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

Final Audit Report

Subject:

AUDIT ON GLOBAL COORDINATION OF BENEFITS FOR BLUECROSS AND BLUESHIELD PLANS

Report No. 1A-99-00-11-055

Date: March 28, 2012

--CAUTION--

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

Office of the
Inspector General

AUDIT REPORT

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

Global Coordination of Benefits
BlueCross and BlueShield Plans

REPORT NO. 1A-99-00-11-055 DATE: 03/28/12

Michael R. Esser
Assistant Inspector General
for Audits

--CAUTION--

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EXECUTIVE SUMMARY

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This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at all BlueCross and BlueShield (BCBS) plans questions $8,898,131 in health benefit charges. The BlueCross BlueShield Association (Association) and/or BCBS plans agreed with $1,529,042 and disagreed with $7,369,089 of the questioned charges.[1]

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covered health benefit payments from July 11, 2010 through April 30, 2011 as reported in the Annual Accounting Statements. Specifically, we identified claims reimbursed from July 11, 2010 through April 30, 2011 that potentially were not coordinated with Medicare. We determined that the BCBS plans did not properly coordinate 13,447 claim line payments with Medicare as required by the FEHBP contract. As a result, the FEHBP was overcharged $8,898,131 for these claim line payments. When we notified the Association of these COB errors on June 15, 2011, the claims were within the Medicare timely filing requirement and could be filed with Medicare for coordination of benefits.

[1] $6,791,225 of the contested amount represents coordination of benefit (COB) errors where the BCBS plans initiated recovery efforts before receiving our audit request (i.e., sample of potential COB errors) on June 15, 2011. However, since the BCBS plans had not completed the recovery process and/or adjusted the claims by the end of our audit scope (i.e., April 30, 2011), we are continuing to question these COB errors in the final report. We also noted that $3,878,274 of these contested COB errors were identified by the BCBS plans after the Association received our audit notification letter, dated March 2, 2011.

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I. INTRODUCTION AND BACKGROUND

INTRODUCTION

This final audit report details the findings, conclusions, and recommendations resulting from our limited scope audit of the Federal Employees Health Benefits Program (FEHBP) operations at all BlueCross and BlueShield (BCBS) plans.

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

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

The Association has also established an FEP Operations Center. The activities of the FEP Operations Center are performed by CareFirst BCBS, located in Washington, D.C. These activities include acting as fiscal intermediary between the Association and member plans, verifying subscriber eligibility, approving or disapproving the reimbursement of local plan payments of FEHBP claims (using computerized system edits), maintaining a history file of all FEHBP claims, and maintaining an accounting of all program funds.

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

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

Findings from our previous global coordination of benefits audit of all BCBS plans (Report No. 1A-99-00-10-055, dated June 8, 2011) for claims reimbursed from January 1, 2009 through May 31, 2010 are in the process of being resolved.

Our preliminary results of the potential coordination of benefit errors were presented in detail in a draft report, dated June 21, 2011. The Association's comments offered in response to the draft report were considered in preparing our final report and are included as the Appendix to this report. Also, additional documentation provided by the Association and BCBS plans on various dates through December 29, 2011 was considered in preparing our final report.

II. OBJECTIVE, SCOPE, AND METHODOLOGY

OBJECTIVE

The objective of this audit was to determine whether the BCBS plans complied with contract provisions relative to coordination of benefits with Medicare.

SCOPE

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

The audit covered health benefit payments from July 11, 2010 through April 30, 2011 as reported in the Annual Accounting Statements. Using our data warehouse, we performed a computer search on the BCBS claims database to identify claims that were reimbursed from July 11, 2010 through April 30, 2011 and potentially not coordinated with Medicare. Based on our claim error reports, we identified 318,990 claim lines, totaling $47,137,654 in payments, that potentially were not coordinated with Medicare. From this universe, we selected and reviewed 30,933 claim lines, totaling $19,420,185 in payments, for coordination of benefits with Medicare. When we notified the Association of these potential errors on June 15, 2011, the claims were within the Medicare timely filing requirement and could be filed with Medicare for coordination of benefits.[2]

We did not consider each BCBS plan's internal control structure in planning and conducting our auditing procedures. Our audit approach consisted mainly of substantive tests of transactions and not tests of controls. Therefore, we do not express an opinion on each BCBS plan's system of internal controls taken as a whole.

We also conducted tests to determine whether the BCBS plans had complied with the contract and the laws and regulations governing the FEHBP as they relate to coordination of benefits. The results of our tests indicate that, with respect to the items tested, the BCBS plans did not fully comply with the provisions of the contract relative to coordination of benefits with Medicare. Exceptions noted in the areas reviewed are set forth in detail in the "Audit Finding and Recommendations" section of this report. With respect to the items not tested, nothing came to our attention that caused us to believe that the BCBS plans had not complied, in all material respects, with those provisions.

In conducting our audit, we relied to varying degrees on computer-generated data provided by the FEP Director's Office, the FEP Operations Center, and the BCBS plans. 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

[2] Starting in 2010, claims with incurred dates of service on or after January 1, 2010 that are received by Medicare more than one calendar year after the date of service could be denied by Medicare as being past the timely filing requirement.

testing, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objective.

