Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF THE ANTHEM BLUE CROSS AND BLUE SHIELD OF CONNECTICUT FISCAL JNTERMEDIARY'S COMPLIANCE WITH MEDICARE LAWS AND REGULATIONS

JUNE GIBBS BROWN
Inspector General

JUNE 1999
A-01-98-005 13

OFFICE OF INSPECTOR GENERAL

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF THE ANTHEM BLUE CROSS AND BLUE SHIELD OF CONNECTICUT FISCAL INTERMEDIARY'S COMPLIANCE WITH MEDICARE LAWS AND REGULATIONS

JUNE GIBBS BROWN
Inspector General

JUNE 1999
A-01-98-00513

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The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Final determination on these matters will be made by authorized officials of the HHS divisions.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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JUN 3 1 1999

CIN: A-O I-98-005 13

Mr. Harry J. Torello
President & Chief Executive Officer
Anthem Blue Cross and Blue Shield of Connecticut
370 Bassett Road
North Haven, Connecticut 06473-420 1

Dear Mr. Torello:

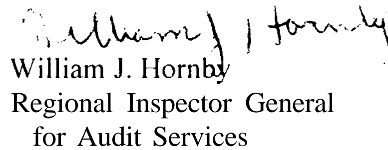
Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services' (OAS) report entitled "Review of the Anthem Blue Cross and Blue Shield of Connecticut Fiscal Intermediary's Compliance with Medicare Laws and Regulations." A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23). OIG. OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification, please refer to Common identification Number A-01-98-005 13 in all correspondence relating to this report.

Sincerely yours.



William J. Hornby
Regional Inspector General
for Audit Services

Enclosures - as stated

Direct Reply to HHS Action Official:

George Jacobs
Regional Administrator
Health Care Financing Administration - Region I
U.S. Department of Health and Human Services
Room 2325; JFK Federal Building
Boston, Massachusetts 02203

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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JUN 2 1 1999

CIN: A-01 -98-005 13

Mr. Harry J. Torello
President & Chief Executive Officer
Anthem Blue Cross and Blue Shield of Connecticut
370 Bassett Road
North Haven, Connecticut 06473-420 1

Dear Mr. Torello:

The purpose of this final report is to provide you with the results of our review of the Anthem Blue Cross and Blue Shield of Connecticut (Anthem) fiscal intermediary's (FI) compliance with laws and regulations related to fiscal year (FY) 1998 Medicare fee-for-service benefit payments. The objective of our review was to determine whether Anthem paid for services which were: (1) furnished by certified Medicare providers to eligible beneficiaries; (2) reimbursed in accordance with Medicare laws and regulations; and (3) medically necessary, accurately coded. and sufficiently documented in the beneficiaries' medical records. We also reviewed the effectiveness of Anthem's internal controls to ensure that Medicare transactions are fully supported and properly reported to the Health Care Financing Administration (HCFA). Our reviews at Anthem and several contractors nationwide were performed as part of our responsibilities under the Chief Financial Officers (CFO) Act of 1990. The CFO Act requires Federal agencies to improve systems of financial management. accounting. and internal controls to assure the issuance of reliable financial information.

Through detailed medical and audit review of a statistical selection of 50 beneficiaries representing 17 1 provider claims processed for payment by Anthem, we identified 28 improper Medicare payments totaling $65,917 of $635.823 reviewed. We found these payments were not in compliance with various Medicare laws and regulations requiring that services be medically necessary, sufficiently documented, and coded correctly. We recommend that Anthem adjust its Medicare accounts for the improper claims. initiate overpayment recovery from the identified providers, and follow up with the providers to address medical necessity and documentation concerns.

We also identified control weaknesses (see OTHER MATTERS) which could impact Anthem's ability to record and report accurate financial data. We recognize that Anthem. as the Medicare contractor for Connecticut. will cease its Medicare operations during July 1999. Accordingly, we recommend that Anthem share the results of our internal control review with the succeeding Medicare contractor.

