



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

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# Final Audit Report

Subject:

**AUDIT OF COVENTRY HEALTH CARE  
AS UNDERWRITER AND ADMINISTRATOR FOR THE  
MAIL HANDLERS BENEFIT PLAN  
ROCKVILLE, MARYLAND**

Report No. 1B-45-00-09-062

Date: April 14, 2010

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Office of the  
Inspector General

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT  
Washington, DC 20415

**AUDIT REPORT**

Federal Employees Health Benefits Program  
Employee Organization Plan

Coventry Health Care  
as Underwriter and Administrator for the  
Mail Handlers Benefit Plan

Contract CS 1146

Plan Codes 45 and 48

Rockville, Maryland

REPORT NO. 1B-45-00-09-062

DATE: April 14, 2010

A handwritten signature in black ink, appearing to read "Michael R. Esser".

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  
Employee Organization Plan

Coventry Health Care  
as Underwriter and Administrator for the  
Mail Handlers Benefit Plan

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Contract CS 1146                      Plan Codes 45 and 48  
Rockville, Maryland

REPORT NO. 1B-45-00-09-062                      DATE: April 14, 2010

This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at Coventry Health Care (Plan), as underwriter and administrator for the Mail Handlers Benefit Plan, questions \$2,300,076 in health benefit charges. The Plan agreed (**A**) with the questioned charges.

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covered claim payments from October 1, 2007 through August 31, 2008.

Questioned health benefit charges are summarized as follows:

- **Coordination of Benefits with Medicare (A)** **\$1,614,575**

The Plan incorrectly paid 2,237 claim lines, resulting in overcharges of \$1,614,575 to the FEHBP. Specifically, the Plan did not properly coordinate 2,195 claim line payments with Medicare as required by the FEHBP contract. As a result, the FEHBP paid as the primary insurer for these claims when Medicare was the primary insurer. Therefore, we estimate that the FEHBP was overcharged by \$1,594,882 for these 2,195 claim lines. The remaining 42 claim line payments were not coordination of benefit errors but contained other Plan payment errors, resulting in overcharges of \$19,693 to the FEHBP.

- **Claims Paid for Ineligible Patients (A)** **\$509,559**

The Plan paid 770 claims that were incurred during gaps in patient coverage or after termination of patient coverage with the Mail Handlers Benefit Plan, resulting in overcharges of \$469,782 to the FEHBP. In addition, the Plan paid 165 claims for patients with no enrollment identification numbers, resulting in overcharges of \$39,777 to the FEHBP. In total, the FEHBP is due \$509,559 for these claim overcharges.

- **Duplicate Claim Payments (A)** **\$175,942**

During our review of potential duplicate claim payments, we found that the Plan incorrectly paid 174 claims, resulting in net overcharges of \$175,942 to the FEHBP. Specifically, we determined that the Plan improperly charged the FEHBP \$169,305 for 164 duplicate claim payments. Also, we identified 10 claims that were not duplicate claim payments but contained other Plan payment errors, resulting in net overcharges of \$6,637 to the FEHBP. In total, the Plan overpaid 173 claims by \$176,917 and underpaid 1 claim by \$975.

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# **I. INTRODUCTION AND BACKGROUND**

## **INTRODUCTION**

This final audit report details the findings, conclusions, and recommendations resulting from our limited scope audit of the Federal Employees Health Benefits Program (FEHBP) operations at Coventry Health Care (Plan) as underwriter and administrator for the Mail Handlers Benefit Plan (MHBP). The Plan is located in Rockville, Maryland.

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

MHBP is an experience-rated employee organization plan offering health care benefits to its subscribers. MHBP is open to all Federal employees and annuitants who are eligible to enroll in the FEHBP and who are, or become, members or associate members of the National Postal Mail Handlers Union (Union). The Union is the sponsor of the MHBP, operating under Contract CS 1146 to provide a health benefits plan authorized by the FEHB Act. During 2007, the Union had the following contractual arrangement with affiliates of Coventry Health Care:

- First Health Life and Health Insurance Company and Cambridge Life Insurance Company to underwrite the MHBP;
- Claims Administration Corp to perform the administrative functions; and
- First Health Group Corporation to provide pharmacy benefit management and health benefit services.

During 2008, these contractual arrangements remained the same, except for Coventry Health Care National Accounts assuming the responsibility of providing the health benefit services.

