DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

November 20, 2002

Our Reference: Common Identification Number A-06-02-00032

Mr. Dan Bloodworth
CFO Medicare Financial Services
Arkansas Blue Cross and Blue Shield
601 Gaines Street
Little Rock, Arkansas 72201

Dear Mr. Bloodworth:

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 "Results of Audit Work Performed at Arkansas Blue Cross Blue Shield as Part of the Office of Inspector General's Nationwide Determination of the Fiscal Year 2001 Medicare Error Rate". 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 (5 U.S.C. 552, as amended by Public Law 104-231), 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-06-02-00032 in all correspondence relating to this report.

Sincerely yours,

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Dr. James R. Farris, MD
Regional Administrator
U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
1301 Young Street, Room 714
Dallas, Texas 75202

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

RESULTS OF AUDIT WORK PERFORMED AT ARKANSAS BLUE CROSS BLUE SHIELD AS PART OF THE OFFICE OF INSPECTOR GENERAL'S NATIONWIDE DETERMINATION OF THE FISCAL YEAR 2001 MEDICARE ERROR RATE

JANET REHNQUIST
Inspector General

NOVEMBER 2002
A-06-02-00032

Office of Inspector General

http://www.hhs.gov/oig/

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Mr. Dan Bloodworth
CFO Medicare Financial Services
Arkansas Blue Cross and Blue Shield
601 Gaines Street
Little Rock, Arkansas 72201

Dear Mr. Bloodworth:

This audit report provides you with the results of our audit work performed at Arkansas Blue Cross and Blue Shield (Arkansas BCBS) as part of the Office of Inspector General's (OIG) nationwide determination of the Fiscal Year (FY) 2001 Medicare error rate. The OIG's annual determination of the Medicare error rate is required by the Chief Financial Officers (CFO) Act of 1990.

The objectives of the nationwide audit were to determine whether: (1) the Centers for Medicare & Medicaid Services (CMS) FY 2001 financial statements accurately reflect its financial position; (2) CMS had an adequate internal control structure; and (3) CMS' expenditures comply with applicable laws and regulations. Arkansas BCBS was selected by the OIG through statistical sampling as one of the CMS Contractors to be audited as part of the FY 2001 nationwide audit. The audit period we reviewed covered the third quarter of FY 2001 (April 1, 2001 through June 30, 2001).

Our audit work at Arkansas BCBS was limited to: (1) identifying all of the Medicare claims paid during the FY 2001 third quarter; (2) verifying the accuracy of Medicare benefit payments and other data reported by Arkansas BCBS on various CMS forms; and, (3) reviewing, with assistance from the Arkansas BCBS medical staff and the Arkansas peer review organization, a statistical sample of Medicare beneficiary expenditures paid during the third quarter for compliance with Medicare laws and regulations.

We identified three areas where Arkansas BCBS could improve its operation. These areas resulted from Arkansas BCBS not:

- Reconciling the funds expended amount reported on the Monthly Contractor Financial Report (CMS 1522) to the Medicare paid claims history file;
- Maintaining an outstanding check register for the banks used in its Medicare operations; and

- Reconciling the draw downs reported on the May 2001 Contractor Draws on Letter of Credit (CMS 1521) for Medicare Part B with the Medicare draw downs reported on the bank statement.

In addition, the medical review of the 788 claims selected in our statistical sample identified 65 claims that did not comply with Medicare laws and regulations, resulting in net questioned costs totaling $9,654.91 that needs to be refunded to Medicare. Appendix I to our report includes various explanations of the data related to the claims selected in our sample.

Prior to the completion of our on-site audit work, Arkansas BCBS had taken the necessary steps to correct the need for an outstanding check register on its banks and to reconcile the incorrect draw downs reported on the May 2001 CMS 1521 report. However, we are recommending that Arkansas BCBS:

- Perform a monthly reconciliation of the funds expended as reported on the CMS 1522 to the Medicare paid claims history file; and,

- Take the steps needed to ensure that adjustments are made to those claims in our sample that contained errors and that the net adjustment amount of $9,654.91 is refunded to Medicare.

In their written response to our draft report, Arkansas BCBS officials agreed with our recommendations. However, in order to comply with our recommendation to perform a monthly reconciliation of the CMS 1522 to the paid claims history file, Arkansas BCBS officials stated that CMS will have to issue a change request that will require the MCS system to produce the report needed to make the reconciliation. Regarding our second recommendation, we have provided Arkansas BCBS with a list of the claims that need to be adjusted in order to recover the amount due Medicare. The complete text of Arkansas BCBS officials' written comments is included as Appendix II to our report.

