US OFFICE OF PERSONNEL MANAGEMENT
OFFICE OF THE INSPECTOR GENERAL
OFFICE OF AUDITS

Final Audit Report

Subject:

AUDIT OF HEALTH CARE SERVICE CORPORATION (BLUECROSS BLUESHIELD OF OKLAHOMA) TULSA, OKLAHOMA

Report No. 1A-10-83-08-018

Date: January 9, 2009

--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

Health Care Service Corporation
Plan Codes 340/840
Tulsa, Oklahoma

REPORT NO. 1A-10-83-08-018 DATE: January 9, 2009

Michael R. Esser
Assistant Inspector General
for Audits

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

Office of the
Inspector General

EXECUTIVE SUMMARY

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

Health Care Service Corporation
Plan Codes 340/840
Tulsa, Oklahoma

REPORT NO. 1A-10-83-08-018 DATE: January 9, 2009

This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at Health Care Service Corporation (Plan), which only included BlueCross BlueShield of Oklahoma, questions $2,049,313 in health benefit charges and $171,670 in administrative expenses. The BlueCross BlueShield Association (Association) and/or Plan agreed *(A)* with $1,724,824 and disagreed *(D)* with $496,159 of the questioned costs. Lost investment income (LII) on the questioned costs amounts to $22,175.

Our audit was conducted in accordance with Government Auditing Standards. The audit covered claim payments from 2005 through 2007, as well as miscellaneous payments and credits and administrative expenses from 2004 through 2006 as reported in the Annual Accounting Statements. In addition, we reviewed the Plan's cash management practices related to FEHBP funds for contract years 2004 through 2006.

Questioned items are summarized as follows:

HEALTH BENEFIT CHARGES

Claim Payments

- **Indian Hospital Facilities - Claim Overpayments *(A)*** **$1,382,373**

  The Plan overcharged the FEHBP for hospital level reimbursements made for professional services from January 2004 through July 2008.

- **Omnibus Budget Reconciliation Act of 1990 Review** **$485,319**

  The Plan incorrectly paid 52 claims that were priced or potentially should have been priced under the Omnibus Budget Reconciliation Act of 1990 pricing guidelines. Specifically, the Plan overpaid 43 claims by $528,790 and underpaid 9 claims by $43,471, resulting in net overcharges of $485,319 to the FEHBP. The Association agreed with $70,146 *(A)* and disagreed with $415,173 *(D)* of the net overcharges.

- **Claim Payment Errors** **$177,982**

  The Plan incorrectly paid 85 claims, resulting in net overcharges of $177,982 to the FEHBP. Specifically, the Plan overpaid 74 claims by $181,247 and underpaid 11 claims by $3,265. The Association agreed with $96,996 *(A)* and disagreed with $80,986 *(D)* of the net overcharges.

Miscellaneous Payments and Credits

- **Refund Advances – Lost Investment Income *(A)*** **$3,639**

  The Plan did not properly invest on average $331,426 in Federal Employee Program refund advances from October 2006 through December 2006. As a result, the FEHBP is due LII of $3,639 on refund advances.

ADMINISTRATIVE EXPENSES

- **Unallowable Cost Center and Natural Account Expenses *(A)*** **$108,220**

  The Plan charged unallowable cost center and natural account expenses to the FEHBP from 2004 through 2006.

- **Pension Costs *(A)*** **$96,632**

  The Plan overcharged the FEHBP for pension costs in 2006.

- **Limits on Executive Compensation *(A)*** **($33,182)**

The Plan overcharged the FEHBP $2,047 for executive compensation in 2004, and undercharged the FEHBP $35,229 in 2005 and 2006.

CASH MANAGEMENT

Overall, we concluded that the Plan handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and regulations, except for the findings pertaining to cash management noted in the "Miscellaneous Payments and Credits" section.

LOST INVESTMENT INCOME ON AUDIT FINDINGS

As a result or our audit findings presented in this audit report, the FEHBP is due LII of **$22,175**, calculated through December 31, 2008.

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 Health Care Service Corporation (Plan or HCSC) pertaining to BlueCross BlueShield of Oklahoma. The Plan includes the Illinois, New Mexico, Oklahoma, and Texas BlueCross and BlueShield plans. The BlueCross BlueShield of Oklahoma plan is located in Tulsa, Oklahoma.

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 Center for Retirement and Insurance Services has overall responsibility for administration of the FEHBP. The provisions of the FEHB Act are implemented by OPM through regulations, which are codified in Title 5, Chapter 1, Part 890 of the Code of Federal Regulations (CFR). Health insurance coverage is made available through contracts with various health insurance carriers.

The BlueCross BlueShield Association (Association), on behalf of participating BlueCross and BlueShield 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 BlueCross and BlueShield plans throughout the United States to process the health benefit claims of its federal subscribers. The Plan is one of approximately 63 local BlueCross and BlueShield 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 BlueCross and BlueShield plans, and OPM.

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

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

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

All findings from our previous audit of the Oklahoma plan (Report No. 1A-10-83-05-002, dated October 17, 2005) for contract years 1999 through 2003 have been satisfactorily resolved, except for two findings. The resolution of these audit issues is still ongoing.

The results of this audit were provided to the Plan in written audit inquiries; were discussed with Plan and/or Association officials throughout the audit and at an exit conference; and were presented in detail in a draft report, dated June 20, 2008. The Association's comments offered in response to the draft report were considered in preparing our final report and are included as Appendix A to this report. Also, additional comments provided by the Plan were considered in preparing our final report and are included as Appendix B to this report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The objectives of our audit were to determine whether the Plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the contract. Specifically, our 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 promptly 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.

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, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We reviewed the BlueCross and BlueShield FEHBP Annual Accounting Statements as they pertain to Plan codes 340/840 (Oklahoma plan) for contract years 2004 through 2007. During this period, the Plan paid approximately $1.2 billion in health benefit charges and $75 million in administrative expenses for the Oklahoma plan (See Figure 1 and Schedule A).

Specifically, we reviewed approximately $12 million in claim payments made from 2005 through 2007 for proper adjudication. In addition, we reviewed miscellaneous payments and credits, such as refunds and subrogation recoveries, administrative expenses, and cash management for 2004 through 2006.

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.