The MHBP's contract (CS 1146) with OPM is experience-rated. Thus, the costs of providing service benefits in the prior years are reflected in current and future year's premium rates. In addition, the contract provides that in the event of termination, unexpended program funds revert to the Federal Government (FEHBP Trust Fund). In recognition of these provisions, the contract requires an accounting of program funds to be submitted at the end of each contract year. The accounting is made on a statement of operations known as the Annual Accounting Statement.

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

Findings from our previous audit of the Plan (Report No. 1B-45-00-08-016, dated March 26, 2009) for contract years 2002 through 2006 (2005 through September 30, 2007 for claim payments) are in the process of being resolved.

The results of this audit were provided to the Plan in written audit inquiries and were discussed with Plan officials throughout the audit and at an exit conference. The Plan's comments offered in response to our audit inquiries were considered in preparing our final report and are included as Appendices to this report. Since the Plan agreed with our audit inquiries, we bypassed the draft report and only issued a final report. The Plan agreed with this decision.

## **II. OBJECTIVES, SCOPE, AND METHODOLOGY**

### **OBJECTIVES**

The objectives of this audit were to determine whether the Plan complied with contract provisions relative to coordination of benefits, duplicate payments, and patient enrollment eligibility.

### **SCOPE**

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

We reviewed the MHBP's FEHBP Annual Accounting Statements for contract years 2007 and 2008. During this period, the Plan paid approximately \$3.5 billion in health benefit charges (See Schedule A). Specifically, we reviewed approximately \$16 million in claim payments made from October 1, 2007 through August 31, 2008 for coordination of benefits, duplicate payments and patient enrollment eligibility.<sup>1</sup>

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.

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.

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<sup>1</sup> Effective September 1, 2008, the Plan started processing the claims for the Mail Handlers Benefit Plan on a different claims system (Coventry Health Care's IDX claims system). This audit is a close-out of the claims that were processed on Coventry Health Care's previous claims system.



In conducting our audit, we relied to varying degrees on computer-generated data provided by the Plan. 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 our office in Cranberry Township, Pennsylvania from September 1, 2009 through February 17, 2010.

The Plan did a great job supporting our audit and promptly responded to our questions, samples, information requests, and audit inquiries. Also, the Plan was very cooperative and well prepared for our audit.

### **METHODOLOGY**

We obtained an understanding of the internal controls over the Plan's claims processing system by inquiry of Plan officials.

To test the Plan's compliance with the FEHBP health benefit provisions, we selected and reviewed samples of 25,279 claims.<sup>2</sup> We used the FEHBP contract, the benefit plan brochure, and the Plan's provider agreements to determine the allowability of benefit payments. The results of these samples were not projected to the universe of claims.

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<sup>2</sup> See the audit findings for "Coordination of Benefits with Medicare" (A1), "Claims Paid for Ineligible Patients" (A2), and "Duplicate Claim Payments" (A3) on pages 5 through 13 for specific details of our sample selection methodologies.

### **III. AUDIT FINDINGS AND RECOMMENDATIONS**

#### **A. HEALTH BENEFIT CHARGES**

##### **1. Coordination of Benefits with Medicare**

**\$1,614,575**

The Plan incorrectly paid 2,237 claim lines, resulting in overcharges of \$1,614,575 to the FEHBP. Specifically, the Plan did not properly coordinate 2,195 claim line payments with Medicare as required by the FEHBP contract. As a result, the FEHBP paid as the primary insurer for these claims when Medicare was the primary insurer. Therefore, we estimate that the FEHBP was overcharged by \$1,594,882 for these 2,195 claim lines. The remaining 42 claim line payments were not coordination of benefit errors but contained other Plan payment errors, resulting in overcharges of \$19,693 to the FEHBP.

The 2008 Mail Handlers Benefit Plan brochure, page 127, Primary Payer Chart, illustrates when Medicare is the primary payer. In addition, page 21 of that brochure states, “We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), regardless of whether Medicare pays.”

Contract CS 1146, Part II, section 2.6 states, “(a) The Carrier shall coordinate the payment of benefits under this contract with the payment of benefits under Medicare, . . . (b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary carrier . . . .” Also, Part III, section 3.2 (b)(1) states, “The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable . . . .”

In addition, Contract CS 1146, Part II, section 2.3(g) states, “If the Carrier or OPM determines that a Member’s claim has been paid in error for any reason . . . the Carrier shall make a prompt and diligent effort to recover the erroneous payment . . . .”

