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

# Final Audit Report

**Subject:**

## AUDIT ON GLOBAL COORDINATION OF BENEFITS FOR BLUECROSS AND BLUESHIELD PLANS

**Report No. 1A-99-00-12-029**

**Date:** March 20, 2013

**--CAUTION--**

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# AUDIT REPORT

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

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Global Coordination of Benefits
BlueCross and BlueShield Plans

REPORT NO. 1A-99-00-12-029 DATE: 03/20/13

Michael R. Esser
Assistant Inspector General
for Audits

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# EXECUTIVE SUMMARY

Federal Employees Health Benefits Program
Service Benefit Plan Contract CS 1039
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Global Coordination of Benefits
BlueCross and BlueShield Plans

REPORT NO. 1A-99-00-12-029 DATE: 03/20/13

This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at all BlueCross and BlueShield (BCBS) plans questions $4,690,639 in health benefit charges. The BlueCross BlueShield Association (Association) and/or BCBS plans agreed with $2,478,834 and disagreed with $2,211,805 of the questioned charges.

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covered health benefit payments from June 1, 2011 through March 31, 2012 as reported in the Annual Accounting Statements. Specifically, we identified claims incurred on or after May 15, 2011 that were reimbursed from June 1, 2011 through March 31, 2012 and potentially not coordinated with Medicare. We determined that the BCBS plans did not properly coordinate 10,771 claim line payments with Medicare as required by the FEHBP contract. As a result, the FEHBP was overcharged $4,393,785 for these claim line payments. When we notified the Association of the coordination of benefit (COB) errors on April 26, 2012, these claims were within the Medicare timely filing requirement and could be filed with Medicare for coordination of benefits. Based on this, since the BCBS plans are required to initiate recovery efforts immediately for the actual COB errors, our expectation is for the plans to recover and return all of the actual COB errors to the FEHBP. A portion of the questioned amount may be determined to be not paid in error during the audit resolution phase.

Additionally, we identified 725 claim line payments that were not COB errors but contained other claim payment errors, resulting in overcharges of $296,854 to the FEHBP. In total, we determined that the BCBS plans incorrectly paid 11,496 claim lines, resulting in overcharges of $4,690,639 to the FEHBP.

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# I. INTRODUCTION AND BACKGROUND

## INTRODUCTION

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

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

## BACKGROUND

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

The BlueCross BlueShield Association (Association), on behalf of participating BCBS plans, has entered into a Government-wide Service Benefit Plan contract (CS 1039) with OPM to provide a health benefit plan authorized by the FEHB Act. The Association delegates authority to participating local BCBS plans throughout the United States to process the health benefit claims of its federal subscribers. There are approximately 64 local BCBS plans participating in the FEHBP.

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

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

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

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

Findings from our previous global coordination of benefits audit of all BCBS plans (Report No. 1A-99-00-11-055, dated March 28, 2012) for claims reimbursed from July 11, 2010 through April 30, 2011 are in the process of being resolved.

Our preliminary results of the potential coordination of benefit errors were presented in detail in a draft report, dated May 2, 2012. The Association's comments in response to the draft report were considered in preparing our final report and are included as the Appendix to this report. Also, additional documentation provided by the Association and BCBS plans on various dates through February 11, 2013 was considered in preparing our final report.

# II. OBJECTIVE, SCOPE, AND METHODOLOGY

## OBJECTIVE

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

## SCOPE

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

The audit covered health benefit payments from June 1, 2011 through March 31, 2012 as reported in the Annual Accounting Statements. Using our data warehouse, we performed a computer search on the BCBS claims database to identify claims incurred on or after May 15, 2011 that were reimbursed from June 1, 2011 through March 31, 2012 and potentially not coordinated with Medicare. Based on our claim error reports, we identified 422,660 claim lines, totaling $48,977,166 in payments, that potentially were not coordinated with Medicare.[2] From this universe, we selected and reviewed 48,559 claim lines, totaling $18,748,248 in payments, for coordination of benefits with Medicare. When we notified the Association of these potential errors on April 26, 2012, the claims were within the Medicare timely filing requirement and could be filed with Medicare for coordination of benefits.[3]

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

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

[2] This universe did not include 3 inpatient claim lines with a discharge date of February 29, 2012 and 46 outpatient and 859 professional claim lines with an incurred date of February 29, 2012. These 908 claim lines with potential coordination of benefit errors, totaling $106,772 in payments, were inadvertently excluded from the universe.
[3] Starting in 2010, claims with incurred dates of service on or after January 1, 2010 that are received by Medicare more than one calendar year after the date of service could be denied by Medicare as being past the timely filing requirement.

In conducting our audit, we relied to varying degrees on computer-generated data provided by the FEP Operations Center and the BCBS plans. Through audits and a reconciliation process, we have verified the reliability of the BCBS claims data in our data warehouse, which was used to identify the universe of potential COB errors. The BCBS claims data is provided to us on a monthly basis by the FEP Operations Center, and after a series of internal steps, uploaded into our data warehouse. However, due to time constraints, we did not verify the reliability of some of the data generated by the BCBS plans' local claims systems. 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 objective.

The audit was performed at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida from May 2012 through February 2013.