The Anthem generally concurred with the findings presented in our draft report. dated March 23, 1999. and agreed to take corrective action in response to our recommendations. The Anthem's response is appended in its entirety to this report (APPENDIX).

INTRODUCTION

BACKGROUND

The Medicare program (Title XVIII of the Social Security Act) was established by the Social Security Amendments of 1965 to cover the health care needs of people aged 65 and over, the disabled, people with end-stage renal disease (ESRD). and certain others who elect to purchase Medicare coverage. In FY 1998, about 39 million beneficiaries were enrolled in the program, and HCFA incurred about $210 billion nationwide in Medicare benefit payments. Fee-for-service payments accounted for about $176.1 billion of this total.

Medicare is a combination of two programs. each with its own enrollment. coverage. and financing:

- Hospital insurance (HI), also known as Medicare Part A, is generally provided automatically to people aged 65 and over and to most disabled people. It covers services rendered by participating hospitals. skilled nursing facilities (SNF), home health agencies, and hospice providers.

- Supplementary medical insurance (SMI), also known as Medicare Part B, is available to nearly all people aged 65 or over and the disabled entitled to Part A. This optional insurance is subject to monthly premium payments by beneficiaries. Medicare Part B covers physician and outpatient care, laboratory tests. durable medical equipment, designated therapy services, and some other services not covered by Part A.

The FIs and carriers, under contract with HCFA, process claims for services covered by Parts A and B, respectively.

OBJECTIVES, SCOPE AND METHODOLOGY

The overall objective of our audit of HCFA's FY 1998 financial statements was to determine whether HCFA's financial statements present fairly in all material respects its financial position and results of operations. As part of our overall objective, the purpose of this segment of the review was to determine whether HCFA's Medicare contractors. including Anthem. have: (1) complied with laws and regulations that could have a direct and material effect on the financial statements; and (2) established an internal control structure that provides reasonable assurance that transactions are properly recorded and accounted for to permit the preparation of reliable financial statements and to maintain accountability.

Compliance With Laws And Regulations

To accomplish our primary objective, we designed and utilized a stratified multi-stage sample based on probability-proportional-to-size selection methodology. The first stage consisted of a random selection of 12 contractor quarters and the second stage consisted of a sample of 50 beneficiaries from each contractor quarter using a stratified random design. The Anthem FI's fourth quarter of FY 1998 was among the contractor quarters randomly selected. We reconciled Medicare contractor claims data for the selected quarter to the HCFA Monthly Contractor Financial Report (HCFA 1522). The Anthem reported benefit payment expenses totaling about $323.2 million for the fourth quarter of FY 1998.

We reviewed all Part A and Part B of A (outpatient) adjudicated fee-for-service claims paid during the applicable FY 1998 contractor quarter for each selected beneficiary to determine whether Anthem made payments for services which were: (1) furnished by certified Medicare providers to eligible beneficiaries; (2) reimbursed in accordance with Medicare laws and regulations; and (3) medically necessary, accurately coded. and sufficiently documented in the beneficiaries' medical records.

To determine whether Anthem made valid Medicare payments, we performed numerous detailed audit procedures, including, but not limited to the following:

- confirming the beneficiary and provider met all Medicare eligibility requirements:

- reviewing for duplicate payments and payments for which another primary insurer may have been responsible for reimbursement (Medicare Secondary Payor (MSP)); and

- verifying that selected services were subjected to applicable deductible and co-insurance amounts and were priced in accordance with Medicare payment regulations.

For all claims, we utilized medical review personnel from Anthem and the Connecticut Peer Review Organization (Qualidigm) to assess the pertinent medical record documentation and determine whether the services billed were reasonable. medically necessary. adequately documented, and coded correctly. The FI medical review personnel are responsible for reviewing certain types of Part A and B of A claims such as SNF, hospital outpatient. and ESRD facility services. Qualidigm has responsibility for medical review over Part A inpatient hospital and Part B of A outpatient ambulatory surgical center (ASC) services. Effective coordination between the auditors and the medical reviewers was integral towards establishing conclusive Medicare benefit payment error determinations.