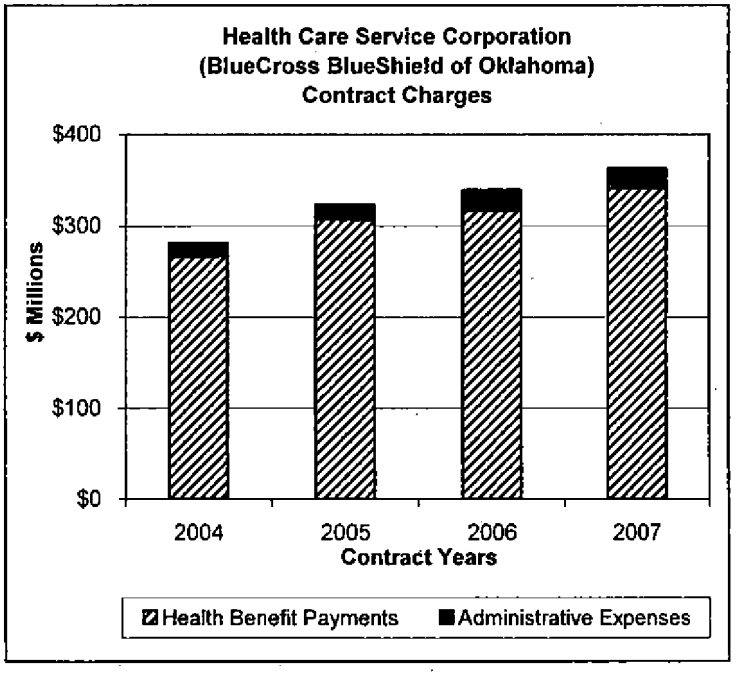

Figure 1 – Contract Charges

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 FEP Director's Office, the FEP Operations Center, 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.

The audit was performed at the Plan's office in Tulsa, Oklahoma from March 10 through March 21, 2008 and April 14 through May 2, 2008. Audit fieldwork was also performed at our offices in Washington, D.C. and Jacksonville, Florida.

METHODOLOGY

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

To test the Plan's compliance with the FEHBP health benefit provisions, we selected and reviewed samples of 519 claims.[2] We used the FEHBP contract, the Service Benefit Plan brochure, the Plan's provider agreements, and the Association's FEP administrative manual to determine the allowability of benefit payments. The results of these samples were not projected to the universe of claims.

We interviewed Plan personnel and reviewed the Plan's policies, procedures, and accounting records during our audit of miscellaneous payments and credits. We also judgmentally selected and reviewed 75 health benefit refunds, totaling $1,096,795 (from a universe of 14,640 refunds, totaling $8,597,247); 45 subrogation recoveries, totaling $1,469,061 (from a universe of 1,406 subrogation recoveries, totaling $3,029,543); and 15 Special Plan Invoices, totaling $873,494 in net payments (from a universe of 74 Special Plan Invoices, totaling $2,801,563 in net payments) to determine if refunds and recoveries were promptly returned to the FEHBP and if miscellaneous payments were properly charged to the FEHBP.

We judgmentally reviewed administrative expenses charged to the FEHBP for contract years 2004 through 2006. Specifically, we reviewed administrative expenses relating to cost centers, natural accounts, out-of-system adjustments, prior period adjustments, pension, post-retirement, employee health benefits, executive compensation, subcontracts, non-recurring projects, lobbying, return on investment, Association dues, and Health Insurance Portability and Accountability Act of 1996 compliance. We used the FEHBP contract, the FAR, and the FEHBAR to determine the allowability, allocability, and reasonableness of charges.

We also reviewed the Plan's cash management to determine whether the Plan handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and regulations.

[2] See the audit findings for "Omnibus Budget Reconciliation Act of 1990 Review" (A1.b) and "Claim Payment Errors" (A1.c) on pages 7 through 15 for specific details of our sample selection methodologies.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. HEALTH BENEFIT CHARGES

1. Claim Payments

a. Indian Hospital Facilities - Claim Overpayments $1,382,373

The Plan overcharged the FEHBP $1,382,373 for hospital level reimbursements made for professional services from January 2004 through July 2008.

Contract CS 1039, Part III, section 3.2 (b) (1) states, "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable." 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 diligent effort to recover an overpayment . . . ."

While conducting a medical review, the Plan's Special Investigation Unit (SIU) found that certain Indian Hospital Facilities (i.e., Lawton Indian Hospital, Anadarko, Carnegie, Choctaw Nation, Chickasaw, and WW Hastings) were billing for hospital-based outpatient clinic services by submitting a facility evaluation and management charge on the UB-92 form (billing form for hospital claims) instead of a professional evaluation and management charge on the CMS 1500 form (billing form for professional claims). The Plan's payment methodology requires professional services to be billed on a CMS 1500 form for proper reimbursement. Consequently, overpayments resulted from professional services being billed on outpatient hospital claim forms (UB-92) instead of professional claim forms (CMS 1500). There were also instances were facilities submitted both types of claim forms and received duplicate reimbursements.

For the period January 2004 through May 2006, the Plan's SIU identified overcharges of $588,328 to the FEHBP as a result of these claim payment errors. In the draft report, we requested the Plan to also identify and review all claims reimbursed for the period June 2006 through July 2008 with this type of potential claim payment error. As a result, the Plan identified additional claim overpayments of $794,045 during the period June 2006 through July 2008. In total, the FEHBP is due $1,382,373 for claim overcharges from January 2004 through July 2008.

Association's Response (Appendix A):

The Association agrees with the questioned overpayments of $588,328 for the period January 2004 through May 2006. The Association states that the Plan is in the process of initiating recoveries for these overpayments. The Association also states that the Plan has developed a corrective action plan to prevent this type of claim payment error in the future.

Plan's Response (Appendix B):

"HCSC has identified and processed recovery requests for claims with this payment error reimbursed during the period June 2006 through July 2008. The refund amount requested for Indian Hospitals is $794,045. All money recovered will be returned to the FEHBP."

Recommendation 1

We recommend that the contracting officer disallow $1,382,373 for claim overcharges, and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 2

We recommend that the contracting officer instruct the Association to verify that the Plan has implemented a corrective action plan to prevent this type of claim payment error in the future.

b. Omnibus Budget Reconciliation Act of 1990 Review **$485,319**

The Plan incorrectly paid 52 claims that were priced or potentially should have been priced under the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) pricing guidelines. Specifically, the Plan overpaid 43 claims by $528,790 and underpaid 9 claims by $43,471, resulting in net overcharges of $485,319 to the FEHBP.

As previously cited from Contract CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments.

OBRA 90 limits the benefit payments for certain inpatient hospital services provided to annuitants age 65 or older who are not covered under Medicare Part A. The FEHBP fee-for-service plans are required to limit the claim payment to the amount equivalent to the Medicare Part A payment.

Using a program developed by the Centers for Medicare and Medicaid Services (CMS) to price OBRA 90 claims, we recalculated the claim payment amounts for the claims in our samples that were subject to and/or processed as OBRA 90.

The following summarizes the claim payment errors.

OBRA 90 Claim Pricing Errors

For the period 2005 through 2007, we identified 1,928 claims, totaling $15,863,071 in payments, that were subject to OBRA 90 pricing guidelines. From this universe, we selected and reviewed a judgmental sample of 111 claims, totaling $4,126,780 in

payments, to determine if these claims were correctly priced by the FEP Operations Center and paid by the Plan. Our sample included all OBRA 90 claims with amounts paid of $20,000 or more.

