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

Final Audit Report

Subject:

AUDIT OF
GOVERNMENT EMPLOYEES HEALTH ASSOCIATION, INC.
BENEFIT PLAN
LEE'S SUMMIT, MISSOURI

Report No. 1B-31-00-10-038

Date: March 12, 2012

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

Office of the
Inspector General

AUDIT REPORT

Federal Employees Health Benefits Program
Employee Organization Plan

Government Employees Health Association, Inc. Benefit Plan
Contract CS 1063 Plan Codes 31 and 34
Lee's Summit, Missouri

REPORT NO. 1B-31-00-10-038 DATE: March 12, 2012

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UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
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EXECUTIVE SUMMARY

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Employee Organization Plan

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Contract CS 1063 Plan Codes 31 and 34
Lee's Summit, Missouri

REPORT NO. 1B-31-00-10-038 DATE: March 12, 2012

This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at the Government Employees Health Association, Inc. (GEHA) Benefit Plan (Plan) questions $1,177,068 in health benefit charges and includes procedural findings regarding the Plan's network pricing oversight and Fraud and Abuse (F&A) Program. The Plan agreed (***A***) with $1,055,910 and disagreed (***D***) with $121,158 of these questioned charges. In addition, the Plan agreed with the procedural finding regarding the network pricing oversight, but only partially agreed with the procedural findings relating to the F&A Program.

Our audit was conducted in accordance with Government Auditing Standards. The audit covered claim payments from January 1, 2007 through May 31, 2010, as well as miscellaneous health benefit payments and credits and administrative expenses from 2006 through 2009 as reported in the Annual Accounting Statements. In addition, we reviewed the Plan's cash management practices related to FEHBP funds for contract years 2006 through 2009.

The audit results are summarized as follows:

HEALTH BENEFIT CHARGES

Claim Payments

- **Coordination of Benefits with Medicare *(A)*** **$436,544**

  The Plan incorrectly paid 578 claim lines, resulting in net overcharges of $436,544 to the FEHBP. Specifically, the Plan did not properly coordinate 540 claim line payments with Medicare as required by the FEHBP contract. As a result, the FEHBP paid as the primary insurer for these claims when Medicare was the primary insurer. Therefore, we estimate that the FEHBP was overcharged by $414,700 for these 540 claim lines. The remaining 38 claim line payments were not coordination of benefit errors but contained other Plan payment errors, resulting in net overcharges of $21,844 to the FEHBP. In total, we estimate that the Plan overpaid 576 claim lines by $436,973 and underpaid 2 claim lines by $429.

- **Assistant Surgeon Review** **$224,163**

  The Plan incorrectly paid 530 assistant surgeon claims, resulting in net overcharges of $224,163 to the FEHBP. Specifically, the Plan overpaid 409 claims by $264,488 and underpaid 121 claims by $40,325. The Plan agreed with $220,857 (***A***) and disagreed with $3,306 (***D***) of these questioned charges.

- **Modifier 62 and 66 Review *(A)*** **$173,117**

  The Plan incorrectly paid 275 multiple surgeon claim lines, resulting in net overcharges of $173,117 to the FEHBP. Specifically, the Plan overpaid 223 claim lines by $196,279 and underpaid 52 claim lines by $23,162.

- **Claims Paid for Ineligible Patients** **$146,481**

  The Plan paid 286 claims that were incurred when no patient enrollment records existed, during gaps in patient coverage, or after termination of patient coverage with the GEHA Benefit Plan, resulting in overcharges of $146,481 to the FEHBP. These claims were paid for ineligible patients. The Plan agreed with $68,893 (***A***) and disagreed with $77,588 (***D***) of these questioned charges.

- **Inpatient Facility Claims - Duplicate or Overlapping Dates of Service *(A)*** **$103,977**

  The Plan incorrectly paid 14 inpatient facility claims, resulting in overcharges of $103,977 to the FEHBP.

- **Duplicate Claim Payments *(A)*** **$50,984**

  During our review of potential duplicate claim payments, we found that the Plan incorrectly paid 68 claims, resulting in overcharges of $50,984 to the FEHBP. Specifically, we determined that the Plan improperly charged the FEHBP $34,052 for 44 duplicate claim payments. Also, we identified 24 claims that were not duplicate claim payments but contained other Plan payment errors, resulting in overcharges of $16,932 to the FEHBP.

- **System Review** **$41,802**

  Based on our review of a judgmental sample of 125 claims, we determined that the Plan incorrectly paid 2 claims, resulting in overcharges of $41,802 to the FEHBP. Also, we identified five instances where the Plan's claims system did not contain the dates when the providers' contracted pricing rates were loaded into the system. The Plan agreed with $1,538 (***A***) and disagreed with $40,264 (***D***) of these questioned charges.

- **Network Pricing Oversight *(A)*** **Procedural**

  The Plan contracts with 15 regional preferred provider organization (PPO) networks throughout the United States to provide members with comprehensive access to in-network providers. Most of these PPO networks administer the pricing of claims and submit pricing sheets to the Plan for claims processing. We found that the Plan does not sufficiently verify the accuracy and integrity of these pricing sheets prior to processing and paying the claims. The Plan relies on what the PPO networks instruct them to price the claims at, leading to potentially increased risk of claim payment errors.

Miscellaneous Payments and Credits

The audit disclosed no findings pertaining to miscellaneous health benefit payments and credits. Overall, we concluded that the Plan returned health benefit refunds and recoveries, including prescription drug rebates, to the FEHBP in a timely manner.

ADMINISTRATIVE EXPENSES

The audit disclosed no findings pertaining to administrative expenses. Overall, we concluded that the administrative expenses charged to the FEHBP were actual, allowable, necessary, and reasonable expenses incurred in accordance with the terms of the contract and applicable laws and regulations.

CASH MANAGEMENT

The audit disclosed no findings pertaining to cash management. Overall, we concluded that the Plan handled FEHBP funds in accordance with Contract CS 1063 and applicable laws and regulations.

FRAUD AND ABUSE PROGRAM

- **Notification of Fraud and Abuse Cases *(D)*** **Procedural**

  The Plan did not refer cases with areas of patient harm or safety issues to the Office of Personnel Management's Office of the Inspector General (OPM/OIG) from 2006 through 2009 that related to member F&A issues, such as doctor shopping for pharmaceuticals/ schedule II – IV drugs and/or membership eligibility issues, regardless of monetary amounts.

- **Fraud and Abuse Annual Reports *(D)*** **Procedural**

  The Plan did not provide the OPM/OIG complete F&A annual reports from 2006 through 2009. By not including all F&A reporting requirements, we could not determine the overall outcome and success of the Plan's prevention, detection, and F&A Program activities.

- **Program Management *(A)*** **Procedural**

  The Plan uses a product called [redacted] to look for abnormal billing patterns. However, the Plan's use of this product may be underutilized, especially if the Plan is not actively seeking post-payment recoveries or performing post-payment investigations. The Plan's Special Investigations Unit (SIU) appears to concentrate their efforts on pre-payment reviews to stop potential fraudulent payments. By focusing on that element of potential fraud and abuse, other fraudulent and abusive practices could go unnoticed that could lead to areas of weaknesses with the Plan's F&A Program.

- **Pharmacy Benefit Manager *(A)*** **Procedural**

  The Plan's process for doctor shopping cases does not include a review by SIU staff to determine if notification to the OPM/OIG is required. In addition, the Plan does not require their Pharmacy Benefit Manager to report potential F&A cases related to pharmacies, physicians with abnormally high rates of prescribing narcotics, member drug misuse or abuse, and other potential fraud related reporting issues. Due to these deficiencies, the Plan is not in compliance with Carrier Letter 2007-12 ("Notifying OPM's Office of the Inspector General Concerning Fraud and Abuse Cases in the FEHBP Program").

CONTENTS

I. INTRODUCTION AND BACKGROUND

INTRODUCTION

This final audit report details the findings, conclusions, and recommendations resulting from our audit of the Federal Employees Health Benefits Program (FEHBP) operations at the Government Employees Health Association, Inc. (GEHA) Benefit Plan (Plan). The Plan is located in Lee's Summit, Missouri.

The audit was performed by the Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as established by the Inspector General Act of 1978, as amended.

BACKGROUND

The FEHBP was established by the Federal Employees Health Benefits (FEHB) Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for federal employees, annuitants, and dependents. OPM's Healthcare and Insurance Office has overall responsibility for administration of the FEHBP. The provisions of the FEHB Act are implemented by OPM through regulations, which are codified in Title 5, Chapter 1, Part 890 of the Code of Federal Regulations (CFR). Health insurance coverage is made available through contracts with various health insurance carriers.

The Plan is a fee-for-service health plan with a preferred provider organization (PPO). The Plan enrollment is open to all federal employees and annuitants who are eligible to enroll in the FEHBP and who are, or become, members of GEHA. GEHA is the underwriter, sponsor and administrator of this Plan, operating under Contract CS 1063 to provide a health benefits plan authorized by the FEHB Act.[1] Members have a choice of enrollment in High Option or Standard Option.

GEHA's contract with OPM is experience-rated. Thus, the costs of providing benefits in the prior year, including underwritten gains and losses which have been carried forward, are reflected in current and future years' premium rates**.** In addition, the contract provides that in the event of termination, unexpended program funds revert to the FEHBP Trust Fund. In recognition of these provisions, the contract requires an accounting of program funds be submitted at the end of each contract year. The accounting is made on a statement of operations known as the Annual Accounting Statement.

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

[1] GEHA is a nonprofit organization whose primary purpose is to provide health insurance coverage to current and retired federal employees. In 2007, GEHA's name changed from the Government Employees Hospital Association, Inc. to the Government Employees Health Association, Inc.

All findings from our previous audit of the Plan (Report No. 1B-31-00-06-044, dated February 6, 2007) for contract years 2000 through 2005 have been satisfactorily resolved.

The results of this audit were provided to the Plan in written audit inquiries; were discussed with Plan officials throughout the audit and at an exit conference; and were presented in detail in a draft report, dated June 10, 2011. The Plan'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. Also, additional documentation provided by the Plan on various dates through October 13, 2011 was considered in preparing our final 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 as follows:

Health Benefit Charges

- To determine whether the Plan complied with contract provisions relative to benefit payments.

- To determine whether miscellaneous payments charged to the FEHBP were in compliance with the terms of the contract.

- To determine whether credits and miscellaneous income relating to FEHBP benefit payments were returned timely to the FEHBP.

Administrative Expenses

- To determine whether administrative expenses charged to the contract were actual, allowable, necessary, and reasonable expenses incurred in accordance with the terms of the contract and applicable regulations.

Cash Management

- To determine whether the Plan handled FEHBP funds in accordance with applicable laws and regulations concerning cash management in the FEHBP.

Fraud and Abuse Program

- To determine whether the Plan operates an effective Fraud and Abuse (F&A) Program for the prevention, detection, and/or recovery of fraudulent claims as required by the FEHBP contract.

SCOPE

We conducted our 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 Plan's FEHBP Annual Accounting Statements for contract years 2006 through 2009. During this period, the Plan paid approximately $6.7 billion in health benefit charges and $323 million in administrative expenses (See Figure 1 and Schedule A). The Plan also paid approximately $59 million in other expenses and retentions (See Schedule A).[2]

Specifically, we reviewed approximately $43 million in claim payments made from January 1, 2007 through May 31, 2010 for coordination of benefits, duplicate payments, and proper adjudication. In addition, we reviewed miscellaneous health benefit payments and credits (e.g., refunds, subrogation recoveries, and prescription drug rebates), administrative expenses, and cash management activities from 2006 through 2009.

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.