For claims incurred and paid from October 1, 2007 through August 31, 2008, we performed a computer search and identified 103,145 claim lines, totaling \$8,223,759 in payments that potentially were not coordinated with Medicare. From this universe, we selected for review a sample of 25,783 claim lines, totaling \$5,061,941 in payments, to determine whether the Plan complied with the contract provisions relative to coordination of benefits (COB) with Medicare. When we submitted our sample of potential COB errors to the Plan on June 15, 2009, the claims were within the Medicare timely filing requirement and could be filed with Medicare for coordination of benefits.

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

Claim Type	Claim Lines	Amounts Paid	Sample Selection Methodology
Medicare Part A Primary for Inpatient (I/P) Facility	267	\$1,690,730	Patients with cumulative claims of \$1,000 or more
Medicare Part A Primary for Skilled Nursing, Home Health Care (HHC), and Hospice Care	318	\$455,367	Patients with cumulative claims of \$1,000 or more
Medicare Part B Primary for Certain I/P Facility Charges	48	\$362,169	Patients with cumulative claims of \$2,500 or more
Medicare Part B Primary for Skilled Nursing, HHC, and Hospice Care	0	\$0	The potential COB errors were immaterial. Therefore, no claim lines were selected.
Medicare Part B Primary for Outpatient Charges	705	\$542,652	Patients with cumulative claims of \$1,000 or more
Medicare Part B Primary for Professional Charges	24,445	\$2,011,023	Patients with cumulative claims of \$1,000 or more
Total	25,783	\$5,061,941	

Generally, Medicare Part A covers 100 percent of inpatient care in hospitals, skilled nursing facilities, hospice care, and home health care. For each Medicare Benefit Period, there is a one-time deductible, followed by a daily copayment beginning with the 61<sup>st</sup> day. Beginning with the 91<sup>st</sup> day of the Medicare Benefit Period, Medicare Part A benefits may be exhausted, depending on whether the patient elects to use their Lifetime Reserve Days. For the uncoordinated Medicare Part A claims, we estimate that the FEHBP was overcharged for the total claim payment amounts.

Medicare Part B pays 80 percent of most outpatient charges and professional claims after the calendar year deductible has been met. Also, Medicare Part B covers a portion of inpatient facility charges for ancillary services such as durable medical equipment, medical supplies, diagnostic tests, and clinical laboratory services. Based on our experience, ancillary items account for approximately 30 percent of the total inpatient claim payment. Therefore, we estimate that the FEHBP was overcharged 25 percent for these inpatient claim lines ( $0.30 \times 0.80 = 0.24 \sim 25$  percent).

Based on our review of the potential COB errors in our sample, we identified 2,237 claim lines that were paid incorrectly, resulting in overcharges of \$1,614,575 to the FEHBP.<sup>3</sup>

<sup>3</sup> In addition, there were 234 claim lines, totaling \$167,237 in payments, with COB errors that were identified and adjusted by the Plan prior to receiving our sample of potential COB errors. Since these COB errors were identified and adjusted by the Plan prior to receiving our sample, we did not question these COB errors in the final report.

The following table details the questioned payments by claim type:

Claim Type	Claim Lines	Amounts Paid	Amounts Questioned
Medicare Part A Primary for I/P Facility	83	\$912,232	\$905,454
Medicare Part A Primary for Skilled Nursing, HHC, and Hospice Care	26	\$19,344	\$19,344
Medicare Part B Primary for Certain I/P Facility Charges	4	\$23,379	\$5,845
Medicare Part B Primary for Skilled Nursing, HHC, and Hospice Care	0	\$0	\$0
Medicare Part B Primary for Outpatient Charges	439	\$375,647	\$300,969
Medicare Part B Primary for Professional Charges	1,685	\$475,250	\$382,963
Total	2,237	\$1,805,852	\$1,614,575

Our audit disclosed the following for the claim payment errors:

- For 2,046 (91.5 percent) of the claim lines questioned, there was incorrect or no Medicare COB information on the Plan's claims system to identify Medicare as the primary payer when the claims were paid. However, when the correct Medicare COB information was subsequently added to the claims system, the Plan did not review and/or adjust the patient's prior claims back to the Medicare effective dates. As a result, we estimate that the FEHBP was overcharged \$1,534,326 for these claim lines that were not coordinated with Medicare.
- For 140 (6.3 percent) of the claim lines questioned, human processor errors caused improper coordination of the claim lines. As a result, we estimate that the FEHBP was overcharged \$56,202 for these claim lines that were not coordinated with Medicare.
- For 42 (1.8 percent) of the claim lines questioned, we found that these claim lines were not actually COB errors but contained other Plan payment errors. As a result, we determined that the FEHBP was overcharged \$19,693 for these claim payment errors.
- For nine (0.4 percent) of the claim lines questioned, various other errors caused the claim lines to be processed incorrectly. As a result, we estimate that the FEHBP was overcharged \$4,354 for these claim lines that were not coordinated with Medicare.