## METHODOLOGY

To test each BCBS plan's compliance with the FEHBP health benefit provisions related to coordination of benefits with Medicare, we selected a judgmental sample of potential uncoordinated claim lines that were identified in a computer search. Specifically, we selected for review 48,559 claim lines, totaling $18,748,248 in payments, from a universe of 422,660 claim lines, totaling $48,977,166 in payments, that potentially were not coordinated with Medicare (See Schedule A for our sample selection methodology).

The claim sample selections were submitted to each applicable BCBS plan for their review and response. We then conducted a limited review of the plans' agreed responses and an expanded review of the plans' disagreed responses to determine the appropriate questioned amount. We also verified on a limited test basis if the plans had initiated recovery efforts, adjusted or voided the claims, and/or completed the recovery process by the audit request due date (i.e., July 31, 2012) for the claim payment errors in our sample. Additionally, we reviewed the status of corrective actions that have been or are in the process of being implemented by the Association, FEP Operations Center and/or BCBS plans, as a result of our previous global audits, to reduce potential coordination of benefit errors. We did not project the sample results to the universe of potentially uncoordinated claim lines.

The determination of the questioned amount is based on the FEHBP contract, the 2011 and 2012 Service Benefit Plan brochures, the Association's FEP Administrative Manual, and various manuals and other documents available from the Center for Medicare and Medicaid Services that explain Medicare benefits.

# III. AUDIT FINDING AND RECOMMENDATIONS

**Coordination of Benefits with Medicare Review** **$4,690,639**

The BCBS plans incorrectly paid 11,496 claim lines, resulting in overcharges of $4,690,639 to the FEHBP. Specifically, the BCBS plans did not properly coordinate 10,771 claim line payments, totaling $5,260,435, 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 $4,393,785 for these 10,771 claim lines. The remaining 725 claim line payments were not coordination of benefit (COB) errors but contained other claim payment errors, resulting in overcharges of $296,854 to the FEHBP.

The 2011 BlueCross and BlueShield Service Benefit Plan brochure, page 121, Primary Payer Chart, illustrates when Medicare is the primary payer. In addition, page 25 of that brochure states, "We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), regardless of whether Medicare pays."

Contract CS 1039, Part II, section 2.6 states, "(a) The Carrier shall coordinate the payment of benefits under this contract with the payment of benefits under Medicare . . . (b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary carrier . . . ." Also, Part III, section 3.2 (b)(1) states, "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable . . . [and] on request, document and make available accounting support for the cost to justify that the cost is actual, reasonable and necessary; and (ii) determine the cost in accordance with: (A) the terms of this contract . . . ."

In addition, Contract CS 1039, Part II, section 2.3(g) states, "If the Carrier or OPM determines that a Member's claim has been paid in error for any reason . . . the Carrier shall make a prompt and diligent effort to recover the erroneous payment . . . ."

For claims incurred on or after May 15, 2011 and reimbursed from June 1, 2011 through March 31, 2012, we performed a computer search and identified 422,660 claim lines, totaling $48,977,166 in payments, that potentially were not coordinated with Medicare. From this universe, we selected for review a sample of 48,559 claim lines, totaling $18,748,248 in payments, to determine whether the BCBS plans complied with the contract provisions relative to COB with Medicare. When we submitted our sample of potential COB errors to the Association on April 26, 2012, the claims were within the Medicare timely filing requirement and could be filed with Medicare for coordination of benefits. Based on this, since the BCBS plans are required to initiate recovery efforts immediately for the actual COB errors, our expectation is for the plans to recover and return all of the actual COB errors to the FEHBP. A portion of the questioned amount may be determined to be not paid in error during the audit resolution phase.

Generally, Medicare Part A pays all covered costs for inpatient care in hospitals, skilled nursing facilities, and hospice care, except for deductibles and coinsurance. For each Medicare Benefit Period, there is a one-time deductible, followed by a daily copayment beginning with the 61st

day. Beginning with the 91st day of the Medicare Benefit Period, Medicare Part A benefits may be exhausted, depending on whether the patient elects to use their Lifetime Reserve Days. For the uncoordinated Medicare Part A claims, we estimate that the FEHBP was overcharged for the total claim payment amounts. When applicable, we reduced the questioned amount by the Medicare deductible and/or Medicare copayment.

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

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

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

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

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

From these six categories, we selected for review a sample of claim lines that potentially were not coordinated with Medicare (See Schedule A for our sample selection methodology). Based on our review, we determined that 59 of the 64 BCBS plan sites did not properly coordinate claim charges with Medicare. Specifically, we identified 10,771 claim lines, totaling $5,260,435 in payments, where the FEHBP paid as the primary insurer when Medicare was the primary insurer. We estimate that the FEHBP was overcharged $4,393,785 for these claim line payments.[4]

[4] In addition, there were 4,937 claim lines, totaling $3,172,585 in COB overpayments, that were identified by the BCBS plans before our audit notification date (i.e., April 2, 2012) and adjusted and returned to the FEHBP by the audit request due date (i.e., July 31, 2012). Since these overpayments were already identified by the BCBS plans before our audit notification date and adjusted and returned to the FEHBP by the audit request due date, we did not question these overpayments in the final report.

