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

Final Audit Report

Subject:

AUDIT OF HIGHMARK BLUECROSS BLUESHIELD CAMP HILL, PENNSYLVANIA

Report No. 1A-10-13-09-001

Date: June 15, 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

Highmark BlueCross BlueShield
Plan Codes 363 and 865
Camp Hill, Pennsylvania

REPORT NO. 1A-10-13-09-001 DATE: June 15, 2009

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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
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Plan Codes 363 and 865
Camp Hill, Pennsylvania

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This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at Highmark BlueCross BlueShield (Plan) in Camp Hill, Pennsylvania questions $872,886 in health benefit charges. The BlueCross BlueShield Association agreed *(A)* with all questioned charges.

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 2003 through 2007 as reported in the Annual Accounting Statements. In addition, we reviewed the Plan's cash management practices related to FEHBP funds for contract years 2003 through 2007.

Questioned items are summarized as follows:

HEALTH BENEFIT CHARGES

Claim Payments

- **System Review *(A)*** **$437,154**

  Based on our review of a judgmental sample of 125 claims, we determined that the Plan incorrectly paid 5 claims, resulting in net overcharges of $437,154 to the FEHBP. Specifically, the Plan overpaid four claims by $441,272 and underpaid one claim by $4,118.

- **Omnibus Budget Reconciliation Act of 1990 Review *(A)*** **$196,264**

  The Plan incorrectly paid 24 claims that were priced or potentially should have been priced under the Omnibus Budget Reconciliation Act of 1990 pricing guidelines, resulting in net overcharges of $196,264 to the FEHBP. Specifically, the Plan overpaid 20 claims by $212,087 and underpaid 4 claims by $15,823.

- **Amounts Paid Greater than Covered Charges *(A)*** **$177,193**

  During our review of claims where the amounts paid were greater than the covered charges, we determined that the Plan incorrectly paid eight claims, resulting in overcharges of $177,193 to the FEHBP.

- **Assistant Surgeon Review *(A)*** **$13,903**

  The Plan incorrectly paid 12 assistant surgeon claims, resulting in net overcharges of $13,903 to the FEHBP. Specifically, the Plan overpaid 10 claims by $14,541 and underpaid 2 claims by $638.

Miscellaneous Payments and Credits

- **Review of Refund Aging Report *(A)*** **$26,571**

  As of the start date of our review, the Plan had not returned a provider audit recovery of $25,483 to the FEHBP. The Plan subsequently returned $26,571 to the FEHBP, consisting of $25,483 for the provider audit recovery and $1,088 for lost investment income on this recovery.

- **Provider Audit Recoveries *(A)*** **$21,801**

  The Plan did not recover and return two provider overpayments to the FEHBP. As a result, the FEHBP is due $21,801 for these provider audit recoveries.

ADMINISTRATIVE EXPENSES

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

CASH MANAGEMENT

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.

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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 Highmark BlueCross BlueShield (Plan). The Plan is located in Camp Hill, Pennsylvania.

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.

The findings from our previous audit of the Plan (Report No. 1A-10-13-03-025, dated February 2, 2004) for contract years 1999 through 2001 have been satisfactorily resolved.

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 February 5, 2009. The Association's comments offered in response to the draft report were considered in preparing our final report and are included as an Appendix to this report.

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

We reviewed the BlueCross and BlueShield FEHBP Annual Accounting Statements as they pertain to Plan codes 363 and 865 for contract years 2003 through 2007. During this period, the Plan paid approximately $1 billion in health benefit charges and $95 million in administrative expenses (See Figure 1 and Schedule A).

Specifically, we reviewed approximately $13 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 2003 through 2007.

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.