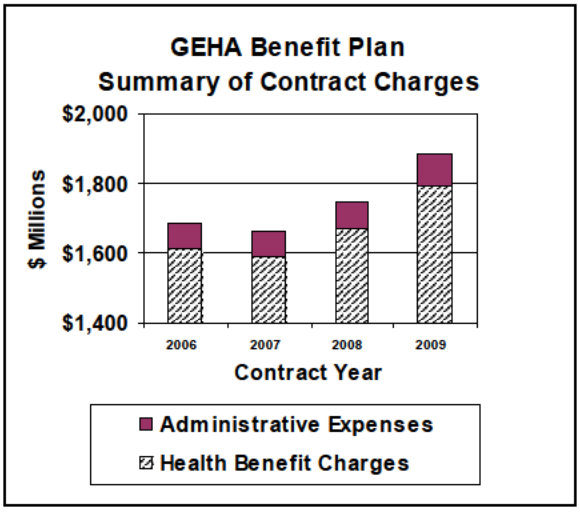

Figure 1 – Contract Charges

We also conducted tests to determine whether the Plan had complied with the contract, the applicable procurement regulations (i.e., Federal Acquisition Regulations (FAR) and Federal Employees Health Benefits Acquisition Regulations (FEHBAR), 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 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.

[2] We did not review other expenses and retentions for contract years 2006 through 2009, except for the cash management of these funds.

The audit was performed at the Plan's office in Lee's Summit, Missouri from October 18 through November 12, 2010. Audit fieldwork was also performed at our office in Cranberry Township, Pennsylvania on various dates from October 2010 through June 2011. Throughout the audit process, we encountered several instances where the Plan responded untimely, or initially provided incomplete responses, to various requests for supporting documentation. As a result, completion of our audit work and issuance of our draft and final reports was delayed.

METHODOLOGY

We obtained an understanding of the internal controls over the Plan's claims processing, financial, cost accounting, and cash management systems by inquiry of Plan officials.

To test the Plan's compliance with the FEHBP health benefit provisions, we selected and reviewed samples of 9,379 claims.[3] We used the FEHBP contract, the benefit plan brochure, and the Plan's provider agreements to determine the allowability of benefit payments. The results of these samples were not projected to the universe of claims.

We interviewed Plan personnel and reviewed the Plan's policies, procedures, and accounting records during our audit of miscellaneous health benefit payments and credits. We also judgmentally selected and reviewed 387 high dollar health benefit refunds, totaling $22,816,616 (from a universe of 136,717 refunds, totaling $87,386,792); 4 monthly subrogation recovery receipts, totaling $607,409 (from a universe of 48 monthly subrogation recovery receipts, totaling $1,830,325); 8 monthly credit balance audit recovery receipts, totaling $1,800,404 (from a universe of 48 monthly credit balance audit recovery receipts, totaling $6,544,128); 4 quarterly prescription drug rebates, totaling $28,364,115 (from a universe of 18 quarterly drug rebates, totaling $137,496,194); and 8 "other" monthly refund and recovery receipts, totaling $509,358 (from a universe of 48 "other" monthly refund and recovery receipts, totaling $2,220,061), to determine if refunds and recoveries were promptly returned to the FEHBP and if miscellaneous payments were properly charged to the FEHBP.[4] The results of these samples were not projected to the universe of miscellaneous health benefit payments and credits.

We judgmentally reviewed administrative expenses charged to the FEHBP for contract years 2006 through 2009. Specifically, we reviewed administrative expenses relating to cost centers, natural accounts, pension, post-retirement, executive compensation, gains and losses, return on investment, and vendor cost containment. We used the FEHBP contract, the FAR, and the FEHBAR to determine the allowability, allocability, and reasonableness of charges.

[3] See the audit findings for "Coordination of Benefits with Medicare" (A1.a), "Assistant Surgeon Review" (A1.b), "Modifier 62 and 66 Review" (A1.c), "Claims Paid for Ineligible Patients" (A1.d), "Inpatient Facility Claims - Duplicate or Overlapping Dates of Service" (A1.e), "Duplicate Claim Payments" (A1.f), and "System Review" (A1.g) on pages 7 through 22 for specific details of our sample selection methodologies.

[4] The sample of health benefit refunds included all refunds greater than $25,000. For subrogation, the sample consisted of the month with the highest dollar recovery receipts from each year. For credit balance audit recoveries, the sample consisted of the two months with the highest dollar recovery receipts from each year. For prescription drug rebates, the sample consisted of one randomly selected quarter from each year. For "other" refunds and recoveries, the sample consisted of the two months with the highest dollar receipts from each year.

We reviewed the Plan's cash management practices to determine whether the Plan handled FEHBP funds in accordance with Contract CS 1063 and applicable laws and regulations.

We also interviewed the Plan's Special Investigations Unit regarding the effectiveness of the Plan's F&A Program.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. HEALTH BENEFIT CHARGES

1. Claim Payments

a. Coordination of Benefits with Medicare $436,544

The Plan incorrectly paid 578 claim lines, resulting in net overcharges of $436,544 to the FEHBP. Specifically, the Plan did not properly coordinate 540 claim line payments with Medicare as required by the FEHBP contract. As a result, the FEHBP paid as the primary insurer for these claims when Medicare was the primary insurer. Therefore, we estimate that the FEHBP was overcharged by $414,700 for these 540 claim lines. The remaining 38 claim line payments were not coordination of benefit errors but contained other Plan payment errors, resulting in net overcharges of $21,844 to the FEHBP. In total, we estimate that the Plan overpaid 576 claim lines by $436,973 and underpaid 2 claim lines by $429.

The 2010 GEHA Benefit Plan brochure, page 85, Primary Payer Chart, illustrates when Medicare is the primary payer. In addition, page 21 of that brochure states, "We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), regardless of whether Medicare pays."

Contract CS 1063, 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 . . . (b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary carrier . . . ."

In addition, Contract CS 1063, Part III, section 3.2 (b)(1) states, "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable." Part II, section 2.3(g) states, "If the Carrier or OPM determines that a Member's claim has been paid in error for any reason . . . the Carrier shall make a prompt and diligent effort to recover the erroneous payment . . . ."

For claims incurred and paid from October 1, 2008 through May 31, 2010, we performed a computer search and identified 356,182 claim lines, totaling $26,509,487 in payments, that potentially were not coordinated with Medicare. From this universe, we selected for review a sample of 3,962 claim lines, totaling $5,727,448 in payments, to determine whether the Plan complied with the contract provisions relative to coordination of benefits (COB) with Medicare. When we submitted our sample of potential COB errors to the Plan on July 15, 2010, the claims were within the Medicare timely filing requirement and could be filed with Medicare for coordination of benefits.

The following table is a summary of the claim lines that were selected for review:

Claim Type	Claim Lines	Amounts Paid	Sample Selection Methodology
Medicare Part A Primary for Inpatient (I/P) Facility	152	$1,955,867	All patients
Medicare Part A Primary for Skilled Nursing, Home Health Care (HHC), and Hospice Care	41	$55,256	Patients with cumulative claims of $250 or more
Medicare Part B Primary for Certain I/P Facility Charges	214	$1,860,531	All patients
Medicare Part B Primary for Skilled Nursing, HHC, and Hospice Care	0	$0	The potential COB errors were immaterial. Therefore, no claim lines were selected.
Medicare Part B Primary for Outpatient Charges	357	$446,251	Patients with cumulative claims of $1,000 or more
Medicare Part B Primary for Professional Charges	3,198	$1,409,543	Patients with cumulative claims of $2,500 or more
Total	3,962	$5,727,448	

Generally, Medicare Part A pays all covered costs for inpatient care in hospitals, skilled nursing facilities, hospice care, and home health care, except for deductibles and coinsurance. For each Medicare Benefit Period, there is a one-time deductible, followed by a daily co-payment beginning with the 61st day. Beginning with the 91st day of the Medicare Benefit Period, Medicare Part A benefits may be exhausted, depending on whether the patient elects to use their Lifetime Reserve Days. For the uncoordinated Medicare Part A claims, we estimate that the FEHBP was overcharged for the total claim payment amounts. When applicable, we reduced the questioned amount by the Medicare deductible and/or Medicare co-payment.

Medicare Part B pays 80 percent of most outpatient charges and professional claims after the calendar year deductible has been met. Also, Medicare Part B covers a portion of inpatient facility charges for ancillary services such as durable medical equipment, medical supplies, diagnostic tests, and clinical laboratory services. Based on our experience, ancillary items account for approximately 30 percent of the total inpatient claim payment. When we could not reasonably determine the actual overcharge for the ancillary items, we questioned 25 percent of the amount paid for the inpatient claim (0.30 x 0.80 = 0.24 ~ 25 percent).

Based on our review of the potential COB errors in our sample, we identified 578 claim lines that were paid incorrectly, resulting in net overcharges of $436,544 to the FEHBP. Specifically, we estimate that 576 claim lines were overpaid by $436,973 and 2 claim lines were underpaid by $429.

The following table details the questioned payments by claim type:

Claim Type	Claim Lines	Amounts Paid	Amounts Questioned
Medicare Part A Primary for I/P Facility	26	$230,911	$195,121
Medicare Part A Primary for Skilled Nursing, HHC, and Hospice Care	1	$55,256	$4,000
Medicare Part B Primary for Certain I/P Facility Charges	9	$133,237	$28,159
Medicare Part B Primary for Skilled Nursing, HHC, and Hospice Care	0	$0	$0
Medicare Part B Primary for Outpatient Charges	102	$142,635	$135,812
Medicare Part B Primary for Professional Charges	440	$84,791	$73,452
Total	578	$646,830	$436,544

Our audit disclosed the following for these claim payment errors:

- For 231 (40 percent) of the claim lines questioned, the patient's Medicare eligibility information was incorrect in the Plan's claims system when the claims were paid. However, when the correct Medicare eligibility information was subsequently added to the claims system, the Plan did not review and/or adjust the patient's prior claims back to the Medicare effective dates. As a result, we estimate that the FEHBP was overcharged $254,565 for these claim lines that were not coordinated with Medicare.

- For 224 (39 percent) of the claim lines questioned, the Plan incorrectly paid these claims due to manual processing errors. Specifically, the claims were deferred for Medicare COB on the claims system, but the system edits were overridden by the processors. As a result, we estimate that the FEHBP was overcharged $22,082 for these claim lines that were not coordinated with Medicare.

- For 55 (9 percent) of the claim lines questioned, various other COB errors caused these claim lines to be processed incorrectly. As a result, we estimate that the FEHBP was overcharged $128,547 for these claim lines that were not coordinated with Medicare.

- For 38 (7 percent) of the claim lines questioned, we found that these claim lines were not actually COB errors but contained other Plan payment errors, resulting in net overcharges of $21,844 to the FEHBP. Specifically, the Plan overpaid 36 claim lines by $22,273 and underpaid 2 claim lines by $429.

- For 30 (5 percent) of the claim lines questioned, manual processing errors caused improper coordination of these claim lines. In each instance, the claims processor inadvertently did not apply the Medicare payment, which was available on the Medicare Explanation of Benefits Statement, when processing the claim. As a result, we estimate that the FEHBP was overcharged $9,506 for these claim lines that were not coordinated with Medicare.

Of the $436,544 in questioned charges, $135,979 (31 percent) was identified by the Plan before receiving our audit request (i.e., sample of potential COB errors) on July 15, 2010. However, since the Plan had not completed the recovery process and/or adjusted these claims by our audit request date, we are continuing to question these claim payment errors. The remaining questioned charges of $300,565 (69 percent) were identified as a result of our audit.

Plan's Response:

In response to the amount questioned in the draft report, the Plan agrees with $436,599 ($457,428 - $20,869) and disagrees with $20,869. The Plan had recovered $411,709 and waived $2,279 of the uncontested amount as of September 2, 2011. The Plan will continue recovery efforts on the remaining uncontested overpayments. Also, the Plan has made additional payments to correct the underpayment errors.

For the contested amount, the Plan states, "Overpayments of $20,869 are being disputed because the amount deemed overpaid is less than previously reported."

In addition, the Plan states, "The following controls are in place to minimize the overpaid claims due to other coverage. Once it is discovered that an enrollee has other coverage, a process has been established to identify all medical and pharmacy claims that were paid after the effective date of coverage to the date we were notified of the other coverage. The claims are investigated for possible overpayments and collections are pursued. GEHA has also established a procedure to automatically code an enrollee's record as having Medicare primary (if the enrollee is in a retired status) once they are eligible to obtain Medicare. Claims incurred after the Medicare eligibility date are pended awaiting information regarding the enrollee's Medicare status.