Of the \$1,614,575 in questioned charges, \$47,908, or 3 percent, were identified by the Plan prior to receiving our sample of potential COB errors on June 15, 2009. However, since the Plan had not completed the recovery process and/or adjusted these claims by June 15, 2009, we are continuing to question these COB errors. The remaining questioned charges of \$1,566,667 (97 percent) were identified as a result of our audit.

**Plan's Response:**

The Plan agrees with this finding and states that these payments were good faith erroneous benefit payments. The Plan promptly initiated efforts to recover these overpayments after determining that an error had occurred. Also, the recovery efforts are ongoing and comply with procedures outlined in the Plan's OPM-approved Overpayment Recovery Guidelines.

The Plan states that "the January 1, 2007-August 31, 2008 time period encompassed by this audit coincides with the time period in which the OIG conducted its audit of the MHBP resulting in its March 26, 2009, issuance of Final Audit Report No. 1B-45-00-08-16. That Report, in addition to containing a similar finding regarding Medicare COB, recommended that the MHBP 'ha[ve] procedures in place to review all claims incurred back to the Medicare effective dates when updated . . . and determine if already paid claims are affected.' The MHBP addressed that recommendation in detail with OPM's contracting office shortly after the OIG issued that Report, summarizing both the efforts it had taken to date and those it planned to implement in response to that recommendation. Please further be advised that in addition to those efforts outlined in that correspondence, the Plan (i) conducted intensive one-on-one training of claims examiners identified as having quality-related errors pertaining to Medicare COB . . . and (ii) provided formal classroom training on Medicare COB to all claims examiners . . . In sum, the Plan already has taken substantial steps towards reducing the frequency with which Medicare COB errors occur on a prospective basis."

**Recommendation 1**

We recommend that the contracting officer disallow \$1,594,882 for uncoordinated claim payments and verify that the Plan returns all amounts recovered to the FEHBP.

**Recommendation 2**

We recommend that the contracting officer disallow \$19,693 in claim overcharges resulting from other Plan payment errors and verify that the Plan returns all amounts recovered to the FEHBP.

## **2. Claims Paid for Ineligible Patients**

**\$509,559**

The Plan paid 770 claims that were incurred during gaps in patient coverage or after termination of patient coverage with the Mail Handlers Benefit Plan, resulting in overcharges of \$469,782 to the FEHBP. In addition, the Plan paid 165 claims for patients with no enrollment identification (ID) numbers, resulting in overcharges of \$39,777 to the FEHBP. In total, the FEHBP is due \$509,559 for these claim overcharges.

As previously cited from Contract CS 1146, 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.

### Enrollees with No Coverage during Dates of Service

We performed a computer search to identify claims that were incurred and paid during gaps in patient coverage or after termination of patient coverage with the Mail Handlers Benefit Plan. For the period October 1, 2007 through August 31, 2008, we identified claim payments, totaling \$10,733,291, for 3,075 patients that met this search criteria.

From this universe of 3,075 patients, we selected for review all patients with cumulative claims of \$5,000 or more. This sample included 7,917 claims, totaling \$9,113,744 in payments, for 261 patients. Our review of this sample identified 770 claims, totaling \$469,782 in payments, that were incurred and paid during gaps in patient coverage or after termination of coverage. As a result, the FEHBP is due \$469,782 for these improper payments.

### Patients with No Enrollment Record

We performed a computer search to identify claims incurred and paid for patients with no enrollment ID numbers. For the period October 1, 2007 through August 31, 2008, our search identified 5,049 claim payments, totaling \$1,449,750, for 518 patients with no enrollment ID numbers. We reviewed all claims for patients in this universe. Our review identified 165 claims, totaling \$39,777 in payments, that were made for patients with no enrollment ID number. As a result, the FEHBP is due \$39,777 for these payments.