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

| Category | Claim Lines | Amount Paid | Amount Questioned |
|---|---|---|---|
| **Category A**: Medicare Part A Primary for Inpatient (I/P) Facility | 80 | $1,354,690 | $1,306,092 |
| **Category B**: Medicare Part A Primary for Skilled Nursing/Home Health Care (HHC)/ Hospice Care | 3,102 | $539,249 | $526,570 |
| **Category C**: Medicare Part B Primary for Certain I/P Facility Charges | 31 | $406,290 | $107,022 |
| **Category D**: Medicare Part B Primary for Skilled Nursing/HHC/Hospice Care | 13 | $93,065 | $23,266 |
| **Category E**: Medicare Part B Primary for Outpatient (O/P) Facility and Professional | 4,792 | $1,483,605 | $1,270,550 |
| **Category F**: Medicare Part B Primary for O/P Facility and Professional (Participation Code F) | 2,753 | $1,383,536 | $1,160,285 |
| **Total** | 10,771 | $5,260,435 | $4,393,785 |

Our audit disclosed the following for the COB errors:

- For 5,499 (51 percent) of the claim lines questioned, the BCBS plans incorrectly paid these claims due to retroactive adjustments. Specifically, there was no special information present on the FEP Direct Claims System to identify Medicare as the primary payer when the claims were paid. However, when the Medicare information was subsequently added to the FEP Direct Claims System, the BCBS plans did not review and/or adjust the patient's prior claim(s) back to the Medicare effective dates. As a result, we estimate that the FEHBP was overcharged $2,358,311 for these COB errors.

- For 2,722 (25 percent) of the claim lines questioned, the BCBS plans incorrectly paid these claims due to manual processing errors. In most cases, there was special information present on the FEP Direct Claims System to identify Medicare as the primary payer when these claims were paid. However, an incorrect Medicare Payment Disposition Code was used to override the FEP Direct Claims System's deferral of these claims. The Medicare Payment Disposition Code identifies Medicare's responsibility for payment on each charge line of a claim. According to the FEP Administrative Manual, the completion of this field is required on all claims for patients who are age 65 or older. We found that codes D, E, F, G and N were incorrectly used. An incorrect entry in this field causes the claim line to be excluded from coordination of benefits with Medicare. As a result, we estimate that the FEHBP was overcharged $1,129,325 for these COB errors.

- For 1,427 (13 percent) of the claim lines questioned, the BCBS plans incorrectly paid these claims due to systematic processing errors. Specifically, the claims were not deferred on the FEP Direct Claims System for Medicare COB review by the processors. As a result, the FEHBP was overcharged $349,252 for these COB errors.

- For 1,123 (11 percent) of the claim lines questioned, the BCBS plans incorrectly paid these claims due to provider billing errors. As a result, we estimate that the FEHBP was overcharged $556,897 for these COB errors.

Of the $4,393,785 in questioned COB errors:

- $2,743,303 (62 percent) represents 6,698 claim line overpayments that were identified as a result of our audit. We noted that the BCBS plans initiated recovery efforts for these overpayments after receiving our audit request on April 26, 2012.

- $866,775 (20 percent) represents 1,824 claim line overpayments where the BCBS plans initiated recovery efforts on or after our audit notification date (i.e., April 2, 2012) but before receiving our audit request (i.e., April 26, 2012), and also completed the recovery process and adjusted the claims by the audit request due date (i.e., July 31, 2012). However, since the recoveries for these overpayments were initiated on or after our audit notification date, we are continuing to question these COB errors.

- $783,707 (18 percent) represents 2,249 claim line overpayments where the BCBS plans initiated recovery efforts before receiving our audit request (i.e., April 26, 2012) but had not recovered the overpayments and adjusted the claims by the audit request due date (i.e., July 31, 2012). Since these overpayments had not been recovered and returned to the FEHBP by the audit request due date, we are continuing to question these COB errors.

Additionally, we identified 725 claim line payments that were not COB errors but contained other claim payment errors, resulting in overcharges of $296,854 to the FEHBP. These claim payment errors resulted from the following:

- The BCBS plans incorrectly paid 558 claim lines due to the plans' local claim systems and/or the FEP Direct Claims System not deferring non-covered ambulance claims. As a result, the FEHBP was overcharged $221,439 for these non-covered ambulance services. The 2011 BlueCross and BlueShield Service Benefit Plan brochure, page 83, states that ambulance transport services are covered under the following circumstances only: "medical emergency or accidental injury, when associated with inpatient hospital care, or when associated with covered hospice care." Additionally, page 83 of this brochure defines non-covered services as: "Ambulance and any other modes of transportation to or from services including but not limited to physician appointments, dialysis, or diagnostic tests not associated with covered inpatient hospital care." In each instance, the BCBS plan paid the claim line for a non-covered ambulance service.

- The BCBS plans paid 167 claim lines using the incorrect procedure allowances or pricing methods when pricing these claim lines, resulting in overcharges of $75,415 to the FEHBP.

Of this $296,854 in questioned claim payment errors (non-COB errors):

- $269,529 (91 percent) represents 710 claim line overpayments that were identified as a result of our audit. We noted that the BCBS plans initiated recovery efforts for these overpayments after receiving our audit request on April 26, 2012.

- $27,301 (9 percent) represents 14 claim line overpayments where the BCBS plans initiated recovery efforts on or after our audit notification date (i.e., April 2, 2012) but before receiving our audit request (i.e., April 26, 2012), and also completed the recovery process and adjusted or voided the claims by the audit request due date (i.e., July 31, 2012). However, since the recoveries for these overpayments were initiated on or after our audit notification date, we are continuing to question these claim payment errors.