INTRODUCTION

BACKGROUND

The CFO Act of 1990 requires each agency of the Federal Government to improve its systems of financial management, accounting, and internal controls to assure the issuance of reliable financial information. The Office of Management and Budget (OMB) Circular A-123 provides guidance to Federal managers on improving the accountability and effectiveness of Federal programs and operations by establishing, assessing, correcting, and reporting on management controls. The OMB Circular A-123 also requires annual reports on management controls to be submitted to the President, Congress, and OMB. The Government Management Reform Act (GMRA) of 1994 broadened the CFO Act by requiring audits of the financial statements of 24

major Federal agencies, including the Department of Health and Human Services (HHS) and covering all accounts and associated activities of each office, bureau and activity of the agency.

Within HHS, CMS has responsibility for administration of the Medicare program including the preparation of financial statements that report reliable financial information covering Medicare activities on an annual basis. The CMS contracts with fiscal intermediaries (FIs) and carriers nationwide to process Medicare claims and to provide CMS with various reports on the results of their Medicare operations that become an integral part of CMS' Medicare financial statement information. The OIG performs an annual audit of a sample of Medicare claims processed by the FIs and carriers to determine an estimated dollar amount of the Medicare claims that have been paid in error. The OIG statistically selects the FIs and carriers that will be included in the annual audit including which 3-month period or periods will be reviewed for each FI and carrier.

Arkansas BCBS was selected as one of the Medicare contractors to be included in the OIG's annual audit for FY 2001. Arkansas BCBS, under contract with CMS, serves as the Medicare Part A FI for the State of Arkansas and serves as the Medicare Part B Carrier for the States of Arkansas, Oklahoma, New Mexico, Eastern Missouri, and Louisiana.

OBJECTIVES AND SCOPE

The objectives of the OIG's nationwide audit were to determine whether: (1) CMS' FY 2001 financial statements accurately reflect its financial position; (2) CMS had an adequate internal control structure; and (3) CMS' expenditures comply with applicable laws and regulations. Arkansas BCBS was selected by the OIG through statistical sampling as one of the CMS Contractors to be audited as part of the FY 2001 nationwide audit. The audit period we reviewed covered the third quarter of FY 2001 (April 1, 2001 through June 30, 2001).

Our audit work at Arkansas BCBS was limited to: (1) identifying all of the Medicare claims paid during the FY 2001 third quarter; (2) verifying the accuracy of Medicare benefit payments and other data reported by Arkansas BCBS on various CMS forms; and, (3) reviewing a statistical sample of Medicare beneficiary expenditures paid during the third quarter for compliance with Medicare laws and regulations. The statistical sample and related claims review involved the following:

- Selecting a sample of 50 Medicare beneficiaries and identifying every Medicare claim paid on their behalf during the third quarter of FY 2001;
- Requesting the providers, who submitted claims to Medicare for services to the selected beneficiaries, to submit copies of the related medical records for review by Arkansas BCBS' medical staff or by the Arkansas Peer Review Organization (PRO) personnel; and
- Reviewing the claims to ensure that they were appropriately paid in accordance with Medicare rules and regulations.

A large part of our audit work centered on reviewing and verifying the accuracy of the information reported by Arkansas BCBS on the CMS forms 1521 and 1522. In addition, we attempted to reconcile the total funds expended on the CMS 1522 to the Medicare paid claims history tape. This reconciliation was important to ensure that we had an accurate universe of Medicare paid claims from which to select our third quarter sample.

Our audit was performed in accordance with generally accepted government auditing standards. We conducted our review primarily at Arkansas BCBS' offices in Little Rock, Arkansas; Baton Rouge, Louisiana; Oklahoma City, Oklahoma; and St. Louis, Missouri. We also performed work at the OIG Regional Office in Dallas, Texas, and at OIG field offices in Oklahoma City, Oklahoma and Baton Rouge, Louisiana during the period April through November 2001.

FINDINGS AND RECOMMENDATIONS

Our audit work disclosed three areas where Arkansas BCBS could improve its operations. These areas centered on the reconciliation requirements of both the CMS 1521 and CMS 1522. In addition, the medical review of the 788 claims selected in our statistical sample identified 65 claims that did not comply with Medicare laws and regulations, resulting in net questioned costs totaling $9,654.91 that needs to be refunded to Medicare. Arkansas BCBS needs to take the appropriate steps to ensure that all the errors identified in the claims review are properly adjusted.