### Summary of Claims Paid to Ineligible Patients

In total, the Plan charged the FEHBP \$509,559 for 935 claim payments made for ineligible patients. Our audit disclosed the following reasons for the errors:

- For 732 of the claims questioned, the Plan received retroactive termination of patient coverage from the Federal agency's payroll office. However, when the termination dates were subsequently received, the Plan did not review and/or adjust the patient's prior claims back to the termination date. As a result, the FEHBP was overcharged \$431,644 in claim payments for patients not eligible for benefits.

- For 201 of the claims questioned, there were various eligibility errors. For example, we identified multiple cases where the patient was not eligible for coverage due to loss in coverage from a divorce and the Plan erroneously paid these claims. As a result, the FEHBP was overcharged \$77,408 in claim payments for patients not eligible for benefits.
- For two of the claims questioned, the claim processors entered incorrect data. As a result, the FEHBP was overcharged \$507 in claim payments for patients not eligible for benefits.

**Plan's Response:**

The Plan agrees with this finding and states that these payments were good faith erroneous benefit payments made during gaps in member coverage or after termination of member coverage. The Plan initiated efforts to recover these overpayments in accordance with the procedures outlined in the Plan's OPM-approved Overpayment Recovery Guidelines.

The Plan states, "As with the OIG's prior inquiry, the MHBP observes that the January 1, 2007-August 31, 2008, time period encompassed by this audit coincides with the time period during which the OIG conducted its prior audit of the MHBP, the results of which are memorialized in the OIG's March 26, 2009, Final Audit Report No. 1B-45-00-08-16. That Report contains a finding similar in nature to the one proposed in this inquiry, together with a recommendation that the OPM Contracting Officer verify that the MHBP has procedures in place to identify and initiate efforts to recover post-termination benefit payments attributable to the aforementioned types of reporting delays. A comparison of the OIG's finding in that Report and its proposed finding here illustrates the existence and operation of those procedures: in that earlier Report, the OIG correctly identified 65% of the claim lines sampled as having been paid during a gap in the enrollee's coverage (10,275 out of 15,864 claim lines sampled), and 8% of the claim lines sampled as having been paid after the enrollee's termination (2,617 out of 26,826 claim lines sample). Here, however, the incidence has been reduced considerably (770 claim lines out of 7,917 sampled, or 10%, and 165 claim lines out of 5,049 sampled, or 3%).

Furthermore, as the auditors know Coventry transitioned to a new claims processing system for the MHBP effective September 1, 2008. Coventry is conducting an ongoing review of the reports that system generates to ensure that this notable improvement not only is maintained, but is enhanced."

**Recommendation 3**

We recommend that the contracting officer disallow \$509,559 for claims paid for ineligible patients and verify that the Plan returns all amounts recovered to the FEHBP.

### 3. Duplicate Claim Payments

\$175,942

During our review of potential duplicate claim payments, we found that the Plan incorrectly paid 174 claims, resulting in net overcharges of \$175,942 to the FEHBP. Specifically, we determined that the Plan improperly charged the FEHBP \$169,305 for 164 duplicate claim payments. Also, we identified 10 claims that were not duplicate claim payments but contained other Plan payment errors, resulting in net overcharges of \$6,637 to the FEHBP. In total, the Plan overpaid 173 claims by \$176,917 and underpaid 1 claim by \$975.

As previously cited from Contract CS 1146, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments.

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

We performed a computer search for potential duplicate payments on claims paid during the period October 1, 2007 through August 31, 2008. We selected and reviewed 435 groups, totaling \$412,902 (out of 7,427 groups, totaling \$647,071) in potential duplicate payments, under our “best matches” criteria. We also selected and reviewed 402 groups, totaling \$332,190 (out of 26,484 groups, totaling \$1,090,739) in potential duplicate payments, under our “near matches” criteria. Our samples included all groups with potential duplicate payments of \$250 or more under the “best matches” criteria and \$350 or more under the “near matches” criteria.

Based on our review, we determined that 117 claim payments in our “best matches” sample were duplicates, resulting in overcharges of \$136,034 to the FEHBP. Also, we determined that 47 claim payments in our “near matches” sample were duplicates, resulting in overcharges of \$33,271 to the FEHBP. In total, the Plan charged the FEHBP \$169,305 for these 164 duplicate claim payments from October 1, 2007 through August 31, 2008.<sup>4</sup> These duplicate claim payments primarily occurred when the claims were deferred as potential duplicates on the claims system, but were overridden by the processors.

During our review of these potential duplicate claim payments, we also identified 10 claims that were not duplicate claim payments but contained other Plan payment errors, resulting in net overcharges of \$6,637 to the FEHBP. Specifically, the Plan overpaid nine of these claims by \$7,612 and underpaid one claim by \$975.