- $24 represents one claim line overpayment where the BCBS plans initiated recovery efforts before receiving our audit request (i.e., April 26, 2012) but had not recovered the overpayment and adjusted or voided the claim by the audit request due date (i.e., July 31, 2012). Since the overpayment had not been recovered and returned to the FEHBP by the audit request due date, we are continuing to question this claim payment error.

Regarding the payment of non-covered ambulance services, in May 2011 the Association identified that the FEP Direct Claims System allowed payment of these claims. According to the Association, the FEP Operations Center implemented corrective actions in April 2012 and developed system edits to defer payment of non-covered ambulance claims in the FEP Direct Claims System. However, the BCBS plans had not previously initiated recoveries for these non-covered ambulance claims. (Note: In our sample of potential COB errors, we identified 558 non-covered ambulance claim lines, totaling $221,439 in overpayments, which were processed by 29 of the 64 BCBS plans. We also noted that the BCBS plans adjusted or voided 171 of these claim lines, totaling $38,619 in payments, in the FEP Direct Claims System after receiving our audit notification letter, dated April 2, 2012. The remaining 387 non-covered ambulance claim lines, totaling $182,820 in payments, had not been adjusted or voided in the FEP Direct claims system as of December 31, 2012.)

Due to the impact of this system-wide error (payment of non-covered ambulance services), we requested the Association to provide a data extract of all FEP claims that were paid during the period June 1, 2011 through December 31, 2012 that contained non-covered transport procedure codes, such as "A0426" (Ambulance Service, Advanced Life Support, Non-emergency Transport), "A0428" (Ambulance Service, Basic Life Support, Non-emergency Transport), and "A0425" (Ground Mileage, per Statute Mile), and/or potentially included non-covered ambulance services. The Association provided the requested data extract on February 11, 2013, identifying 24,425 FEP claim lines, totaling $3,266,025 in payments, related to potentially non-covered ambulance services. After completing our review of these claim line payments, we will issue a supplemental final report if there are significant overcharges to the FEHBP for non-covered ambulance claims.

**Association's Response:**

In response to the draft report, the Association states, "After reviewing the OIG listing of potentially uncoordinated Medicare COB claims . . . the BCBS Association agrees that claims totaling $2,351,475 were paid incorrectly and identified by the audit."

The Association disagrees with $13,414,106 of the questioned charges in the draft report. For this contested amount, the Associations states, "we noted the following:

- $8,589,815 in claims that were paid correctly;
- $3,086,043 in claims that were initially paid incorrectly but the error was identified and corrected before the Audit Notification date and overpayment was recovered and returned before the response was due to OPM;
- $851,335 in claims that were initially paid incorrectly but recovery was initiated on or after the Audit Notification date but before receiving the OIG sample and the overpayment was recovered and returned before the response was due to OPM;
- $886,952 [in] claims that were initially paid incorrectly but recovery was initiated before receiving the OIG sample, however overpayment was not recovered and returned before the response was due to OPM;"

Regarding corrective actions, the Association states, "The Association's Action Plan includes steps to include that the top 10 Plans with COB errors are following the corrective action plan. In addition, to reduce the number and frequency of uncoordinated Medicare COB claims, BCBSA has completed the following:

- Implemented an edit to defer all facility claims with Medicare B Revenue Codes where the member does not have Part A but has Part B. . . .
- Modified the Uncoordinated Medicare Application to run monthly . . .
- Required the top ten Plans with the highest COB findings to develop and implement action plans to improve performance and address the root causes behind erroneous Medicare COB payments. These Plans have taken steps to address operational weaknesses such as proactively working daily retroactive enrollment reports to ensure corrective action is completed timely, training for processing staff, communicating with the provider community to reinforce optimal billing practices that reduce downstream issues, and enhancing in-line auditing techniques to focus on claims with a high potential for claims payment errors.
- Modified the FEP post payment review process to match with OIG global audit claims listings where appropriate. . . .
- Modified the FEP claims system to defer inpatient facility Part B charges as well as changes related to payment of Home Health and Skill Nursing Facility Medicare claims for review and coordination. . . .
- Modified existing pre-payment compatibility editing to increase clarity around Medicare Payment Disposition usage. . . .

The following corrective actions remain in process and under review:

- Provide additional Plan guidance on mapping data from Medicare crossover claims to the correct Medicare Payment Disposition code. . . .
- Modify the FEP claims system to require Plans to indicate that facility claims not coordinated with Medicare Part A are supported by a Medical Denial Notice. . . .
- Create new Explanation of Benefit Remarks to more accurately explain denials due to no Medicare coordination. . . .
- Modify the FEP claims system to accept Medicare denial reasons. This will allow additional editing of Medicare claims to ensure that claims are paid correctly. . . .

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

- FEP updated the Plan Administrative Manual to instruct the Plans on what to do with the Retroactive Enrollment Report.
- As part of the FEP CPR, FEP reviews Plan procedures for reviewing retroactive enrollment reports as well as tests transactions to ensure that all claims are reviewed back to the Medicare effective dates."