Based on our review, we determined that 30 claims were paid incorrectly, resulting in net overcharges of $342,882 to the FEHBP. Specifically, the Plan overpaid 24 claims by $377,507 and underpaid 6 claims by $34,625.

The claim payment errors resulted from the following:

- The Plan paid 18 claims that were not priced correctly in accordance with OBRA 90 pricing, resulting in net overcharges of $248,827 to the FEHBP. Specifically, the Plan overpaid 16 claims by $270,433 and underpaid 2 claims by $21,606.

- The Plan paid three claims using incorrect local pricing amounts, resulting in overcharges of $70,714 to the FEHBP.

- The Plan paid three claims using incorrect reimbursement rates, resulting in net overcharges of $12,043 to the FEHBP. Specifically, the Plan overpaid one claim by $18,953 and underpaid two claims by $6,910.

- In one instance, the FEP Operations Center priced the OBRA 90 claim using an incorrect patient status code, resulting in an overcharge of $5,717 to the FEHBP.

- The FEP Operations Center priced five claims using incorrect Medicare Diagnostic Related Group (DRG) codes. Consequently, the Plan overpaid three claims by $11,690 and underpaid two claims by $6,109, resulting in net overcharges of $5,581 to the FEHBP.

Claims Not Priced Under OBRA 90 (Possible OBRA 90 Claims)

For the period 2005 through 2007, we identified 187 claims, totaling $2,336,858 in payments, that were potentially subject to OBRA 90 pricing guidelines but appeared to be priced under the Plan's standard pricing procedures. From this universe, we selected and reviewed a judgmental sample of 78 claims, totaling $1,380,471 in payments, to determine if the Plan paid these claims properly. Our sample included all possible OBRA 90 claims with amounts paid of $5,000 or more.

Based on this review, we determined that 22 claims were paid incorrectly, resulting in net overcharges of $142,437 to the FEHBP. Specifically, the Plan overpaid 19 claims by $151,283 and underpaid 3 claims by $8,846.

The claim payment errors resulted from the following:

- The Plan inadvertently did not price 18 claims under OBRA 90, resulting in net overcharges of $117,973 to the FEHBP. Specifically, the Plan overpaid 15 claims by $126,819 and underpaid 3 claims by $8,846.

- In one instance, the Plan split a claim and paid twice for one continuous admission, resulting in an overcharge of $13,744 to the FEHBP. The Plan should have paid one DRG amount for the entire length of stay.

- The Plan paid three claims using incorrect local pricing amounts, resulting in overcharges of $10,720 to the FEHBP.

Association's Response:

In response to the amount questioned in the draft report, the Association agrees with $70,146 and disagrees with $473,438 of the net overcharges. The Association states that the Plan has initiated recoveries for the uncontested claim overpayments. The Association also states that these payments were good faith erroneous benefit payments and fall within the context of CS 1039, Part II, section 2.3(g). Any payments the Plan is unable to recover are allowable charges to the FEHBP. As good faith erroneous payments, lost investment income (LII) does not apply to the claim payment errors identified in this finding.

For the "OBRA 90 Claim Pricing Errors" finding, the Association states, "We do not contest . . . a net overpayment of $9,331. We do contest 18 claims that were overpaid by $446,084. The Plan identified these claims and requested refunds prior to receiving the audit sample. . . . The Plan also disagrees with underpayments of $15,288 for a net contested amount of $430,795."

Regarding the "Possible OBRA Claims" finding, the Association states, "We do not contest . . . a net overpayment of $60,815. We do contest 3 claims totaling $25,295 because the Plan identified and requested the refunds prior to the audit sample being received and one claim for $22 because the amount was allowed by FEPOC . . . We also contest 2 claims totaling $17,327 because when re-priced by the Operations Center OBRA 90 pricing software, the resulting price was different than the price calculated by the OPM auditors using the CMS PC pricer. The Operations Center OBRA 90 pricing software is the official OPM approved source for FEP OBRA 90 pricing and must be used to determine payment. The claims were repriced with the most up-to-date version of the Operations Center OBRA '90 pricer software. Because the final updated version of the Operations Center OBRA '90 pricer is the tool used to price Medicare Part A claims by the Medicare Part A Intermediaries and the fact that the PC Pricer was developed for providers to use to check the amount that they may receive when the claim is processed by the Medicare Part A Intermediary, FEP continues to believe that the pricing differences obtained by the Operations Center

OBRA '90 Mainframe pricer is the most accurate. Also, since 2005, the Operations Center updates the OBRA '90 pricing software on a quarterly basis. This has minimized pricing differences."

In addition, the Association states, "To reduce the occurrence of Plan OBRA '90 pricing errors in the future, the FEPDO has implemented the following action plan:

- Identify all claims that were not OBRA '90 priced and provide to Plans for correction as part of the new FEP System-wide Claims Review process;

- Modify FEP claims system to defer claims whenever the Plan indicates the provider is not an approved facility . . .

- Override Plan's indication of whether or not the Provider is a Medicare approved provider and validate status through the FEP OBRA '90 software; and

- Determine the feasibility of using the CMS PC Pricer in our current OBRA '90 Mainframe Pricing process."

OIG Comments:

After reviewing the Association's response and documentation provided by the Plan, we revised the amount questioned from the draft report to net overcharges of $485,319. Based on the response, the Association agrees with $70,146 and disagrees with $415,173 of these net overcharges.

Based on the Association's response and/or the Plan's documentation, the contested amount represents claim payment errors where recovery efforts were initiated by the Plan before receiving our information requests/audit samples. However, the Plan had not recovered these overpayments and adjusted the claims by the response due date (March 21, 2008) to our samples. Since these overpayments had not been recovered and returned to the FEHBP by March 21, 2008, we are continuing to question this amount in the final report. Of this contested amount, we verified that the Plan subsequently recovered and returned $263,449 of these overpayments to the FEHBP.

Recommendation 3

We verified that the Plan returned $263,449 of the questioned overcharges to the FEHBP. For these overpayments, the Plan returned the funds to the FEHBP and adjusted the claims after March 21, 2008 (Plan's response due date to the audit samples). No further action is required for these overpayments.

Recommendation 4

We recommend that the contracting officer disallow $265,341 ($528,790 overcharges - $263,449 amount previously returned) in claim overcharges, and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 5

We recommend that the contracting officer allow the Plan to charge the FEHBP $43,471 if additional payments are made to the providers to correct the underpayment errors.

Recommendation 6

Although the Association has developed a corrective action plan to reduce OBRA 90 findings, we recommend that the contracting officer instruct the Association to ensure that the Plan is following the corrective action plan.

c. Claim Payment Errors **$177,982**

The Plan incorrectly paid 85 claims, resulting in net overcharges of $177,982 to the FEHBP. Specifically, the Plan overpaid 74 claims by $181,247 and underpaid 11 claims by $3,265.