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<sup>4</sup> In addition, there were 90 duplicate claim payments, totaling \$81,552, that were identified and adjusted or voided by the Plan prior to receiving our samples on June 15, 2009. Since these duplicate claim payments were identified and adjusted or voided by the Plan prior to receiving our samples, we did not question these duplicate claim payments in the final report.



### **Plan's Response:**

The Plan agrees with this finding and states that these payments were good faith erroneous benefit payments. The Plan initiated efforts to recover these overpayments in accordance with the procedures outlined in the Plan's OPM-approved Overpayment Recovery Guidelines.

The Plan states that "the time period encompassed by this audit . . . coincides roughly with the time period during which the OIG conducted its prior audit of the MHBP, the results of which are memorialized in the OIG's Final Audit Report No. 1B-45-00-08-16 (March 26, 2009). That Report contains a similar finding regarding duplicate claim payments, along with a recommendation that the MHBP identify their cause(s) 'and develop an action plan' to prevent their future occurrence. The duplicate payments identified in this inquiry occurred months (if not years) before that Report was issued; nevertheless, the MHBP would like to make the OIG aware of the substantial steps it has taken in 2009 to implement that Report's recommendation.

For example . . . the MHBP has conducted a pair of training initiatives directed at the duplicate claims payment issue. The first initiative, which commenced shortly after that Report's publication, was providing one-on-one, focused duplicate claim training to all claims examiners who demonstrated a need for it based on the MHBP's internal audits for claims processing quality control. The second initiative was provided to all MHBP claims examiners in October, 2009, and consisted of providing duplicate claims processing training using materials specially-prepared for that purpose, followed by live duplicate claims processing overseen by individuals with established expertise in that area. . . . While it is too soon to reach any measurable conclusions about the efficacy of these training initiatives, the MHBP is optimistic that together they will have a favorable impact on reducing the frequency with which duplicate claims payments occur."

### **Recommendation 4**

We recommend that the contracting officer disallow \$169,305 for duplicate claim payments and verify that the Plan returns all amounts recovered to the FEHBP.

### **Recommendation 5**

We recommend that the contracting officer disallow \$7,612 in claim overcharges resulting from other Plan payment errors and verify that the Plan returns all amounts recovered to the FEHBP.

### **Recommendation 6**

We recommend that the contracting officer allow the Plan to charge the FEHBP \$975 if an additional payment is made to the provider to correct the underpayment error.

#### **IV. MAJOR CONTRIBUTORS TO THIS REPORT**

##### Experience-Rated Audits Group

██████████, Lead Auditor

██████████ Auditor

██████████ Auditor

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████████████████████ Chief ██████████

██████████ Senior Team Leader

**V. SCHEDULE A**

**COVENTRY HEALTH CARE AS UNDERWRITER AND ADMINISTRATOR  
FOR THE MAIL HANDLERS BENEFIT PLAN  
ROCKVILLE, MD**

**HEALTH BENEFIT CHARGES AND AMOUNTS QUESTIONED**

<b>HEALTH BENEFIT CHARGES</b>	<b>2007</b>	<b>2008</b>	<b>TOTAL</b>
<b>HEALTH BENEFIT CHARGES*</b>	<b>\$1,768,957,342</b>	<b>\$1,741,915,608</b>	<b>\$3,510,872,950</b>
<b>AMOUNTS QUESTIONED</b>	<b>2007</b>	<b>2008</b>	<b>TOTAL</b>
<b>1. COORDINATION OF BENEFITS WITH MEDICARE</b>	<b>\$275,760</b>	<b>\$1,338,815</b>	<b>\$1,614,575</b>
<b>2. CLAIMS PAID FOR INELIGIBLE PATIENTS</b>	<b>123,009</b>	<b>386,550</b>	<b>509,559</b>
<b>3. DUPLICATE CLAIM PAYMENTS</b>	<b>20,770</b>	<b>155,172</b>	<b>175,942</b>
<b>TOTAL AMOUNTS QUESTIONED</b>	<b>\$419,539</b>	<b>\$1,880,537</b>	<b>\$2,300,076</b>

\* The audit covered claim payments from October 1, 2007 through August 31, 2008.