**OIG Comments:**

After reviewing the Association's response and additional documentation provided by the BCBS plans, we revised the questioned charges from our draft report to $4,690,639. If the BCBS plans identified the claim payment errors and initiated recovery efforts before our audit notification date (i.e., April 2, 2012) and completed the recovery process (i.e., adjusted or voided the claims and recovered and returned the overpayments to the FEHBP) by the audit request due date (i.e., July 31, 2012), we did not question these claim payment errors in the final report. Based on the Association's response and the BCBS plans' additional documentation, we determined that the Association and/or plans agree with $2,478,834 and disagree with $2,211,805 of the revised questioned charges. Although the Association only agrees with $2,351,475 in its response, the BCBS plans' documentation supports concurrence with $2,478,834.

Based on the Association's response and/or the BCBS plans' documentation, the contested amount of $2,211,805 represents the following items:

- $894,076 ($866,775 for COB errors plus $27,301 for non-COB errors) of the contested amount represents claim overpayments where the BCBS plans initiated recovery efforts on or after our audit notification date (i.e., April 2, 2012) but before receiving our audit request (i.e., April 26, 2012), and also completed the recovery process and adjusted or voided the claims by the audit request due date (i.e., July 31, 2012). However, since the recoveries for these overpayments were initiated on or after our audit notification date, we are continuing to question this amount in the final report.

- $783,731 ($783,707 for COB errors plus $24 for non-COB errors) of the contested amount represents claim overpayments where the BCBS plans initiated recovery efforts before receiving our audit request (i.e., April 26, 2012) but had not recovered the overpayments and/or adjusted or voided the claims by the audit request due date (i.e., July 31, 2012). Since these overpayments had not been recovered and returned to the FEHBP by the audit request due date, we are continuing to question this amount in the final report.

- $221,439 of the contested amount represents non-covered ambulance claims (non-COB errors). Even though the Association has implemented corrective actions to defer non-covered ambulance claims in the FEP Direct Claims System and the BCBS plans have initiated recovery efforts for many of these claim payments, the Association and BCBS plans disagree with these questioned charges pending further review.

- $192,135 of the contested amount represents COB errors where Medicare rejected claims because providers did not bill Medicare correctly for covered services. As a result, the FEHBP paid primary for these services instead of Medicare. The BCBS plans state that these claims were paid correctly since the member's Medicare Explanation of Benefits included a rejection code for these services. Since the BCBS plans did not provide sufficient documentation to support that the FEHBP should have paid these claims as the primary insurer, instead of as secondary insurer, we are continuing to question this amount in the final report.

- $93,329 of the contested amount represents claim lines that the BCBS plans agree were COB errors. However, since all recovery efforts have been exhausted, the plans state that these claim payments are uncollectible. The plans did not provide sufficient documentation to support that all recovery efforts have been exhausted. Therefore, we are continuing to question this amount in the final report.

- $27,095 of the contested amount represents COB errors that the BCBS plans state were not charged to the FEHBP. However, the plans did not provide sufficient documentation to support that these claims were not charged to the FEHBP. Therefore, we are continuing to question this amount in the final report.

**Recommendation 1**

We recommend that the contracting officer disallow $4,393,785 for the uncoordinated claim payments and verify that the BCBS plans return all amounts recovered to the FEHBP (See Schedule B for a summary of these questioned uncoordinated claim payments by BCBS plan).

**Recommendation 2**

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

**Recommendation 3**

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

**Recommendation 4**

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

**Recommendation 5**

Due to the significant number of manual processing errors, we recommend that the contracting officer require the Association to ensure that the FEP Operations Center's corrective action, inputting a field(s) in the FEP Direct Claims System to collect Remittance Advice Remark Codes (RARC) and Claim Adjustment Reason Codes (CARC) from the BCBS plans, is implemented during 2013. These Medicare generated codes (RARC and CARC) provide the reason Medicare denied a claim payment. The Association should also have the FEP Operations Center and BCBS plans utilize the RARC and CARC field(s) when implementing the Medicare Disposition Code corrective actions.

**Recommendation 6**

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

**Recommendation 7**

We recommend that the contracting officer disallow $296,854 for the non-COB claim payment errors and verify that the BCBS plans return all amounts recovered to the FEHBP (See Schedule B for a summary of these questioned non-COB claim payment errors by BCBS plan).

# IV. MAJOR CONTRIBUTORS TO THIS REPORT

Experience-Rated Audits Group

[redacted], Auditor-In-Charge

[redacted], Auditor

[redacted], Auditor

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[redacted], Chief [redacted]

Information Systems Audits Group

[redacted], Chief

[redacted], Information Technology Project Manager

[redacted] Senior Information Technology Specialist

**SCHEDULE A**

**V. SCHEDULES**

**Coordination of Benefits with Medicare**
**BlueCross and BlueShield Plans**
**Claims Reimbursed from June 1, 2011 through March 31, 2012**

