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

Final Audit Report

Audit of Blue Shield of California

Report Number 1A-10-67-15-001
October 2, 2015

EXECUTIVE SUMMARY

Audit of Blue Shield of California

Report No. 1A-10-67-15-001 **October 2, 2015**

Why Did We Conduct the Audit?

The objectives of our audit were to determine whether Blue Shield of California (Plan) charged costs to the Federal Employees Health Benefits Program (FEHBP) and provided services to FEHBP members in accordance with the terms of its contract with the U.S. Office of Personnel Management. Specifically, our objectives were to determine whether the Plan complied with contract provisions relative to claim payments.

What Did We Audit?

The Office of the Inspector General has completed a limited scope audit of the FEHBP operations at Blue Shield of California.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

Our limited scope audit was conducted in accordance with Government Audit Standards. The audit covered Blue Shield of California claim payments from January 1, 2011 through September 30, 2014, as reported on the Annual Accounting Statements. The report questions $47,752 in health benefit charges. The questioned health benefit charges are summarized as follows:

A. Omnibus Budget Reconciliation Act of 1993 (OBRA 93) Review
- The Federal Employee Program Operations Center did not properly price 278 claim lines in accordance with OBRA 93 pricing guidelines, resulting in overcharges of $27,152 to the FEHBP.

B. Co-Surgeon Discount Review
- The Plan incorrectly paid six claim lines that contained a co-surgeon procedure code modifier, resulting in overcharges of $16,884 to the FEHBP.

C. Bilateral Procedures Review
- The Plan incorrectly paid six claim lines that contained a bilateral procedure code, resulting in overcharges of $3,716 to the FEHBP.

ABBREVIATIONS

Association	**BlueCross BlueShield Association**
BCBS	**BlueCross BlueShield**
CFR	**Code of Federal Regulations**
DO	**Director's Office**
FEHB	**Federal Employees Health Benefits**
FEHBP	**Federal Employees Health Benefits Program**
FEP	**Federal Employee Program**
FEP OC	**Federal Employee Program Operations Center**
OBRA 93	**Omnibus Budget Reconciliation Act of 1993**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
Plan	**Blue Shield of California**

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I. BACKGROUND

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 Blue Shield of California (Plan). The Plan is located in San Francisco, California. The audit was performed by the U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as authorized by the Inspector General Act of 1978, as amended.

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 BlueCross and BlueShield (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 BCBS plans participating in the FEHBP.

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

The Association has also established an FEP Operations Center (OC). The activities of the FEP OC 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.

The most recent audit report issued that covered claim payments for Blue Shield of California was Report No. 1A-10-67-05-012, dated January 25, 2006. All findings from the previous audit have been satisfactorily resolved.

The results of this audit were provided to the Plan in written audit inquiries; were discussed with Plan and/or Association officials throughout the audit and at an exit conference; and were presented in detail in a draft audit report, dated June 1, 2015. 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 objective was to determine whether the Plan complied with contract provisions relative to health benefit payments.

Scope and Methodology

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 code 542 (Blue Shield of California) for contract years 2011 through 2014. During this period, the Plan paid approximately $1.6 billion in health benefit charges (See Figure 1 and Schedule A). From this universe, we judgmentally selected various samples. We reviewed approximately 480 claims, totaling $15.8 million in payments, for the period January 1, 2011 through September 30, 2014 for proper adjudication. We used the FEHBP contract, the 2011 through 2014 Service Benefit Plan brochures, 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.