RECONCILIATION OF THE CMS 1521 & 1522

The Contractor Draws on Letter of Credit (CMS 1521) and Monthly Contractor Financial Report (CMS 1522) are prepared by Arkansas BCBS on a monthly basis. The reports are designed to provide a reconciliation of Medicare program cash benefit payments among CMS, Arkansas BCBS and Arkansas BCBS' bank. Information reported through the CMS 1522 is derived from internal contractor reports including benefit payments, periodic interim payments, pass through payments, cost report final settlements, manual checks issued and other miscellaneous adjustments.

Arkansas BCBS provided the OIG with copies of the CMS 1521 and 1522 with all supporting documentation for the period April through June 2001. Arkansas BCBS also provided computerized Part A and Part B paid claims data for the same period. Our analysis of CMS 1521, CMS 1522 and the related supporting data disclosed that Arkansas BCBS did not:

- Reconcile the funds expended amount reported on the CMS 1522 to the Medicare paid claims history file;
- Maintain an outstanding check register for the banks used in its Medicare operations; and
- Reconcile the draw downs reported on the May 2001 CMS 1521 for Medicare Part B with the draw downs reported on the bank statement;

Differences Between the Paid Claims Tape and the CMS 1522

The CMS requires each contractor to perform a reconciliation of the Medicare paid claims history tape to the CMS 1522. This requirement is set forth in CMS Change Request (CR) #1330. Arkansas BCBS did not perform this reconciliation. Instead, Arkansas BCBS reconciled the system reports and registers to the CMS 1522. Reconciling to these documents does not ensure that the paid claims data reported on the CMS 1522 agrees with the Medicare paid claims history tape. Our attempt to reconcile the paid claims data between the CMS 1522 and the paid claims tape disclosed that the computerized Part B claims data would not reconcile to the CMS 1522. Arkansas BCBS officials could not explain the differences and did not have the documentation needed to support the Medicare claim expenditures reported on the CMS 1522. However, we believe that these differences were immaterial. The differences between the tapes and the CMS 1522 for each month in our quarter were:

- $(733.28) for April
- $(758.77) for May
- $1,392.37 for June

One of the purposes for reconciling the CMS 1522 to the paid claims tape, is to provide the OIG with assurance that the universe we select our sample from is accurate and complete. In the absence of reconciling data, the OIG used the available data on the paid claims tape to select its beneficiary sample. Arkansas BCBS should perform a reconciliation of the paid claims tape to the CMS 1522. This would ensure more accurate reporting of the paid claims on the CMS 1522 and should eliminate any differences in the future.

Outstanding Checks

To fulfill Part B reconciliation requirements related to accurate reporting to CMS, it was necessary to verify the beginning and ending cash balances reported on the CMS 1522. In order to verify the cash balances, we requested a detailed outstanding checklist from Arkansas BCBS. Arkansas BCBS was unable to provide a detailed outstanding checklist for its banks. Therefore, the outstanding check amount reported on the CMS 1522 could not be verified. Arkansas BCBS changed banks during the quarter to a bank that provides an outstanding check register for all bank accounts beginning March 2002. The old bank account will be completely closed when all outstanding checks on the account have been satisfied.

Medicare Federal Reserve Draw Downs

Part of the reconciliation review process requires verification of the Medicare draw downs from the Federal Reserve that are reported on the CMS 1521. The CMS 1521 is prepared by Arkansas BCBS and transmitted on a monthly basis to CMS. The drawdowns reported by Arkansas BCBS on the CMS 1521 for May 2001 was $6,000.72 less than the draw down amounts shown on Arkansas BCBS' Medicare bank account statement.

According to Arkansas BCBS, this occurred because the bank reported to Arkansas BCBS the amount needed for funding and not the actual amount received from the Federal Reserve. We requested, and Arkansas BCBS has since submitted a supplemental CMS 1521 for May 2001 to show the correct amount of funding received from the Federal Reserve.

SAMPLE CLAIMS REVIEW

The random sample of 50 beneficiaries selected for review had a total of 788 claim transactions paid during the FY 2001 third quarter. The 788 transactions included 55 Part A claim transactions comprised of 33 inpatient transactions and 22 outpatient transactions. The remaining 733 transactions were Part B. The total amount paid for all of the sampled claims was $258,497.42, and was comprised of $176,374.13 of Part A inpatient claims, $1,138.62 of Part B of A outpatient claims, and $80,984.67 of Part B outpatient claims. The sample claims were selected from a universe of approximately $1.02 billion in paid claims.