**UNIVERSE AND SAMPLE OF POTENTIALLY UNCOORDINATED CLAIM LINES**

| | UNIVERSE | | | | SAMPLE | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **CATEGORY** | **Number of Claims** | **Number of Claim Lines** | **Number of Patients** | **COB Universe Total Payments** | **Sample Selection Methodology** | **Number of Claims** | **Number of Claim Lines** | **Number of Patients** | **Amounts Paid** | **Estimated Overcharge Percentage** | **Potential Overcharge** |
| Category A: Medicare Part A Primary for Inpatient Facility | 327 | 327 | 267 | $4,248,365 | all patients selected | 327 | 327 | 267 | $4,248,365 | 100% | $4,248,365 |
| Category B: Medicare Part A Primary for Skilled Nursing/HHC/Hospice Care | 3,864 | 12,403 | 1,133 | $2,286,319 | patients with cumulative claims of $1,000 or more | 2,510 | 9,129 | 426 | $2,015,018 | 100% | $2,015,018 |
| Category C: Medicare Part B Primary for Certain Inpatient Facility Charges | 49 | 49 | 47 | $592,652 | all patients selected | 49 | 49 | 47 | $592,652 | 25% | $148,163 |
| Category D: Medicare Part B Primary for Skilled Nursing/HHC/Hospice Care | 100 | 216 | 53 | $310,624 | patients with cumulative claims of $2,500 or more | 50 | 50 | 28 | $290,429 | 25% | $72,607 |
| Category E: Medicare Part B Primary for Outpatient Facility and Professional | 7,970 | 14,928 | 2,379 | $4,143,214 | patients with cumulative claims of $1,000 or more | 5,075 | 10,785 | 679 | $3,583,303 | 80% | $2,866,642 |
| Category F: Medicare Part B Primary for Outpatient Facility and Professional (Participation Code F) | 268,410 | 394,737 | 146,513 | $37,395,992 | patients with cumulative claims of $3,500 or more | 11,107 | 28,219 | 1,024 | $8,018,481 | 80% | $6,414,785 |
| **Totals** | **280,720** | **422,660** | | **$48,977,166** | | **19,118** | **48,559** | | **$18,748,248** | | **$15,765,581** |

Coordination of Benefits with Medicare
BlueCross and BlueShield Plans
Claims Reimbursed from June 1, 2011 through March 31, 2012