GEHA is required by CMS (Centers for Medicare/Medicaid Services) to send medical coverage information on a quarterly basis for all members over age 45 that are actively employed on the MSP (Medicare Secondary Payer) file under Section 111. GEHA also participates in the optional Section 111 Non-MSP Part D sharing of information by providing a monthly file to CMS of retirees that are covered by GEHA. CMS provides a response file to both the mandatory quarterly MSP file and the optional monthly Non-MSP file with Medicare information. The information is used to update eligibility data on GEHA's claim system and identify overpayments that may have occurred."

OIG Comments:

After reviewing the Plan's response and additional documentation, we revised the questioned charges from our draft report to $436,544. The Plan's response and additional documentation support concurrence with the revised questioned charges.

Recommendation 1

We recommend that the contracting officer disallow $436,973 for claim overcharges ($414,700 for COB errors and $22,273 for other claim payment errors) 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 $429 for additional payments made to the providers to correct the underpayment errors. However, before allowing any additional payment(s) to a provider, the contracting officer should require the Plan to first recover any questioned overpayment(s) for that provider.

b. Assistant Surgeon Review **$224,163**

The Plan incorrectly paid 530 assistant surgeon claims, resulting in net overcharges of $224,163 to the FEHBP. Specifically, the Plan overpaid 409 claims by $264,488 and underpaid 121 claims by $40,325.

As previously cited from CS 1063, 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.

For the period January 1, 2007 through May 31, 2010, we identified 2,688 assistant surgeon claim groups, totaling $646,737 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 111 assistant surgeon claim groups (representing 181 claims), totaling $190,903 in potential overpayments,

to determine if the Plan paid these claims properly. Our sample included all assistant surgeon claim groups with potential overpayments of $750 or more. The majority of these claim groups contained at least one primary surgeon and one assistant surgeon claim.

Since most of the assistant surgeon claims in our initial sample (claims in 109 of the 111 assistant surgeon claim groups) were paid incorrectly, we expanded our testing to include all groups in the universe with potential overpayments of $100 or more. This expanded sample included an additional 1,610 assistant surgeon claim groups, totaling $547,878 in potential overpayments.

Based on our review, we determined that 530 claims were paid incorrectly, resulting in net overcharges of $224,163 to the FEHBP. Specifically, the Plan overpaid 409 claims by $264,488 and underpaid 121 claims by $40,325.

The claim payment errors resulted from the following reasons:

- The Plan incorrectly paid 73 assistant surgeon claims, resulting in overcharges of $79,063 to the FEHBP. These overcharges were due to errors in the calculation of the assistant surgeon fee, which should have been priced at 20 percent of the primary surgeon's allowed amount.

- The Plan incorrectly applied the PPO network pricing when processing 169 claims, resulting in net overcharges of $70,908 to the FEHBP. Specifically, the Plan overpaid 136 claims by $85,493 and underpaid 33 claims by $14,585.

- The Plan incorrectly paid 238 claims due to manual processing errors, resulting in net overcharges of $36,447 to the FEHBP. Specifically, the Plan overpaid 155 claims by $64,296 and underpaid 83 claims by $27,849.

- The Plan paid 12 claims twice, resulting in duplicate charges of $20,165 to the FEHBP. In each instance, the Plan paid the same surgeon as both the primary and assistant on the procedures.

- The Plan incorrectly paid six claims that were subject to the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) pricing guidelines, resulting in overcharges of $6,528 to the FEHBP. These claims were paid in error due to the Plan not recognizing the physician assistant pricing modifier and erroneously calculating the assistant surgeon fee. In each instance, the assistant surgeon claim should have been priced according to the Medicare fee schedule amount (i.e., 16 percent of the primary surgeon's allowed amount).

- The Plan incorrectly paid four multiple surgeon claims, resulting in overcharges of $5,016 to the FEHBP. These overcharges were due to the Plan not recognizing the co-surgeon procedure modifier "62" or surgical team procedure modifier "66" when pricing these claims. Specifically, the Plan priced these claims without applying the co-surgeon reimbursement rate of 62.5 percent to the applicable procedure allowances.

- The Plan incorrectly paid 19 assistant surgeon claims where either the primary surgeon procedure codes were different than the assistant surgeon procedure codes, the primary surgeon claims were denied, or the primary surgeon claims were not submitted. In each instance, the Plan should have denied the assistant surgeon claim. As a result, the FEHBP was overcharged $4,631 for these claims.

- The Plan incorrectly paid nine claims with procedure modifier "51", resulting in overcharges of $1,935 to the FEHBP. These overcharges were due to the Plan incorrectly processing procedure modifier "51" when calculating the assistant surgeon fee. In each instance, the Plan should have priced the highest allowable procedure amount at 100 percent and each remaining allowable procedure amount at 50 percent.

Plan's Response:

In response to the amount questioned in the draft report, the Plan agrees with $209,298 ($133,276 plus $76,022) in overpayments, and disagrees with $566,829 ($776,127 minus $209,298) in overpayments and $3,222 in underpayments. The Plan had recovered $84,107 of the uncontested overpayments as of September 2, 2011. For the contested amounts, the Plan states that these claims were paid with the correct assistant surgeon benefits.

In addition, the Plan states, "GEHA relies on the pricing systems of our multiple leased PPO networks to provide accurate pricing. Each network surveyed has a process in place to audit pricing and resolve deficiencies. We are implementing periodic audits of PPO network pricing. On a quarterly basis GEHA audits a sample of provider contracts in order to confirm network pricing is accurate."

OIG Comments:

After reviewing the Plan's response and additional documentation, we revised the questioned charges from our draft report to $224,163. The Plan's response and/or additional documentation support agreement with $220,857 and disagreement with $3,306 of the revised questioned charges.

Regarding the contested amount, the Plan could not determine if the claims were priced at the correct percentage because the primary surgeon did not bill for the procedure or the assistant surgeon billed a different procedure code than the primary

surgeon. We will continue to question the total charges for each of these claims because the assistant surgeon should not be paid if there is no support for a primary surgeon for the procedure.

Recommendation 3

We recommend that the contracting officer disallow $264,488 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 4

We recommend that the contracting officer allow the Plan to charge the FEHBP $40,325 if additional payments are made to the providers to correct the underpayment errors. However, before making any additional payment(s) to a provider, the contracting officer should require the Plan to first recover any questioned overpayment(s) for that provider.

c. Modifier 62 and 66 Review $173,117

The Plan incorrectly paid 275 multiple surgeon claim lines, resulting in net overcharges of $173,117 to the FEHBP. Specifically, the Plan overpaid 223 claim lines by $196,279 and underpaid 52 claim lines by $23,162.

As previously cited from CS 1063, 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.

For the period January 1, 2007 through May 31, 2010, we identified 544 multiple surgeon claim groups, totaling $897,677 in potential "estimated" overpayments, that contained at least one claim line with co-surgeon procedure modifier "62" or surgical team procedure modifier "66". From this universe, we selected and reviewed a judgmental sample of 516 groups (representing 937 claim lines), totaling $882,500 in potential overpayments, for the purpose of determining if the Plan paid these claim lines properly. Our sample included all groups with potential overpayments of $100 or more.

Based on our review, we determined that 275 multiple surgeon claim lines were paid incorrectly due to the Plan not recognizing the procedure modifier "62" or "66" when pricing these claims. The Plan priced these claim lines without applying the co-surgeon reimbursement rate of 62.5 percent to the applicable procedure allowances. Consequently, the Plan overpaid 223 claim lines by $196,279 and underpaid 52 claim lines by $23,162, resulting in net overcharges of $173,117 to the FEHBP.

Plan's Response:

In response to the amount questioned in the draft report, the Plan agrees with $170,290 and disagrees with $712,210. The Plan will pursue the uncontested overpayments.

For the contested amount, the Plan states, "The overpayment amount computed by the OIG was based on the allowed amount at the time of original adjudication multiplied by the standard co-surgeon rate of 62.5%. This amount inflates the overpayments because it assumes that all of the claims are not reduced to the 62.5% co-surgeon rate . . . We disagree with the remaining balance of $712,210 as it was determined that the claims were paid according to the co-surgeon benefits."

In addition, the Plan states, "GEHA relies on the pricing systems of our multiple leased PPO networks to provide accurate pricing. Each network surveyed has a process in place to audit pricing and resolve deficiencies. We are implementing periodic audits of PPO network pricing. On a quarterly basis GEHA audits a sample of provider contracts in order to confirm network pricing is accurate."

OIG Comments:

Based on our review of the Plan's response and additional documentation, we revised the questioned charges from our draft report to $173,117. The Plan's response and/or additional documentation support concurrence with the revised questioned charges.

Recommendation 5

We recommend that the contracting officer disallow $196,279 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 6

We recommend that the contracting officer allow the Plan to charge the FEHBP $23,162 if additional payments are made to the providers to correct the underpayment errors. However, before making any additional payment(s) to a provider, the contracting officer should require the Plan to first recover any questioned overpayment(s) for that provider.

d. Claims Paid for Ineligible Patients $146,481

The Plan paid 286 claims that were incurred when no patient enrollment records existed, during gaps in patient coverage, or after termination of patient coverage with the GEHA Benefit Plan, resulting in overcharges of $146,481 to the FEHBP. These claims were paid for ineligible patients.

As previously cited from CS 1063, 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.

Enrollee Coverage Conflicts with Dates of Service

We performed a computer search to identify claims paid that were potentially incurred during gaps in patient coverage or after termination of patient coverage with the GEHA Benefit Plan. For the period January 1, 2007 through May 31, 2010, we identified 10,937 claim line payments, totaling $2,180,291, for 1,922 patients that met this search criteria. Our search criteria took into consideration the 31-day grace period of temporary continuing coverage following termination of eligibility.

From this universe of 1,922 patients, we selected all patients with cumulative claim line payments of $2,500 or more to review. Our sample included 3,377 claim lines, totaling $1,719,678 in payments, for 124 patients. Based on our review, we determined that 218 claims, totaling $133,671 in payments, were paid for ineligible patients.

Patients with No Enrollment Records

We performed a computer search to identify claims paid that were potentially incurred when no patient enrollment records existed. For the period January 1, 2007 through May 31, 2010, we identified 63,849 claim line payments, totaling $9,637,511, for 1,265 patients that met this search criteria. Our search criteria took into consideration the 31-day grace period of temporary continuing coverage following termination of eligibility.

From this universe of 1,265 patients, we selected all patients with cumulative claim line payments of $5,000 or more to review. Our sample included 42,516 claim lines, totaling $8,563,560 in payments, for 285 patients. Based on our review, we determined that 68 claims, totaling $12,810 in payments, were paid for ineligible patients.

Summary of Claims Paid for Ineligible Patients

In total, the Plan overcharged the FEHBP $146,481 for 286 claims that were paid for ineligible patients. Our audit disclosed the following reasons for these claim payment errors:

- For 218 of the claims questioned, the members' enrollment data records that identified the patients' eligibility status in the Plan's claims system were incorrect when the claims were paid. However, after receiving the patients' updated enrollment data, the Plan did not review and/or adjust these claims that were incurred after the patients' termination dates of coverage. For these 218 claims, the enrollment data errors were identified on the members' rosters or the

members' termination notices, which were received from the federal payroll offices, after the claims were already paid. As a result, the FEHBP was overcharged $59,579 in claim payments for patients not eligible for benefits.

- For 68 of the claims questioned, there were various processing errors. For example, we identified multiple cases where the patients were not eligible for coverage due to loss in coverage from divorce and the Plan erroneously paid these claims. As a result, the FEHBP was overcharged $86,902 in claim payments for patients not eligible for benefits.

Plan's Response:

The Plan agrees with $157,442 of the questioned charges from the draft report and states, "GEHA identified . . . $100,533 . . . of the questioned costs prior to the OIG audit. . . . As of the date of the response, we have recovered $29,839 and waived $11,707. We will continue collection efforts on the remaining outstanding balance."