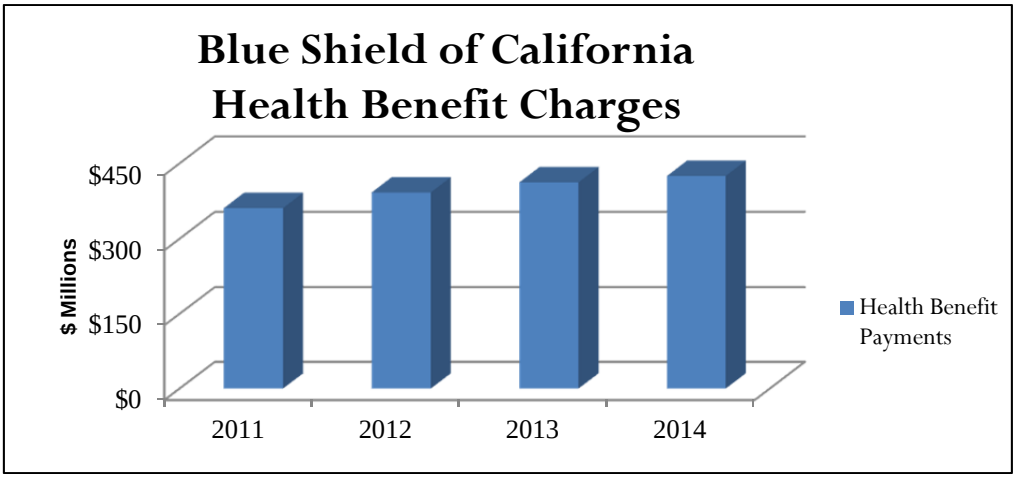

Figure 1 – Health Benefit Charges

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. 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 operations. 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 and the laws and regulations governing the FEHBP as they relate to claim payments. The results of our tests indicate that, with respect to the items tested, the Plan did not fully comply with the provisions of the contract relative to claim payments. 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 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 DO, the FEP OC, and the Plan. Through audits and a reconciliation process, we have verified the reliability of the BCBS claims data in our data warehouse, which was used to identify the universe of claims for each type of review. The BCBS claims data is provided to us on a monthly basis by the FEP OC, and after a series of internal steps, uploaded into our data warehouse. However, due to time constraints, we did not verify the reliability of the data generated by the Plan's local claims system. While utilizing the computer-generated data during our audit, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

Audit fieldwork was performed at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida through July, 2015.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. Omnibus Budget Reconciliation Act of 1993 (OBRA 93) Review $27,152

The OBRA 93 regulation limits the benefit payment for certain physician services provided to annuitants age 65 or older who are not covered under Medicare Part B. The FEHBP is required to limit the claim payment to the lesser of the amount equivalent to the Medicare Part B payment or the billed charges. The results of our review of claims containing co-surgeon modifiers or bilateral procedure codes (detailed in sections B, and C, below) indicated that the Plan was not properly paying certain claims in accordance with OBRA 93 pricing guidelines. Due to the complexity of this finding, we performed an expanded review of OBRA 93 claims and separated this audit finding from the co-surgeon and bilateral procedures reviews for reporting purposes.

The FEP OC did not apply the Medicare bilateral, multiple, and co-surgeon procedure discounts to 278 claim lines resulting in overcharges of $27,152 to the FEHBP.

In 2012, the OPM OIG performed a global OBRA 93 audit on all BCBS Plans (Report No. 1A-99-00-12-001, dated July 16, 2012). This audit recommended that the FEP OC implement system edits to the FEP Express claims system that automatically applied the applicable Medicare discount percentages during the pricing of OBRA 93 claims. The Association and OPM's contracting office agreed that a feasibility analysis would be conducted by the fourth quarter of 2012 to determine if these system edits were reasonable to implement. On January 23, 2014, the OPM contracting office requested the Association to provide a status of the analysis, and was informed that it had not been completed. The feasibility analysis was eventually completed on July 31, 2014, and the Association determined that the modifications would be made to the system. The Association also stated that for all OBRA 93 claims processed after July 2014, the FEP OC would provide a monthly listing of claims to be manually adjudicated by the BCBS Plans until these system modifications were implemented. However, our initial work during this audit determined that the FEP OC and/or the Plan were not performing the manual adjustments in a timely manner, resulting in unreasonable overcharges to the FEHBP. Therefore, we expanded our review of OBRA 93 claims.

For the scope of January 1, 2011 through September 30, 2014, we identified and reviewed 529 claim lines, totaling $112,951 in payments, that contained modifier 50, 51 or 62 (bilateral, multiple, and co-surgeon procedure indicators, respectively) and were also eligible for OBRA 93 pricing. Our review determined that the FEP OC did not correctly apply the Medicare bilateral, multiple, and co-surgeon procedure discounts to 278 claim lines. As a result, the Plan incorrectly paid these 278 claim lines, totaling $27,152 in overcharges 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." Additionally, 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 . . . ."

Plan's Response:

"Claims were contested as a result of the following . . . [claims] were paid in accordance with the OBRA '93 pricing guidelines as administered by the OPM authorized OBRA '93 pricing vendor, Palmetto. Although the 2012 OPM Global OBRA '93 audit report recommended implementation of Medicare discount pricing for modifier 50, 51, and 62, BCBSA [the Association] did not agree to implement the new methodology until it determined that it was feasible to do so. That determination was made in first quarter 2014. As a result, only those claims paid after BCBSA [the Association] agreed to implement the new calculation method are recognized as claim overpayments. . . .