SUMMARY OF QUESTIONED CHARGES

| | | | COB Category A | | COB Category B | | COB Category C | | COB Category D | | COB Category E | | COB Category F | | ALL COB Errors | | Non-COB Errors | | TOTAL QUESTIONED | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Plan Site | Plan State | Plan Name | Claim Lines | Amount Questioned | Claim Lines | Amount Questioned | Claim Lines | Amount Questioned | Claim Lines | Amount Questioned | Claim Lines | Amount Questioned | Claim Lines | Amount Questioned | Claim Lines | Amount Questioned | Claim Lines | Amount Questioned | Claim Lines | Amount Questioned |
| 003 | NM | BlueCross BlueShield of New Mexico (HCSC) | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 1 | $5,504 | 1 | $5,504 | 0 | $0 | 1 | $5,504 |
| 005 | GA | WellPoint BlueCross BlueShield of Georgia | 2 | $70,346 | 100 | $12,149 | 2 | $2,224 | 0 | $0 | 220 | $56,782 | 127 | $21,702 | 451 | $163,204 | 20 | $6,444 | 471 | $169,648 |
| 006 | MD | CareFirst BlueCross BlueShield (Maryland Service Area) | 2 | $28,254 | 28 | $12,725 | 1 | $27,257 | 0 | $0 | 476 | $196,191 | 70 | $38,780 | 577 | $303,207 | 110 | $9,909 | 687 | $313,116 |
| 007 | LA | BlueCross BlueShield of Louisiana | 8 | $133,454 | 159 | $20,892 | 0 | $0 | 0 | $0 | 203 | $40,214 | 18 | $1,629 | 388 | $196,189 | 54 | $26,068 | 442 | $222,256 |
| 009 | AL | BlueCross BlueShield of Alabama | 3 | $7,096 | 2 | $11,160 | 0 | $0 | 0 | $0 | 140 | $59,628 | 4 | $4,541 | 149 | $82,425 | 40 | $14,524 | 189 | $96,948 |
| 010 | ID | BlueCross of Idaho Health Service | 0 | $0 | 4 | $1,401 | 0 | $0 | 0 | $0 | 34 | $16,930 | 0 | $0 | 38 | $18,331 | 3 | $216 | 41 | $18,547 |
| 011 | MA | BlueCross BlueShield of Massachusetts | 1 | $459 | 50 | $4,986 | 0 | $0 | 0 | $0 | 15 | $2,339 | 24 | $7,523 | 90 | $15,307 | 2 | $4,200 | 92 | $19,506 |
| 012 | NY | BlueCross BlueShield of Western New York | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 18 | $13,218 | 18 | $13,218 | 0 | $0 | 18 | $13,218 |
| 013 | PA | Highmark BlueCross BlueShield | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 118 | $45,009 | 193 | $281,219 | 311 | $326,229 | 0 | $0 | 311 | $326,229 |
| 015 | TN | BlueCross BlueShield of Tennessee | 1 | $7,436 | 33 | $4,485 | 0 | $0 | 0 | $0 | 16 | $4,312 | 65 | $24,948 | 115 | $41,181 | 41 | $7,904 | 156 | $49,085 |
| 016 | WY | BlueCross BlueShield of Wyoming | 0 | $0 | 13 | $1,680 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 13 | $1,680 | 0 | $0 | 13 | $1,680 |
| 017 | IL | BlueCross BlueShield of Illinois (HCSC) | 2 | $56,253 | 63 | $7,936 | 2 | $3,162 | 0 | $0 | 196 | $46,280 | 47 | $44,860 | 310 | $158,491 | 15 | $7,092 | 325 | $165,583 |
| 021 | OH | WellPoint BlueCross BlueShield of Ohio | 0 | $0 | 62 | $38,015 | 1 | $1,249 | 5 | $6,677 | 0 | $0 | 24 | $43,654 | 92 | $89,595 | 10 | $2,765 | 102 | $92,360 |
| 024 | SC | BlueCross BlueShield of South Carolina | 3 | $33,764 | 35 | $2,920 | 0 | $0 | 0 | $0 | 9 | $1,302 | 0 | $0 | 47 | $37,987 | 0 | $0 | 47 | $37,987 |
| 027 | NH | WellPoint BlueCross BlueShield of New Hampshire | 0 | $0 | 31 | $22,059 | 0 | $0 | 1 | $5,214 | 0 | $0 | 14 | $3,137 | 46 | $30,410 | 0 | $0 | 46 | $30,410 |
| 028 | VT | BlueCross BlueShield of Vermont | 0 | $0 | 7 | $1,306 | 0 | $0 | 0 | $0 | 7 | $1,805 | 2 | $105 | 16 | $3,216 | 0 | $0 | 16 | $3,216 |
| 029 | TX | BlueCross BlueShield of Texas (HCSC) | 4 | $58,261 | 80 | $4,995 | 6 | $12,065 | 0 | $0 | 729 | $219,122 | 128 | $65,354 | 947 | $359,796 | 184 | $108,405 | 1,131 | $468,201 |
| 030 | CO | WellPoint BlueCross BlueShield of Colorado | 1 | $13,386 | 19 | $3,314 | 0 | $0 | 0 | $0 | 14 | $2,883 | 6 | $8,789 | 40 | $28,372 | 14 | $14,045 | 54 | $42,417 |
| 031 | IA | Wellmark BlueCross BlueShield of Iowa | 1 | $5,335 | 31 | $3,108 | 0 | $0 | 0 | $0 | 40 | $2,951 | 0 | $0 | 72 | $11,394 | 0 | $0 | 72 | $11,394 |
| 032 | MI | BlueCross BlueShield of Michigan | 0 | $0 | 31 | $5,186 | 0 | $0 | 0 | $0 | 71 | $10,132 | 316 | $70,410 | 418 | $85,728 | 0 | $0 | 418 | $85,728 |
| 033 | NC | BlueCross BlueShield of North Carolina | 4 | $83,493 | 146 | $10,511 | 1 | $894 | 0 | $0 | 296 | $60,073 | 103 | $31,362 | 550 | $186,334 | 22 | $2,607 | 572 | $188,941 |
| 034 | ND | BlueCross BlueShield of North Dakota | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 28 | $3,900 | 0 | $0 | 28 | $3,900 | 0 | $0 | 28 | $3,900 |
| 036 | PA | Capital BlueCross | 2 | $18,602 | 9 | $1,315 | 1 | $4,808 | 0 | $0 | 0 | $0 | 15 | $5,709 | 27 | $30,434 | 0 | $0 | 27 | $30,434 |
| 037 | MT | BlueCross BlueShield of Montana | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 4 | $1,376 | 4 | $1,376 |
| 038 | HI | BlueCross BlueShield of Hawaii | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 |
| 039 | IN | WellPoint BlueCross BlueShield of Indiana | 0 | $0 | 4 | $15,100 | 0 | $0 | 0 | $0 | 43 | $11,383 | 11 | $15,025 | 58 | $41,508 | 42 | $13,186 | 100 | $54,694 |
| 040 | MS | BlueCross BlueShield of Mississippi | 1 | $1,472 | 50 | $5,214 | 0 | $0 | 0 | $0 | 39 | $7,709 | 121 | $16,944 | 211 | $31,339 | 17 | $8,959 | 228 | $40,298 |
| 041 | FL | BlueCross BlueShield of Florida | 9 | $289,317 | 111 | $14,767 | 2 | $4,378 | 0 | $0 | 175 | $55,918 | 399 | $188,158 | 696 | $552,538 | 6 | $4,878 | 702 | $557,417 |
| 042 | MO | BlueCross BlueShield of Kansas City | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 2 | $3,648 | 27 | $11,395 | 29 | $15,043 | 0 | $0 | 29 | $15,043 |
| 043 | ID | Regence BlueShield of Idaho | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 |
| 044 | AR | BlueCross BlueShield of Arkansas | 3 | $18,147 | 0 | $0 | 0 | $0 | 0 | $0 | 146 | $13,156 | 0 | $0 | 149 | $31,303 | 2 | $528 | 151 | $31,831 |
| 045 | KY | WellPoint BlueCross BlueShield of Kentucky | 1 | $214 | 57 | $8,820 | 1 | $7,789 | 0 | $0 | 0 | $0 | 1 | $45 | 60 | $16,868 | 7 | $1,043 | 67 | $17,911 |
| 047 | WI | WellPoint BlueCross BlueShield United of Wisconsin | 0 | $0 | 249 | $19,527 | 0 | $0 | 0 | $0 | 14 | $30,274 | 14 | $10,857 | 277 | $60,657 | 0 | $0 | 277 | $60,657 |
| 048 | NY | Empire BlueCross BlueShield (WellPoint) | 2 | $60,852 | 68 | $8,236 | 2 | $1,231 | 0 | $0 | 204 | $23,172 | 254 | $22,666 | 530 | $116,157 | 2 | $639 | 532 | $116,796 |
| 049 | NJ | Horizon BlueCross BlueShield of New Jersey | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 15 | $2,455 | 74 | $17,002 | 89 | $19,457 | 2 | $593 | 91 | $20,050 |
| 050 | CT | WellPoint BlueCross BlueShield of Connecticut | 0 | $0 | 64 | $5,341 | 0 | $0 | 1 | $3,219 | 0 | $0 | 2 | $2,960 | 67 | $11,520 | 2 | $1,121 | 69 | $12,640 |
| 052 | CA | WellPoint BlueCross of California | 1 | $15,306 | 294 | $69,410 | 0 | $0 | 0 | $0 | 112 | $27,681 | 13 | $9,093 | 420 | $121,490 | 0 | $0 | 420 | $121,490 |
| 053 | NE | BlueCross BlueShield of Nebraska | 0 | $0 | 15 | $1,343 | 0 | $0 | 0 | $0 | 36 | $13,516 | 1 | $360 | 52 | $15,219 | 0 | $0 | 52 | $15,219 |
| 054 | WV | Mountain State BlueCross BlueShield | 0 | $0 | 26 | $2,622 | 0 | $0 | 0 | $0 | 2 | $2,089 | 1 | $4,864 | 29 | $9,574 | 0 | $0 | 29 | $9,574 |
| 055 | PA | Independence BlueCross | 11 | $126,873 | 12 | $15,969 | 0 | $0 | 0 | $0 | 20 | $5,353 | 0 | $0 | 43 | $148,196 | 0 | $0 | 43 | $148,196 |
| 056 | AZ | BlueCross BlueShield of Arizona | 2 | $55,090 | 175 | $12,019 | 0 | $0 | 0 | $0 | 104 | $17,051 | 7 | $21,983 | 288 | $106,143 | 0 | $0 | 288 | $106,143 |