In regards to preventing these types of errors, the Plan states, "When a termination is received or a member changes from a self and family contract to a self contract, a report is systematically generated that lists all the medical claims paid from the effective date of the termination or change in plan. The claims are reviewed and collection action is initiated for claims that were paid after the effective date. Most of the claims cited as overpayments were the result of GEHA receiving retroactive termination notices from federal payroll offices."

OIG Comments:

Based on our review of the Plan's response and supporting documentation, we revised the questioned charges from our draft report to $146,481. After providing the response, the Plan provided additional documentation supporting agreement with $68,893 and disagreement with $77,588 of the revised questioned charges.

Regarding the contested charges, the Plan states that these overpayments were waived because the providers refused to refund these amounts. However, since these claims were paid for ineligible patients, we will continue to question these improper payments.

Recommendation 7

We recommend that the contracting officer disallow $146,481 for claims that were paid for ineligible patients, and verify that the Plan returns all amounts recovered to the FEHBP.

e. Inpatient Facility Claims - Duplicate or Overlapping Dates of Service $103,977

The Plan incorrectly paid 14 inpatient facility claims, resulting in overcharges of $103,977 to the FEHBP.

As previously cited from CS 1063, 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.

Section 6(h) of the FEHB Act provides that rates should reasonably and equitably reflect the costs of benefits provided.

We performed a computer search for potential duplicate payments on inpatient facility claims paid during the period January 1, 2007 through May 31, 2010. We identified 146 groups of inpatient facility claims with duplicate or overlapping dates of service. These 146 groups included 301 claims with total amounts paid of $6,507,532. Based on our review, we determined that 14 of these claims were paid incorrectly (i.e., as duplicate claim payments), resulting in overcharges of $103,977 to the FEHBP.

These duplicate claim payments resulted from the following reasons:

- For 12 of these duplicate payments, the Plan incorrectly paid the claims due to manual processing errors, resulting in overcharges of $88,264 to the FEHBP. Specifically, these claims were deferred as potential duplicates on the claims system, but the system edits were overridden by the processors.

- For two of these duplicate payments, the Plan incorrectly paid the claims due to systematic processing errors, resulting in overcharges of $15,713 to the FEHBP. Specifically, these claims were not deferred on the claims system as potential duplicates for review by the processors.

Plan's Response:

The Plan agrees with this finding. The Plan had recovered $38,762 of the duplicate payments as of September 2, 2011. The Plan will continue to pursue the remaining duplicate payments.

In regards to preventing these types of errors, the Plan states, "GEHA's claims system has edits that screen claims for duplicates. The system automatically ranks duplicate claims as disallowable or possible duplicates. In addition, GEHA's Internal Audit Department conducts an audit of potential duplicate claims each quarter. Duplicates are referred to the Claims Department for review and collections are pursued."

Recommendation 8

We recommend that the contracting officer disallow $103,977 for duplicate claim payments charged to the FEHBP, and verify that the Plan returns all amounts recovered to the FEHBP.

f. Duplicate Claim Payments $50,984

During our review of potential duplicate claim payments, we found that the Plan incorrectly paid 68 claims, resulting in overcharges of $50,984 to the FEHBP. Specifically, we determined that the Plan improperly charged the FEHBP $34,052 for 44 duplicate claim payments. Also, we identified 24 claims that were not duplicate claim payments but contained other Plan payment errors, resulting in overcharges of $16,932 to the FEHBP.

As previously cited from CS 1063, 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.

Section 6(h) of the FEHB Act provides that rates should reasonably and equitably reflect the costs of benefits provided.

We performed a computer search for potential duplicate payments on claims paid during the period January 1, 2007 through May 31, 2010. We selected and reviewed 869 groups, totaling $1,309,865 (out of 33,169 groups, totaling $1,644,823) in potential duplicate payments, under our "best matches" criteria. We also selected and reviewed 829 groups, totaling $1,394,960 (out of 101,575 groups, totaling $3,605,449) in potential duplicate payments, under our "near matches" criteria. Our samples included all groups with potential duplicate payments of $350 or more under the "best matches" criteria and $500 or more under the "near matches" criteria.

Based on our review, we determined that 21 claim payments in our "best matches" sample were duplicates, resulting in overcharges of $15,715 to the FEHBP. Also, we determined that 23 claim payments in our "near matches" sample were duplicates, resulting in overcharges of $18,337 to the FEHBP. In total, the Plan charged the FEHBP $34,052 for these 44 duplicate claim payments from January 1, 2007 through May 31, 2010.

These duplicate claim payments resulted from the following reasons:

- For 31 of these duplicate payments, the Plan incorrectly paid the claims due to manual processing errors, resulting in overcharges of $25,149 to the FEHBP. Specifically, these claims were deferred as potential duplicates on the claims system, but the system edits were overridden by the processors.

- For 13 of these duplicate payments, the Plan incorrectly paid the claims due to systematic processing errors, resulting in overcharges of $8,903 to the FEHBP. Specifically, these claims were not deferred on the claims system as potential duplicates for review by the processors.

During our review of potential duplicate claim payments in our "best matches" sample, we identified 14 claims that were not duplicate claim payments but contained other Plan payment errors, resulting in overcharges of $10,373 to the FEHBP. In our "near matches" sample, we also identified 10 claims that were not duplicate claim payments but contained other Plan payment errors, resulting in overcharges of $6,559 to the FEHBP. In total, the Plan overcharged the FEHBP $16,932 for these 24 claim payment errors.

These non-duplicate claim payment errors resulted from the following reasons:

- The Plan incorrectly paid 15 claims since the patients' anesthesia allowable benefits had been exhausted, resulting in overcharges of $12,817 to the FEHBP.

- The Plan incorrectly paid six claims due to manual pricing errors, resulting in overcharges of $3,082 to the FEHBP.

- The Plan paid two claims using the incorrect procedure allowances, resulting in overcharges of $573 to the FEHBP.

- In one instance, the Plan priced a claim without applying the multiple procedure discount, resulting in an overcharge of $460 to the FEHBP.

Plan's Response:

The Plan agrees with this finding. The Plan had recovered $35,885 of the overpayments as of September 2, 2011. The Plan will continue to pursue the remaining overpayments.

In regards to preventing these types of errors, the Plan states, "GEHA's claims system has edits that screen claims for duplicates. The system automatically ranks duplicate claims as disallowable or possible duplicates. In addition, GEHA's Internal Audit Department conducts an audit of potential duplicate claims each quarter. Duplicates are referred to the Claims Department for review and collections are pursued."

Recommendation 9

We recommend that the contracting officer disallow $50,984 for claim overcharges ($34,052 for duplicate claim payments and $16,932 for other claim payment errors) and verify that the Plan returns all amounts recovered to the FEHBP.

g. System Review **$41,802**

Based on our review of a judgmental sample of 125 claims, we determined that the Plan incorrectly paid 2 claims, resulting in overcharges of $41,802 to the FEHBP. Also, we identified five instances where the Plan's claims system did not contain the dates when the providers' contracted pricing rates were loaded into the system.

As previously cited from CS 1063, 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.

For health benefit claims paid during the period January 1, 2009 through May 31, 2010 (excluding OBRA 90, OBRA 93, and case management claims), we identified 12,500,531 claim lines, totaling $1,527,263,087 in payments, where the FEHBP paid as the primary insurer. From this universe, we selected and reviewed a judgmental sample of 125 claims (representing 449 claim lines), totaling $6,546,415 in payments, to determine if the Plan adjudicated these claims properly and/or priced them according to the provider contract rates.[5] As part of our review, we also verified if the provider contract rates were accurately and timely updated in the pricing systems of the Plan's PPO networks for 38 claims in our sample.

Based on our review, we identified two claim payment errors, resulting in overcharges of $41,802 to the FEHBP. In each instance, the Plan paid the claim without applying the discounted pricing rate. In addition to these overcharges, we identified five instances where the Plan's claims system did not include the dates when the providers' contracted pricing rates were loaded into the system. Therefore, we could not determine if these contracted rates were loaded timely into the system. Because these could result in potential systematic errors, the Plan should identify when the providers' contracted pricing rates were loaded into the claims system and determine if the applicable claims were priced and paid correctly.

Plan's Response:

In response to the amount questioned in the draft report, the Plan disagrees with the questioned overpayments.

For the contested amount, the Plan states, "We verified the discounts to provider agreements without exception on the 38 sample items. For the provider agreements above we obtained information from PPO networks to confirm the date provider rates were entered into the network's pricing systems. We noted only three sample items where the rate load dates were after the effective date of the provider agreements and

[5] 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.

none of those claims were overpaid. . . . we don't believe this issue is a systemic risk and there may be very good reasons why the load date would vary from the effective date. The networks have established procedures for the maintenance of rates in their systems to ensure that pricing is accurate.

The remainder of the provider agreements had rates loaded prior to the effective date of the agreement or our PPO networks were not in place as of the effective date of the provider agreements.

There were also four provider agreements on GEHA's pricing system with effective dates from January 1, 1999 to January 1, 2005 that the rate input date could not be confirmed. All of these discount rates have not changed since the initial provider contract was effective."

Regarding corrective actions to prevent these types of errors, the Plan states, "We will evaluate the results of the OIG's audit findings and implement procedures we deem necessary to resolve the issues noted. The PPO networks we have contacted have policies and procedures in place to address provider contracting and the administration of discounts rates. We are implementing periodic audits of PPO network pricing. On a quarterly basis GEHA audits a sample of provider contracts in order to confirm network pricing is accurate."

OIG Comments:

Based on our review of the Plan's response and supporting documentation, we revised the questioned charges from our draft report to $41,802. After providing the response, the Plan provided additional documentation supporting agreement with $1,538 and disagreement with $40,264 of the revised questioned charges.

We are continuing to question the contested amount as an overcharge to the FEHBP because the Plan did not provide sufficient documentation to support that the claims were properly paid at the contracted discount rate.

Recommendation 10

We recommend that the contracting officer disallow $41,802 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

h. Network Pricing Oversight **Procedural**

The Plan contracts with 15 regional PPO networks throughout the United States to provide members with comprehensive access to in-network providers. Most of these PPO networks administer the pricing of claims and submit pricing sheets to the Plan for claims processing. We found that the Plan does not sufficiently verify the accuracy and integrity of these pricing sheets prior to processing and paying the

claims. The Plan relies on what the PPO networks instruct them to price the claims at, leading to potentially increased risk of claim payment errors.

The Plan has a fiduciary responsibility to the FEHBP to accurately price and process claims according to the GEHA Benefit Plan brochure and the PPO network contracts. A good internal control structure requires that sufficient audit testing occur to obtain reasonable assurance that the Plan's PPO networks are properly pricing claims in accordance with the current provider contracts. However, we noted that the Plan is reviewing only 60 FEHBP claims a calendar quarter. In our opinion, this sample size is too small considering the Plan processes approximately 1.4 million claims a calendar quarter (based on the 2010 Annual Accounting Statement) and relies on the PPO networks to price most of these claims.

The potential risk for claim payment errors increases due to the Plan's insufficient oversight of the multiple PPO networks. Without sufficient network oversight, the FEHBP claims are at risk for being priced incorrectly and/or potentially subject to high error rates, resulting in overcharges to the FEHBP. For example, during our review of assistant surgeon claims, we identified numerous instances where the PPO networks were not reducing the allowed amounts on the pricing sheets for the assistant surgeon modifiers (See "Assistant Surgeon Review" audit finding - A1.b). Since the Plan was unaware that PPO networks were not adjusting or reducing the allowed amounts for assistant surgeon claims, these claims resulted in overpayments.

Plan's Response:

The Plan agrees with this finding.

The Plan states, "We obtained the auditing procedures performed by the provider networks we lease. They all have procedures in place to audit pricing and implement corrective action. If GEHA or the provider determines that pricing is inaccurate, corrected pricing can be produced by the networks.

On a quarterly basis GEHA audits a sample of provider contracts in order to confirm network pricing is accurate. We are implementing periodic audits of PPO network pricing, with an emphasis on assistant surgeon and co-surgeon pricing."