The audit was performed at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida from June 2011 through January 2012.

METHODOLOGY

To test each BCBS plan's compliance with the FEHBP health benefit provisions related to coordination of benefits with Medicare, we selected a judgmental sample of potential uncoordinated claim lines that were identified in a computer search. Specifically, we selected for review 30,933 claim lines, totaling $19,420,185 in payments, from a universe of 318,990 claim lines, totaling $47,137,654 in payments, that potentially were not coordinated with Medicare (See Schedule A for our sample selection methodology).

The claim sample selections were submitted to each applicable BCBS plan for their review and response. For each plan, we then conducted a limited review of their agreed responses and an expanded review of their disagreed responses to determine the appropriate questioned amount. We did not project the sample results to the universe of potentially uncoordinated claim lines.

The determination of the questioned amount is based on the FEHBP contract, the Service Benefit Plan brochure, the Association's FEP administrative manual, and various manuals and other documents available from the Center for Medicare and Medicaid Services that explain Medicare benefits.

III. AUDIT FINDING AND RECOMMENDATIONS

Coordination of Benefits with Medicare **$8,898,131**

The BCBS plans did not properly coordinate 13,447 claim line payments, totaling $10,936,392, 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 $8,898,131 for these claim lines.

The 2010 BlueCross and BlueShield Service Benefit Plan brochure, page 121, Primary Payer Chart, illustrates when Medicare is the primary payer. In addition, page 24 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 1039, Part II, section 2.6 states, "(a) The Carrier shall coordinate the payment of benefits under this contract with the payment of benefits under Medicare . . . (b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary carrier . . . ." Also, 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 . . . [and] on request, document and make available accounting support for the cost to justify that the cost is actual, reasonable and necessary; and (ii) determine the cost in accordance with: (A) the terms of this contract . . . ."

In addition, Contract CS 1039, 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 reimbursed from July 11, 2010 through April 30, 2011, we performed a computer search and identified 318,990 claim lines, totaling $47,137,654 in payments, that potentially were not coordinated with Medicare. From this universe, we selected for review a sample of 30,933 claim lines, totaling $19,420,185 in payments, to determine whether the BCBS plans complied with the contract provisions relative to coordination of benefits (COB) with Medicare. When we submitted our sample of potential COB errors to the Association on June 15, 2011, the claims were within the Medicare timely filing requirement and could be filed with Medicare for coordination of benefits.

Generally, Medicare Part A pays all covered costs for inpatient care in hospitals, skilled nursing facilities and hospice care, except for deductibles and coinsurance. For each Medicare Benefit Period, there is a one-time deductible, followed by a daily copayment 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 copayment.

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 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. Therefore, we estimate that the FEHBP was overcharged 25 percent for these inpatient claim lines (0.30 x 0.80 = 0.24 ~ 25 percent).

We separated the uncoordinated claims into the following six categories based on the clinical setting and whether Medicare Part A or B should have been the primary payer.

- Categories A and B consist of inpatient claims that should have been coordinated with Medicare Part A. In a small number of instances where the BCBS plans indicated that Medicare Part A benefits were exhausted, we reviewed the claims to determine whether there were any inpatient services that were payable by Medicare Part B. For these claim lines, we only questioned the services covered by Medicare Part B.

- Categories C and D include inpatient claims with ancillary items that should have been coordinated with Medicare Part B. When we could not reasonably determine the actual overcharge for the ancillary items, we questioned 25 percent of the amount paid for these inpatient claim lines. In a small number of instances where the BCBS plans indicated that members had Medicare Part B only and priced the claims according to the Omnibus Budget Reconciliation Act of 1990 pricing guidelines, we reviewed the claims to determine whether there were any inpatient services that were payable by Medicare Part B.

- Categories E and F include outpatient and professional claims where Medicare Part B should have been the primary payer. When we could not reasonably determine the actual overcharge for a claim line, we questioned 80 percent of the amount paid for these claim lines.

From these six categories, we selected for review a sample of claim lines that potentially were not coordinated with Medicare (See Schedule A for our sample selection methodology). Based on our review, we determined that 57 of the 63 BCBS plan sites did not properly coordinate claim charges with Medicare. Specifically, we identified 13,447 claim lines, totaling $10,936,392 in payments, where the FEHBP paid as the primary insurer when Medicare was the primary insurer. We estimate that the FEHBP was overcharged $8,898,131 for these claim line payments.