As previously cited from Contract CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments

In addition, 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 . . . ."

The following summarizes the claim payment errors.

Amounts Paid Greater than Covered Charges

For the period of 2005 through 2007, we identified 15,436 claims where the amounts paid were greater than the covered charges by a total of $12,568,722. From this universe, we selected and reviewed a judgmental sample of 90 claims with a total variance of $3,868,041, and determined if the Plan paid these claims properly. Our sample included all claims where the amounts paid exceeded the amounts covered by $15,000 or more. Based on our review, we identified five claim payment errors, resulting in overcharges of $93,664 to the FEHBP.

The claim payment errors resulted from the following reasons:

- The Plan paid one claim at an incorrect per diem amount, resulting in an overcharge of $29,950 to the FEHBP.

- The Plan did not coordinate one claim with Medicare, resulting in an overcharge of $26,188 to the FEHBP.

- In one instance, the Plan incorrectly paid a continuous stay claim due to a processing error, resulting in an overcharge of $18,434 to the FEHBP.

- The Plan paid one claim using an incorrect DRG code, resulting in an overcharge of $17,724 to the FEHBP.

- The Plan paid one claim using an incorrect allowance, resulting in an overcharge of $1,368 to the FEHBP. Although the Plan initiated recovery on this overpayment prior to receiving our audit sample, the Plan had not recovered the overpayment and adjusted the claim by the response due date (March 10, 2008) to the sample. Therefore, we are continuing to question this overpayment in the final report.

System Review

For health benefit claims incurred and reimbursed during the period January 1, 2007 through December 31, 2007, we identified 2,466,467 claim lines, totaling $256,561,518 in payments, using a standard criteria based on our experience. From this universe, we judgmentally selected and reviewed a sample of 100 claims (representing 988 claim lines), totaling $2,742,772 in payments, to determine if the Plan adjudicated these claims properly.[3]

Our review identified 10 claim payment errors, resulting in net overcharges of $43,986 to the FEHBP. Specifically, the Plan overpaid nine claims by $46,162 and underpaid one claim by $2,176.

The claim payment errors resulted from the following:

- The Plan paid eight claims at incorrect allowed amounts, resulting in net overcharges of $35,439 to the FEHBP. Specifically, the Plan overpaid seven claims by $37,615 and underpaid one claim by $2,176.

[3] 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.

- The Plan inadvertently paid double the DRG amount for one claim, resulting in an overcharge of $8,380 to the FEHBP.

- The Plan did not coordinate one claim with Medicare, resulting in an overcharge of $167 to the FEHBP.

Assistant Surgeon Review

For the period 2005 through 2007, we identified 1,261 assistant surgeon claim groups, totaling $231,441 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 140 assistant surgeon claim groups, totaling $85,841 in potential overpayments, to determine if the Plan paid these claims properly. Our sample included all assistant surgeon claim groups with potential overpayments of $400 or more.

Based on our review, we identified 70 claim payment errors, resulting in net overcharges of $40,332 to the FEHBP. Specifically, the Plan overpaid 60 claims by $41,421 and underpaid 10 claims by $1,089.

The claim payment errors resulted from the following:

- The Plan incorrectly paid 27 assistant surgeon claims that were subject to Omnibus Budget Reconciliation Act of 1993 (OBRA 93) pricing guidelines, resulting in overcharges of $19,262 to the FEHBP. These errors were due to Palmetto (OBRA 93 pricing vendor) not recognizing the assistant surgeon pricing modifier and erroneously calculating the assistant surgeon fee.

- The Plan paid 32 claims using the incorrect assistant surgeon pricing percentage, resulting in net overcharges of $14,320 to the FEHBP. Specifically, the Plan overpaid 22 claims by $15,409 and underpaid 10 claims by $1,089.

- The Plan paid seven claims without applying the multiple surgery reduction, resulting in overcharges of $3,999 to the FEHBP.

- The Plan incorrectly paid two claims due to processor errors on the medical review pricing, resulting in overcharges of $1,847 to the FEHBP.

- The Plan did not properly coordinate one claim line with Medicare Part B, resulting in an overcharge of $467 to the FEHBP.

- The Plan made one duplicate claim payment, resulting in an overcharge of $437 to the FEHBP.

Association's Response:

The Association agrees with $96,996 ($36,158, $20,506 and $40,332) and disagrees with $80,986 of the net overcharges. The Association states that the Plan has initiated recoveries for the uncontested claim overpayments. For the contested claim payment errors, the Association states that Plan had already identified and requested refunds for these overpayments before receiving the audit samples. The Association also states that these payments were good faith erroneous benefit payments and fall within the context of CS 1039, Part II, section 2.3(g). Any payments the Plan is unable to recover are allowable charges to the FEHBP. As good faith erroneous payments, LII does not apply to these claim payment errors.

In addition, the Association states that the FEP Director's Office and Plan have implemented correction action plans to prevent these types of claim payment errors.

OIG Comments:

After reviewing the Association's response and documentation provided by the Plan, we revised the amount questioned from the draft report to net overcharges of $177,982. Based on the response, the Association agrees with $96,996 and disagrees with $80,986 of these net overcharges.

Based on the Association's response and/or the Plan's documentation, the contested amount represents claim payment errors where recovery efforts were initiated by the Plan before receiving our information requests/audit samples. However, the Plan had not recovered these overpayments and adjusted the claims by the response due date (March 10, 2008) to our samples. Since these overpayments had not been recovered and returned to the FEHBP by March 10, 2008, we are continuing to question this amount in the final report. Of this contested amount, we verified that the Plan subsequently recovered and returned $13,630 of these overpayments to the FEHBP.

Recommendation 7

We verified that the Plan returned $13,630 of the questioned overcharges to the FEHBP. For these overpayments, the Plan returned the funds to the FEHBP and adjusted the claims after March 10, 2008 (Plan's response due date to the audit samples). Therefore, no further action is required for these overpayments.

Recommendation 8

We recommend that the contracting officer disallow $167,617 ($181,247 questioned - $13,630 amount previously returned) in claim overcharges, and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 9

We recommend that the contracting officer allow the Plan to charge the FEHBP $3,265 if additional payments are made to the providers to correct the underpayment errors.

Recommendation 10

We recommend that the contracting officer instruct the Association to verify that the Plan is following the corrective action plan to prevent these types of claim payment errors in the future.

2. Miscellaneous Payments and Credits

a. Refund Advances – Lost Investment Income $3,639

The Plan did not properly invest on average $331,426 in FEP refund advances from October 2006 through December 2006. As a result, the FEHBP is due LII of $3,639 on refund advances.

FEP Financial Policies and Procedures Bulletin Number 54, Refunds to FEP Letter of Credit Account, states: "A Plan receiving routine refunds is responsible for crediting the funds to the FEP Letter of Credit Account (LOCA) and investing the funds until the credit occurs. The Plan invests the refunds for the benefit of the FEHBP in the Plan's dedicated FEP Investment Account. Plans may be liable for lost investment income if the funds are not invested or returned within 30 days of receipt. . . ."