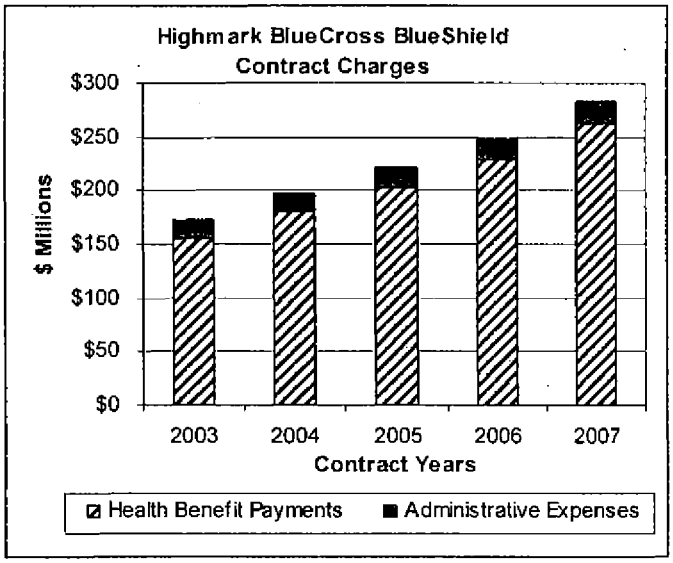

Figure 1 – Contract Charges

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 offices in Camp Hill, Pennsylvania from October 27 through November 21, 2008 and December 8 through December 19, 2008. Audit fieldwork was also performed at our offices in Washington, D.C. and Cranberry Township, Pennsylvania.

METHODOLOGY

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

To test the Plan's compliance with the FEHBP health benefit provisions, we selected and reviewed samples of 412 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 178 health benefit refunds, totaling $1,928,743 (from a universe of 39,181 refunds, totaling $7,627,190); 47 provider audit recoveries, totaling $657,157 (from a universe of 394 provider audit recoveries, totaling $932,776); 30 Special Plan Invoices, totaling $1,886,081 in net payments (from a universe of 369 Special Plan Invoices, totaling $4,375,055 in net payments); 10 subrogation recoveries, totaling $122,994 (from a universe of 228 subrogation recoveries, totaling $324,850); 6 hospital settlements, totaling $1,127,147 in payments (from a universe of 183 hospital settlements, totaling $2,007,589 in net payments); and 5 fraud recoveries, totaling $11,423 (from a universe of 24 fraud recoveries, totaling $13,357), to determine if refunds and recoveries were promptly returned to the FEHBP and if miscellaneous payments were properly charged to the FEHBP. In addition, we judgmentally selected and reviewed 6 health benefit refunds and recoveries, totaling $1,281,590 (from a universe of 105 refunds and recoveries, totaling $1,703,949) from the Plan's December 2007 refund aging report. The results of these samples were not projected to the universe of miscellaneous payments and credits.

We judgmentally reviewed administrative expenses charged to the FEHBP for contract years 2003 through 2007. 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, Association dues, inter-company profits, nonrecurring projects, return on investment, subcontracts, 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 "System Review" (A1.a), "Omnibus Budget Reconciliation Act of 1990 Review" (A1.b), "Amount Paid Greater than Covered Charges" (A1.c), and "Assistant Surgeon Review" (A1.d) on pages 6 through 13 for specific details of our sample selection methodologies.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. HEALTH BENEFIT CHARGES

1. Claim Payments

a. System Review $437,154

The Plan incorrectly paid five claims, resulting in net overcharges of $437,154 to the FEHBP. Specifically, the Plan overpaid four claims by $441,272 and underpaid one claim by $4,118.

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 prompt and diligent effort to recover the erroneous payment . . . ."

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, other group health benefits coverages, and the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. (b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary carrier . . . ."

For health benefit claims reimbursed during the period January 1, 2007 through December 31, 2007, we identified 3,205,763 claim lines, totaling $213,211,574 in payments, using a standard criteria based on our audit experience. From this universe, we selected and reviewed a judgmental sample of 125 claims (representing 827 claim lines), totaling $5,725,164 in payments, to determine if the Plan adjudicated these claims properly.[3] Our review identified five claim payment errors, resulting in net overcharges of $437,154 to the FEHBP. Specifically, the Plan overpaid four claims by $441,272 and underpaid one claim by $4,118.

The claim payment errors resulted from the following:

- The Plan did not properly coordinate one claim with Medicare, resulting in an overcharge of $432,173 to the FEHBP.

[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 did not properly coordinate two claims with the patient's primary insurance carrier, resulting in overcharges of $8,937 to the FEHBP.

- The Plan paid two claims at total billed charges instead of applying the applicable contract rates, resulting in net undercharges of $3,956 to the FEHBP. Specifically, the Plan overpaid one claim by $162 and underpaid one claim by $4,118.