Our random sample of a total of 50 beneficiaries from the Anthem fourth quarter of FY 1998 produced 171 claims for review totaling $635.823. Of the 17 1 total claims, 57 were Part A claims totaling $603,025 paid through the HI Trust Fund. These claims included payment for services provided to beneficiaries by inpatient hospitals and inpatient SNFs. The other 114

- claims totaling $32,798 were outpatient claims paid through the SMI Trust Fund. These claims included reimbursement for services furnished by outpatient hospital departments and ESRD facilities.

Internal Control Structure

We performed a review of Anthem's internal control structure as it relates to selected aspects of its Medicare operations, including the benefit payment process, non-claims related transactions. accounts receivable, accounts payable, cash receipts, and the reconciliation of monthly program expenses. For instance, we:

- reviewed the benefit payment process to determine whether controls exist. are operational, and achieve control objectives;

- verified that non-claims related disbursements and withholdings represent valid and accurate Medicare transactions;

- tested accounts receivable transactions to determine whether receivable amounts are supported, reported, and written-off in accordance with applicable regulations:

- tested the support and accuracy of cash receipt transactions, and verified receipts are deposited timely and properly applied against accounts receivable; and

- reviewed Anthem's reconciliation of its monthly HCFA 1522 reports to ensure reported claims and non-claims activity is correct and fully supported.

Our audit was conducted in accordance with generally accepted government auditing standards. . We performed our field work during the period August 1998 through February 1999 at the Anthem FI in Meriden, Connecticut. On February 2.5, 1999 we discussed the results of our review with Anthem officials. We have also shared our results with the HCFA Central Office and the HCFA Boston Regional Office. The draft report was issued to Anthem on March 23, 1999. On July 9, 1999 Anthem will withdraw from the Medicare program. Some of the corrective actions which address our recommendations may be initiated or completed by Anthem's successor in the Medicare program. Accordingly. we plan to discuss the results of this review with the incoming contractor.

FINDINGS AND RECOMMENDATIONS

RESULTS OF REVIEW OF COMPLIANCE WITH LAWS AND REGULATIONS

Through detailed medical and audit review of a statistical selection of 50 beneficiaries representing 17 1 provider claims processed for payment by Anthem, we identified 28 improper Medicare payments totaling $65,917 of $635,823 reviewed (See Attachments A and B). Our analysis showed that providers were reimbursed by Medicare for services which were:

- not medically necessary ($54,188);
- insufficiently documented to support the services billed ($15.343):
- inappropriately coded resulting in under-payments ($8.382) and overpayments ($3,987); and
- not in compliance with various Medicare regulations resulting in overpayments ($2,426). and under-payments ($645).

It should be noted that Anthem's claims processing controls were generally adequate for: (1) ensuring beneficiary and provider Medicare eligibility; and (2) ensuring the services as billed were allowable under Medicare rules and regulations. When the improperly billed claims were submitted for payment to Anthem, they contained no visible errors. Consequently. most of the improper payments in our sample were detected through medical record reviews coordinated by the OIG in conjunction with medical personnel.

The payment errors from the sampled claims fell into the following four general categories: (1) lack of medical necessity; (2) insufficient documentation; (3) incorrect coding: and (4) noncompliance with various Medicare regulations. These categories are discussed below in more detail with relevant examples.

Lack of Medical Necessity

Section 1862 of the Social Security Act (SSA) excludes from Medicare items and services which are not medically necessary and reasonable. Decisions on medical necessity were made by Qualidigm or the FI medical review staff using Medicare reimbursement rules and regulations. They followed their normal review procedures to determine whether services were medically necessary and reasonable. We found that the lack of medical necessity accounted for $54,188 of the total improper payments. For instance:

- A beneficiary was admitted to an acute care hospital for a trachael resection surgical procedure. The beneficiary was discharged without having the procedure, and the

hospital was paid $15.625. The beneficiary was subsequently readmitted to the same hospital, and the procedure was performed during the second admission. Based on a review of the medical records. Qualidigm concluded that the procedure should have been completed during the initial hospital stay and that the beneficiary was prematurely discharged at that time. As a result, the second admission was determined not medically necessary and the total payment of $2 1,284 for that admission was denied.