Also, based on an agreement between OPM and the Association, dated March 26, 1999, BlueCross and BlueShield plans have 30 days to return refunds to the FEHBP if received after March 31, 1999 before LII will be assessed.

48 CFR 1652.215-71(e) states that investment income lost on these funds should be credited to the FEHBP. In addition, section (f) of this regulation states, "All lost investment income payable shall bear simple interest at the quarterly rate determined by the Secretary of the Treasury . . . ."

For the period 2004 through 2006, we reviewed the Plan's refund advance calculations to determine if the advances were properly calculated and invested. From January 2004 through October 2006, the Oklahoma plan consistently maintained a refund advance balance of $60,000. In 2005, the Oklahoma plan merged with the Plan (Health Care Service Corporation). Starting in October 2006, the Plan calculated a refund advance balance, totaling $416,764, for the Oklahoma plan. We found that the Plan did not maintain the stated refund advance balance in the FEP investment account during the period October 2006 through December 2006. We performed our own calculations to determine how much of the advance was actually being invested. In our calculations,

we used the stated refund advance amount and any deposits into the FEP investment account and working capital. For each month, we determined what the average daily investment balance should have been, and then calculated the difference between the investment balance per the bank statement and the investment balance that should have been maintained. We determined that on average $331,426 in FEP refund advances were not being invested properly. As a result, the FEHBP is due LII of $3,639 on these refund advances.

Association's Response:

The Association agrees with this finding. The Association states that Plan will submit a Special Plan Invoice to credit the LII to the FEHBP by August 29, 2008.

Recommendation 11

We recommend that the contracting officer verify that the Plan credited the FEHBP $3,639 for LII on refund advances.

B. ADMINISTRATIVE EXPENSES

1. Unallowable Cost Center and Natural Account Expenses — $108,220

The Plan charged unallowable cost center and natural account expenses of $108,220 to the FEHBP from 2004 through 2006.

Contract CS 1039, Part III, section 3.2 (b)(1) states, "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable." Part III, section 3.8 states, "the Carrier shall retain and make available all records applicable to a contract term . . . ."

48 CFR 31.205-19(e)(2)(vi) states, "Cost of insurance on the lives of officers, partners, or proprietors are allowable only to the extent that the insurance represents additional compensation."

For the period 2004 through 2006, the Plan allocated administrative expenses of $40,267,417 (before adjustments) to the FEHBP from 1,058 cost centers and 416 natural accounts. From this universe, we selected a judgmental sample of 53 cost centers to review, which totaled $20,976,830 in expenses allocated to the FEHBP. We also selected a judgmental sample of 26 natural accounts to review, which totaled $6,142,465 in expenses allocated to the FEHBP. We selected the cost centers and natural accounts based on high dollar amounts, our nomenclature review, and significant dollar amount fluctuations from year to year. We reviewed the expenses from these cost centers and natural accounts for allowability, allocability, and reasonableness. Based on our review, we identified unallowable expenses of $108,220 from two cost centers and four natural accounts that were charged to the FEHBP.

The following is a summary of the unallowable cost center (CC) and natural account (NA) expenses that were charged to the FEHBP:

- NA 623800 (Life Insurance) - $53,466
- NA 680002 (Auditing Services) - $39,000
- CC 400950 (Oklahoma Marketing Development) - $14,439
- CC 400178 (Oklahoma Caring Foundation) - $1,095
- NA 690041 (Finance Charges) and NA 690042 (Interest and Penalties) - $220

In 2006, the Plan charged the FEHBP $53,466 from NA 623800 for the cost of life insurance for its officers. Prior to the merger with HCSC, the Oklahoma plan did not charge the FEHBP for this expense. However, when the accounts migrated to HCSC, the expense was classified as split-dollar life insurance, which may be allowable depending on the agreement between the employer and employee. Based on our discussions with the Plan, we determined that this is "Key-Man" life insurance and the Plan is the beneficiary. As a result, since this expense does not represent additional compensation to the employee, the charge is unallowable under 48 CFR 31.205-19(e)(2)(vi).

In 2006, the Plan charged the FEHBP $60,000 from NA 680002 for auditing services related to an Independent Public Accountant audit. However, the Plan only provided documentation to support $21,000 of these charges, resulting in unsupported charges of $39,000 to the FEHBP.

In 2005 and 2006, the Plan incorrectly allocated $14,439 in manager salary expenses to the FEHBP from CC 400950. Based on discussions with the Plan, we determined that these expenses should not have been charged to the FEHBP since the manager position was phased-out in 2005 and there were no actual work hours recorded in this CC.

In 2005, the Plan allocated unallowable charitable contributions of $1,095 to the FEHBP from CC 400178. 48 CFR 31.205-8 states "Contributions or donations, including cash, property and services, regardless of recipient, are unallowable, except as provided in 48 CFR 31.205-1(e)(3)." The activities in this CC are not consistent with the exceptions in 48 CFR 31.205-1(e)(3).

In 2004 and 2005, the Plan allocated unallowable finance and interest charges of $220 to the FEHBP from NA's 690041 and 690042. 48 CFR 31.205-20 states, "Interest on borrowings (however represented) . . . are unallowable . . . ."

In total, the FEHBP is due $108,220 for unallowable CC and NA expenses that were charged to the FEHBP from 2004 through 2006.

Association's Response:

The Association agrees with this finding. The Association states that the Plan will submit a prior period adjustment by August 20, 2008.

Recommendation 12

We recommend that the contracting officer verify that the Plan returned $108,220 to the FEHBP for unallowable CC and NA expenses that were charged to the FEHBP.

2. Pension Costs $96,632

The Plan overcharged the FEHBP $96,632 for pension costs in 2006.

48 CFR 31.205-6(j) (2) states, "The cost of all defined-benefit pension plans shall be measured, allocated, and accounted for in compliance with the provisions of 48 CFR 9904.412 . . . and 48 CFR 9904.413 . . . The costs of all defined-contribution pension plans shall be measured, allocated, and accounted for in accordance with the provisions of 48 CFR 9904.412 and 48 CFR 9904.413. Pension costs are allowable subject to the referenced standards and the cost limitations and exclusions set forth in paragraph (j)(2)(i) and in paragraphs (j)(3) through (8) of this subsection."

Contract CS 1039, Part III, section 3.2 (b)(1) states, "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable."

As a result of an FEP Director's Office audit in 2006, the Plan was instructed to allocate pension costs based on an actual FEP salary ratio (FEP allocated salaries to total corporate salaries). Therefore, the Plan recalculated the FEHBP pension costs for 2004 and 2005, and submitted prior period adjustments to the FEP Director's Office in January 2007. We reviewed the Plan's prior period adjustments, and verified that these adjustment amounts were processed to the FEHBP. Therefore, these adjustment amounts were not included in this audit finding.

