARGES

1. Amounts Paid Greater than Covered Charges **\$314,993**

The Plan incorrectly paid 20 claims, resulting in net overcharges of \$314,993 to the FEHBP. Specifically, the Plan overpaid 17 claims by \$317,383 and underpaid 3 claims by \$2,390.

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 diligent effort to recover an overpayment"

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, other group health benefits coverages . . . (b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary carrier"

For the period 2005 through 2007, we identified 13,886 claims where the amounts paid were greater than the covered charges by a total of \$18,222,691. From this universe, we selected and reviewed a judgmental sample of 517 claims with a total variance of \$7,327,591, and determined if the Plan adjudicated these claims properly. Our sample included all claims where the amounts paid exceeded covered charges by \$2,500 or more for the Connecticut, Maine and New Hampshire plans, and \$10,000 or more for the Virginia plan. Based on our review, we determined that 20 of these claims were paid incorrectly, resulting in net overcharges of \$314,993 to the FEHBP. Specifically, the Plan overpaid 17 claims by \$317,383 and underpaid 3 claims by \$2,390.

These claim payment errors resulted from the following reasons:

- The Plan paid three claims using the incorrect pricing methodology, resulting in overcharges of \$164,497 to the FEHBP.
- The Plan priced one claim using the incorrect number of units, resulting in an overcharge of \$36,491 to the FEHBP.
- The Plan incorrectly paid four claims due to processor errors, resulting in net overcharges of \$34,160 to the FEHBP. Specifically, the Plan overpaid three claims by \$34,760 and underpaid one claim by \$600. For example, the Plan inadvertently priced two separate claims (split bills) for a patient when only one claim should have been priced for the entire admission.

- The Plan did not correctly bundle claim line charges for two claims, resulting in overcharges of \$30,331 to the FEHBP.
- The Plan paid two claims using incorrect billed charges, resulting in overcharges of \$16,389 to the FEHBP.
- The Plan paid three claims using incorrect per diem allowances, resulting in net overcharges of \$13,076 to the FEHBP. Specifically, the Plan overpaid two claims by \$14,246 and underpaid one claim by \$1,170.
- The Plan did not properly coordinate one claim with Medicare, resulting in an overcharge of \$10,805 to the FEHBP.
- The Plan did not properly coordinate one claim with the patient's primary insurance carrier, resulting in an overcharge of \$5,700 to the FEHBP.
- The Plan paid one claim using an incorrect fee schedule amount, resulting in an overcharge of \$3,440 to the FEHBP.
- The Plan paid two claims using the incorrect types of services, resulting in net overcharges of \$104 to the FEHBP. Specifically, the Plan overpaid one claim by \$724 and underpaid one claim by \$620.

Association's Response:

The Association agrees with this finding. The Association states that the Plan has initiated recoveries of the overpayments and has recovered \$216,067 as of December 31, 2008.

The Association also states, "The errors that occurred in this area appear to be mostly human error. To ensure these types of errors do not occur in the future, the Plan will review processing procedures and ensure training materials are up to date. This review should be concluded by February 28, 2009. The FEP Director's Office System Wide Claims Review process includes Amounts Paid Greater than Covered Charges claims for Plan review and identification of overpayments. This review process should continue to reduce these types of findings in the future."

Recommendation 1

We recommend that the contracting officer disallow \$317,383 in claim overcharges, and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 2

We recommend that the contracting officer allow the Plan to charge the FEHBP \$2,390 if additional payments are made to the providers to correct the underpayment errors.

2. Assistant Surgeon Review

\$170,820

The Plan incorrectly paid 185 assistant surgeon claims, resulting in overcharges of \$170,820 to the FEHBP.

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

For the period 2005 through 2007, we identified 2,350 assistant surgeon claim groups, totaling \$826,013 in potential overpayments, that may not have been paid in accordance with the Plan's assistant surgeon pricing procedures. From this universe, we selected and reviewed a judgmental sample of 406 assistant surgeon claim groups, totaling \$609,129 in potential overpayments, to determine if the Plan paid these claims properly. Our sample included all assistant surgeon claim groups with potential overpayments of \$500 or more. The majority of these claim groups contained one primary surgeon and one assistant surgeon claim. Based on our review, we determined that 185 claims were paid incorrectly, resulting in overcharges of \$170,820 to the FEHBP.