Recommendation 11

We recommend that the contracting officer ensure that the Plan is conducting periodic audits of the PPO networks' pricing practices to obtain reasonable assurance that the correct provider contract rates are being used to accurately price the claims.

2. Miscellaneous Payments and Credits

The audit disclosed no findings pertaining to miscellaneous health benefit payments and credits. Overall, we concluded that the Plan returned health benefit refunds and recoveries, including prescription drug rebates, to the FEHBP in a timely manner.

B. ADMINISTRATIVE EXPENSES

The audit disclosed no findings pertaining to administrative expenses. Overall, we concluded that the Plan charged expenses related to administrative expenses to the FEHBP in accordance with the terms of the contract and applicable regulations.

C. CASH MANAGEMENT

The audit disclosed no findings pertaining to cash management. Overall, we concluded that the Plan handled FEHBP funds in accordance with Contract CS 1063 and applicable laws and regulations.

D. FRAUD AND ABUSE PROGRAM

1. Notification of Fraud and Abuse Cases — Procedural

The Plan did not refer cases with areas of patient harm or safety issues to the Office of Personnel Management's Office of the Inspector General (OPM/OIG) from 2006 through 2009 that related to member fraud and abuse issues, such as doctor shopping for pharmaceuticals/schedule II – IV drugs and/or membership eligibility issues, regardless of monetary amounts.

The Plan has not fully adopted Carrier Letter 2007-12 ("Notifying OPM's Office of the Inspector General Concerning Fraud and Abuse Cases in the FEHBP Program"), which states, "All carriers must send a written notification/referral to the OPM-OIG within 30 days of becoming aware of any cases involving suspected false, fictitious, fraudulent, or misleading insurance claims, when . . . conditions are met . . . All carriers must also send a prompt written notification/referral to their Contracting Officer and OPM-OIG for any cases, regardless of the dollar amount of claims paid, if there is an indication of patient harm, potential for significant media attention, or other exceptional circumstances."

Carrier Letter 2003-23 ("Industry Standards for Fraud and Abuse Programs") defines indicators of areas that contain patient harm or patient safety issues to include, but not be limited to: (1) pharmaceuticals, such as altered prescriptions, illegal refills, prescription splitting, and abuse of controlled substances; (2) medical errors in both inpatient and outpatient care, resulting in unfavorable outcomes; and (3) improper settings for procedures and services that result in poor outcomes.

By not notifying or referring potential patient harm or patient safety cases, regardless of monetary amounts, to the OPM/OIG, issues related to pharmaceutical abuse and medical errors could go undetected, leading to the continuation of fraud and abuse.

Plan's Response:

The Plan disagrees with this finding.

The Plan states, "As noted in the Audit Report the Carrier Letter dated March 30, 2007 provides for a threshold of $20,000 for reporting provider fraud or abuse, except when patient harm is indicated. Because GEHA is a nationwide plan and its membership is not evenly distributed throughout the United States, we do not reach this threshold in many cases. That does not, however, mean fraud is not addressed. Many providers are 'flagged' in our system and their claims come directly to the SIU before they are paid. If fraud or abuse is indicated, these claims are denied by SIU personnel. OPM/OIG does not receive information on many of these providers (approximately 7,000 providers) because the threshold is not reached. However, GEHA will evaluate this finding and will emphasize to all involved personnel the requirements of the Carrier Letter.

GEHA management has met with all personnel in the SIU, provided them with another copy of the Carrier Letter (it was provided when issued by OPM) and a copy of the Audit Findings. There was discussion about both documents. GEHA management will be monitoring our compliance and looks forward to working closely with OPM/OIG to address fraud. We have also been communicating with GEHA's Medical Director and Managed Care Unit to review procedures for reporting cases of suspected fraud or potential patient harm to the SIU for further action and reporting to OIG. GEHA believes the quarterly Carrier/OIG task force conferences can be used to further assist Carriers in getting feedback from OIG on a continuing basis on the quantity and quality of referrals they receive, and on issues relating to interpretation of the Carrier Letter. We will also be working with our Pharmacy Department and Medco to refine our procedures for obtaining information and reports from Medco. [redacted] has a pharmacy module in their fraud detection software that we will be evaluating for purchase this year.

Although the Plan disagrees with the finding that no cases involving potential patient harm were referred to OIG during the applicable period, it does agree these referrals were limited in number. After discussion with OIG personnel subsequent to the audit finding, the Plan has implemented new procedures with its case management, pharmacy unit and the Medical Director to receive information about potential patient harm cases so they can be referred to OIG."

OIG Comments:

The Plan provided no further documentation to support that patient harm and/or safety cases are being referred to the OPM/OIG. Therefore, we continue to question whether the Plan has implemented all components of a complete and comprehensive F&A

Program, as described in Carrier Letters 2003-23 and 2007-12, and whether the Plan has proper program management over F&A Program components related to patient harm and safety issues. As a result, we continue to recommend that the contracting officer ensure that the Plan is complying with the FEHBP Carrier Letters related to fraud and abuse.

Recommendation 12

We recommend that the contracting officer ensure that the Plan implements all components of Carrier Letters 2003-23 ("Industry Standards for Fraud & Abuse Programs") and 2007-12 ("Notifying OPM's Office of the Inspector General Concerning Fraud and Abuse Cases in the FEHBP Program").

2. Fraud and Abuse Annual Reports — Procedural

The Plan did not provide the OPM/OIG complete F&A annual reports from 2006 through 2009.

Carrier Letter 2007-12 states that F&A annual reports, as described in Carrier Letter 2003-25 ("Revised FEHB Quality Assurance and Fraud and Abuse Reports") are required. Carrier Letter 2003-25 states, "The . . . F&A report will now include collecting the following information:

- Cases Opened – only cases opened within report period
- Total Dollars Identified as Loss – total dollar amount verified as a loss
- Total Dollars Recovered – dollars actually received
- Actual Savings – dollars saved due to a claim rejection, prepayment review, etc.
- Projected Savings – calculated based on the amount of loss that would have been incurred had the fraudulent conduct not been stopped due to anti-fraud efforts – 12 month period
- Number of Cases referred to Law Enforcement – total cases referred to local, state, or federal law enforcement agencies
- Number of Cases Resolved through negotiated settlement – cases resolved via settlement negotiation
- Number of Arrests – number of cases that resulted in an arrest
- Number of Criminal Convictions – number of cases that resulted in criminal convictions"

Although the Plan implemented some of the F&A report requirements, we could not find any information related to the number of cases referred to law enforcement (including the OPM/OIG), the number of cases resolved through negotiated settlement, the number of arrests, and the number of criminal convictions during the period 2006 through 2009.

Additionally, the Plan stated that they are actively involved in class action lawsuits against the pharmaceutical industry. The Plan suggested that many of the class action lawsuits involve adverse drug effects and off-label marketing issues. However, the Plan

did not report these cases to the OPM/OIG nor report these recoveries in the annual F&A reports.

By not including all F&A reporting requirements, we could not determine the overall outcome and success of the Plan's prevention, detection, and F&A Program activities.

Plan's Response:

The Plan disagrees with this finding.

The Plan states, "GEHA did submit Annual Reports as required by the contract for the years 2006-2009, with all fields in the standard report completed. However, we understand the Audit Findings to indicate these reports were not complete. GEHA did provide total dollars recovered, and actual and projected savings. GEHA did work with regional and local law enforcement entities in limited cases.

GEHA did not begin to report DOJ/OPM/OIG recoveries in our fraud report until the OPM/OIG's creation of a process for notifying carriers that a recovery had been achieved and a recovery was credited to each Plan's Contingency Reserve. Prior to that time, we were seldom aware of the amount of the recovery or the credit to the Plan on cases in which GEHA SIU personnel were involved. That did not occur, we believe, until late 2008. We believed that OPM/OIG wanted us to include fraud recoveries from any source in our annual report because there was a credit to our contingency reserve from a fraud recovery. We would appreciate being advised by OPM/OIG whether they want plans to exclude these amounts.

With regard to drug class actions, GEHA began participating as one of many plaintiffs in class actions in the 2001-2002 timeframe. In every case in which a settlement was reached with a defendant, there was a specific denial of liability or wrongdoing and no judicial determination that any violations were committed. These were all civil cases in which GEHA had no direct information or support for a finding of fraud. For this reason, these recoveries, as noted in the OIG Audit Findings, were reported as third party subrogation recoveries. Since 2002, net recoveries have been obtained by GEHA for the FEHB program of $4,709,134.53 in these cases.

GEHA will initiate discussion with OPM/OIG to be certain GEHA is providing required Annual Reports consistent with OPM/OIG expectations and understanding of the Carrier Letter. GEHA intends to work cooperatively with OPM/OIG to react to areas of deficiency perceived by OIG in our procedures and in the reporting to OPM/OIG. GEHA regards this as a serious matter and will promptly initiate discussion with OPM/OIG and proceed with diligence to address areas identified by OPM/OIG. Based on that dialogue, GEHA will meet regularly with all GEHA SIU personnel to discuss procedures to be followed to ensure full compliance with the Carrier Letter, and will also review procedures with other applicable GEHA business units and Medco to obtain all pertinent information relative to fraud, abuse and patient harm."

OIG Comments:

With respect to class action lawsuits, we acknowledge that the Plan has opened discussions with the OPM/OIG, and has agreed to and started notifying the OPM/OIG of any and all class action lawsuit cases.

We also acknowledge that the Plan has provided annual F&A reports to OPM as required, but the reports were incomplete in reporting the number of cases referred to law enforcement (including the OPM/OIG), the number of cases resolved through negotiated settlement, the number of arrests, and the number of criminal convictions during the audit scope. We agree that the Plan has reported recoveries. However, until the Plan provides complete annual F&A reports, as noted above, we will continue to recommend that the contracting officer ensure that the Plan implements all components of the F&A report, as required and described in Carrier Letter 2003-25.

Recommendation 13

We recommend that the contracting officer ensure that the Plan implements all components of the F&A report, as required and described in Carrier Letter 2003-25 ("Revised FEHB Quality Assurance and Fraud and Abuse Reports").

3. Program Management **Procedural**

In a meeting to discuss the Plan's F&A Program, the Plan provided an overview of a product that their Special Investigations Unit uses, called [redacted] ([redacted]) which is supported by [redacted]. The Plan described the process and use of the product to be a post-payment tool only. The Plan provides post-payment data to [redacted] who then uses various methodologies to review, sort, and manipulate the data to look for abnormal billing patterns, such as providers who could be billing outside the normal ranges for particular procedure codes. [redacted] then sends a report back to the Plan identifying any providers with unusual billing patterns. These reports are sent directly to the Plan's fraud analysts for further review. However, the Plan's use of the [redacted] program may be underutilized, especially if the Plan is not actively seeking post-payment recoveries or performing post-payment investigations.

The Plan could not provide any documentation to support that the process described above uncovered any fraud cases for an OPM/OIG referral. In response to an OPM/OIG Office of Investigation's information request, the Plan provided a document titled "Goals and Projects for SIU" that stated, "training a new specialist on [redacted] access to [redacted] newest system after GEHA's new claims processing system is implemented."

Sharing the [redacted] report with the OPM/OIG on a regular basis as a notification tool, regardless of potential dollar losses, should increase the number of referrals the Plan provides to the OPM/OIG and improve communication between the Plan's SIU and the OPM/OIG.

As one of their top priorities, the Plan's SIU provides support for OPM/OIG related investigations. The Plan's SIU appears to concentrate their overall efforts on pre-payment reviews to stop potential fraudulent payments. By focusing on that element of potential fraud and abuse, and not taking full advantage of the post-payment capabilities of [redacted] other fraudulent and abusive practices could go unnoticed that could lead to areas of weakness with the Plan's F&A Program.

Plan's Response:

The Plan agrees with this finding.