However, we noted that the Plan did not use an acceptable or reasonable method of allocating pension costs to the FEHBP in 2006. In accordance with Federal regulations, a salary ratio is a reasonable allocation methodology for pension costs. As a result of our audit, the Plan recalculated the FEHBP pension costs for 2006 in accordance with the regulations. We reviewed the Plan's revised pension cost calculation noting that the FEHBP was overcharged $96,632 for 2006.

Association's Response:

The Association agrees with this finding. The Association states that the Plan will submit a prior period adjustment.

Recommendation 13

We recommend that the contracting officer ensure that the Plan returns $96,632 to the FEHBP for pension cost overcharges.

3. Limits on Executive Compensation ($33,182)

The Plan overcharged the FEHBP $2,047 for executive compensation in 2004, and undercharged the FEHBP $35,229 in 2005 and 2006.

48 CFR 31.205-6(p) limits the allowable compensation costs for senior executives to a benchmark amount established each year by the Office of Federal Procurement Policy. This limit is applicable to the five most highly compensated employees in management positions at each home office and each segment of the Plan, whether or not the home office or segment reports directly to the Plan's headquarters. The benchmark compensation amounts were $432,851 in 2004, $473,318 in 2005, and $546,689 in 2006.

48 CFR 31.205-6(p)(2)(i) states, "'Compensation' means the total amount of wages, salary, bonuses, deferred compensation . . . and employer contributions to defined contribution pension plans . . . for the fiscal year, whether paid, earned, or otherwise accruing, as recorded in the contractor's cost accounting records for the fiscal year."

To determine the allowability of the amounts charged to the FEHBP for executive compensation, we reviewed the Plan's allocations for 2004 through 2006 to determine if the executives compensation amounts were limited to the amounts set forth in 48 CFR 31.205-6(p). We noted the following exceptions:

- For 2004, the Plan understated the executive compensation adjustment by inadvertently excluding the executives' 401K benefits in the calculation, resulting in an overcharge of $2,047 to the FEHBP.
- For 2005, the Plan inadvertently applied the 2004 adjustment to the 2005 calculation. Also, the Plan did not include the executives' 401K benefits in the 2005 calculation. As a result, the Plan undercharged the FEHBP $25,673 for executive compensation.
- For 2006, the Plan did not charge the FEHBP for one executive's salary, resulting in an undercharge of $9,556 to the FEHBP.

In total, the FEHBP was undercharged $33,182 (net) for executive compensation from 2004 through 2006.

Association's Response:

The Plan agrees with this finding.

Recommendation 14

We recommend that the contracting officer disallow $2,047 for executive compensation overcharges in 2004.

Recommendation 15

We recommend that the contracting officer allow the Plan to charge the FEHBP $35,229 for executive compensation undercharges in 2005 and 2006.

C. CASH MANAGEMENT

Overall, we concluded that the Plan handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and regulations, except for the audit findings pertaining to cash management noted in the "Miscellaneous Payments and Credits" section.

D. LOST INVESTMENT INCOME ON AUDIT FINDINGS $22,175

As a result of the audit findings presented in this report, the FEHBP is due LII of $22,175 from January 1, 2005 through December 31, 2008.

48 CFR 1652.215-71 requires the carrier to invest and reinvest all excess FEHBP funds on hand, and to credit all investment income earned on those funds to the Special Reserve on behalf of the FEHBP. When the carrier fails to comply with these requirements, the carrier shall credit the Special Reserve with investment income that would have been earned at the rates specified by the Secretary of the Treasury. LII payable on questioned costs bears simple interest.

We computed investment income that would have been earned using the semiannual rates specified by the Secretary of the Treasury. Our computations show that the FEHBP is due LII of $22,175 from January 1, 2005 through December 30, 2008 on questioned costs for contract years 2004 through 2006 (see Schedule C).

Association's Response:

The draft audit report did not include an audit finding for LII. Therefore, the Association did not address this item in its reply.

Recommendation 16

We recommend that the contracting officer direct the Plan to credit $22,175 (plus interest accruing after December 31, 2008) to the Special Reserve for LII on audit findings.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Experienced-Rated Audits Group

[redacted] Auditor-In-Charge

[redacted] Auditor

[redacted] Auditor

[redacted] Auditor

[redacted] Chief [redacted]

[redacted] Senior Team Leader

SCHEDULE A

HEALTH CARE SERVICE CORPORATION
(BLUECROSS BLUESHIELD OF OKLAHOMA)
TULSA, OKLAHOMA

CONTRACT CHARGES

CONTRACT CHARGES	2004	2005	2006	2007	TOTAL
A. HEALTH BENEFIT CHARGES*					
PLAN CODE 340	$152,602,529	$173,457,867	$166,917,425	$182,539,806	$675,517,627
MISCELLANEOUS PAYMENTS AND CREDITS	734,915	944,966	622,815	841,632	3,144,328
PLAN CODE 840	112,899,640	132,131,039	149,417,666	157,596,987	552,045,332
MISCELLANEOUS PAYMENTS AND CREDITS	0	0	0	0	0
TOTAL HEALTH BENEFIT CHARGES	$266,237,085	$306,533,871	$316,957,906	$340,978,425	$1,230,707,287
B. ADMINISTRATIVE EXPENSES**					
PLAN CODES 340/840	$14,472,912	$16,351,662	$23,216,817	$21,923,147	$75,964,538
PRIOR PERIOD ADJUSTMENTS	(14,627)	(76,618)	(31,422)	(40,607)	(163,274)
COST SETTLEMENT REDUCTIONS	0	0	(1,195,907)		(1,195,907)
TOTAL ADMINISTRATIVE EXPENSES	$14,458,285	$16,275,044	$21,989,488	$21,882,540	$74,605,357
TOTAL CONTRACT CHARGES	$280,695,370	$322,808,915	$338,947,394	$362,860,965	$1,305,312,644

* We did not review claim payments for contract year 2004 and miscellaneous payments and credits for contract year 2007.