Association's Response:

The Association agrees with this finding. The Association states that the Plan has recovered and returned $440,055 to the FEHBP as of February 20, 2009. Also, the Plan has made an adjustment to the claim that was underpaid and charged the FEHBP accordingly for the additional payment made to the provider.

The Plan is in the process of developing a training program specifically designed to address these errors. The Plan will conduct this training program in April or May 2009 depending on the availability of training resources.

Recommendation 1

We recommend that the contracting officer disallow $441,272 for claim overcharges, and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 2

We recommend that the contracting officer allow the Plan to charge the FEHBP $4,118 for the claim undercharge, and verify that that the Plan made an additional payment to the provider.

b. Omnibus Budget Reconciliation Act of 1990 Review **$196,264**

The Plan incorrectly paid 24 claims that were priced or potentially should have been priced under the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) pricing guidelines, resulting in net overcharges of $196,264 to the FEHBP. Specifically, the Plan overpaid 20 claims by $212,087 and underpaid 4 claims by $15,823.

As previously cited from 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 prompt and diligent effort to recover the overpayments. Also, the Plan must coordinate the payment of benefits with Medicare.

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 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 861 claims, totaling $6,928,947 in payments, that were subject to OBRA 90 pricing guidelines. From this universe, we selected and reviewed a judgmental sample of 101 claims, totaling $3,037,198 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 $12,500 or more.

Based on our review, we determined that 12 of these claims were paid incorrectly, resulting in net overcharges of $171,460 to the FEHBP. Specifically, the Plan overpaid 11 claims by $176,451 and underpaid 1 claim by $4,991.

These claim payment errors resulted from the following:

- The Plan incorrectly bundled claim lines for six claims, resulting in overcharges of $157,319 to the FEHBP.

- The FEP Operations Center priced three claims using incorrect Medicare provider numbers, resulting in overcharges of $17,260 to the FEHBP.

- The Plan priced one claim using a per diem rate of $963 instead of a per diem rate of $900, resulting in an overcharge of $1,116 to the FEHBP.

- The Plan did not properly coordinate one claim with Medicare, resulting in an overcharge of $756 to the FEHBP.

- In one instance, the Plan inadvertently did not use the per diem pricing method to price the claim, resulting in an undercharge of $4,991 to the FEHBP.

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

For the period 2005 through 2007, we identified 589 claims, totaling $952,974 in payments, that were potentially subject to OBRA 90 pricing guidelines but appeared to be paid under the Plan's standard pricing procedures. From this universe, we selected and reviewed a judgmental sample of 54 claims, totaling $741,717 in payments, to determine if the Plan paid these claims properly. Our sample included all possible OBRA 90 claims with amounts paid of $2,500 or more.

Based on our review, we determined that 12 of these claims were paid incorrectly, resulting in net overcharges of $24,804 to the FEHBP. Specifically, the Plan overpaid nine claims by $35,636 and underpaid three claims by $10,832.

These claim payment errors resulted from the following:

- The Plan did not properly coordinate five claims with Medicare, resulting in overcharges of $23,028 to the FEHBP.

- The Plan paid five claims using incorrect pricing rates, resulting in net overcharges of $7,540 to the FEHBP. Specifically, the Plan overpaid four claims by $12,608 and underpaid one claim by $5,068.

- The Plan inadvertently did not price two claims under OBRA 90, resulting in undercharges of $5,764 the FEHBP.

Association's Response:

The Association agrees with this finding. The Association states that the Plan has recovered and returned $192,692 to the FEHBP as of February 20, 2009. Also, the Plan has made adjustments to the claims that were underpaid and charged the FEHBP accordingly for the additional payments made to the providers.

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.

The Association states, "The Plan identified the root cause as stemming from manual processing errors and incorrect data on its provider file. The provider file was corrected in July 2008.

In addition to these controls, the Plan has other methods in place to identify overpayments. These methods include, but are not limited to, System-Wide Claims Reports, COB Claims Reports and Duplicate Claims Reports provided by the FEP

Director's Office and worked by the Plan, as well as routine claims quality assurance audits performed by the Plan's Performance Measurement and Reporting Department. While these measures are not absolute, they provide reasonable assurances that such items will be identified. Efforts will be made to periodically examine existing procedures and add additional controls where necessary. . . .