Insufficient Documentation

Medicare regulation, 42 Code of Federal Regulations (CFR), Section 482.24 (c). specifically requires providers to maintain medical records that contain sufficient documentation to justify admission. services furnished, diagnoses, treatment performed and continued care. If providers l'ailed to furnish supporting medical records or submitted insufficient records after the initial request. we generally requested such documentation numerous times before the medical reviewers determined the payment to be improper. However, we still found insufficient documentation accounted for $15.343 of the total improper payments. For example:

- A hospital was paid $78 for outpatient laboratory services. The FI medical review determined that the medical records submitted by the hospital did not provide sufficient clinical documentation (i.e., physician progress notes) to support the services billed. Accordingly, the entire payment was denied.

Incorrect Coding

Medicare regulation, 42 CFR, Section 482.24 (c) requires that the medical industry use a standard coding system to bill Medicare for services provided. Incorrectly coded claims in our sample accounted for underpayments of $8,382 and overpayments of $2.987. For instance:

- Qualidigm's correction of the procedure code for an inpatient hospital claim produced a lesser valued diagnosis-related group (DRG) payment. The change in the DRG resulted in a decrease in provider reimbursement of $2,987.

Noncompliance with Various Medicare Regulations

Medicare noncovered or unallowable services are defined in Section 1862 of the SSA as those Medicare will not reimburse because the services do not meet Medicare rules and regulations. Additionally, payment for allowable Medicare services must be made in accordance with applicable reimbursement methodologies. Our review identified a net overpayment of $1,78 1 resulting from noncovered services or services which were reimbursed incorrectly. For instance. our claims review determined that:

- The FI made an (1) underpayment of $102 for 2 ESRD claims because certain ESRD drugs which should be separately reimbursed were instead included in the composite rate;

and (2) overpayment of $2.414 for one ESRD claim because total charges were used as the basis for dialysis reimbursement rather than the appropriate composite rate.

Recommendations

Based on the results of our detailed review of Medicare fee-for-service claims, we recommend that Anthem adjust its Medicare accounts for the denied claims totaling $65.917 and initiate immediate overpayment recovery from the identified providers. The Anthem should also follow up with specific providers identified in our sample to address medical necessity. coding, and documentation concerns.

Anthem Response

In its written response to our draft report, Anthem concurred with the findings and has initiated overpayment recovery from the identified providers.

OTHER MATTERS

During our review, we identified internal control deficiencies which could impact Anthem's ability to record and report accurate financial information. We attribute certain control weaknesses to the absence of formal written procedures and/or independent verification. Some of the control weaknesses, however, are due to problems encountered by Anthem during transition to a new claims processing system and/or deficiencies inherent in the core claims processing system. During the course of the review, under separate cover, we provided Anthem with a full text of the control weaknesses. We recognize that Anthem will cease its Medicare operations during July 1999. Accordingly, we recommend that Anthem share the results of our internal control review with the succeeding Medicare contractor. Controls which are less than effective are summarized below-.

Absence of Written Procedures and Independent Verification Controls

Written policies and procedures should be formally established for all functional areas. and updated as necessary, to provide reasonable assurance that Medicare regulations and directives are properly implemented by applicable personnel. Written policies and procedures should also provide consistent guidance during transitional stages. Independent verification controls are essential to provide assurance as to the validity. accuracy. and completeness of reported financial data. We identified the following matters which show these controls need to be strengthened:

- Amounts reported to the HCFA 75 1 by Anthem as allowances for uncollectible MSP represent 90 percent of the reported MSP accounts receivable ending balances. At the time of our review. Anthem had not established written procedures demonstrating its basis for estimating the allowances for uncollectible MSP. As a result, we were unable to

determine the validity of the balance reported as "Total MSP Receivables Net of Allowance".