The following table details the six categories of questioned uncoordinated claim lines:

Category	Claim Lines	Amount Paid	Amount Questioned
Category A: Medicare Part A Primary for Inpatient (I/P) Facility	290	$4,947,945	$4,947,945
Category B: Medicare Part A Primary for Skilled Nursing/Home Health Care (HHC)/ Hospice Care	2,354	$595,529	$595,529
Category C: Medicare Part B Primary for Certain I/P Facility Charges	127	$1,704,124	$426,031
Category D: Medicare Part B Primary for Skilled Nursing/HHC/Hospice Care	19	$40,743	$10,186
Category E: Medicare Part B Primary for Outpatient (O/P) Facility and Professional	8,343	$2,587,361	$2,069,888
Category F: Medicare Part B Primary for O/P Facility and Professional (Participation Code F)	2,314	$1,060,690	$848,552
Total	13,447	$10,936,392	$8,898,131

Our audit disclosed the following for the COB errors:

- For 5,517 (41 percent) of the claim lines questioned, the BCBS plans incorrectly paid these claims due to retroactive adjustments. Specifically, there was no special information present on the FEP national claims system to identify Medicare as the primary payer when the claims were paid. However, when the Medicare information was subsequently added to the FEP national claims system, the BCBS plans did not review and/or adjust the patient's prior claim(s) back to the Medicare effective dates. As a result, we estimate that the FEHBP was overcharged $3,887,806 for these COB errors.

- For 3,891 (29 percent) of the claim lines questioned, the BCBS plans incorrectly paid these claims due to systematic processing errors. Specifically, the claims were not deferred on the FEP national claims system for Medicare COB review by the processors. As a result, the FEHBP was overcharged $2,555,838 for these COB errors.

- For 3,623 (27 percent) of the claim lines questioned, the BCBS plans incorrectly paid these claims due to manual processing errors. In most cases, there was special information present on the FEP national claims system to identify Medicare as the primary payer when these claims were paid. However, an incorrect Medicare Payment Disposition Code was used to override the FEP national claims system's deferral of these claims. The Medicare Payment Disposition Code identifies Medicare's responsibility for payment on each charge line of a claim. According to the FEP Administrative Manual, the completion of this field is required on all claims for patients who are age 65 or older. We found that codes E, F, and N were

incorrectly used. An incorrect entry in this field causes the claim line to be excluded from coordination of benefits with Medicare. As a result, we estimate that the FEHBP was overcharged $2,122,621 for these COB errors.

- For 380 (3 percent) of the claim lines questioned, we could not determine the specific reasons why these claims were not coordinated with Medicare. We estimate that these COB errors totaled $318,983.

- For 36 (0.3 percent) of the claim lines questioned, the BCBS plans incorrectly paid these claims due to provider billing errors. As a result, we estimate that the FEHBP was overcharged $12,883 for these COB errors.

Of the $8,898,131 in questioned charges, $6,791,225 (76 percent), representing 8,539 claim line overpayments, were identified by the BCBS plans before receiving our audit request (i.e., sample of potential COB errors) on June 15, 2011. However, since the BCBS plans had not completed the recovery process and/or adjusted these claims by the end of our audit scope (i.e., by April 30, 2011), we are continuing to question these COB errors.[3] The remaining questioned charges of $2,106,906 (24 percent), representing 4,908 claim line overpayments, were identified as a result of our audit.

Association's Response:

In response to the draft report, the Association states, "After reviewing the OIG listing of potentially uncoordinated Medicare COB claims . . . BCBSA identified $8,066,089 in claims that were paid correctly and $6,655,154 that . . . initially paid incorrectly but the error was identified and corrected before the response was due to OPM in the amount of $5,721,351, or the error was identified and recovery was initiated before the audit started in the amount of $993,803 but was still uncollected when the response was due to OPM. We agree that $1,334,355 . . . of the questioned amount was paid in error and the error was not identified by the start of the audit."

The Association disagrees with $14,781,248 of the questioned charges in the draft report. For $8,066,089 of the contested amount, the Association states that the claims were paid correctly for various reasons. For the remaining contested amount of $6,715,159, the Association states, "$3,853,508 were initially paid correct, however subsequent Medicare updates were received. Once the updates were processed on the FEP system, the Plans initiated recovery before the audit started. Of this amount, $843,023 was recovered before the audit started or the report response was due to the OIG.

For claims totaling $2,861,651, the Plans initially paid the claims incorrectly because:

- Missed EOB during processing of FEP Direct didn't defer
- FEP edits were overridden
- Processor errors

[3] Of these questioned COB errors, $3,878,274, representing 4,905 claim line overpayments, were identified by the BCBS plans after the Association received our audit notification letter, dated March 2, 2011.

However, before the audit started, through post payments review controls implemented by the Plans and BCBSA; the Plans identified the incorrect payments and initiated recovery and/or returned the funds to the Program. As of September 30, 2011, the Plans have returned $5,721,351 to the FEHBP."

For the uncontested amount of $1,334,355, the Association states that "the Plans agreed that these were claim payment errors identified as a result of this audit . . . The Plans will continue to pursue the remaining overpayments . . . ."

Regarding corrective actions, the Association states, "The Association's Action Plan includes oversight and governance procedures to assure all BCBS Plans are following the corrective action plans. To reduce the number and frequency of uncoordinated Medicare claims, the BCBSA has implemented additional steps to our action plan . . .

To ensure that Plans review all claims incurred back to the Medicare effective date:

- The FEP Operations Center produces the Retroactive Enrollment reports daily, which identifies individuals who are eligible for Medicare A and/or B. This file is reviewed daily by the Plans, who are required to go back and review all claims for this member.
- FEP updated the Plan Administrative Manual to instruct the Plans on what to do with the Retroactive Enrollment Report."