Further, the FEP Director's Office has implemented the following action steps to reduce OBRA '90 questioned items:

- 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; and

- Modified 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."

Recommendation 3

We recommend that the contracting officer disallow $212,087 for claim overcharges, and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 4

We recommend that the contracting officer allow the Plan to charge the FEHBP $15,823 for the claim undercharges, and verify that that the Plan made additional payments to the providers.

c. Amounts Paid Greater than Covered Charges $177,193

The Plan incorrectly paid eight claims, resulting in overcharges of $177,193 to the FEHBP.

As previously cited from 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 prompt and diligent effort to recover the overpayments.

For the period 2005 through 2007, we identified 584 claims where the amounts paid were greater than the covered charges by a total of $2,624,294. From this universe, we selected and reviewed a judgmental sample of 93 claims with a total variance of $2,473,215, and determined if the Plan adjudicated these claims properly. Our sample included all claims where the amounts paid exceeded covered charges by $2,500 or more. Based on our review, we determined that eight claims were paid incorrectly, resulting in overcharges of $177,193 to the FEHBP.

The claim payment errors resulted from the following reasons:

- In two instances, providers submitted inaccurate claims, resulting in overcharges of $113,701 to the FEHBP. Subsequently, the providers identified this oversight and submitted revised claims for processing and payment on February 23, 2008 and June 13, 2008. The Plan voided the inaccurate claims on June 13, 2008 and July 10, 2008. However, since these errors were corrected by the Plan after receiving our audit sample on May 6, 2008, we are continuing to question these claim payment errors in the final report.

- The Plan incorrectly paid six claims, resulting in overcharges of $63,492 to the FEHBP. These overcharges were due to the Plan's processors erroneously adjusting four claims that were correctly priced and paid, entering an incorrect per diem rate for one claim, and using an incorrect pricing method for one claim.

Association's Response:

The Association agrees with this finding. The Association states that the Plan has recovered the overpayments and returned $177,193 to the FEHBP.

The Association also states that the Plan identified the root cause as stemming from manual processing errors and inaccurate provider claims submission. The Plan is in the process of developing a training program specifically designed to address these errors. The Plan will conduct this training program in April or May 2009 depending on the availability of training resources.

Recommendation 5

We recommend that the contracting officer disallow $177,193 for claim overcharges, and verify that the Plan has returned all amounts recovered to the FEHBP.

d. Assistant Surgeon Review **$13,903**

The Plan incorrectly paid 12 claims, resulting in net overcharges of $13,903 to the FEHBP. Specifically, the Plan overpaid 10 claims by $14,541 and underpaid 2 claims by $638.

As previously cited from 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 prompt and diligent effort to recover the overpayments.

For the period 2005 through 2007, we identified 3,169 assistant surgeon claim groups, totaling $242,382 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 28 assistant surgeon claim groups,

totaling $41,702 in potential overpayments, to determine if the Plan paid these claims properly. Our sample included all assistant surgeon claim groups with potential overpayments of $500 or more. The majority of these claim groups contained one primary surgeon and one assistant surgeon claim.

Based on our review, we determined that 12 claims were paid incorrectly, resulting in net overcharges of $13,903 to the FEHBP. Specifically, the Plan overpaid 10 claims by $14,541 and underpaid 2 claims by $638.

The claim payment errors resulted from the following:

- The Plan incorrectly paid six assistant surgeon claims, resulting in overcharges of $12,812 to the FEHBP. These overcharges were due to processor errors in the calculation of the assistant surgeon or physician assistant fees, which should have been priced at 20 percent of the primary surgeon allowed amount.

- The Plan incorrectly paid four claims that were subject to the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) pricing guidelines, resulting in overcharges of $1,729 to the FEHBP.

  - Two of the claims were paid in error due to a Palmetto (OBRA 93 pricing vendor) claims processing system error that caused an incorrect calculation of the assistant surgeon fee for claims containing assistant surgeon pricing modifier "82". These assistant surgeon claims should have been priced according to the Medicare fee schedule (16 percent of the primary surgeon fee). Consequently, the Plan overpaid these claims by $1,623.