These claim payment errors resulted from the following:

- The Plan incorrectly paid 172 assistant surgeon claims, resulting in overcharges of \$158,564 to the FEHBP. These overcharges were due to errors in the calculation of the assistant surgeon fee, which should have been priced at 10, 16, 20, or 25 percent of the primary surgeon's allowed amount.
- The Plan incorrectly paid 12 assistant surgeon claims, resulting in overcharges of \$11,934 to the FEHBP. These overcharges were due to errors in the calculation of the assistant surgeon fee for claims that were subject to the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), which should have been priced at 13.6 or 16 percent of the primary surgeon's Medicare allowed amount.
- The Plan did not properly coordinate one claim with Medicare, resulting in an overcharge of \$322 to the FEHBP.

Association's Response:

The Association agrees with this finding. The Association states that the Plan has initiated recoveries of the overpayments and has recovered \$169,796 as of December 31, 2008.

The Association also states, "The Plan reviewed the errors identified . . . and determined that these errors could be identified as system errors. The Plan has created or strengthened their procedures"

In addition, the Association states, "For the Assistant Surgeon claim errors noted during the audit, the FEPDO implemented the following:

- Palmetto began correctly pricing AS modifier claims. A final comprehensive list that identifies all unadjusted Assistant Surgeon claims will be issued to all Plans by January 31, 2009 so that claims can be adjusted as necessary.
- Assistant Surgeon claims are included in the periodic System-Wide Claims Review process to ensure that any claim payment errors are identified and corrected in a timely manner."

Recommendation 3

We recommend that the contracting officer disallow \$170,820 in claim overcharges, and verify that the Plan returns all amounts recovered to the FEHBP.

3. System Review

\$117,354

The Plan incorrectly paid five claims, resulting in net overcharges of \$117,354 to the FEHBP. Specifically, the Plan overpaid four claims by \$118,617 and underpaid one claim by \$1,263.

As previously cited from CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments. Also, the Plan must coordinate the payment of benefits with Medicare or other health insurance coverage.

For health benefit claims reimbursed during the period January 1, 2007 through December 31, 2007, we identified 8,696,487 claim lines, totaling \$858,826,237 in payments, using a standard criteria based on our audit experience. From this universe, we selected and reviewed a judgmental sample of 290 claims (representing 3,191 claim lines), totaling \$13,349,211 in payments, to determine if the Plan adjudicated these claims properly.³ Our review identified five claim payment errors, resulting in net overcharges of \$117,354 to the FEHBP. Specifically, the Plan overpaid four claims by \$118,617 and underpaid one claim by \$1,263.

These claim payment errors resulted from the following:

- The Plan made one duplicate claim payment, resulting in an overcharge of \$97,230 to the FEHBP.

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

- The Plan did not properly coordinate one claim with the patient's primary insurance carrier, resulting in an overcharge of \$10,335 to the FEHBP.
- The Plan paid one claim at total billed charges instead of applying the applicable contract rate, resulting in an overcharge of \$5,543 to the FEHBP.
- The Plan paid one claim at percent of charges instead of applying the applicable fee schedule amount, resulting in an overcharge of \$5,509 to the FEHBP.
- The Plan paid one claim using an incorrect percent of charges, resulting in an undercharge of \$1,263 to the FEHBP.

Association's Response:

The Association agrees with this finding. The Association states that the Plan has initiated recoveries of the overpayments and has recovered \$108,282 as of December 31, 2008. The Association also states that these payments were good faith erroneous benefit payments and fall within the context of CS 1039, Part II, section 2.3(g). Any payments the Plan is unable to recover are allowable charges to the FEHBP. As good faith erroneous payments, lost investment income does not apply to the claim payment errors identified in this finding.

The Association states, "The Plan will review processing procedures and documentation to ensure training materials are up to date as well as provide refresher training to claims processors as necessary to reduce these types of payment errors in the future.

The Plan has several methods in place to identify overpayments. These methods include, but are not limited to the System Wide Claims Reports . . . COB claims reports and Duplicate claims reports provided by the FEP Director's Office and routine claims quality assurance audits performed by the Plan's Internal Auditors. While these measures are not absolute, they provide reasonable assurances that such items will be identified. Efforts will be made to periodically examine existing procedures and add additional controls where necessary."

Recommendation 4

We recommend that the contracting officer disallow \$118,617 in claim overcharges, and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 5

We recommend that the contracting officer allow the Plan to charge the FEHBP \$1,263 if an additional payment is made to the provider to correct the underpayment error.