- Anthem did not record cumulative MSP credit balance activity to the HCFA 750/75 1 at September 30, 1998. Although the June 30, 1998 quarterly credit balance summary report showed all credit balance receivables were recovered through cash collections or offsets, our sample of credit balance transactions showed that some of the credit balances were not offset and were still accounts receivable at September 30, 1998. As a result. the ending MSP accounts receivable balances are understated by unreported credit balances.

- Anthem overstated "new/accrued receivables" by about $14 million on its September 30. 1998 HCFA 75 1 because it included "H" code amounts from HCFA's Provider Overpayment Report. The "H" codes are suspended payments due providers which will not be released until providers submit delinquent Medicare cost reports. Therefore. "H" code amounts should be reported as accounts payable rather than accounts receivable.

- Anthem has not established a complete quality control program to review. on a sample basis, the resolution of suspended claims and processed claims adjustments. The absence of a full quality control review increases the risk that suspended claims are not resolved correctly and that edits may be inappropriately bypassed.

- Anthem has not established independent verification procedures to provide reasonable assurance that amounts reported to HCFA through the HCFA 1521/1522 and 750/751 reports are valid, accurately summarized, and sufficiently documented. The absence of an independent review increases the risk that material reporting errors may occur and not be detected on a timely basis or detected at all.

Control Weaknesses Inherent in Core System

Anthem recently transitioned to the Fiscal Intermediary Shared System (FISS) for processing claims. Subsequent to the transition, Anthem experienced difficulties with the "core" FISS which impeded claims processing, financial reporting, and data analysis. In addition to the FISS. Anthem also uses HCFA's System for Tracking Overpayments (STOP) and Provider Overpayment Reporting System (PORS). These systems were primarily designed to process claims and track overpayments from different contractor activities, and were not part of a fully integrated financial management system containing attributes such as full accrual accounting and proper cut-off procedures. As a result, these systems were not designed to record and summarize information for the preparation of reliable financial statements. In this regard, we understand that HCFA is currently developing a standard general ledger which will be provided to the Medicare contractors for use with the selected claims processing systems. The following conditions underscore the effect of the transition as well as deficiencies inherent in the "core" FISS:

- Anthem paid some providers unusually large interest payments due to claims which were paid late during its initial pay cycles after transitioning to the FISS. Furthermore. some of the interest payments to providers were based on interest rates which were not in compliance with interest rates established by the Treasury Department.

- Our sample for testing paid claims included only 3 ESRD claims. For each of the 3 claims, we found errors caused by a claims processing deficiency which affected the manner in which the services were priced by Anthem for payment to the provider.

- Anthem does not use general and subsidiary ledgers to record financial data. As a result. Medicare transactions are not processed within the framework of an integrated financial management system. For instance, cash collections reported on the September 30. 1998 HCFA 75 1 totaling about $148 million could not be fully supported. The reported amount was essentially a “forced figure” to reconcile beginning and ending balances.

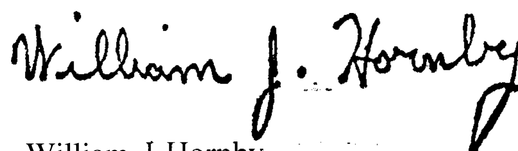
- Anthem had encountered difficulties in downloading and updating MSP data from the Arkansas System Caseworks File to the FISS Recovery Tracking System. As a result, the MSP receivable balances reported to HCFA at September 30. 1998, are not reliable.

- HCFA requires the FI medical review and fraud and abuse units to refine data analysis approaches and software to improve the identification of overutilization and abusive practices. The “core” FISS may require program supplements to effectively produce required reports for analyzing provider aberrancies and determining cost savings.

Anthem Response

In its written response to our draft report, Anthem generally concurred with the identified internal control deficiencies. As Anthem indicates in its response, some of the control activity did not occur due to the decision not to renew Anthem’s Part A Medicare contract.