    We noted that the FEP Director's Office issued a memorandum instructing BCBS plans of the steps to take to identify and correct claims affected by this system error. Also, the system error has been corrected as of February 12, 2005. Therefore, we did not review this issue any further.

  - Two of the claims were paid in error due to Palmetto not recognizing the physician assistant pricing modifier "AS" and erroneously calculating the physician assistant fee. These physician assistant claims should have been priced according to the Medicare fee schedule (13.6 percent of the primary surgeon fee). Consequently, the Plan overpaid these claims by $106.

- In one instance, the Plan used an incorrect fee schedule amount, resulting in an undercharge of $272 to the FEHBP.

- In one instance, the Plan paid the primary surgeon claim lines but did not pay the assistant surgeon claim lines, resulting in an undercharge of $366 to the FEHBP.

Association's Response:

The Association agrees with this finding. The Association states that the Plan has recovered and returned all the overpayments to the FEHBP.

The Association states, "The Plan identified the root cause of these errors as stemming from manual processing errors and a Palmetto (the OBRA '93 pricing vendor used by the Program) claims processing system error.

The FEP Director's Office has implemented the following controls to minimize future payment errors related to Assistant Surgeon claims:

- Modified its contract with Palmetto to include the pricing of AS modifier claims; and

- A final comprehensive listing that identifies all unadjusted OBRA '93 Assistant Surgeon claims with the AS Modifier was issued to all Plans on the January 2009 System-wide Claims Review listing so that claims could be adjusted as necessary.

In addition to these controls, the Plan has other methods in place to identify overpayments. These methods include, but are not limited to: System-Wide Claims Reports . . . provided by the FEP Director's Office and worked by the Plan as well as routine claims quality assurance audits performed by the Plan's Performance Measurement and Reporting Department. While these measures are not absolute, they provide reasonable assurances that such items will be identified. Efforts will be made to periodically examine existing procedures and add additional controls where necessary."

Recommendation 6

We recommend that the contracting officer disallow $14,541 for claim overcharges, and verify that the Plan has returned all amounts recovered to the FEHBP.

Recommendation 7

We recommend that the contracting officer allow the Plan to charge the FEHBP $638 if additional payments are made to the providers to correct the underpayment errors.

2. Miscellaneous Payments and Credits

a. Review of Refund Aging Report — $26,571

The Plan had not returned a provider audit recovery amount of $25,483 to the FEHBP as of November 19, 2008.[4] Subsequent to this date, the Plan returned $26,571 to the FEHBP, consisting of $25,483 for the provider audit recovery and $1,088 for LII on this recovery.

48 CFR 31.201-5 states, "The applicable portion of any income, rebate, allowance, or other credit relating to any allowable cost and received by or accruing to the contractor shall be credited to the Government either as a cost reduction or by cash refund."

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.

48 CFR 52.232-17(a) states, "all amounts that become payable by the Contractor . . . shall bear simple interest from the date due . . . The interest rate shall be the interest rate established by the Secretary of the Treasury as provided in Section 611 of the Contract Disputes Act of 1978 (Public Law 95-563), which is applicable to the period in which the amount becomes due, as provided in paragraph (e) of this clause, and then at the rate applicable for each six-month period as fixed by the Secretary until the amount is paid."

We reviewed the Plan's "Not Fully Allocated Aging Report" for the year ending 2007. This report included 105 recoveries, totaling $1,703,949, which were researched to determine if the recoveries belonged to FEP or another line of business. From this universe, we judgmentally selected a sample of six recoveries, totaling $1,281,590, for the purpose of determining if the recoveries belonged to the FEP. Our sample included the six highest dollar recovery amounts.

Based on our review, we determined that the Plan had not returned one recovery to the FEHBP. The Plan received a provider audit recovery of $690,206 on December 19, 2007. As of the date of our audit sample (November 19, 2008), the Plan had not returned FEP's portion of this recovery to the FEHBP. Subsequently, the Plan returned $25,483 to the FEHBP for this provider audit recovery on November 24, 2008 (11 months after receiving the recovery). On this date, the Plan also transferred $1,088 into the dedicated FEP bank account for LII on this recovery. Based on our review of the Plan's LII calculation, we agree with the amount determined by the Plan and will not assess additional LII.

[4] We submitted our audit sample to the Plan on November 19, 2008. As of this date, the Plan had not returned this recovery to the FEHBP.