** We did not review administrative expenses for contract year 2007.

SCHEDULE B

HEALTH CARE SERVICE CORPORATION
(BLUECROSS BLUESHIELD OF OKLAHOMA)
TULSA, OKLAHOMA

QUESTIONED CHARGES

AUDIT FINDINGS	2004	2005	2006	2007	2008	TOTAL
A. HEALTH BENEFIT CHARGES						
1. Claim Payments						
a. Indian Hospital Facilities - Claim Overpayments	$0	$0	$588,328	$0	$794,045	$1,382,373
b. Omnibus Budget Reconciliation Act of 1990 Review	0	92,987	122,978	269,354	0	485,319
c. Claim Payment Errors	0	7,450	62,025	108,507	0	177,982
Total Claim Payments	$0	$100,437	$773,331	$377,861	$794,045	$2,045,674
2. Miscellaneous Payments and Credits						
a. Refund Advances - Lost Investment Income	$0	$0	$3,639	$0	$0	$3,639
Total Miscellaneous Payments and Credits	$0	$0	$3,639	$0	$0	$3,639
TOTAL HEALTH BENEFIT CHARGES	$0	$100,437	$776,970	$377,861	$794,045	$2,049,313
B. ADMINISTRATIVE EXPENSES*						
1. Unallowable Cost Center and Natural Account Expenses	$524	$6,005	$101,691	$0	$0	$108,220
2. Pension Costs	0	0	96,632	0	0	96,632
3. Limits on Executive Compensation	2,047	(25,673)	(9,556)	0	0	(33,182)
TOTAL ADMINISTRATIVE EXPENSES	$2,571	($19,668)	$188,767	$0	$0	$171,670
C. CASH MANAGEMENT	$0	$0	$0	$0	$0	$0
D. LOST INVESTMENT INCOME ON AUDIT FINDINGS	$0	$113	$467	$11,379	$10,216	$22,175
TOTAL QUESTIONED CHARGES	$2,571	$80,882	$966,204	$389,240	$804,261	$2,243,158

* Only the administrative expense overcharges are subject to lost investment income.

SCHEDULE C

HEALTH CARE SERVICE CORPORATION
(BLUECROSS BLUESHIELD OF OKLAHOMA)
TULSA, OKLAHOMA

LOST INVESTMENT INCOME CALCULATION

	2004	2005	2006	2007	2008	TOTAL
A. QUESTIONED CHARGES (Subject to Lost Investment Income)						
Administrative Expenses*	$2,571	$6,005	$198,323	$0	$0	$206,899
TOTAL	$2,571	$6,005	$198,323	$0	$0	$206,899
B. LOST INVESTMENT INCOME CALCULATION						
a. Prior Years Total Questioned (Principal)	$0	$2,571	$6,005	$198,323	$0	
b. Cumulative Total	0	0	2,571	8,576	206,899	
c. Total	$0	$2,571	$8,576	$206,899	$206,899	
d. Treasury Rate: January 1 - June 30	4.000%	4.250%	5.125%	5.250%	4.750%	
e. Interest (d * c)	$0	$55	$220	$5,431	$4,914	$10,620
f. Treasury Rate: July 1 - December 31	4.500%	4.500%	5.750%	5.750%	5.125%	
g. Interest (f * c)	$0	$58	$247	$5,948	$5,302	$11,555
Total Interest By Year (e + g)	$0	$113	$467	$11,379	$10,216	$22,175

* Only the administrative expense overcharges on Schedule B are subject to lost investment income.

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

Federal Employee Program
1310 G Street, N.W.
Washington, D.C. 20005
202.942.1000
Fax 202.942.1125

August 19, 2008

[redacted]

Group Chief
BCBS Audits Group
U.S. Office of Personnel Management
1900 E Street, N.W., Room 6400
Washington, D.C. 20415-1100

Reference: **OPM DRAFT AUDIT REPORT**
HEALTH CARE SERVICE CORPORATION-HCSC
OKLAHOMA
Audit Report Number - 1A-10-83-08-018
(Dated and received June 20, 2008)

Dear [redacted]

This is in response to the above referenced U.S. Office of Personnel Management (OPM) Final Audit Report concerning Health Care Service Corporation-HCSC. Our comments concerning the findings in the report are as follows:

A. HEALTH BENEFIT CHARGES

1. Claim Payments

a. Indian Hospital (IH) Facilities - Claim Overpayments $588,328

We do not contest the identified overpayment of $588,328. These overpayments resulted from physician (professional) services being billed on outpatient hospital claims (UB-92) instead of professional claim forms (CMS-1500). Some IH facilities sent in both types of claim forms and received duplicate reimbursement. However, the overpayment was identified by the Plan's Special Investigation Unit as determined from the hospital level reimbursements made for physician services. The Plan's payment methodology requires professional services to be billed on a CMS-1500 for proper reimbursement. The

overpayment due the FEBHP is not necessarily the result of duplicate payments.

The recovery process included coordination with the Special Investigations Unit of the Federal Employee Health Benefit Program, Blue Cross and Blue Shield Association. An attempt was made by the BCBSOK Special Investigation Division to recover the overpayments from the IH facilities but was disputed by their Regional Director. Since the overpayments involved two federal agencies, BCBSOK requested the BCBSA FEP Special Investigations Unit Director coordinate a resolution at the federal level. A final decision and authorization to proceed with collection efforts was received May 8, 2008, by the FEP Director's Office.

HCSC Corrective Action:

A claims lock was put in place for FEP Indian Health Services claims in June 2008. The claims are being manually adjudicated until a system fix can be implemented in the Blue Chip system. The system fix to the Oklahoma APG pricing module will prevent future claims payment errors and allow for systematic adjudication.

HCSC is currently in the process of initiating the refund request for the January 2004 - May 2006 claims.

Corrective Action to prevent future overpayments:

- When a system problem is discovered, a listing of impacted claims will be generated within 30 days of discovery of the problem to determine the number of claims and dollar impact.
- Upon receipt of the listing, claims will be reviewed to determine the amount of overpayment and recovery of the overpayments will be initiated within 30 days of receiving the listing.
- Interim processing steps for the situation will be identified and implemented to ensure correction.
- Once the system problem has been corrected, a complete audit of all claims affected by the system error will be performed to ensure that these claims have been correctly adjudicated.

b. Omnibus Budget Reconcillation Act of 1990 Review $543,584

OBRA 90 Claim Pricing Errors

We do not contest that an overpayment totaling $30,220 (3 claims) and an underpayment of $20,889 (2 claims), for a net overpayment of

$9,331. We do contest 18 claims that were overpaid by $446,084. The Plan identified these claims and requested refunds prior to receiving the audit sample. Supporting documentation was submitted to the auditors prior to their arriving on-site. We can supply this information again if needed. The Plan also disagrees with underpayments of $15,288 for a net contested amount of $430,795.

Claims Not Priced Under OBRA 90 (Possible OBRA 90 Claims)

We do not contest an overpayment of $69,661 (14 claims) and an underpayment of $8,846 (3 claims), for a net overpayment of $60,815. We do contest 3 claims totaling $25,295 because the Plan identified and requested the refunds prior to the audit sample being received and one claim for $22 because the amount was allowed by FEPOC. The supporting documentation can be resubmitted if needed. We also contest 2 claims totaling $17,327 because when re-priced by the Operations Center OBRA 90 pricing software, the resulting price was different than the price calculated by the OPM auditors using the CMS PC pricer. The Operations Center OBRA 90 pricing software is the official OPM approved source for FEP OBRA 90 pricing and must be used to determine payment. The claims were repriced with the most up-to-date version of the Operations Center OBRA '90 pricer software. Because the final updated version of the Operations Center OBRA '90 pricer is the tool used to price Medicare Part A claims by the Medicare Part A Intermediaries and the fact that the PC Pricer was developed for providers to use to check the amount that they may receive when the claim is processed by the Medicare Part A Intermediary, FEP continues to believe that the pricing differences obtained by the Operations Center OBRA '90 Mainframe pricer is the most accurate. Also, since 2005, the Operations Center updates the OBRA '90 pricing software on a quarterly basis. This has minimized pricing differences.