OIG Comments:

After reviewing the Association's response and additional documentation provided by the BCBS plans, we revised the questioned charges from our draft report to $8,898,131. If the BCBS plans identified and adjusted the COB errors by April 30, 2011, which was the end of our audit scope, we did not question these COB errors in the final report. Based on the Association's response and the BCBS plans' additional documentation, we determined that the Association and/or plans agree with $1,529,042 and disagree with $7,369,089 of the revised questioned charges. Although the Association agrees with $1,334,355 in its response, the BCBS plans' documentation supports concurrence with $1,529,042.

Based on the Association's response and/or the BCBS plans' documentation, the contested amount of $7,369,089 represents the following items:

- $5,809,617 of the contested amount represents COB errors where the BCBS plans initiated recovery efforts before receiving our audit request (i.e., June 15, 2011), and recovered the overpayments and adjusted the claims by the response due date to the audit request (i.e., September 16, 2011). However, since these overpayments had not been recovered and returned to the FEHBP by the end of the audit scope (i.e., April 30, 2011), we are continuing to question this amount in the final report.

- $981,608 of the contested amount represents COB errors where the BCBS plans initiated recovery efforts before receiving our audit request, but have not recovered the overpayments and adjusted the claims. Since these overpayments had not been recovered and returned to the

FEHBP by the end of the audit scope, we are continuing to question this amount in the final report.

- $407,977 of the contested amount represents COB errors where the BCBS plans initiated recovery efforts for the overpayments. However, when responding to our audit request, the BCBS plans state that these claims were paid correctly. Since the BCBS plans did not provide sufficient documentation to support these contested items, we are continuing to question this amount in the final report.

- $169,887 of the contested amount represents COB errors where Medicare rejected claims because providers did not bill Medicare correctly for covered services. As a result, the FEHBP paid primary for these services instead of Medicare. The BCBS plans state that these claims were paid correctly, since the member's Medicare Explanation of Benefits included a rejection code for these services. Since the BCBS plans did not provide sufficient documentation to support that the FEHBP should have paid these claims as the primary insurer, instead of as secondary insurer, we are continuing to question this amount in the final report.

Recommendation 1

We recommend that the contracting officer disallow $8,898,131 for uncoordinated claim payments and verify that the BCBS plans return all amounts recovered to the FEHBP (See Schedule B for a summary of these questioned uncoordinated claim payments by BCBS plan).

Recommendation 2

Although the Association has developed a corrective action plan to reduce COB findings, we recommend that the contracting officer instruct the Association to ensure that all BCBS plans are following the corrective action plan. We also recommend that the contracting officer ensure that the Association's additional corrective actions for improving the prevention and detection of uncoordinated claim payments are being implemented. These additional corrective actions are included in the Association's response to the draft report.

Recommendation 3

Since the highest percentage of the COB errors resulted from retroactive adjustments, we recommend that the contracting officer require the Association to ensure that the BCBS plans are reviewing all claims incurred back to the Medicare effective dates when the other party liability information is updated in the FEP national claims system. When Medicare eligibility is subsequently reported, the plans are expected to immediately determine if previously paid claims are affected and, if so, to initiate the recovery process within 30 days.

Recommendation 4

Due to the significant number of retroactive COB adjustments, we recommend that the contracting officer require the Association to ensure that the FEP Operations Center is utilizing the Medicare Data Exchange Agreement that requires a quarterly exchange of enrollment data between Medicare and the FEHBP. We also recommend that the contracting officer require the Association to ensure that the enrollment data provided by Medicare is updated in a timely manner in the FEP national claims system.

Recommendation 5

Due to the significant number of manual processing errors, we recommend that the contracting officer require the Association to direct the FEP Operation Center to input a field(s) in the FEP national claims system to collect Remittance Advice Remark Codes (RARC) and Claim Adjustment Reason Codes (CARC) from the BCBS plans. These Medicare generated codes (RARC and CARC) provide the reason Medicare denied a claim payment. The Association should also have the FEP Operations Center and BCBS plans utilize the RARC and CARC field(s) when implementing the Medicare Disposition Code corrective actions.

Recommendation 6

We recommend that the contracting officer require the Association to have the FEP Operations Center identify the reason(s) why the FEP national claims system continues to allow claims that require Medicare COB to bypass COB edits. After identifying the reason(s) why, the FEP Operations Center should implement corrective edits in the system.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Experience-Rated Audits Group

[redacted], Lead Auditor

[redacted], Auditor

[redacted], Auditor

[redacted], Auditor

[redacted], Chief [redacted]