The medical review of the 788 claims selected in our statistical sample identified 65 claims that did not comply with Medicare laws and regulations, resulting in net questioned costs totaling $9,654.91 that needs to be refunded to Medicare. We are recommending that Arkansas BCBS make the appropriate adjustments resulting from the medical review of the Medicare claims included in our sample.

Medical Records Review

All of the providers, who performed services related to the sampled claims, provided copies of the applicable medical record for use during the medical review of the sample claims. The documentation from the providers was reviewed for elements such as medical necessity, accurate coding, and sufficient documentation. The PRO reviewed inpatient hospital claims and hospital swingbed claims. Arkansas BCBS' medical review staff reviewed claims relating to services for skilled nursing facilities (SNF), Part B of A outpatient services, and all Part B services. The review of providers' medical records by both the PRO and Arkansas BCBS' medical review staff identified problems with the validity of some of the sample claims. The results of these reviews are discussed below.

PRO Medical Review

The PRO reviewed 31 inpatient claims consisting of 25 PPS, 5 Non-PPS claims, and 1 swingbed, and identified 2 inpatient claims with errors. The effect of these two errors resulted in a net overpayment to the providers of $5,497.50. The circumstances surrounding these claims were as follows:

- There was an invalid inpatient admission. The medical reviewers determined that outpatient treatment would have been appropriate in the circumstances. This resulted in the entire claim totaling $9,760.00 being denied.

- For the other inpatient claim, the secondary diagnosis was substantiated in the records but not billed, resulting in a new DRG for the claim. The new DRG increased the Medicare payment by $4,262.50.

The payment adjustments for these two claims either have been or will be processed by Arkansas BCBS' staff.

Arkansas BCBS Medical Review

The Arkansas BCBS medical review staff reviewed 757 claims. These claims were comprised of claim services for SNFs, Part B of A outpatient services, and all Part B services. From this review, 2 SNF inpatient claims, 4 Part B of A claims, and 57 Part B claims were found to contain errors. The medical review staff identified errors such as insufficient documentation, no documentation, medically unnecessary service or treatment, and services incorrectly coded.

A net total of $4,157.41 for 63 claims was questioned. The medical reviewers allowed some claims that were previously denied by the shared system. The questioned cost of $4,157.41 is the net of these claims and the claims disallowed by the medical reviewers during the audit. The questioned costs consisted of $1,434.84 for 2 SNF inpatient claims, $173.21 for 4 Part B of A outpatient claims, and $2,549.36 for 57 Part B claims.

We provided Arkansas BCBS' staff with a detailed listing, by claim, of those claims that needed to be adjusted. Arkansas BCBS' staff agreed to take appropriate adjudication action for these claims.

Appendix I to our report contains detailed information, by claim type, for the dollar and claim errors identified in the review.

OIG Claims Review

We tested the 788 sampled claims to determine whether they were paid in accordance with Medicare laws and regulations. This testing included audit steps to determine whether: (1) services were furnished by certified Medicare providers to eligible beneficiaries; (2) duplicate payments were made; (3) Medicare appropriately paid the claims as primary or secondary payer; (4) claim adjustments were warranted and properly accounted for in the contractor's records; (5) claim payments were properly priced; and (6) all claims were billed in a timely manner. Our testing did not disclose any errors.

RECOMMENDATIONS

Prior to the completion of our on-site audit work, Arkansas BCBS had taken the necessary steps to correct the need for an outstanding check register on one of its banks and to reconcile the incorrect draw downs reported on the May 2001 CMS 1521 report. However, we recommend that Arkansas BCBS:

- Perform a monthly reconciliation of the funds expended as reported on the CMS 1522 to the Medicare paid claims history file; and,

- Take the steps needed to ensure that adjustments are made to those claims in our sample that contained errors and that the net adjustment amount of $9,654.91 is refunded to Medicare.

Auditee Comments

In their written response to our draft report, Arkansas BCBS officials agreed with our recommendations. Regarding our recommendation for Arkansas BCBS to reconcile the funds expended as reported on the CMS 1522 to the Medicare paid claims history file, Arkansas BCBS officials stated that the MCS claims processing system does not currently produce a paid claims detail report needed to perform the reconciliation. However, these officials stated that CMS has indicated that a MCS system change request will be initiated in the future to require the MCS system to produce the paid claims detail report. According to Arkansas BCBS officials, once that report is available Arkansas BCBS will begin to reconcile the report to the CMS 1522.