The FEP claims system will be enhanced by September 30, 2015 to apply the appropriate modifier reductions for modifier 50, 51 and 62 claims. Until the FEP claims system can systematically calculate the price, Plans are provided a listing of claims to review and calculate the Medicare reductions.

Where possible, the Plan has initiated recovery on agreed to claim errors. Any funds recovered will be returned to the FEP Program."

OIG Comment:

After reviewing the Plan's response to the draft report, we determined the Plan agrees with $5,609 and disagrees with $21,543 of the questioned charges. The Association states that they did not implement corrective actions until they determined that is was feasible to do so, and does not believe it is responsible for claim overpayments before it completed a feasibility study. However, the OIG's OBRA 93 final report clearly identified and stated, "we estimate potential savings of approximately $1.8 million a year to the FEHBP if the FEP Operations Center would start applying the multiple procedure and surgeon discounts to claim lines subject to OBRA 93 pricing." The Association's decision to delay the feasibility study has no impact on the fact that these claims were paid in error. If the Association had timely completed the OBRA 93 analysis in the fourth quarter of 2012, the process of updating the FEP Express system would have not been delayed and the Plan could have been promptly notified to identify OBRA 93 claim payment errors. These actions would have resulted in immediate savings to the FEHBP. This audit continues to question all OBRA 93 claim payment errors processed after the issuance of the OPM OIG OBRA 93 final report.

Recommendation 1

We recommend that the contracting officer disallow $27,152 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

B. Co-Surgeon Discount Review $16,884

The Plan incorrectly priced six claim lines containing a co-surgeon procedure code, resulting in overcharges of $16,884 to the FEHBP.

For the scope of January 1, 2011 through September 30, 2014, we identified 1,327 claim lines, totaling $1,119,475 in payments, containing a co-surgeon procedure code. From this universe, we judgmentally selected to review 13 claims with the highest amounts paid to determine if the Plan properly applied the Plan's local co-surgeon pricing discounts.[2] These 13 claims represent 43 claim lines, totaling $177,687 in payments.

Our review determined that the Plan incorrectly priced six claim lines due to claims processors manually applying the co-surgeon procedure discounts in error, resulting in overcharges of $16,884 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 recovery of any overpayment must be treated as an erroneous benefit payment, regardless of any time period limitations in the written provider agreement.

Plan's Response:

The Plan agrees with this finding. The Plan states additional training is being provided to the processors to reduce these types of errors from occurring in the future.

Recommendation 2

We recommend that the contracting officer disallow $16,884 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

C. Bilateral Procedures Review $3,716

The Plan incorrectly paid six claim lines containing a bilateral procedure, resulting in overcharges of $3,716 to the FEHBP.

For the scope of January 1, 2011 through September 30, 2014, we identified 27,352 claim lines, totaling $3,221,697 in payments, containing a bilateral procedure. A bilateral procedure is when a service is performed on both sides of the body. From this universe, we judgmentally selected to review 50 claims with the highest amounts paid to determine if the Plan properly priced and paid the claims. These 50 claims represent 173 claim lines, totaling $141,940 in payments.

[2] In general, the Plan's local policy applies a 62.3 percent discount to qualified co-surgeon procedures.

Our review determined that the Plan incorrectly paid six claim lines, due to claims processors manually applying the bilateral procedure discounts in error, resulting in overcharges of $3,716 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 recovery of any overpayment must be treated as an erroneous benefit payment, regardless of any time period limitations in the written provider agreement.

Plan's Response:

The Plan agrees with this finding. The Plan states, additional training to their processors has been completed in this area and where possible, recovery has been initiated and all funds recovered will be returned to the FEHBP.