Information Systems Audits Group

[redacted], Chief

[redacted], Information Technology Project Manager

[redacted], Senior Information Technology Specialist

Coordination of Benefits with Medicare

BlueCross and BlueShield Plans

Claims Reimbursed from July 11, 2010 through April 30, 2011

UNIVERSE AND SAMPLE OF POTENTIALLY UNCOORDINATED CLAIM LINES

	UNIVERSE				SAMPLE						
CATEGORY	**Number of Claims**	**Number of Claim Lines**	**Number of Patients**	**COB Universe Total Payments**	**Sample Selection Methodology**	**Number of Claims**	**Number of Claim Lines**	**Number of Patients**	**Amounts Paid**	**Estimated Overcharge Percentage**	**Potential Overcharge**
Category A: Medicare Part A Primary for Inpatient Facility	467	471	383	$6,811,362	all patients selected	467	471	383	$6,811,362	100%	$6,811,362
Category B: Medicare Part A Primary for Skilled Nursing/HHC/Hospice Care	3,000	9,883	1,050	$2,069,713	patients with cumulative claims of $1,500 or more	1,266	5,493	248	$1,662,392	100%	$1,662,392
Category C: Medicare Part B Primary for Certain Inpatient Facility Charges	139	139	121	$1,807,196	all patients selected	139	139	121	$1,807,196	25%	$451,799
Category D: Medicare Part B Primary for Skilled Nursing/HHC/Hospice Care	87	150	59	$248,229	patients with cumulative claims of $2,500 or more	48	55	29	$220,624	25%	$55,156
Category E: Medicare Part B Primary for Outpatient Facility and Professional	9,709	16,595	3,132	$4,135,592	patients with cumulative claims of $1,500 or more	4,468	9,596	514	$3,077,717	80%	$2,462,174
Category F: Medicare Part B Primary for Outpatient Facility and Professional (Participation Code F)	212,078	291,752	114,202	$32,065,562	patients with cumulative claims of $4,000 or more	6,291	15,179	636	$5,840,894	80%	$4,672,715
Totals	**225,480**	**318,990**		**$47,137,654**		**12,679**	**30,933**		**$19,420,185**		**$16,115,598**

Coordination of Benefits with Medicare
BlueCross and BlueShield Plans
Claims Reimbursed from July 11, 2010 through April 30, 2011

SUMMARY OF QUESTIONED CHARGES

			COB Category A		COB Category B		COB Category C		COB Category D		COB Category E		COB Category F		ALL COB Categories	
Plan Site Number	Plan State	Plan Name	m Lines	Amount Questioned	Claim Lines	Amount Questioned	m Lines	Amount Questioned	m Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned
003	NM	BCBS of New Mexico	4	$39,402	1	$4,200	1	$1,598	0	$0	45	$21,299	3	$1,145	54	$67,643
005	GA	WellPoint BCBS of Georgia	17	$275,234	68	$20,571	2	$4,504	10	$328	745	$135,942	44	$15,859	886	$452,438
006	MD	CareFirst BCBS	3	$13,601	38	$9,210	3	$16,193	0	$0	19	$21,826	5	$4,009	68	$64,839
007	LA	BCBS of Louisiana	16	$138,350	28	$8,181	4	$11,719	0	$0	439	$72,145	44	$104,793	531	$335,187
009	AL	BCBS of Alabama	5	$60,192	1	$1,765	3	$5,061	0	$0	41	$76,992	17	$15,878	67	$159,889
010	ID	BC of Idaho Health Service	1	$39,650	0	$0	0	$0	0	$0	28	$5,312	0	$0	29	$44,962
011	MA	BCBS of Massachusetts	1	$15,915	60	$4,918	1	$2,663	0	$0	71	$8,086	0	$0	133	$31,582
012	NY	BCBS of Western New York	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
013	PA	Highmark BCBS	2	$88,396	0	$0	4	$6,748	0	$0	329	$57,707	11	$24,293	346	$177,144
015	TN	BCBS of Tennessee	3	$32,351	0	$0	0	$0	0	$0	143	$30,071	109	$28,915	255	$91,336
016	WY	BCBS of Wyoming	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
017	IL	BCBS of Illinois	23	$220,611	100	$10,381	7	$22,598	0	$0	664	$159,116	4	$5,433	798	$418,140
021	OH	WellPoint BCBS of Ohio	2	$6,721	2	$10,200	5	$15,115	6	$6,347	15	$4,353	121	$28,128	151	$70,864
024	SC	BCBS of South Carolina	9	$74,541	1	$1,890	2	$36,801	0	$0	227	$33,275	0	$0	239	$146,508
027	NH	WellPoint BCBS of New Hampshire	0	$0	16	$1,787	2	$10,341	0	$0	0	$0	11	$9,264	29	$21,392
028	VT	BCBS of Vermont	1	$10,584	0	$0	0	$0	0	$0	0	$0	0	$0	1	$10,584
029	TX	BCBS of Texas	56	$1,147,609	256	$30,437	22	$82,867	0	$0	1,423	$394,181	220	$92,085	1,977	$1,747,178
030	CO	WellPoint BCBS of Colorado	7	$101,754	22	$2,281	5	$7,659	0	$0	373	$87,891	33	$6,689	440	$206,274
031	IA	Wellmark BCBS of Iowa	0	$0	14	$1,629	1	$2,365	0	$0	2	$1,644	3	$5,031	20	$10,669
032	MI	BCBS of Michigan	1	$3,427	44	$5,552	4	$9,602	0	$0	0	$0	25	$21,736	74	$40,317
033	NC	BCBS of North Carolina	5	$137,845	124	$18,147	8	$20,565	0	$0	344	$66,886	30	$21,449	511	$264,892
034	ND	BCBS of North Dakota	0	$0	0	$0	0	$0	0	$0	8	$26,061	0	$0	8	$26,061
036	PA	Capital BC	1	$26,611	0	$0	4	$8,401	0	$0	0	$0	0	$0	5	$35,012
037	MT	BCBS of Montana	1	$12,484	0	$0	0	$0	0	$0	0	$0	0	$0	1	$12,484
038	HI	BCBS of Hawaii	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
039	IN	WellPoint BCBS of Indiana	4	$193,336	18	$29,779	0	$0	1	$825	235	$76,269	0	$0	258	$300,210
040	MS	BCBS of Mississippi	1	$3,285	152	$14,025	0	$0	0	$0	4	$4,254	214	$70,698	371	$92,263
041	FL	BCBS of Florida	1	$21,603	237	$30,796	4	$7,621	0	$0	115	$18,659	362	$111,499	719	$190,178
042	MO	BCBS of Kansas City	0	$0	0	$0	0	$0	0	$0	0	$0	4	$4,990	4	$4,990
043	ID	Regence BS of Idaho	0	$0	0	$0	0	$0	0	$0	2	$561	0	$0	2	$561
044	AR	Arkansas BCBS	0	$0	39	$3,999	4	$4,688	0	$0	22	$4,043	2	$17,392	67	$30,122
045	KY	WellPoint BCBS of Kentucky	4	$34,187	65	$14,742	2	$3,651	0	$0	46	$11,946	58	$22,906	175	$87,432
047	WI	WellPoint BCBS United of Wisconsin	6	$63,404	1	$2,600	1	$3,743	0	$0	275	$96,867	95	$21,106	378	$187,720
048	NY	Empire BCBS	20	$361,247	73	$29,471	3	$6,568	0	$0	239	$46,430	128	$9,216	463	$452,932
049	NJ	Horizon BCBS of New Jersey	0	$0	66	$3,230	5	$37,123	0	$0	60	$14,501	387	$26,354	518	$81,207