Arkansas BCBS officials also agreed to make the adjustments needed to those claims in our sample that contained errors and to pursue collection of the amounts paid in error. These officials did request that we provide them with a list of the claims requiring adjustment. Although we provided Arkansas BCBS officials with the list prior to leaving the audit site at the completion of our fieldwork, we have sent another copy of the list to Arkansas BCBS officials so that they can take the appropriate actions needed to resolve the payment errors identified in our sample.

A copy of the Arkansas BCBS officials' written comments is included as Appendix II to our report.

OTHER MATTERS

During our review, we identified two electronic data processing (EDP) issues that are of concern.

- The first issue identified was a result of the conversion from the General Telephone & Electronics (GTE) claims processing system to the Multi Carrier Systems (MCS). During the conversion, the group number was left off MCS. This resulted in claims

being inappropriately denied because MCS could not identify the group the claim should be applied to.

- The second issue identified resulted from claims that were processed through the system but were delayed at the time of payment. For the date of June 21, claims appeared on the History Inquiry screen and the Beneficiary History screens as being paid. However, these claims were never paid. Our analysis disclosed that the paid date changed on the Beneficiary History screen to a later date, but did not change to a later date on the History Inquiry screen.

Arkansas BCBS will need to continue to address these issues to find solutions. The OIG will follow-up on the corrective actions taken at a later date.

Sincerely,

Gordon L. Sato
Regional Inspector General
for Audit Services

601 S. Gaines St.
P.O. Box 2181
Little Rock, Arkansas 72203-2181

July 26, 2002

Mr. Sam Patterson
Audit Manager
DHHS/OIG/Office of Audit Services
3625 N.W. 56th Street, Room 101
Oklahoma City, Oklahoma 73112

Re: Common Identification Number A-06-02-00032

Dear Mr. Patterson:

This letter is in response to the draft report issued June 28, 2002, by the U.S. Department of Health and Human Services, Office of Inspector General, Office of Audit Services' entitled "Results of Audit Work Performed at Arkansas Blue Cross Blue Shield as Part of the Office of Inspector General's Nationwide Determination of the Fiscal Year 2001 Medicare Error Rate". In that letter, it was requested that we provide written comments to the draft report and a status update of any action taken or contemplated on the recommendations contained within the report.

It was recommended in the draft report that Arkansas Blue Cross and Blue Shield perform a monthly reconciliation of the funds expended as reported on the CMS 1522 to the Medicare paid claims history file. Currently, ABCBS is performing a monthly reconciliation of the CMS 1522 funds expended to the Multi Carrier System (MCS) monthly summary of paid claims report, HBDR 2002. This MCS system report is a summary total report of all claims and adjustments paid during the month. We have contacted Electronic Data Systems (EDS), the maintainer of the MCS system, and there is currently no claims paid detail report produced by the MCS Medicare Part B standard system. This has also been communicated the Centers for Medicare and Medicaid Services (CMS) that the base system does not produce a paid claims detail report. CMS has indicated that an MCS system change request will be initiated in the future to require the MCS system to produce a paid claims detail report. Once the MCS system begins producing a paid claims detail report, ABCBS will begin to reconcile that report monthly to the CMS 1522 funds expended.

It was also recommended in the draft report that Arkansas Blue Cross and Blue Shield take the steps needed to ensure that adjustments are made to those claims in the OIG sample that contained errors and that the net adjustment amount of $9,654.91 is refunded to the Medicare program. It is stated in the draft report that a detailed listing by claim, of those claims needing to be adjusted was provided to the ABCBS staff. We have researched this issue and can find no evidence of such a listing. Once ABCBS receives

the listing of claims requiring adjustment, we will perform the adjustments on the claims paid in error and pursue collection of the amounts paid in error.

Thank you for the opportunity to provide a formal response and comments to the draft report issued by your office. If you have any additional questions or comments you may address them to:

Ken Cole
Medicare Financial Services
Arkansas Blue Cross and Blue Shield
601 Gaines Street
Little Rock, Arkansas 72201

Sincerely yours,

Dan Bloodworth
Chief Financial Officer
Medicare Financial Services
Arkansas Blue Cross and Blue Shield