4. Omnibus Budget Reconciliation Act of 1990 Review

\$90,628

The Plan incorrectly paid 18 claims that were priced or potentially should have been priced under the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), resulting in net overcharges of \$90,628 to the FEHBP. Specifically, the Plan overpaid 13 claims by \$120,647 and underpaid 5 claims by \$30,019.

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

Contract CS 1039, Part III, Section 3.8 states, “the Carrier shall retain and make available all records applicable to a contract term that support the annual statement of operations and . . . the rate submission for that contract term”

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

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

The following summarizes the claim payment errors.

OBRA 90 Claim Pricing Errors

For the period 2005 through 2007, we identified 4,083 claims, totaling \$30,932,902 in payments, that were subject to OBRA 90 pricing guidelines. From this universe, we selected and reviewed a judgmental sample of 175 claims, totaling \$5,936,959 in payments, to determine if these claims were correctly priced by the FEP Operations Center and paid by the Plan. Our sample included all OBRA 90 claims with amounts paid of \$20,000 or more. Based on our review, we determined that nine of these claims were paid incorrectly, resulting in net overcharges of \$28,663 to the FEHBP. Specifically, the Plan overpaid six claims by \$39,745 and underpaid three claims by \$11,082.

These claim payment errors resulted from the following:

- The FEP Operations Center priced seven claims at incorrect Medicare diagnosis related grouping (DRG) allowances. Consequently, the Plan overpaid four claims by \$25,621 and underpaid three claims by \$11,082, resulting in net overcharges of \$14,539 to the FEHBP.

- The Plan priced one claim using an incorrect Medicare DRG code, resulting in an overcharge of \$12,564 to the FEHBP.
- The Plan paid one claim using an incorrect percent of charges, resulting in an overcharge of \$1,560 to the FEHBP.

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

For the period 2005 through 2007, we identified 1,756 claims, totaling \$3,565,768 in payments, that were potentially subject to OBRA 90 pricing guidelines but appeared to be paid under the Plan's standard pricing procedures. From this universe, we selected and reviewed a judgmental sample of 68 claims, totaling \$1,699,353 in payments, to determine if the Plan paid these claims properly. Our sample included all possible OBRA 90 claims with amounts paid of \$10,000 or more. Based on our review, we determined that nine of these claims were paid incorrectly, resulting in net overcharges of \$61,965 to the FEHBP. Specifically, the Plan overpaid seven claims by \$80,902 and underpaid two claims by \$18,937.

These claim payment errors resulted from the following:

- The Plan did not provide supporting documentation for five claims, resulting in overcharges of \$75,336 to the FEHBP.
- The Plan inadvertently did not price one claim under OBRA 90, resulting in an overcharge of \$530 to the FEHBP.
- The FEP Operations Center priced three claims at incorrect Medicare DRG allowances. Consequently, the Plan overpaid one claim by \$5,036 and underpaid two claims by \$18,937, resulting in net undercharges of \$13,901 to the FEHBP.

Association's Response:

The Association agrees with \$76,089 and disagrees with \$14,539 of the questioned charges. The Association states that the Plan has recovered \$8,577 of the uncontested amount as of December 31, 2008.

For the contested amount, the Association states, "The claims were contested because when re-priced by the Operations Center OBRA '90 pricing software, it resulted in a different price than the price calculated by the CMS PC pricer. The Operations Center OBRA '90 pricing software is the official OPM approved source for FEP OBRA '90 pricing and must be used to determine payment. The claims were repriced with the most up-to-date version of the Operations Center OBRA '90 pricer software. Because the final updated version of the Operations Center OBRA '90 pricer was used to reprice the claims, FEP continues to believe that the resulting price obtained by the Operations Center OBRA '90 Mainframe pricer software is the most accurate."

In addition, the Association states, "To reduce pricing errors in the future, the Plan has implemented and updated its Policy & Procedure for OBRA 90 and an OBRA 90 Processing guide. Further, the FEP Director's Office includes . . . OBRA '90 priced claims on the periodic System-Wide Review process to facilitate early identification and recovery of OBRA '90 claim payment errors."