The Plan states, "With respect to [redacted] GEHA agrees that this tool has been underutilized and we have adjusted our procedures to require that all of its investigators use [redacted] as a primary source of leads. Our Specialists need to make greater use of the [redacted] tool and to balance prepayment and post payment recoveries. We will initiate dialogue with OPM/OIG and will renew our efforts with respect to emphasizing our investigative and reporting obligations under the Carrier Letter. In particular, we will train all of our Specialists on the use of the [redacted] tool. We welcome communication and feedback from OPM/OIG at any time to ensure our full compliance with the Carrier Letter. We will be monitoring our SIU's use of [redacted] software to ensure that our procedures are followed and expectations for [redacted] use are met.

GEHA places emphasis on prepayment review and investigation. We do that by identification of suspected fraudulent providers based on leads from a variety of sources, i.e. [redacted] Claims Department referrals, NHCAA case information sharing meetings, NHCAA requests for investigative assistance, and information received from OPM/OIG. A suspected fraudulent provider is flagged in our system and any claims submitted by that provider are directed to the SIU. We believe, to the extent possible, it is better to prevent fraudulent claims from being paid, rather than trying to recover it later. It is thus correct to say we emphasize prepayment review. Post payment recovery attempts can be difficult, time consuming and expensive, although we agree they are a necessary part of a fraud program."

Recommendation 14

We recommend that the contracting officer ensure that the Plan trains the SIU specialists so that [redacted] can be a fully utilized tool that provides a basis for post-payment claims reviews and investigations by SIU staff.

4. Pharmacy Benefit Manager **Procedural**

The Plan's process for doctor shopping cases does not include a review by SIU staff to determine if notification to the OPM/OIG is required. In addition, the Plan does not require their Pharmacy Benefit Manager (PBM) to report potential F&A cases related to pharmacies, physicians with abnormally high rates of prescribing narcotics, member drug misuse or abuse, and other potential fraud related reporting issues. Due to these deficiencies, the Plan is not in compliance with Carrier Letter 2007-12 ("Notifying OPM's Office of the Inspector General Concerning Fraud and Abuse Cases in the FEHBP Program").

The Plan's PBM is MEDCO. The Plan's protocol for fraud issues within the pharmacy and pharmaceutical areas is for MEDCO to refer all incidents of member fraud and doctor shopping for narcotics to the Plan's Medical Director, who then sends letters to the member's physicians notifying them of the member's activities.

As far as pharmacy related cases, there was no documentation to support that MEDCO provided or referred any pharmacy related fraud issues to the Plan's SIU during the period 2006 through 2009. Furthermore, when potential pharmacy related fraud issues and referrals from the PBM were discussed, the Plan stated that there is a process for doctor shopping cases, but the process does not include a review from SIU staff to determine if notification to the OPM/OIG is required. Doctor shopping losses are not limited to the pharmacies or prescriptions, but also include the doctor and/or hospital emergency room costs that are associated with the drug seeking activity.

Plan's Response:

The Plan agrees with this finding.

Recommendation 15

We recommend that the contracting officer ensure that the Plan updates their process for doctor shopping cases to include a review by SIU staff to determine if notification to the OPM/OIG is required.

Recommendation 16

We recommend that the contracting officer verify that the Plan requires their PBM to report all potential F&A cases related to pharmacies, physicians with abnormally high rates of prescribing narcotics, member drug misuse or abuse, and other potential fraud related reporting issues so that the Plan can implement all requirements in Carrier Letter 2007-12 ("Notifying OPM's Office of the Inspector General Concerning Fraud and Abuse Cases in the FEHBP Program").

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Experience-Rated Audits Group

[redacted], Lead Auditor

[redacted], Lead Auditor

[redacted], Auditor

[redacted], Auditor

[redacted], Auditor

[redacted], Auditor

[redacted], Chief [redacted]

[redacted] Senior Team Leader

Community-Rated Audits Group

[redacted], Chief

Office of Investigations

[redacted], Special Agent-In-Charge

[redacted], Special Agent

SCHEDULE A

V. SCHEDULES

GOVERNMENT EMPLOYEES HEALTH ASSOCIATION, INC. BENEFIT PLAN
LEE'S SUMMIT, MISSOURI

CONTRACT CHARGES AND AMOUNTS QUESTIONED

CONTRACT CHARGES	2006	2007	2008	2009	TOTAL
HEALTH BENEFIT CHARGES*	$1,610,025,105	$1,588,952,508	$1,665,751,668	$1,793,716,151	$6,658,445,432
ADMINISTRATIVE EXPENSES	75,227,082	76,413,234	81,091,662	90,704,004	323,435,982
OTHER EXPENSES AND RETENTIONS**	14,775,460	14,382,534	14,632,358	15,207,450	58,997,802
TOTAL CONTRACT CHARGES	$1,700,027,647	$1,679,748,276	$1,761,475,688	$1,899,627,605	$7,040,879,216

AMOUNTS QUESTIONED (PER SCHEDULE B)	2006	2007	2008	2009	2010	TOTAL
A. HEALTH BENEFIT CHARGES	$0	$244,325	$214,992	$395,199	$322,551	$1,177,068
B. ADMINISTRATIVE EXPENSES	0	0	0	0	0	0
C. CASH MANAGEMENT	0	0	0	0	0	0
D. FRAUD AND ABUSE PROGRAM	0	0	0	0	0	0
TOTAL AMOUNTS QUESTIONED	$0	$244,325	$214,992	$395,199	$322,551	$1,177,068

* We reviewed claim payments from January 1, 2007 through May 31, 2010, and miscellaneous health benefit payments and credits from 2006 through 2009.
** We did not review other expenses and retentions, except for the cash management of these funds.

SCHEDULE B

GOVERNMENT EMPLOYEES HEALTH ASSOCIATION, INC. BENEFIT PLAN
LEE'S SUMMIT, MISSOURI

QUESTIONED CHARGES

AUDIT FINDINGS	2006	2007	2008	2009	2010	TOTAL
A. HEALTH BENEFIT CHARGES						
1. Claim Payments						
a. Coordination of Benefits with Medicare	$0	$0	$33,719	$160,787	$242,038	$436,544
b. Assistant Surgeon Review	0	44,246	45,546	83,867	50,504	224,163
c. Modifier 62 and 66 Review	0	22,078	62,964	72,149	15,926	173,117
d. Claims Paid for Ineligible Patients	0	116,320	2,164	21,722	6,274	146,481
e. Inpatient Facility Claims - Duplicate or Overlapping Dates of Service	0	49,757	53,841	378	0	103,977
f. Duplicate Claim Payments	0	11,924	16,758	14,494	7,808	50,984
g. System Review	0	0	0	41,802	0	41,802
h. Network Pricing Oversight (Procedural)	0	0	0	0	0	0
Total Claim Payments	$0	$244,325	$214,992	$395,199	$322,551	$1,177,068
2. Miscellaneous Payments and Credits	$0	$0	$0	$0	$0	$0
TOTAL HEALTH BENEFIT CHARGES	$0	$244,325	$214,992	$395,199	$322,551	$1,177,068
B. ADMINISTRATIVE EXPENSES	$0	$0	$0	$0	$0	$0
C. CASH MANAGEMENT	$0	$0	$0	$0	$0	$0
D. FRAUD AND ABUSE PROGRAM (Procedural)						
1. Notification of Fraud and Abuse Cases	$0	$0	$0	$0	$0	$0
2. Fraud and Abuse Annual Reports	0	0	0	0	0	0
3. Program Management	0	0	0	0	0	0
4. Pharmacy Benefit Manager	0	0	0	0	0	0
TOTAL FRAUD AND ABUSE PROGRAM	$0	$0	$0	$0	$0	$0
TOTAL QUESTIONED CHARGES	$0	$244,325	$214,992	$395,199	$322,551	$1,177,068

GEHA®

The Health Plan *for* Federal Employees

September 2, 2011

[redacted] Group Chief
Experience-Rated Audits Group
Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, Room 6400
Washington, DC 20415-1100

Dear [redacted],

We have completed our review of the OIG audit report draft of the Government Employees Health Association, Inc. (GEHA) dated June 10, 2011. We have included our responses for each audit area on the OIG report draft. We have also sent via electronic submission documentation to support our response.

SYSTEM REVIEW

OIG Finding:

We have reviewed the System Review findings and provided an initial audit response on July 11, 2011 to clarify findings that were on the OIG's report draft. Updated and previous documentation sent to the OIG was provided on this submission. Please refer to this response and the spreadsheet comments for this audit for GEHA's position on individual claim exceptions.

Recommendation 1

We recommend that the contracting officer disallow $2,657,160 for claim overcharges, and verify that the Plan has returned all amounts recovered to the FEHBP.

GEHA Response:

As agreed to by OPM-OIG, we obtained the provider agreements for 38 sample items to confirm the discounts taken. We verified the discounts to provider agreements without exception on the 38 sample items. For the provider agreements above we obtained information from PPO networks to confirm the date provider rates were entered into the network's pricing systems. We noted only three sample items where the rate load dates were after the effective date of the provider agreements and none of those claims were overpaid. As we discussed previously we don't believe this issue is a systemic risk and there may be very good reasons why the load date would vary from the effective date. The

networks have established procedures for the maintenance of rates in their systems to ensure that pricing is accurate.

The remainder of the provider agreements had rates loaded prior to the effective date of the agreement or our PPO networks were not in place as of the effective date of the provider agreements.

There were also four provider agreements on GEHA's pricing system with effective dates from January 1, 1999 to January 1, 2005 that the rate input date could not be confirmed. All of these discount rates have not changed since the initial provider contract was effective.

We disagree with the overpayments totaling $2,657,160 and agree with $0.00. See the accompanying System Review spreadsheet and documentation for details regarding our position on these sample items.

Recommendation 2

We recommend that the contracting officer allow the Plan to charge the FEHBP $32,295 if additional payments are made to the providers to correct the underpayment errors.

GEHA Response:

GEHA has resolved $30,692 of this total as described on the System Review spreadsheet and the provided documentation. There was no underpayment on this sample item.

The remainder of the underpayment of $1,603 is the result of rounding for unit values on four sample items. GEHA rounds unit pricing on national contracts items that are computed based on average wholesale pricing.. This has been GEHA's practice since the inception of the national contract program. It is accepted by national contract vendors and has not resulted in enrollee's being balance billed by providers.

Recommendation 3

We recommend that the contracting officer instruct the Plan to identify the root cause(s) of the claim payment errors and develop an action plan to prevent these types of errors in the future.

GEHA Response:

We will evaluate the results of the OIG's audit findings and implement procedures we deem necessary to resolve the issues noted. The PPO networks we have contacted have policies and procedures in place to address provider contracting and the administration of discounts rates. We are implementing periodic audits of PPO network pricing. On a quarterly basis GEHA audits a sample of provider contracts in or order to confirm network pricing is accurate. If there is any industry practice guidelines that GEHA is not following in the adjudication of claims we would be open to discuss them.

PROCEDURE CODE MODIFIERS 62/66 (Co-Surgeons)

OIG Finding:

For the period January 1, 2007 through May 31, 2010, we identified 544 claim groupings containing procedure modifier codes "62 or 66", totaling $897,677 in potential overpayments that may not have been paid in accordance with the contract or the Plan's pricing procedures. From this universe, we selected a judgmental sample of 516 procedure modifier claim groupings, totaling $882,500 in potential overpayments, to determine if the Plan paid these claims properly. Our sample included all claim groupings containing procedure modifier codes "62 or 66" with potential overpayments of $100 or more.

We determined these 516 claims to be paid in error due to the Plan not recognizing the co-surgeon pricing modifiers "62 or 66". These co-surgeon claims should have been priced at 62.5 percent for each surgeon per procedure code with attached modifier. Consequently, the Plan potentially overpaid these claims, resulting in estimated overcharges of $882,500 to the FEHBP.

Recommendation 4

We recommend that the contracting officer disallow $882,500 for claim overcharges, and verify that the Plan has returned all amounts recovered to the FEHBP.

GEHA Response:

The overpayment amount computed by the OIG was based on the allowed amount at the time of original adjudication multiplied by the standard co-surgeon rate of 62.5%. This amount inflates the overpayments because it assumes that all of the claims are not reduced to the 62.5% co-surgeon rate.