Recommendation 3

We recommend that the contracting officer disallow $3,716 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Information Systems Audits Group

[redacted], Auditor

[redacted], Auditor-in-Charge

[redacted], Senior Team Leader

[redacted], Group Chief

V. SCHEDULE A

BLUE SHIELD OF CALIFORNIA
SAN FRANCISCO, CALIFORNIA

HEALTH BENEFIT CHARGES AND AMOUNTS QUESTIONED

HEALTH BENEFIT CHARGES		2011	2012	2013	2014	TOTAL
CLAIM PAYMENTS		$360,537,464	$392,363,660	$412,620,205	$425,215,730	$1,590,737,059
MISC. PAYMENTS AND CREDITS		462,673	(186,385)	(354,546)	(190,159)	(268,417)
	TOTAL	$361,000,137	$392,177,275	$412,265,659	$425,025,571	$1,590,468,642

AMOUNTS QUESTIONED	2011	2012	2013	2014	TOTAL
A. OBRA 93 REVIEW	$0	$11,365	$9,667	$6,120	$27,152
B. CO-SURGEON DISCOUNT REVIEW	0	6,855	10,029	0	16,884
C. BILATERAL PROCEDURES REVIEW	0	3,716	0	0	3,716
TOTAL QUESTIONED CHARGES	$0	$21,936	$19,696	$6,120	$47,752

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
Phone # 202.942.1000
Fax 202.942.1125

July 28, 2015

[redacted], Group Chief
Claims & IT Audits Group
U.S. Office of Personnel Management
1900 E Street, Room 6400
Washington, D.C. 20415-1100

Reference: **OPM FINAL AUDIT REPORT**
Blue Shield of California
Audit Report Number 1A-10-67-15-001
(Dated and Received June 1, 2015)

Dear [redacted]:

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

HEALTH BENEFIT CHARGES

A. Omnibus Budget Reconciliation Act of 1993 (OBRA 93) Review $47,508

Recommendation 1

We recommend that the contracting officer disallow $47,508 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Plan Response:

The Plan agrees that $5,609 was paid in error and disagrees with $41,899 in questioned claims.

Claims were contested as a result of the following:

- Claims totaling $38,488 were paid in accordance with the OBRA ’93 pricing guidelines as administered by the OPM authorized OBRA ’93 pricing vendor, Palmetto. Although the 2012 OPM Global OBRA ’93 audit report recommended implementation of Medicare discount pricing for modifier 50, 51, and 62, BCBSA did not agree to implement the new methodology until it determined that it was feasible to do so. That determination was made in first quarter 2014. As a result, only those claims paid after BCBSA agreed to implement the new calculation method are recognized as claim overpayments.
- Claims totaling $2,466 are not surgical codes, and therefore, no reduction is required.
- Claims totaling $541 are below the recovery threshold.

The FEP claims system will be enhanced by September 30, 2015 to apply the appropriate modifier reductions for modifier 50, 51 and 62 claims. Until the FEP claims system can systematically calculate the price, Plans are provided a listing of claims to review and calculate the Medicare reductions.

Where possible, the Plan has initiated recovery on agreed to claim errors. Any funds recovered will be returned to the FEP Program.

B. Co-Surgeon Discount Review $26,256

Recommendation 2

We recommend that the contracting officer disallow $26,256 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Plan Response:

The Plan agrees that $16,884 in claim payments were paid in error and disagrees that claims totaling $8,372 were paid in error.

For the 6 claim overpayments totaling $16,884, the errors were the result of Plan processor error. The Plan has provided additional training to the processors to reduce these types of errors from occurring in the future. Where possible, the Plan has initiated recovery on agreed to claim errors. Any funds recovered will be returned to the FEP Program.

The Plan disagrees that the member liability was incorrectly applied to one claim line totaling $9,372. The member's liability, as shown on the Members Explanation of Benefits, as the total billed amount, is correct. The payment was sent to the member directly; as such it is the member's responsibility to pay the non-par provider the entire amount billed for the services rendered.

C. Bilateral Procedures Review **$3,716**

Recommendation 3

We recommend that the contracting officer disallow $3,716 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Plan Response

The Plan agrees that 6 claim lines of 173 claim lines, totaling $3,716 were incorrectly priced. These claim line errors were the result of Plan processor. The Plan has provided feedback and additional training to the processors. Additionally, the Plan performed a focus audit of Bilateral Procedures to assure processor compliance.

Where possible, the Plan has initiated recovery on agreed to claim errors. Any funds recovered will be returned to the FEP Program.

We appreciate the opportunity to provide our response to each of the findings in this report and request that our comments be included in their entirety and are made a part of the Final Audit Report. If you have any questions, please contact me at [redacted] or [redacted] at [redacted].

Sincerely,

[redacted]
Managing Director, Program Assurance

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