Association's Response:

The Association agrees with this finding. The Association states that the Plan deposited the principal amount of $25,483 into the dedicated FEP bank account on November 24, 2008 and returned the funds to the FEHBP with a reduction to the letter of credit account (LOCA) drawdown on November 24, 2008.

The Association also states that the Plan transferred the corresponding LII of $1,088 into the dedicated FEP bank account on November 24, 2008. In addition, the Plan submitted a Special Plan Invoice for the LII on December 22, 2008 and wire transferred the LII to the Association on January 6, 2009.

Recommendation 8

We verified that the Plan returned $25,483 to the FEHBP on November 24, 2008 for this provider audit recovery. Therefore, no further action is required for this questioned amount.

Recommendation 9

Since we only verified that the Plan transferred the LII into the dedicated FEP bank account on November 24, 2008, we recommend that the contracting officer verify that the Plan returned the questioned LII of $1,088 to the LOCA.

b. Provider Audit Recoveries **$21,801**

The Plan did not recover and return two provider overpayments to the FEHBP. As a result, the FEHBP is due $21,801 for these provider overpayments.

As previously cited from FAR, the Plan is required to return any income, rebate, allowance, or other credit relating to any allowable cost and received by or accruing to the Plan.

Contract CS 1039, Part I, section 1.9 (f)(3) states that the Plan has an average of 30 working days to commence overpayment collection action against a provider following identification of an overpayment.

For the period 2003 through 2007, there were 394 provider audit recoveries totaling $932,776. From this universe, we selected a judgmental sample of 47 provider audit recoveries, totaling $657,157, for the purpose of determining if the Plan returned these recoveries to the FEHBP in a timely manner. Our sample included all provider audit recoveries of $5,000 or more.

For two of the provider audit recoveries in our sample, the Plan could not provide documentation to support the recovery and return of these funds to the FEHBP. After further research, we found that the Plan made adjustments to the applicable claims to initiate the provider offset process, but the adjustments were performed incorrectly. Due to the manual processing errors on these claim adjustments, the offsets were not initiated and the providers were not notified to repay the debt. When the erroneous adjustments were made, information was given to the provider audit vendor showing that the recoupment process was underway. As a result, the vendor updated its system to note that the funds had been recovered, when in fact the funds had not been recovered.

Consequently, these two provider overpayments, totaling $21,801, were not recovered and returned to the FEHBP. Since these exceptions were isolated cases and the Plan did not have possession of the funds, we did not assess LII on this questioned amount.

Association's Response:

The Association agrees with this finding. The Association states, "Both erroneous adjustments were made in 2004. Due to the age of the adjustments on the claims in question, a decision was made not to pursue repayments from the facilities, but instead credit the FEHBP for these Provider Audit Recoveries with Highmark funds. No lost investment income was assessed because the Plan never received these refunds from the providers."

The Plan returned these funds to the FEHBP on March 10, 2009.

Recommendation 10

We recommend that the contracting officer verify that the Plan credited the FEHBP $21,801 for provider overpayments.

B. ADMINISTRATIVE EXPENSES

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

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 findings pertaining to cash management noted in the "Miscellaneous Payments and Credits" section.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Experience-Rated Audits Group

[redacted] Lead Auditor

[redacted] Auditor

[redacted] Auditor

[redacted] Auditor

[redacted] Chief [redacted]