Based on our review of the sample we identified 203 claim groupings that included 316 co-surgeon procedures, where the proper co-surgeon rate was not applied, resulting in a net overpayment amount of $170,290. We will pursue the overpayments on the outstanding balance. We disagree with the remaining balance of $712,210 as it was determined that the claims were paid according to the co-surgeon benefits.

Recommendation 5

We recommend that the contracting officer instruct the Plan to identify the root cause(s) of the claim payment errors and develop an action plan to prevent these types of errors in the future.

GEHA Response:

GEHA relies on the pricing systems of our multiple leased PPO networks to provide accurate pricing. Each network surveyed has a process in place to audit pricing and resolve deficiencies. We are implementing periodic audits of PPO network pricing. On a quarterly basis GEHA audits a sample of provider contracts in or order to confirm network pricing is accurate.

ASSISTANT SURGEON

OIG finding (Initial Sample):

The Plan incorrectly paid 107 claims, resulting in net overcharges of $225,027. Specifically, the Plan overpaid 103 claims by $228,249 and underpaid four claims by $3,222. We also expanded our sample to include 1,610 assistant surgeon claim groups, totaling $547,878 in potential overpayments.

Recommendation 6

We recommend that the contracting officer disallow $776,127 for claim overcharges, and verify that the Plan has returned all amounts recovered to the FEHBP.

GEHA Response:

For the initial sample of 103 overpaid claims totaling $228,249, we agree to overpayments totaling $133,276. We have collected $84,107and waived $3,209 to date. We will continue collection efforts on the remaining outstanding balance. We disagree with the remaining balance as these claims were paid with the correct assistant surgeon benefit. See the detailed spreadsheet and documentation provided.

Recommendation 7

We recommend that the contracting officer allow the Plan to charge the FEHBP $3,222 if additional payments are made to the providers to correct the underpayment errors.

GEHA Response:

We disagree with the four underpayments totaling $3,222 as they were paid with the correct assistant surgeon benefits.

OIG Finding (Expanded Sample):

As a result of this high error rate in the initial assistant surgeon sample, we have expanded our sample to include all patient groupings in the universe with potential overcharges of $100 or more. This expanded sample contains 1,610 assistant surgeon claim groups, totaling $547,878 in potential overpayments that may not have been paid in accordance with the contract or the Plan's assistant surgeon pricing procedure

GEHA Response:

We agree with a total of $76,022 in overpayments for the assistant surgeon – expanded sample and disagree with $471,856. We disagree with the remaining balance as these claims were paid with the correct assistant surgeon benefit. See the detailed spreadsheet and documentation provided.

Recommendation 8

We recommend that the contracting officer instruct the Plan to identify the root cause(s) of the claim payment errors and develop an action plan to prevent these types of errors in the future.

GEHA Response:

GEHA relies on the pricing systems of our multiple leased PPO networks to provide accurate pricing. Each network surveyed has a process in place to audit pricing and resolve deficiencies. We are implementing periodic audits of PPO network pricing. On a quarterly basis GEHA audits a sample of provider contracts in or order to confirm network pricing is accurate.

COORDINATION OF BENEFITS WITH MEDICARE

OIG Finding:

The Plan incorrectly paid 581 claim lines, resulting in net overcharges of $457,428 to the FEHBP. Specifically, 579 claim lines were overpaid by $457,857 and two claim lines were underpaid by $429. The Plan did not properly coordinate 441 claim line payments with Medicare as required by the FEHBP contract. As a result, the FEHBP paid as the primary insurer for these claims when Medicare was the primary insurer. Therefore, we estimate that the FEHBP was overcharged by $435,584 for these claim lines. The remaining 38 claim line payments were not coordination of benefit (COB) errors but contained other Plan payment errors, resulting in overcharges of $21,844 to the FEHBP.

Recommendation 9

We recommend that the contracting officer disallow $457,857 for claim overcharges, and verify that the Plan has returned all amounts recovered to the FEHBP.

GEHA Response:

The OIG reported $457,428 in overpayments; however a total of $135,979 (30%) of this total was discovered by GEHA prior to the inception of the OIG's audit. We have collected overpayments totaling $411,709 and waived overpayments totaling $2,279. Overpayments of $20,869 are being disputed because the amount deemed overpaid is less than previously reported. We will continue collection efforts on the remaining outstanding balance. See the spreadsheet and documentation provided for details.

Recommendation 10

We recommend that the contracting officer allow the Plan to charge the FEHBP $429 if additional payments are made to the providers to correct the underpayment errors.

GEHA Response:

Additional payments have been made to correct the underpayments of $429.

Recommendation 11

We recommend that the contracting officer instruct the Plan to identify the root cause(s) of the claim payment errors and develop an action plan to prevent these types of errors in the future.

GEHA Response:

The following controls are in place to minimize the overpaid claims due to other coverage. Once it is discovered that an enrollee has other coverage, a process has been established to identify all medical and pharmacy claims that were paid after the effective date of coverage to the date we were notified of the other coverage. The claims are investigated for possible overpayments and collections are pursued. GEHA has also established a procedure to automatically code an enrollee's record as having Medicare primary (if the enrollee is in a retired status) once they are eligible to obtain Medicare. Claims incurred after the Medicare eligibility date are pended awaiting information regarding the enrollee's Medicare status.

GEHA is required by CMS (Centers for Medicare/Medicaid Services) to send medical coverage information on a quarterly basis for all members over age 45 that are actively employed on the MSP (Medicare Secondary Payer) file under Section 111. GEHA also participates in the optional Section 111 Non-MSP Part D sharing of information by providing a monthly file to CMS of retirees that are covered by GEHA. CMS provides a response file to both the mandatory quarterly MSP file and the optional monthly Non-MSP file with Medicare information. The information is used to update eligibility data on GEHA's claim system and identify overpayments that may have occurred.

CLAIMS PAID FOR INELIGIBLE PATIENTS

OIG Finding:

The Plan paid 234 claims that were incurred during gaps in patient coverage or after termination of patient coverage, resulting in overcharges of $144,632 to the FEHBP. In addition, the Plan paid 68 claims for patients with no enrollment identification (ID) numbers, resulting in overcharges of $12,810 to the FEHBP. In total, the FEHBP is due $157,442 for claim overcharges.

Recommendation 12

We recommend that the contracting officer disallow $157,442 for claim overcharges, and verify that the Plan has returned all amounts recovered to the FEHBP.

GEHA Response:

The Plan agrees with $157,442 in overcharges. GEHA identified a total of $100,533 (64%) of the questioned costs prior to the OIG audit. We agree with the total amount of overcharges noted by the OIG. As of the date of the response, we have recovered $29,839 and waived $11,707. We will continue collection efforts on the remaining outstanding balance.

Recommendation 13

We recommend that the contracting officer instruct the Plan to identify the root cause(s) of the claim payment errors and develop an action plan to prevent these types of errors in the future.

GEHA Response:

When a termination is received or a member changes from a self and family contract to a self contract, a report is systematically generated that lists all the medical claims paid from the effective date of the termination or change in plan. The claims are reviewed and collection action is initiated for claims that were paid after the effective date. Most of the claims cited as overpayments were the result of GEHA receiving retroactive termination notices from federal payroll offices.

Deleted by the Office of the Inspector General – Not Relevant to the Final Report

Recommendation 15

We recommend that the contracting officer allow the Plan to charge the FEHBP $13,183 if additional payments are made to the providers to correct the underpayment errors.

GEHA Response:

We disagree with $13,183 in underpayments. See the spreadsheet and documentation provided for details.

Recommendation 16

We recommend that the contracting officer instruct the Plan to identify the root cause(s) of the claim payment errors and develop an action plan to prevent these types of errors in the future.

GEHA Response:

GEHA has procedures in place to systematically route OBRA 90 claims to specific adjustors for processing in order for a trained employee to review these claims prior to payment.

INPATIENT FACILITY CLAIMS – DUPLICATE OR OVERLAPPING DATES OF SERVICE

OIG Finding:

The Plan incorrectly paid 14 inpatient facility claims, resulting in overcharges of $103,977 to the FEHBP.

Recommendation 17

We recommend that the contracting officer disallow $103,977 for claim overcharges, and verify that the Plan has returned all amounts recovered to the FEHBP.

GEHA Response:

GEHA agrees with the overpayments totaling $103,977. As of the date of this response, collections of $38,762 have been received. We will continue to pursue the remaining outstanding overpayments.

Recommendation 18

We recommend that the contracting officer instruct the Plan to identify the root cause(s) of the claim payment errors and develop an action plan to prevent these types of errors in the future.

Deleted by the Office of the Inspector General – Not Relevant to the Final Report

DUPLICATE CLAIM PAYMENTS

OIG Finding:

The Plan incorrectly paid 68 claims, resulting in net overcharges of $50,984 to the FEHBP. Specifically, we determined that the Plan improperly charged the FEHBP $34,501 for 45 duplicate claim payments. In addition, we found 23 claims that were not duplicate claim payments but contained other Plan payment errors, resulting in net overcharges of $16,483 to the FEHBP.

Recommendation 19

We recommend that the contracting officer disallow $50,984 for claim overcharges, and verify that the Plan has returned all amounts recovered to the FEHBP.

GEHA Response:

GEHA agrees with the overpayments totaling $50,984. As of the date of this response, collections of $35,885 have been received. We will continue to pursue the remaining outstanding overpayments.

Recommendation 20

We recommend that the contracting officer instruct the Plan to identify the root cause(s) of the claim payment errors and develop an action plan to prevent these types of errors in the future.

GEHA Response:

GEHA's claims system has edits that screen claims for duplicates. The system automatically ranks duplicate claims as disallowable or possible duplicates. In addition, GEHA's Internal Audit Department conducts an audit of potential duplicate claims each quarter. Duplicates are referred to the Claims Department for review and collections are pursued.

NETWORK PRICING OVERSIGHT

OIG Finding:

The Plan contracts with 15 different provider networks across the United States. The majority of these provider networks administers the pricing of member claims and issues a pricing sheet to the Plan. We found that the Plan does not sufficiently verify the integrity or accuracy of these pricing sheets prior to paying FEHBP claims. The Plan relies heavily on what the networks instruct them to pay leading to increase risk of claim payment errors.

Recommendation 21

We recommend that the contracting officer require the Plan to conduct routine claim audits of the pricing practices of its networks to obtain reasonable assurance that the current and correct provider contracts are being used to accurately price FEHBP claims.

GEHA Response:

We obtained the auditing procedures performed by the provider networks we lease. They all have procedures in place to audit pricing and implement corrective action. If GEHA or the provider determines that pricing is inaccurate, corrected pricing can be produced by the networks.

On a quarterly basis GEHA audits a sample of provider contracts in order to confirm network pricing is accurate. We are implementing periodic audits of PPO network pricing, with an emphasis on assistant surgeon and co-surgeon pricing.

ADMINISTRATIVE EXPENSES

OIG Finding:

The audit disclosed no findings pertaining to administrative expenses. Overall, we concluded that the Plan charged expenses related to administrative expenses to the FEHBP in accordance with the terms of the contract and applicable regulations.

GEHA Response:

We agree with OIG's findings.

CASH MANAGEMENT

OIG Finding:

The audit disclosed no findings pertaining to cash management. Overall, we concluded that the Plan handled FEHBP funds in accordance with Contract CS 1063 and applicable laws and regulations.

GEHA Response:

We agree with OIG's findings.

FRAUD AND ABUSE PROGRAM

NOTIFYING THE OFFICE OF PERSONNEL MANAGEMENT'S OFFICE OF THE INSPECTOR GENERAL CONCERNING FRAUD AND ABUSE CASES

OIG Finding:

The Plan did not refer cases indicating areas of patient harm or safety issues to the Office of Personnel Management's Office of the Inspector General (OPM/OIG) during 2006 through 2009 that dealt with member related Fraud and Abuse (F&A) issues, such as doctor shopping for pharmaceuticals/schedule II – IV drugs and/or membership eligibility issues regardless of the dollar amount of claims paid.
The Plan has not fully adopted Carrier Letter 2007-12 "Notifying OPM's Office of the Inspector General Concerning Fraud and Abuse Cases in the FEHBP Program" required by the OPM/OIG. The carrier letter states that, "All carriers must also send a prompt written notification/referral to their Contracting Officer and OPM-OIG for any cases, regardless of the dollar amount of claims paid, if there is an indication of patient harm, potential for significant media attention, or other exceptional circumstances."