Sincerely,



William J. Hornby
Regional Inspector General
for Audit Services

ANTHEM BLUE CROSS AND BLUE SHIELD OF CONNECTICUT
SCHEDULE OF CLAIMS DENIED BY MEDICAL REVIEW

#	Medicare Part	Document Control Number	Reason for Denial	Amount
1	A	19823700414302	Lack of medical necessity	$27,584.00
2	A	19823700210602	Invalid inpatient admission (Lack of medical necessity)	21,284.21
3	A	19824500450202	Insufficient clinical documentation	14,422.43
4	A	r9823600366602	Lack of medical necessity	4753.98
5	A	19820500276402	Services incorrectly coded	2987.07
6	a	~9821600265002	Pricing error & Insufficient documentation	2,420.7 1
	A	19818000151402	Utilization error (Lack of medical necessity)	555.72
a	3	19821000112102	Insufficient clinical documentation	201.69
9	B	19818000237602	No documentation submitted	161.71
10	B	19818700365502	Services not rendered per documentation	131.35
11	B	19822500076002	Insufficient clinical documentation	78.10
12	B	19818700580502	Services not rendered per documentation	54.45
13	B	19820300337602	Services not rendered per documentation	54.45
14	B	19825300463302	Services not rendered per documentation	54.45
15	B	19819500164602	Pricing error & Insufficient clinical documentation	49.91
16	B	19823100119402	No documentation submitted	18.00
17	B	19824600286002	Insufficient clinical documentation	14.85
18	B	19822500393002	Insufficient clinical documentation	13.25
19	B	19819100204102	Lack of medical necessity	10.32
20	B	19818100061602	Non-covered service	9.96
21	3	19825100551 102	Insufficient clinical documentation	3.09
22	3	19824700302702	Insufficient clinical documentation	5.00
23	3	1982180011[illegible]	Insufficient clinical documentation	[illegible]
24	3	19823000419402	Non-covered service	1.47
25	3	'9819700127602	Non-covered service	0.56
26	3	'98196001'3102	Pricing error & Insufficient clinical documentation	(37.691
27	3	19820300086802	Pricing error	(542.88)
28	A	19817105301S0C1	Services incorrectly coded	(8,382.34)
28			Totals	$65,917.03

OIG claims review determined pricing error of $2,414.15.
FI medical review determined insufficient documentation error of $6.56.
OIG claims review determined pricing error of ($43.89).
FI medical review determined insufficient documentation error of $93.80.
OIG claims review determined pricing error of ($58.52).
FI medical review determined insufficient documentation error of $20.83.

ANTHEM BLUE CROSS AND BLUE SHIELD OF CONNECTICUT IMPROPER PAYMENTS BY PROVIDER TYPE

The following chart shows the types of claims by provider, amounts reviewed, number of claims reviewed. number of claims with improper payments, and total dollar of improper payments. About 95 percent of these improper payments were attributed to inpatient hospital claims.

Total Dollars, Number of Claims, and Improper Payments by Provider Type

Type of Claim	Dollars Reviewed	Number of Claims Reviewed	Number of Claims with Improper Payments	Total Dollar Improper Payments
Inpatient PPS Claims	$502,461	42	5	$35,065
Inpatient Non PPS Claims	53,542	4	1	27,584
Inpatient SNF Claims	47,022	11	0	0
Outpatient Hospital Claims	17,295	101	18	279
ESRD Claims	9,334	4	3	2,433
ASC Claims	6,169	9	1	556
Totals	$635,823	171	28	$65,917

APPENDIX

June 17, 1999

William J. Homby
Regional Inspector General for Audit Services
Office of Audit Services
Office of Inspector General
Region 1
John F. Kennedy Federal Building
Boston, MA 02203

Dear Mr. Homby:

Thank you for the opportunity to respond to the draft report detailing the results of your review of Anthem Blue Cross and Blue Shield of Connecticut (Anthem) fiscal intermediary's compliance with laws and regulations related to the fiscal year (FY) 1998 Medicare fee-for-service benefit payments.