OIG Comments:

For the contested amount, the FEP Operations Center's OBRA 90 pricing amounts differed from the CMS Pricer amounts. Based on our experience with auditing BlueCross and BlueShield plans, we have found that these pricing differences occur because the mainframe pricing software used by the FEP Operations Center is not always up-to-date. Therefore, we will continue to use the latest version of the CMS Pricer program, which includes up-to-date pricing, to determine if claims paid under OBRA 90 were correctly priced by the FEP Operations Center and paid by the Plan.

In addition, the Association did not provide documentation to support the amounts that were repriced by the FEP Operations Center for the contested items.

Recommendation 6

We recommend that the contracting officer disallow \$120,647 in claim overcharges, and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 7

We recommend that the contracting officer allow the Plan to charge the FEHBP \$30,019 if additional payments are made to the providers to correct the underpayment errors.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Experience-Rated Audits Group

██████████ Auditor-In-Charge

██████████ Auditor

██████████ Chief ██████████

██████████ Senior Team Leader

V. SCHEDULE A

WELLPOINT SOUTHEAST
MASON, OHIO

HEALTH BENEFIT CHARGES AND AMOUNTS QUESTIONED

HEALTH BENEFIT CHARGES	2005	2006	2007	TOTAL
CONNECTICUT:				
PLAN CODE 060	\$34,441,782	\$38,461,343	43,880,063	\$116,783,188
MISCELLANEOUS PAYMENTS	(483,252)	675,486	369,772	562,006
PLAN CODE 560	34,330,771	38,190,380	41,590,817	114,111,968
MISCELLANEOUS PAYMENTS	0	0	0	0
MAINE:				
PLAN CODE 180	56,160,565	61,702,739	62,090,550	179,953,855
MISCELLANEOUS PAYMENTS	1,146,882	189,301	218,624	1,554,806
PLAN CODE 680	27,100,197	29,354,775	31,042,179	87,497,151
MISCELLANEOUS PAYMENTS	0	0	0	0
NEW HAMPSHIRE:				
PLAN CODE 270	69,706,529	80,590,561	85,948,394	236,245,484
MISCELLANEOUS PAYMENTS	227,229	631,075	487,931	1,346,235
PLAN CODE 770	37,760,586	41,387,654	45,069,304	124,217,544
MISCELLANEOUS PAYMENTS	0	0	0	0
VIRGINIA:				
PLAN CODE 423	273,684,651	295,986,960	334,081,611	903,753,222
MISCELLANEOUS PAYMENTS	3,027,186	4,149,757	4,250,063	11,427,006
PLAN CODE 923	245,080,499	273,307,410	307,334,758	825,722,667
MISCELLANEOUS PAYMENTS	0	0	0	0
TOTAL HEALTH BENEFIT CHARGES	\$782,183,626	\$864,627,440	\$956,364,066	\$2,603,175,131
AMOUNTS QUESTIONED				
	2005	2006	2007	TOTAL
1. AMOUNTS PAID GREATER THAN COVERED CHARGES	\$293,625	\$16,104	\$5,264	\$314,993
2. ASSISTANT SURGEON REVIEW	50,763	24,041	96,016	170,820
3. SYSTEM REVIEW	0	0	117,354	117,354
4. OMNIBUS BUDGET RECONCILIATION ACT OF 1990 REVIEW	28,661	4,668	57,299	90,628
TOTAL AMOUNTS QUESTIONED	\$373,049	\$44,813	\$275,933	\$693,795



**BlueCross BlueShield
Association**

An Association of Independent
Blue Cross and Blue Shield Plans

January 19, 2008

[REDACTED] Group Chief
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**Reference: OPM DRAFT AUDIT REPORT
WellPoint Southeast
Audit Report Number 1A-10-63-08-044
(Dated November 18 and received November 19, 2008)**

Dear [REDACTED]

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

A. HEALTH BENEFIT CHARGES

1. Amounts Paid Greater than Covered Charges \$314,993

We do not contest this audit finding. Recovery has been initiated to recover the overpayments. The errors that occurred in this area appear to be mostly human error. To ensure these types of errors do not occur in the future, the Plan will review processing procedures and ensure training materials are up to date. This review should be concluded by February 28, 2009. The FEP Director's Office System Wide Claims Review process includes Amounts Paid Greater than Covered Charges claims for Plan review and identification of overpayments. This review process should continue to reduce these types of findings in the future.

As of December 31, 2008, the Plan has recovered \$216,067.