Coordination of Benefits with Medicare
BlueCross and BlueShield Plans
Claims Reimbursed from July 11, 2010 through April 30, 2011

SUMMARY OF QUESTIONED CHARGES

			COB Category A		COB Category B		COB Category C		COB Category D		COB Category E		COB Category F		ALL COB Categories	
Plan Site Number	Plan State	Plan Name	m Lines	Amount Questioned	Claim Lines	Amount Questioned	m Lines	Amount Questioned	m Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned	Claim Lines	Amount Questioned
050	CT	WellPoint BCBS of Connecticut	0	$0	2	$11,780	0	$0	0	$0	14	$2,160	47	$17,177	63	$31,116
052	CA	WellPoint BC of California	15	$389,630	89	$46,071	10	$58,572	0	$0	270	$85,873	3	$4,171	387	$584,317
053	NE	BCBS of Nebraska	0	$0	42	$4,491	0	$0	0	$0	21	$1,233	0	$0	63	$5,724
054	WV	Mountain State BCBS	3	$10,510	0	$0	1	$1,532	0	$0	8	$9,549	0	$0	12	$21,592
055	PA	Independence BC	9	$237,623	154	$17,752	0	$0	0	$0	109	$63,957	0	$0	272	$319,332
056	AZ	BCBS of Arizona	5	$74,662	126	$19,865	0	$0	0	$0	0	$0	1	$4,094	132	$98,621
058	OR	Regence BCBS of Oregon	1	$42,599	82	$10,140	1	$1,115	1	$2,061	16	$5,438	60	$18,185	161	$79,539
059	ME	WellPoint BCBS of Maine	0	$0	0	$0	2	$7,125	0	$0	17	$2,793	8	$3,096	27	$13,014
060	RI	BCBS of Rhode Island	0	$0	142	$18,517	0	$0	0	$0	0	$0	0	$0	142	$18,517
061	NV	WellPoint BCBS of Nevada	2	$14,658	0	$0	0	$0	0	$0	9	$1,335	5	$1,321	16	$17,314
062	VA	WellPoint BCBS of Virginia	1	$21,042	0	$0	5	$7,873	0	$0	40	$13,469	1	$43	47	$42,427
064	NY	Excellus BCBS Rochester	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
066	UT	Regence BCBS of Utah	3	$19,812	13	$703	0	$0	0	$0	64	$8,994	7	$9,941	87	$39,450
067	CA	BS of California	0	$0	0	$0	0	$0	0	$0	902	$102,766	86	$4,174	988	$106,939
069	WA	Regence BS	0	$0	0	$0	0	$0	0	$0	1	$116	8	$2,569	9	$2,684
070	AK	BCBS of Alaska	1	$21,425	0	$0	0	$0	0	$0	48	$11,078	13	$3,655	62	$36,158
074	SD	Wellmark BCBS of South Dakota	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
075	WA	Premera BC	12	$141,036	2	$5,400	1	$2,500	1	$626	204	$76,597	6	$8,447	226	$234,608
076	MO	WellPoint BCBS of Missouri	24	$516,694	53	$86,145	2	$2,882	0	$0	99	$21,767	0	$0	178	$627,488
078	MN	BCBS of Minnesota	4	$103,605	31	$4,419	0	$0	0	$0	41	$11,493	34	$18,351	110	$137,867
079	NY	Excellus BCBS of Central New York	0	$0	0	$0	0	$0	0	$0	0	$0	1	$18	1	$18
082	KS	BCBS of Kansas	2	$32,049	0	$0	0	$0	0	$0	17	$2,891	0	$0	19	$34,939
083	OK	BCBS of Oklahoma	4	$22,816	32	$2,967	2	$6,391	0	$0	356	$56,799	0	$0	394	$88,972
084	NY	Excellus BCBS of Utica-Watertown	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
085	DC	CareFirst BCBS	7	$142,730	75	$48,282	5	$9,326	0	$0	80	$98,438	62	$75,847	229	$374,622
088	PA	BC of Northeastern Pennsylvania	0	$0	2	$13,512	0	$0	0	$0	0	$0	0	$0	2	$13,512
089	DE	BCBS of Delaware	3	$34,711	65	$43,865	0	$0	0	$0	22	$2,850	0	$0	90	$81,426
092	DC	CareFirst BCBS (Overseas)	0	$0	18	$1,830	1	$520	0	$0	91	$13,979	42	$8,596	152	$24,926
		TOTALS	**290**	**$4,947,945**	**2,354**	**$595,529**	**127**	**$426,031**	**19**	**$10,186**	**8,343**	**$2,069,888**	**2,314**	**$848,552**	**13,447**	**$8,898,131**