FINDING 1 Results of Review of Compliance with Laws and Regulations

You identified 28 Medicare payments totaling $65,917 that *need* to be adjusted. As noted in your report "when the improperly billed claims were submitted for payment to Anthem, they contained no visible errors. The payment errors from the sampled claims fell into the following four general categories: (1) lack of medical necessity; (2) insufficient documentation; (3) incorrect coding; and (4) noncompliance with various Medicare regulations".

We concur with the findings and will follow through with the recommendation to adjust the Medicare accounts for the denied claims and initiate overpayment recovery from the identified providers.

STATUS: For twenty one of the twenty eight claims on Attachment A we have adjusted our Medicare accounts for the denied claims and initiated overpayment recovery from the identified providers.

For seven of the claims, reference numbers 1,2,3,4,5,7 and 28 we needed to obtain from the OIG the HIC number and details regarding the denial in order to have sufficient information to adjust our Medicare accounts for the denied claims and initiate overpayment recovery from the providers. In June, 1999, we obtained the necessary information from the OIG and we are in the process of adjusting the related Medicare accounts and initiating overpayment recovery.

FINDING 2 Absence of Written Procedures and Independent Verification Controls

The OIG identified five areas where you feel controls need to be strengthened. A brief summary of each area and our response are noted below:

(a) ***Condition:*** At the time of OIG's review, Anthem had not established written procedures demonstrating its basis for estimating the allowances for uncollectible MSP.

Contractor Response: As noted in our January, 1999 response to OIG, beginning with the FY 1999 HCFA 750/751, Anthem will estimate its collections based on final FY 1998 liability settlements, MSP Backlog, and Datamatch divided by the initial FY 1998 MSP Backlog and Datamatch amount. The estimated uncollectible percentage for 1999 is 78% (Part A) and 85% (Part B).

(b) ***Condition:*** Anthem did not record cumulative MSP credit balance activity to the HCFA 750/75 1 at September 30, 1998. The ending MSP accounts receivable balances are understated by unreported credit balances.

Contractor Response: Anthem noted in our January, 1999 response to OIG that we would begin reporting credit balances on the HCFA 750/75 1 report as both a receivable and a recovery. Since the credit balance reporting period does not coincide with the HCFA 750/75 1 reporting period, the credit balance reports will be a calendar quarter earlier than the rest of the HCFA 750/751.

For the quarter ended December 3 1, 1998, Anthem audited our credit balance reports. We are drafting a cover letter to send to each provider in order to identify claims that were mistakenly reported as credit balances.

(c) ***Condition:*** Anthem overstated "new/accrued receivables" by about $14 million on its September 30, 1998 HCFA 751 because it included "H" code amounts from HCFA's Provider Overpayment Report (POR). The "H" code amounts should be reported as accounts payable rather than accounts receivable.

Contractor Response: Anthem concurs with this finding. Anthem had been including these amounts on both the payable line of the HCFA 750 and in the POR amount which represents new accounts receivable for the current quarter. Anthem has removed from the POR amount those items with an "H" designation. The suspended amounts will continue to be recorded in the accounts payable.

(d) *Condition:* Anthem has not established a complete quality control program to review, on a sample basis, the resolution of suspended claims and processed claims adjustments.

Contractor Response: In January, 1999, Anthem had noted to the OTG that we submitted a Quality Assurance Customer Action Request (CAR) *seeking* an enhancement to the FISS. Anthem proposed that on a sample basis the FISS print a copy of a claim the way it was initially submitted and print a copy of the claim after it was processed. This sampling would occur for claims processed by each clerk. This quality assurance procedure was available to Arkansas system users but is not available since Anthem's transition to FISS.

In May, 1999 Anthem discovered that an inadvertent oversight occurred and the CAR was not submitted by us. The OIG was informed of this oversight on May 17, 1999. Anthem submitted to HCFA an alternative plan we believe meets the objectives of the OTG recommendations. On June 15, 1999, Anthem received a letter from HCFA which stated: "The alternative plan that you developed to implement this program in order to comply with the OIG findings has been reviewed and appears to be acceptable to the OIG".