HCSC Corrective Action:

Initiation of recoveries has been made on all claims identified as having been paid incorrectly. The Plan also completes the periodic FEP System-Wide Claims review process, which includes Possible OBRA'90 claims. Completing this report will minimize OBRA '90 claim errors in the future.

FEP DO Corrective Action:

To reduce the occurrence of Plan OBRA '90 pricing errors in the future, the FEPDO has implemented the following action plan:

- Identify all claims that were not OBRA '90 priced and provide to Plans for correction as part of the new FEP System-wide Claims Review process;

- Modify FEP claims system to defer claims whenever the Plan indicates the provider is not an approved facility this will force the Plan to ensure that the proper information has been submitted;

- Override Plan's indication of whether or not the Provider is a Medicare approved provider and validate status through the FEP OBRA '90 software; and

- Determine the feasibility of using the CMS PC Pricer in our current OBRA '90 Mainframe pricing process.

Accordingly, to the extent that errors did occur, the payments are good faith erroneous benefits payments and fall within the context of CS 1039, Section 2.3(g). Any benefit payments the Plan is unable to recover are allowable charges to the Program. In addition, as good faith erroneous payments, lost investment income does not apply to the payments identified in this finding.

c. **Claim Payment Errors** **$260,954**

Amounts Paid Greater than Covered Charges
We do not contest an overpayment totaling $36,158 (2 Claims). We do contest 5 claims that were overpaid by $140,387 because the Plan identified and requested refunds prior to the audit sample being received. We can provide this documentation again if needed.

The errors were caused due to the following reasons:

- Duplicate payment issued
- Incorrect allowed amount due to processor manually paying claim
- Medicare Part A primary at time of service

Initiation of recoveries has been made on all claims identified as having been paid incorrectly.

System Review

Plan agrees to an overpayment of $22,682 (8 Claims) and an underpayment of $2,176 (1 claim), for a net overpayment of $20,506. The Plan disagrees that 2 claims were overpaid by $23,571 because

the plan identified and requested refunds prior to the audit sample being received. We can provide this documentation again if needed.

The errors were caused due to the following reasons:

- Incorrect allowed amount due to processor manually paying claim;
- Incorrect allowed amount due to processor not pricing correctly on Premier Pricing system; and
- Medicare files not updated at time claim payment issued

Initiation of recoveries has been made on all claims identified as having been paid incorrectly.

Assistant Surgeon Review
The Plan agrees with this audit finding of an overpayment of $40,332.

The errors were caused due to the following reasons:

- OBRA 93 software issue for Modifier AS (these claims were not on the FEP provided OBRA '93 AS Modifier listing we received);
- Incorrect allowed amount due to processor manually paying claim; and
- Incorrect allowed amount due to processor not pricing correctly on Premier Pricing system.

Initiation of recoveries has been made on all claims identified as having been paid incorrectly.

HCSC Corrective Action:

The Plan has limited the number of users who can do manual calculations. The Plan also works the new Assistant Surgeon listing included in the FEP Director's Office periodic System-Wide Claims Review process.

FEPDO Corrective Action:

In addition, for assistant surgeon claim errors noted during the audit, the FEPDO implemented the following:

- The OBRA '93 vendor, Palmetto, corrected pricing of the assistant surgeon modifier during May 2008.

- A final comprehensive list that identifies all unadjusted assistant surgeon claims will be issued by September 30, 2008 so that claims can be adjusted as necessary.

- Assistant Surgeon (non-OBRA '93) claims are now included in the FEP System-Wide Claims Review process for Plans to review for accuracy.

Accordingly, to the extent that errors did occur, the payments are good faith erroneous benefits payments and fall within the context of CS 1039, Section 2.3(g). Any benefit payments the Plan is unable to recover are allowable charges to the Program. In addition, as good faith erroneous payments, lost investment income does not apply to the payments identified in this finding.

2. Miscellaneous Payments and Credits

a. Refund Advance **$3,639**

We do not contest this audit finding of $3,639 and the Plan will be submitting a Special Plan Invoice by August 29, 2008.

B. ADMINISTRATIVE EXPENSES

1. Pension Costs **$342,508**

HCSC agrees with the finding but not the amount. This is for two reasons.

First, we used an amount of $1,308,184 as the "FEP Charges in Cost System" when we made our year end adjustment. This is the amount that was charged from the Oklahoma pool cost center to FEP products in the four HCSC states. This method is consistent with the adjustment made for the other HCSC states. Therefore, when this amount is added to the year end adjustment of $311,549, the "Total FEP Charges" are $1,619,733.

Second, we believe our method of calculating the FEP salary ratio is consistent with that used for the other HCSC states, and should not be compared to the method used for 2004 and 2005 since the 2006 period was post merger and therefore using the HCSC account structure is appropriate. We believe that an average of the FEP salary ratios used for 2004 and 2005 is not relevant for 2006, and is therefore not appropriate. We believe the correct method, consistent with the

method used for other HCSC states for 2006, results in an FEP salary ratio of 13.24%.

Based on the above facts, we believe the FEHBP was overcharged by $96,632 for 2006. When a mutual amount is agreed upon, the Plan will submit a Prior Period Adjustment.

2. Unallowable Expenses **$118,809**

The Plan concurs with the audit findings totaling $108,220 in unallowable expenses and will file a Prior Period Adjustment by August 20, 2008 for processing.

The Plan contests the $10,589 audit finding for cost centers 0058 and 0059, United Way cost centers. The FAR states in part 31.205 that the cost of participation in community service activities such as charity drives are allowable.

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

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

4. **Limits on Executive Compensation** **($33,182)**

The Plan concurs with this finding

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

Sincerely,

[redacted]

for Executive Director
Program Integrity

[redacted]

cc: [redacted]

HEALTH CARE SERVICE CORPORATION

Audit Inquiry Response # 8B

Audit Title: OPM Audit Coordination (OK - pre August 06 Merger)

Audit Finding: Additional Claim Recovery - Indian Hospital Facilities

---

Response:

HCSC has identified and processed recovery requests for claims with this payment error reimbursed during the period June 2006 through July 2008. The refund amount requested for Indian Hospitals is $794,045. All money recovered will be returned to the FEHBP.

DATE: 10-8-08 **SIGNATURE:** [redacted] Sr Mgr, FEP