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

Federal Employee Program
1310 G. Street, NW
Washington, DC 20005
202.942.1000
Fax 202.942.1125

October 14, 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

Reference: **OPM DRAFT AUDIT REPORT**
Tier XI Global Coordination of Benefits
Audit Report #1A-99-00-11-055

Dear [redacted]:

This is in response to the above - referenced U.S. Office of Personnel Management (OPM) Draft Audit Report concerning the Global Coordination of Benefits Audit for claims paid from July 11, 2010 through April 30, 2011. Our comments concerning the findings in the report are as follows:

Recommendation 1 and 3:

Coordination of Benefits with Medicare Questioned Amount **$16,115,598**

The OPM OIG submitted their sample of potential Medicare Coordination of Benefits errors to the Blue Cross Blue Shield Association (BCBS) on June 21, 2011. The BCBS Association and/or the BCBS Plans were requested to review these potential errors and provide responses by September 30, 2011. These listings included claims incurred on or after July 11, 2010 and reimbursed from July 11, 2010 through April 30, 2011. OPM OIG identified 318,990 claim lines, totaling $47,137,654 in payments, which potentially were not coordinated with Medicare. From this universe, OPM OIG selected for review a sample of 30,933 claim lines, totaling $19,420,185 in payments with a potential overpayment of $16,115,589 to the Federal Employee Health Benefit Program. Furthermore, although the Association has developed corrective actions to reduce COB findings, OPM OIG recommended that the contracting officer instruct the Association to ensure that all BCBS Plans are following the corrective action plan. Also, the Association should continue to identify additional corrective actions to further reduce COB findings.

Blue Cross Blue Shield Association (BCBSA) Response to Recommendation 1 and 3:

After reviewing the OIG listing of potentially uncoordinated Medicare COB claims totaling $16,115,598, BCBSA identified $8,066,089 in claims that were paid correctly and $6,655,154 that was either; initially paid incorrectly but the error was identified and corrected before the response was due to OPM in the amount of $5,721,351, or the error was identified and recovery was initiated before the audit started in the amount of $993,803 but was still uncollected when the response was due to OPM. We agree that $1,334,355 or 8 percent of the questioned amount was paid in error and the error was not identified by the start of the audit.

We disagree with $14,781,248 in improper claim payments. For claims totaling $8,066,089, the initial payment was correct based on the following reasons:

- Medicare Part A was secondary for claim payments totaling $375,808;
- Medicare Part B was secondary for claim payments totaling $75,551;
- Medicare Part A was exhausted for claim payments totaling $82,668;
- There were no Medicare Part B charges for claim payments totaling $53,618;
- The Provider opted out of Medicare pricing for claim payments totaling $119,548;
- Medicare benefits were exhausted and the member has used all available services during a benefit period for outpatient services for claim payments totaling $105,419;
- Medicare denied the charges for claim payments totaling $4,515,986;
- Services were provided by a non covered Medicare Home Health or Long Term Care provider for claim payments totaling $84,706;
- Services were provided by a government facility not paid by Medicare (VA; DOD, UHSFP) for claim payments totaling $524,204;
- Services were provided by a non-covered Indian Health Service (IHS) facilities for claim payments totaling $1,208;
- Services were provided by a non-covered Medicare provider for claim payments totaling $491,448;
- The claim was coordinated with Medicare; however the claim line identified in the sample was not covered for claim payments totaling $480,768;
- The claim was priced according to Case Management guidelines for claim payments totaling $63,019;
- FEP paid the member's Medicare cost sharing (coinsurance or deductible) for claim payments totaling $88,420; and
- The claim was paid correctly for other reasons for claim payments totaling $1,003,718.