2. Assistant Surgeon Review \$170,820

We do not contest this finding. Recovery has been initiated to recover the overpayments. The Plan reviewed the errors identified on the Assistant Surgeon claims list and determined that these errors could be identified as system errors. The Plan has created or strengthened their procedures to include the following:

- **Virginia Corporate Provider Allowance Assistant Surgeon Pricing defect:** When modifier 80, 81, or 83 was reported on claims for providers with specially negotiated contract rates, the corporate provider allowance file gave the same allowance for both type service 200 and 2T0. Corrective action was implemented on August 19, 2008 to set up a separate allowance for type service 2T0 which reflects the appropriate reduction for assistant surgeons (10% of type service 200) and then apply the appropriate negotiated rate.
- **Virginia Streamline Provider Allowance Assistant Surgeon Pricing defect:** When modifier AS was reported on claims for providers with specially negotiated contract rates, the Streamline system incorrectly set a type of service 2T0 which allows 10% of the base allowance. Corrective action was implemented on August 19, 2008 so that when a provider has a specially negotiated contract rate, the Streamline system uses type of service 200 and calculates the correct allowance using the base allowance for type of service 200 multiplied by the provider's negotiated rate.
- **NE (CT, ME, & NH) Assistant Surgeon Pricing defect:** When multiple modifiers were reported on claims, a system limitation of the ACES pricer accepted only the modifier located in position # 1. The Streamline system was programmed to send only the modifier in position # 1 to ACES for pricing. Modifiers located in positions 2, 3, and 4 were not considered. A system enhancement was implemented in production on February 17, 2008 to correct the pricing problems in both systems.

For the Assistant Surgeon claim errors noted during the audit, the FEPDO implemented the following:

- Palmetto began correctly pricing AS modifier claims. A final comprehensive list that identifies all unadjusted Assistant Surgeon claims will be issued to all Plans by January 31, 2009 so that claims can be adjusted as necessary.
- Assistant Surgeon claims are included in the periodic System-Wide Claims Review process to ensure that any claim payment errors are identified and corrected in a timely manner.

As of December 31, 2008, the Plan has recovered \$169,796.

3. Omnibus Budget Reconciliation Act 1990 Review \$90,628

The Plan does not contest \$76,089. However, the Plan does contest \$14,539. The claims were contested because when they were re-priced by the Operations Center OBRA '90 pricer software, it resulted in a different price than the price calculated by the CMS PC pricer. The Operations Center OBRA '90 pricer software is the official OPM approved source for FEP OBRA '90 pricing and must be used to determine payment. The claims were repriced with the most up-to-date version of the Operations Center OBRA '90 pricer software. Because the final updated version of the Operations Center OBRA '90 pricer was used to reprice the claims, FEP continues to believe that the resulting price obtained by the Operations Center OBRA '90 Mainframe pricer software is the most accurate.

To reduce pricing errors in the future, the Plan has implemented and updated its Policy & Procedure for OBRA 90 and an OBRA90 Processing guide. Further, the FEP Director's Office includes not OBRA '90 priced claims on the periodic System-Wide Review process to facilitate early identification and recovery of OBRA'90 claim payment errors.

As of December 31, 2008, the Plan has recovered \$8,577.

4. System Review \$117,354

We do not contest this audit finding. All claims have been adjusted to recover the overpayments. The Plan will review processing procedures and documentation to ensure training materials are up to date as well as provide refresher training to claims processors as necessary to reduce these types of payment errors in the future.

The Plan has several methods in place to identify overpayments. These methods include, but are not limited to the System Wide Claims Reports (which includes a listing of Assistant Surgeon Claims, Amount Paid Greater than Charges Claims, OBRA '90, and Termination Claims), COB claims reports and Duplicate claims reports provided by the FEP Director's Office and routine claims quality assurance audits performed by the Plan's Internal Auditors. While these measures are not absolute, they provide reasonable assurances that such items will be identified. Efforts will be made to periodically examine existing procedures and add additional controls where necessary. Accordingly, to the extent that errors did occur, the payments are good faith erroneous benefits payments and fall within the context of CS 1039, Section 2.3(g). Any benefit payments the Plan is unable to recover are allowable charges to the Program. In addition, as good faith erroneous

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payments, lost investment income does not apply to the payments identified in this finding.

As of December 31, 2008, the Plan has recovered \$108,282.

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

[REDACTED]

Executive Director
Program Integrity

[REDACTED]

cc:

[REDACTED]