To: [REDACTED] Auditor-in-Charge  
[REDACTED] Auditor  
[REDACTED] Auditor

From: Thomas R. Kirkpatrick  
Chief Financial Officer, Group Health Services  
Coventry Health Care

Date: February 17, 2010

Re: Mail Handlers Benefit Plan Response to OPM OIG Audit Inquiry #1  
– Duplicate Claim Payments

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

**MHBP Response:** The MHBP concurs with the OIG auditors' proposed finding that it made \$169,305 in duplicate payments erroneously but in good faith on 164 of the 837 claims contained in the auditors' "best matches" and "near matches" duplicate claims payment samples. The MHBP also concurs with the OIG auditors' proposed finding that \$6,637 in net benefit overpayments were made erroneously but in good faith on an additional 10 claims identified in those samples. Finally, the MHBP agrees with the OIG's determination that virtually every such payment error occurred on a claim that the FirstClaim® claims processing system then in use for the MHBP had identified as a possible duplicate and routed for further investigation, and that the MHBP claims examiner thereafter mistakenly authorized for payment. In other words, the payment errors identified in this inquiry were attributable to human error. The MHBP initiated recovery efforts on each overpayment identified in this inquiry in accordance with the policies and procedures enumerated in its OPM-approved Overpayment Recovery Guidelines, including the ability to track and report back to OPM on its progress in recouping them.

The MHBP observes that the time period encompassed by this audit (January 1, 2007-August 31, 2008) coincides roughly with the time period during which the OIG conducted its prior audit of the MHBP, the results of which are memorialized in the OIG's Final Audit Report No. 1B-45-00-08-16 (March 26, 2009). That Report contains a similar finding regarding duplicate claim payments, along with a recommendation that the MHBP identify their cause(s) "and develop an action plan" to prevent their future occurrence. The duplicate payments identified in this inquiry occurred months (if not years) before that Report was issued; nevertheless, the MHBP would like to make the OIG aware of the substantial steps it has taken in 2009 to implement that Report's recommendation.

For example, since Report No. AB-45-00-08-16's March 26, 2009, issuance date, the MHBP has conducted a pair of training initiatives directed at the duplicate claims payment issue. The first initiative, which commenced shortly after that Report's publication, was providing one-on-one, focused duplicate claim training to all claims examiners who demonstrated a need for it based on the MHBP's internal audits for claims processing quality control. The second initiative was provided to all MHBP claims examiners in October, 2009, and consisted of providing duplicate claims processing training using materials specially-prepared for that purpose, followed by live duplicate claims processing overseen by individuals with established expertise in that area. A copy of the materials furnished during this second training initiative are attached for the OIG auditors' reference. While it is too soon to reach any measurable conclusions about the efficacy of these training initiatives, the MHBP is optimistic that together they will have a favorable impact on reducing the frequency with which duplicate claims payments occur.

The MHBP trusts the above reply adequately responds to the OIG auditors' Audit Inquiry No. 1. Please do not hesitate to request further clarification or information, however.



To: [REDACTED] Auditor-in-Charge  
[REDACTED] Auditor  
[REDACTED] Auditor

From: Thomas R. Kirkpatrick  
Chief Financial Officer, Group Health Services  
Coventry Health Care

Date: February 17, 2010

Re: Mail Handlers Benefit Plan Response to OPM OIG Audit Inquiry #2  
– Claims Paid for Ineligible Patients

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

**MHBP Response:** The MHBP concurs with the OIG auditors' proposed finding that it made 935 claims payments totaling \$509,559 erroneously but in good faith during gaps in an MHBP member's coverage, or following their termination. These erroneous payments were out of 12,966 claim lines totaling \$10,563,494 in benefit payments that the OIG auditors sampled for review. The MHBP further concurs with the OIG auditors' determination that these erroneous claims payments were almost entirely attributable to delays by the responsible entities in reporting events affecting member eligibility that, had they been reported timely, would have resulted in the questioned claim line being adjudicated correctly. As indicated in your inquiry, all but two of those 935 erroneous claims payments were due either to payroll office delays in reporting enrollment changes (732, or 78.3%), or to other delays such as enrollees failing to timely notify it of a divorce or other change in family status affecting eligibility (201, or 21.5%).<sup>1</sup> The MHBP has initiated recovery efforts on each one of the overpaid claim lines identified in this inquiry in accordance with the procedures enumerated in its OPM-approved MHBP Overpayment Recovery Guidelines, including the ability to track and report back to OPM on its progress in recouping them.