[redacted] Senior Team Leader

SCHEDULE A

V. SCHEDULES

HIGHMARK BLUECROSS BLUESHIELD
CAMP HILL, PENNSYLVANIA

CONTRACT CHARGES AND AMOUNTS QUESTIONED

CONTRACT CHARGES*	2003	2004	2005	2006	2007	TOTAL
A. HEALTH BENEFIT CHARGES						
PLAN CODE 363	$35,070,988	$42,945,199	$44,627,275	$45,591,795	$52,620,478	$220,855,735
MISCELLANEOUS PAYMENTS	148,310	513,138	501,646	468,553	394,221	2,025,868
PLAN CODE 865	118,231,737	135,920,441	157,896,030	181,801,946	207,994,644	801,844,798
MISCELLANEOUS PAYMENTS	1,195,177	358,363	(312,172)	202,987	736,520	2,180,875
TOTAL	$[redacted]	$179,737,141	$[redacted]	$[redacted]	$[redacted]	$1,026,907,276
B. ADMINISTRATIVE EXPENSES						
PLAN CODE 865	$17,561,498	$17,163,115	$17,984,668	$20,227,752	$22,339,246	$95,276,279
PRIOR PERIOD ADJUSTMENTS	0	0	(18,981)	(34,559)	(246,597)	(300,137)
BUDGET SETTLEMENT REDUCTION	0	(17,161)	0	0	0	(17,161)
TOTAL	$17,561,498	$17,145,954	$17,965,687	$20,193,193	$22,092,649	$94,958,981
TOTAL CONTRACT CHARGES	$172,207,710	$196,883,095	$220,678,466	$248,258,474	$283,838,512	$1,121,866,257

AMOUNTS QUESTIONED (PER SCHEDULE B)	2003	2004	2005	2006	2007	TOTAL
A. HEALTH BENEFIT CHARGES	$0	$21,801	$101,650	$10,191	$739,244	$872,886
B. ADMINISTRATIVE EXPENSES	0	0	0	0	0	0
C. CASH MANAGEMENT	0	0	0	0	0	0
TOTAL QUESTIONED CHARGES	$0	$21,801	$101,650	$10,191	$739,244	$872,886

* We did not review claim payments for contract years 2003 and 2004.

SCHEDULE B

HIGHMARK BLUECROSS BLUESHIELD
CAMP HILL, PENNSYLVANIA

QUESTIONED CHARGES

AUDIT FINDINGS	2003	2004	2005	2006	2007	TOTAL
A. HEALTH BENEFIT CHARGES						
1. Claim Payments						
a. System Review	$0	$0	$0	$0	$437,154	$437,154
b. Omnibus Budget Reconciliation Act of 1990 Review	0	0	99,141	(3,720)	100,843	196,264
c. Amounts Paid Greater than Covered Charges	0	0	0	6,800	170,393	177,193
d. Assistant Surgeon Review	0	0	2,509	7,111	4,283	13,903
Total Claim Payments	$0	$0	$101,650	$10,191	$712,673	$824,514
2. Miscellaneous Payments and Credits						
a. Review of Refund Aging Report*	$0	$0	$0	$0	$26,571	$26,571
b. Provider Audit Recoveries	$0	$21,801	$0	$0	$0	$21,801
Total Miscellaneous Payments and Credits	$0	$21,801	$0	$0	$26,571	$48,372
TOTAL HEALTH BENEFIT CHARGES	$0	$21,801	$101,650	$10,191	$739,244	$872,886
B. ADMINISTRATIVE EXPENSES	$0	$0	$0	$0	$0	$0
C. CASH MANAGEMENT	$0	$0	$0	$0	$0	$0
TOTAL QUESTIONED CHARGES	$0	$21,801	$101,650	$10,191	$739,244	$872,886

* This finding includes lost investment income of $1,088 calculated in 2008.

APPENDIX

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

April 10, 2009

[redacted] Group Chief
Experience-Rated Audits Group
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Reference: **OPM DRAFT AUDIT REPORT**
Highmark Inc.
Audit Report Number 1A-10-13-09-001
(Dated and received February 5, 2009)

Dear [redacted]

This is our response to the above-referenced U.S. Office of Personnel Management (OPM) Draft Audit Report covering the Federal Employees' Health Benefits Program (FEHBP) operations for Highmark. Our comments concerning the findings in the report are as follows:

A. HEALTH BENEFIT CHARGES

1. Claim Payments

a. System Review $437,154

The Plan does not contest that a net of $437,154 in claim payments were paid in error. As of February 20, 2009, $440,055 of overpayments have been recovered and returned to the Program through normal business processes. Adjustments to claims that were underpaid have been processed and the additional payments have been charged appropriately. It should be noted that one error accounted for $432,173 of the overpayment error. This error occurred because Highmark was not informed that Medicare was the primary payer until nearly a year after the claim was processed. Highmark processes claims based on information on hand at the time the claim is processed. The balance of the errors occurred because of manual processing errors. The Plan is in the process of developing a training Program specifically designed to address these errors as well as any other remedial opportunities that are identified between now and the training delivery date. The Program will be conducted between late April, 2009 and early May, 2009, depending on the availability of training resources.

b. Omnibus Budget Reconciliation Act of 1990 Review $196,264

The Plan does not contest that $196,264 in claim payments were paid in error. As of February 20, 2009, $192,692 of overpayments have been recovered and returned to the Program via normal business processes. Adjustments to claims that were underpaid have been processed appropriately. The Plan identified the root cause as stemming from manual processing errors and incorrect data on its provider file. The provider file was corrected in July 2008.