(e) *Condition:* Anthem has not established independent verification procedures to provide reasonable assurance that amounts reported to HCFA through the HCFA 152111522 and 750/75 1 reports are valid, accurately summarized, and sufficiently documented.

Contractor *Response:* Anthem had noted in January, 1999 that Corporate Audit was beginning its risk assessment process to help determine allocation of audit resources for 1999. The Medicare Intermediary Operation was to be considered in that process. Due to the decision in January to transition out of the Fiscal Intermediary function, the above noted activity related to Medicare did not take place.

FINDING 3 Control Weaknesses Inherent in Core System

Your letter specifies the following conditions related to the effect of Anthem's transition to FISS as well as deficiencies inherent in the "core" FISS.

(a) *Condition:* Anthem paid some providers unusually large interest payments due to claims which were paid late during its initial pay cycles after transitioning to the FISS. Some of the interest payments to providers *were* based on interest rates which were not in compliance with interest rates established by the Treasury Department.

Contractor *Response:* The clean claims interest payments could not be referenced back to rates entered in the FISS on-line interest screen. Anthem reported this problem to its data center. Subsequently FISS corrected the problem.

Subsequent to the OIG review, Anthem reviewed and evaluated its original bill pending claims volume as reported on its monthly HCFA 1566 workload report. Anthem's objective is to avoid interest payments by paying as many original bills as possible within the payment window.

(b) *Condition:* For each of the 3 ESRD claims in the OIG sample, errors were found that were caused by a claims processing deficiency which affected the manner in which the services were priced by Anthem for payment to the provider.

Contractor Response: As Anthem noted in our January, 1999 response, AdminaStar and FISS corrected the claims processing deficiency. Anthem reviewed the credit balance report and adjusted claims with payment errors related to this system deficiency.

(c) *Condition--* Anthem does not use general and subsidiary ledgers to record financial data. As a result, Medicare transactions are not processed within the fi-amework of an integrated management system.

Contractor Response: Anthem currently has no Medicare general ledger used solely for Medicare operations. Clifton Gunderson noted the same condition as above in its report dated March 25, 1998. Clifton Gunderson stated "The lack of general ledger and subsidiary ledger systems is inherent to Medicare Standard Systems".

HCFA Response: HCFA is currently developing a standard general ledger which will be provided to the contractors for use with the selected claims processing system.

(d) ***Condition:*** *Anthem* encountered difficulties in downloading and updating MSP data from the Arkansas System Caseworks File to the FISS Recovery Tracking System As a result, the MSP receivable balances reported to HCFA at September 30, 1998 are not reliable.

Contractor Response: The MSP accounts receivable balance reported by Anthem at 9/30/98 was the same as the balance reported at 6/30/98. This was due to difficulties encountered in the FISS transition. The report, which runs quarterly, did not run for the quarter ended 9/30/98. The report has been run for subsequent quarters.

(e) **Condition:** HCFA requires the FI medical review and fraud and abuse units to refine data analysis approaches and software to improve the identification of over-utilization and abusive practices. The "core" FISS may require program supplements to effectively produce required reports for analyzing provider aberrancies and determining cost savings.

Contractor Response: Anthem's January 1999 response noted that HCFA has instructed contractors not to modify or enhance the FISS core system Anthem's HCFA Regional Office has indicated a willingness to consider funding supplements to the FISS core system. Anthem was actively researching supplements to the core FTSS and requested guidance from the HCFA Central Office regarding which supplements to the core FISS should be pursued.

In January, 1999, Anthem was in the process of obtaining VIPS/STARS to perform data analysis when the decision was made not to renew our Part A Medicare contract. On January 15, 1999, I received a verbal waiver from the HCFA Regional Office in Boston regarding data analysis and the pursuing of VIPS/STARS.

Anthem would like to thank Mr. Armstrong, Mr. Lamir and Mr. Delbene for the level of expertise and professionalism they brought to the review process.

Sincerely,

Patricia Callahan, Director
Government Programs
Anthem Blue Cross and Blue Shield of Connecticut

cc: S. Amtsen