As with the OIG's prior inquiry, the MHBP observes that the January 1, 2007-August 31, 2008, time period encompassed by this audit coincides with the time period during which the OIG conducted its prior audit of the MHBP, the results of which are memorialized in the OIG's March 26, 2009, Final Audit Report No. 1B-45-00-08-16. That Report contains a finding similar in nature to the one proposed in this inquiry, together with a recommendation that the OPM

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<sup>1</sup> FEHBP enrollees oftentimes continue to list their spouse as a covered dependent after obtaining a divorce from them. It is common for the MHBP to learn of the divorce only in the event that the enrollee remarries and thereafter tries to add the new spouse to his/her enrollment.

Contracting Officer verify that the MHBP has procedures in place to identify and initiate efforts to recover post-termination benefit payments attributable to the aforementioned types of reporting delays. A comparison of the OIG's finding in that Report and its proposed finding here illustrates the existence and operation of those procedures: in that earlier Report, the OIG correctly identified 65% of the claim lines sampled as having been paid during a gap in the enrollee's coverage (10,275 out of 15,864 claim lines sampled), and 8% of the claim lines sampled as having been paid after the enrollee's termination (2,617 out of 26,826 claim lines sample). Here, however, the incidence has been reduced considerably (770 claim lines out of 7,917 sampled, or 10%, and 165 claim lines out of 5,049 sampled, or 3%).

Furthermore, as the auditors know Coventry transitioned to a new claims processing system for the MHBP effective September 1, 2008. Coventry is conducting an ongoing review of the reports that system generates to ensure that this notable improvement not only is maintained, but is enhanced.

The MHBP trusts the above reply adequately responds to the OIG auditors' Audit Inquiry No. 2. Please do not hesitate to request further clarification or information, however.



To: [REDACTED] Auditor-in-Charge  
[REDACTED], Auditor  
[REDACTED] Auditor

From: Thomas R. Kirkpatrick  
Chief Financial Officer, Group Health Services  
Coventry Health Care

Date: February 17, 2010

Re: Mail Handlers Benefit Plan Response to OPM OIG Audit Inquiry #3  
– Coordination of Benefits with Medicare

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

**MHBP Response:** The MHBP concurs that it paid \$1,614,575 in charges questioned in this inquiry erroneously but in good faith as a result of errors made in coordinating the Plan's benefits with Medicare on 2,237 of the 25,873 claim lines (8.6%) that the OIG auditors selected for sampling.<sup>1</sup> The MHBP initiated recoupment efforts on each one of those claim lines promptly after determining that a Medicare coordination of benefits ("COB") error (or other error) had occurred contemporaneously with its Fall, 2009, response to the OIG auditors' Information Request ("IR") No. 1. Those recovery efforts are ongoing, and comply with the procedures enumerated in the Plan's OPM-approved Overpayment Recovery Guidelines (including the ability to track and report to OPM its progress in recouping the payments).

The MHBP also observes that the January 1, 2007-August 31, 2008, time period encompassed by this audit coincides with the time period in which the OIG conducted its audit of the MHBP resulting in its March 26, 2009, issuance of Final Audit Report No. 1B-45-00-08-16. That Report, in addition to containing a similar finding regarding Medicare COB, recommended that the MHBP "ha[ve] procedures in place to review all claims incurred back to the Medicare effective dates when updated ... and determine if already paid claims are affected." The MHBP addressed that recommendation in detail with OPM's contracting office shortly after the OIG issued that Report, summarizing both the efforts it had taken to date and those it planned to implement in response to that recommendation. Please further be advised that in addition to those efforts outlined in that correspondence, the Plan (i) conducted

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<sup>1</sup> In concurring with this proposed finding, the MHBP notes that based upon its showing, the OPM OIG auditors no longer question whether the MHBP coordinated 31 questioned claim lines totaling \$6,269 improperly with Medicare due to a claims system error. Rather, the auditors concur that those incorrect claim payments were, like the remaining claim lines questioned in this inquiry, paid incorrectly as a result of human (*i.e.*, claims examiner) error.



intensive one-on-one training of claims examiners identified as having quality-related errors pertaining to Medicare COB in June-July of 2009, and (ii) provided formal classroom training on Medicare COB to all claims examiners in November, 2009. This latter activity took the form of a 5-6 hour training session, to be supplemented a later, follow-up assessment and additional one-on-one training as required. In sum, the Plan already has taken substantial steps towards reducing the frequency with which Medicare COB errors occur on a prospective basis.

The MHBP trusts the above reply adequately responds to the OIG auditors' Audit Inquiry No. 3. Please let us know if you require further information, however.