In addition to these controls, the Plan has other methods in place to identify overpayments. These methods include, but are not limited to, System-Wide Claims Reports, COB Claims Reports and Duplicate Claims Reports provided by the FEP Director's Office and worked by the Plan, as well as routine claims quality assurance audits performed by the Plan's Performance Measurement and Reporting Department. While these measures are not absolute, they provide reasonable assurances that such items will be identified. Efforts will be made to periodically examine existing procedures and add additional controls where necessary. Accordingly, to the extent that errors did occur, the payments are good faith erroneous benefit 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.

Further, the FEP Director's Office has implemented the following action steps to reduce OBRA '90 questioned items:

- 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; and

- Modified 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;

c. **Amounts Paid Greater than Covered Charges** **$177,193**

The Plan does not contest that $177,193 in claim payments were paid in error. The Plan reported that the entire $177,193 has been recovered and returned to the Program via normal business processes. The Plan identified the root cause as stemming from manual processing errors and inaccurate provider claims submission. The Plan is in the process of developing a training Program specifically designed to address these errors as well as any other remedial opportunities that are identified between now and the training delivery date. The Program will be between late April, 2009 and early May, 2009 , depending on the availability of training resources.

d. **Assistant Surgeon Review** **$ 13,903**

The Plan does not contest that $13,903 in claim payments were paid in error. The Plan reported that all overpayments have been recovered and returned to the Program via normal business processes. The Plan identified the root cause of these errors as stemming from manual processing errors and a Palmetto (the OBRA '93 pricing vendor used by the Program) claims processing system error.

The FEP Director's Office has implemented the following controls to minimize future payment errors related to Assistant Surgeon claims:

- Modified its contract with Palmetto to include the pricing of AS modifier claims; and

- A final comprehensive listing that identifies all unadjusted OBRA '93
- Assistant Surgeon claims with the AS Modifier was issued to all Plans on the January 2009 System-wide Claims Review listing so that claims could be adjusted as necessary.

In addition to these controls, the Plan has other methods in place to identify overpayments. These methods include, but are not limited to: System-Wide Claims Reports, COB Claims Reports and Duplicate Claims Reports provided by the FEP Director's Office and worked by the Plan as well as routine claims quality assurance audits performed by the Plan's Performance Measurement and Reporting Department. While these measures are not absolute, they provide reasonable assurances that such items will be identified. Efforts will be made to periodically examine existing procedures and add additional controls where necessary. Accordingly, to the extent that errors did occur, the payments are good faith erroneous benefit 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. **Review of Refund Aging Report** **$ 26,571**

   The Plan does not contest this finding. On November 24, 2008, the Plan deposited the principal amount of $25,483 into its dedicated FEP bank account. On November 24, 2008, the Plan returned the funds to the FEHBP with a reduction in the Letter of Credit Account (LOCA) drawdown.

   In addition, the Plan transferred the corresponding lost investment income (LII) of $1,088 into its dedicated FEP bank account on November 24, 2008. The Plan also submitted a Special Plan Invoice for the LII on December 22, 2008 and wired the LII to the Blue Cross Blue Shield Association on January 6, 2009. The Association received those funds on the same day.

   b. **Provider Audit Recoveries** **$ 21,801**

   The Plan does not contest this finding. Both erroneous adjustments were made in 2004. Due to the age of the adjustments on the claims in question, a decision was made not to pursue repayments from the facilities, but instead credit the FEHBP for these Provider Audit Recoveries with Highmark funds. No lost investment income was assessed because the Plan never received these refunds from the providers.

   The Plan returned these funds to the Program via an adjustment to its LOCA on March 10, 2009.

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.

[redacted]
Executive Director
Program Integrity

[redacted]

cc: [redacted]