Recommendation 22

We recommend that the contracting officer ensure that the Plan implements all components of Carrier Letter 2007-12 "Notifying OPM's Office of the Inspector General Concerning Fraud and Abuse Cases in the FEHBP Program."

GEHA Response:

As noted in the Audit Report the Carrier Letter dated March 30, 2007 provides for a threshold of $20,000 for reporting provider fraud or abuse, except when patient harm is indicated. Because GEHA is a nationwide plan and its membership is not evenly distributed throughout the United States, we do not reach this threshold in many cases. That does not, however, mean fraud is not addressed. Many providers are "flagged" in our system and their claims come directly to the SIU before they are paid. If fraud or abuse is indicated, these claims are denied by SIU personnel. OPM/OIG does not receive information on many of these providers (approximately 7,000 providers) because the threshold is not reached. However, GEHA will evaluate this finding and will emphasize to all involved personnel the requirements of the Carrier Letter.

GEHA management has met with all personnel in the SIU, provided them with another copy of the Carrier Letter (it was provided when issued by OPM) and a copy of the Audit Findings. There was discussion about both documents. GEHA management will be monitoring our compliance and looks forward to working closely with OPM/OIG to

address fraud. We have also been communicating with GEHA's Medical Director and Managed Care Unit to review procedures for reporting cases of suspected fraud or potential patient harm to the SIU for further action and reporting to OIG. GEHA believes the quarterly Carrier/OIG task force conferences can be used to further assist Carriers in getting feedback from OIG on a continuing basis on the quantity and quality of referrals they receive, and on issues relating to interpretation of the Carrier Letter. We will also be working with our Pharmacy Department and Medco to refine our procedures for obtaining information and reports from Medco. [redacted]as a pharmacy module in their fraud detection software that we will be evaluating for purchase this year.

Although the Plan disagrees with the finding that no cases involving potential patient harm were referred to OIG during the applicable period, it does agree these referrals were limited in number. After discussion with OIG personnel subsequent to the audit finding, the Plan has implemented new procedures with its case management, pharmacy unit and the Medical Director to receive information about potential patient harm cases so they can be referred to OIG.

FRAUD AND ABUSE ANNUAL REPORTS

OIG Finding:

The Plan did not provide the OPM/OIG complete F&A annual reports during 2006 through 2009. Carrier Letter 2007-12 states that F&A annual reports, as described in Carrier Letter 2003-25 "Revised FEHB Quality Assurance and Fraud and Abuse Reports," are required.

The Plan did implement some of the F&A report requirements; however, we could not find evidence of one or more of: the number of cases referred to law enforcement (including the OIG), number of cases resolved through negotiated settlement, number of arrests and number of criminal convictions over the past four years.

Additionally, the Plan advised that they are actively involved in Class Action lawsuits against the pharmaceutical industry. The Plan suggested many of the Class Action lawsuits involve adverse drug effects and off-label marketing issues. The Plan does not report the cases to OPM/OIG nor do they report these recoveries in their annual F&A report.

By not including all report requirements the OPM/OIG is unable to determine the overall outcome and success of the Plan's prevention, detection, and F&A program activities.

Recommendation 23

We recommend that the contracting officer ensure that the Plan implements all components of the F&A report as required and described in Carrier Letter 2003-25 "Revised FEHB Quality Assurance and Fraud and Abuse Reports."

GEHA Response:

GEHA did submit Annual Reports as required by the contract for the years 2006-2009, with all fields in the standard report completed. However, we understand the Audit Findings to indicate these reports were not complete. GEHA did provide total dollars recovered, and actual and projected savings. GEHA did work with regional and local law enforcement entities in limited cases.

GEHA did not begin to report DOJ/OPM/OIG recoveries in our fraud report until the OPM/OIG's creation of a process for notifying carriers that a recovery had been achieved and a recovery was credited to each Plan's Contingency Reserve. Prior to that time, we were seldom aware of the amount of the recovery or the credit to the Plan on cases in which GEHA SIU personnel were involved. That did not occur, we believe, until late 2008. We believed that OPM/OIG wanted us to include fraud recoveries from any source in our annual report because there was a credit to our contingency reserve from a fraud recovery. We would appreciate being advised by OPM/OIG whether they want plans to exclude these amounts.

With regard to drug class actions, GEHA began participating as one of many plaintiffs in class actions in the 2001-2002 timeframe. In every case in which a settlement was reached with a defendant, there was a specific denial of liability or wrongdoing and no judicial determination that any violations were committed. These were all civil cases in which GEHA had no direct information or support for a finding of fraud. For this reason, these recoveries, as noted in the OIG Audit Findings, were reported as third party subrogation recoveries. Since 2002, net recoveries have been obtained by GEHA for the FEHB program of $4,709,134.53 in these cases.

GEHA will initiate discussion with OPM/OIG to be certain GEHA is providing required Annual Reports consistent with OPM/OIG expectations and understanding of the Carrier Letter. GEHA intends to work cooperatively with OPM/OIG to react to areas of deficiency perceived by OIG in our procedures and in the reporting to OPM/OIG. GEHA regards this as a serious matter and will promptly initiate discussion with OPM/OIG and proceed with diligence to address areas identified by OPM/OIG. Based on that dialogue, GEHA will meet regularly with all GEHA SIU personnel to discuss procedures to be followed to ensure full compliance with the Carrier Letter, and will also review procedures with other applicable GEHA business units and Medco to obtain all pertinent information relative to fraud, abuse and patient harm.

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Deleted by the Office of the Inspector General – Not Relevant to the Final Report

PROGRAM MANAGEMENT

OIG Finding:

In a meeting to discuss the Plan's Special Investigations Unit (SIU) F&A program, Plan personnel provided a brief overview of a product it uses called [redacted] which is supported by [redacted]. The Plan described the process and use of the product to be a post-payment tool only. The Plan provides post payment data to [redacted] who then uses various methodologies to review, sort and manipulate the data to look for abnormal billing patterns, such as providers who may be billing outside the normal ranges for particular procedure codes. [redacted] then sends a report back to the Plan identifying any providers with unusual billing patterns. These reports are sent directly to the Fraud Analysts for further review. However, the Plan's use of the [redacted] program by [redacted] may be underutilized, especially if they are not actively seeking post payment recoveries or performing post payment investigations.

Sharing the [redacted] report with the OIG on a regular basis as a notification tool regardless of potential dollar losses may increase the amount of referrals the Plan provides to the OIG on an annual basis and improve communication between the OIG and the Plan's SIU.

The Plan's SIU provides (as one of its top priorities) support for OIG related investigations. The Plan's SIU appears to concentrate its own efforts on pre-payment review to stop potential fraudulent payments. By focusing on that element of potential fraud and abuse other fraudulent and abusive practices are going unnoticed which may lead to areas of weaknesses with the F&A program at the Plan.

Recommendation 24

We recommend that the contracting officer ensure that the Plan trains an SIU specialist so that [redacted] can be a fully utilized tool by the SIU and provide a basis for post-payment claims review and investigations by SIU staff.

GEHA Response:

With respect to [redacted] GEHA agrees that this tool has been underutilized and we have adjusted our procedures to require that all of its investigators use [redacted] as a primary source of leads. Our Specialists need to make greater use of the [redacted] tool and to balance prepayment and post payment recoveries. We will initiate dialogue with OPM/OIG and

will renew our efforts with respect to emphasizing our investigative and reporting obligations under the Carrier Letter. In particular, we will train all of our Specialists on the use of the [redacted] tool. We welcome communication and feedback from OPM/OIG at any time to ensure our full compliance with the Carrier Letter. We will be monitoring our SIU's use of [redacted] software to ensure that our procedures are followed and expectations for [redacted]s use are met.

GEHA places emphasis on prepayment review and investigation. We do that by identification of suspected fraudulent providers based on leads from a variety of sources, i.e. [redacted] Claims Department referrals, NHCAA case information sharing meetings, NHCAA requests for investigative assistance, and information received from OPM/OIG. A suspected fraudulent provider is flagged in our system and any claims submitted by that provider are directed to the SIU. We believe, to the extent possible, it is better to prevent fraudulent claims from being paid, rather than trying to recover it later. It is thus correct to say we emphasize prepayment review. Post payment recovery attempts can be difficult, time consuming and expensive, although we agree they are a necessary part of a fraud program.

PHARMACY BENEFIT MANAGER

OIG Finding:

The Plan's process for doctor shopping cases does not include a review by SIU staff to determine if notification to the OIG is required. In addition, the Plan does not require its Pharmacy Benefit Manager (PBM) to report any potential F&A cases related to pharmacies, abnormally high prescribing physicians of narcotics, member drug misuse/abuse and other potential fraud related reporting issues.

Due to the above deficiencies, the Plan is not in compliance with Carrier Letter 2007-12 "Notifying OPM's Office of the Inspector General Concerning Fraud and Abuse Cases in the FEHBP Program."

The Plan indicated MEDCO was their PBM. Their protocol for fraud issues within the pharmacy and pharmaceutical area was that MEDCO referred any incidents of Member Fraud / Doctor Shopping for Narcotics to the Plan's Medical Director, who writes letters to the members' physicians notifying them of the member's activities.

As far as pharmacy related cases, there was no indication that MEDCO has provided or referred any pharmacy related fraud issue to the Plan's SIU.

Furthermore when potential pharmacy related fraud issues and referrals from their PBM were discussed, the Plan indicated it had a process for doctor shopping cases, but the process did not include a review from SIU staff to determine if notification to the OIG was required. Doctor shopping losses are not limited to the pharmacy or prescriptions, but include the doctor or hospital emergency room costs associated with the drug seeking activity.

Recommendation 25

We recommend that the contracting officer ensure that the Plan updates its process for doctor shopping cases to include a review from SIU staff to determine if notification to the OIG is required.

GEHA Response:

GEHA agrees with the finding.

Recommendation 26

We recommend that the contracting officer ensure that the Plan requires its PBM to report any potential F&A cases related to pharmacies, abnormally high prescribing physicians of narcotics, member drug misuse/abuse and other potential fraud related reporting issues so that the Plan is able to implement all requirements in Carrier Letter 2007-12 "Notifying OPM's Office of the Inspector General Concerning Fraud and Abuse Cases in the FEHBP Program."

GEHA Response:

GEHA agrees with the finding.

Conclusion

As outlined above, GEHA has procedures in place to identify certain types of claims that require special processing and to detect eligibility changes that effect benefit determination. A number of the exceptions noted were related to applying benefits with the information that was available at the time of processing. Subsequent claim, eligibility or policy information was received that changed the benefit determination. Claims are generally adjusted once additional information is received that changes the benefits payable. If claims are overpaid, GEHA has collection policies and procedures that meet and often times exceed FEHB requirements.

GEHA contracts with a number of provider networks throughout the nation in order to provide comprehensive access to in-network providers. We rely on these networks to perform services that provide seamless operations for our membership, including pricing claims and provider network management. In the future, we will monitor the networks more closely and question pricing that appears suspect.

We are disappointed when overpayments occur, but we also understand that health insurance billing and processing can be complicated given the number of parties involved and the complex nature of the industry. Therefore, we apply prudent business practices to minimize the errors on the front end, and when necessary, execute sound collection efforts to recover funds for the FEHB program.

We are constantly evaluating and improving our internal controls and processes in areas that generated claim overpayments during the audit. We will diligently pursue collections of all overpayments. We thank you and your staff for your assistance in identifying the areas needing improvement.

Sincerely,

Richard G. Miles
President

Attachments: Draft Audit Report

CC: [redacted] Chief of Health Insurance II Insurance Operations
[redacted] Chief of Program Planning and Evaluation
Eileen Hutchinson, GEHA CFO
[redacted] GEHA VP - Claims
[redacted] GEHA Manager of Internal Audit