For the remaining $6,715,159 claims, $3,853,508 were initially, paid correct, however subsequent Medicare updates were received. Once the updates were

processed on the FEP system the Plans initiated recovery before the audit started. Of this amount $843,023 was recovered before the audit started or the report response was due to the OIG.

For claims totaling, $2,861,651, the Plans initially paid the claims incorrectly because:

- Missed EOB During processing or FEP Direct didn't defer
- FEP edits were overridden
- Processor errors

However, before the audit started, through post payments review controls implemented by the Plans and BCBSA; the Plans identified the incorrect payments and initiated recovery and/or returned the funds to the Program. As of September 30, 2011, the Plans have returned $5,721,351 to the FEHBP.

For the remaining $1,334,355 questioned in the draft report the Plans agreed that these were claim payment errors identified as a result of this audit. The errors resulted from the following reasons:

- $341,713 of these claims were paid incorrectly because the claims processor did not use the Medicare Summary Notice submitted by the provider to process the claim correctly;
- $13,403 of these claims were paid incorrectly because the claim was not worked timely from the retroactive enrollment report or the FEP on-line uncoordinated Medicare application;
- $96,288 of these claims were paid incorrectly because the claim was not included on the retroactive enrollment report, FEP on-line uncoordinated Medicare application or FEP adhoc reports, and therefore the Plan was not aware that the claim needed to be adjusted;
- $36,487 of these claims were paid incorrectly because the Medicare EOB was missed when processing the claim;
- $63,302 of these claims were paid incorrectly because the processor incorrectly overrode the Medicare deferral;
- $244,258 of these claims were paid incorrectly because of manual coding errors;
- $101,599 of these claims were paid incorrectly because a system coding error caused claim to pay incorrectly;
- $155,746 of these claims were paid incorrectly because the FEP claims system did not defer the claim;
- $33,468 were paid incorrectly because the appropriate documentation was not available at the time of processing; and
- $248,091 in claim payments were paid incorrectly for other reasons.

The Plans will continue to pursue the remaining overpayments as required by CS 1039, Section 2.3(g) (l).

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The Association's Action Plan includes oversight and governance procedures to assure all BCBS Plans are following the corrective action plans. In addition, to reduce the number and frequency of uncoordinated Medicare claims, BCBSA has implemented additional steps to our action plan that includes the following:

- Work with top 10 poor performing Plans to develop and implement an action plan to improve performance. We expect to be on target to have the action plans in place by fourth quarter 2011.
- Modify FEP post payment review processes to match with OIG global audit claims listings where appropriate. We have completed the analysis of the OIG and are on target to update the current FEP Uncoordinated Medicare application by second quarter 2012.
- Identify new Medicare COB pre-payment edits to implement in the FEP Claims System. Two additional system modifications have been identified that would also reduce the Medicare COB findings that deal with inpatient facility Part B charges as well as changes related to payment of Home Health and Skill Nursing Facility Medicare claims. All new edits are to be completed by fourth quarter 2012.
- Enhance pre-payment editing of Home Health claims with no Medicare A coordination that may be eligible for Medicare B coordination to be completed by January 2012.
- Modify existing pre-payment compatibility editing to increase clarity around Medicare Payment Disposition usage to be completed by January 2012.
- Provide additional Plan guidance on mapping data from Medicare crossover claims to the correct Medicare Payment Disposition to be completed by January 2012.
- Create new Explanation of Benefit Remarks to more accurately explain denials due to no Medicare coordination to be completed by January 2012.

Recommendation 2:

OPM OIG recommended that BCBSA provide support for each COB error that is identified during the audit (even if identified and/or adjusted prior to this audit by the BCBS Association and/or a BCBS Plan).

BCBSA Response:

Documentation to support the contested amounts and the initiation of overpayment recovery before the audit has been provided. In addition, we have attached a schedule listed as Attachment A that shows the amount questioned, contested, and agreed by each Plan location.

Recommendation 4:

OPM OIG recommended that the contracting officer require the Association to ensure that the BCBS Plans have procedures in place to review all claims incurred back to the Medicare effective dates when updated, Other Party Liability information is added to the FEP national claims system. When Medicare eligibility is subsequently reported, the Plans are expected to immediately determine if previously paid claims are affected and, if so, to initiate the recovery process within 30 days.

BCBSA Response:

To ensure that Plans review all claims incurred back to the Medicare effective date:

- The FEP Operations Center produces the Retroactive Enrollment reports daily, which identifies individuals who are eligible for Medicare A and/or B. This file is reviewed daily by the Plans, who are required to go back and review all claims for this member.
- FEP updated the Plan Administrative Manual to instruct the Plans on what to do with the Retroactive Enrollment Report.

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

[redacted]

[redacted]
Executive Director
FEP Program Integrity

cc: [redacted], OPM
[redacted], FEP
[redacted], FEP

Attachment