Coordination of Benefits with Medicare
BlueCross and BlueShield Plans
Claims Reimbursed from June 1, 2011 through March 31, 2012

SUMMARY OF QUESTIONED CHARGES

| | | | COB Category A | | COB Category B | | COB Category C | | COB Category D | | COB Category E | | COB Category F | | ALL COB Errors | | Non-COB Errors | | TOTAL QUESTIONED | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Plan Site | Plan State | Plan Name | Claim Lines | Amount Questioned | Claim Lines | Amount Questioned | Claim Lines | Amount Questioned | Claim Lines | Amount Questioned | Claim Lines | Amount Questioned | Claim Lines | Amount Questioned | Claim Lines | Amount Questioned | Claim Lines | Amount Questioned | Claim Lines | Amount Questioned |
| 058 | OR | Regence BlueCross BlueShield of Oregon | 1 | $250 | 9 | $1,630 | 0 | $0 | 0 | $0 | 5 | $7,394 | 5 | $8,988 | 20 | $18,262 | 8 | $7,010 | 28 | $25,272 |
| 059 | ME | WellPoint BlueCross BlueShield of Maine | 0 | $0 | 32 | $4,337 | 3 | $9,213 | 2 | $2,354 | 1 | $51 | 3 | $103 | 41 | $16,057 | 0 | $0 | 41 | $16,057 |
| 060 | RI | BlueCross BlueShield of Rhode Island | 1 | $37,644 | 67 | $1,360 | 2 | $3,857 | 0 | $0 | 15 | $853 | 2 | $20 | 87 | $43,733 | 0 | $0 | 87 | $43,733 |
| 061 | NV | WellPoint BlueCross BlueShield of Nevada | 0 | $0 | 19 | $1,910 | 0 | $0 | 0 | $0 | 18 | $4,439 | 0 | $0 | 37 | $6,349 | 0 | $0 | 37 | $6,349 |
| 062 | VA | WellPoint BlueCross Blue Shield of Virginia | 2 | $21,144 | 55 | $28,128 | 1 | $1,483 | 3 | $3,656 | 227 | $32,452 | 106 | $19,140 | 394 | $106,003 | 9 | $881 | 403 | $106,884 |
| 064 | NY | Excellus BlueCross BlueShield of the Rochester Area | 0 | $0 | 68 | $6,795 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 68 | $6,795 | 1 | $21 | 69 | $6,815 |
| 066 | UT | Regence BlueCross BlueShield of Utah | 0 | $0 | 82 | $6,714 | 0 | $0 | 0 | $0 | 24 | $9,899 | 3 | $463 | 109 | $17,076 | 2 | $601 | 111 | $17,676 |
| 067 | CA | BlueShield of California | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 329 | $43,862 | 31 | $12,222 | 360 | $56,084 | 40 | $31,510 | 400 | $87,594 |
| 068 | PR | Triple-S Salud, Inc. | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 |
| 069 | WA | Regence BlueShield of Washington | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 68 | $6,729 | 26 | $11,497 | 94 | $18,226 | 13 | $7,989 | 107 | $26,215 |
| 070 | AK | BlueCross BlueShield of Alaska | 0 | $0 | 0 | $0 | 1 | $4,094 | 0 | $0 | 0 | $0 | 1 | $26 | 2 | $4,120 | 0 | $0 | 2 | $4,120 |
| 074 | SD | Wellmark BlueCross BlueShield of South Dakota | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 |
| 075 | WA | Premera BlueCross | 1 | $33,308 | 1 | $274 | 0 | $0 | 0 | $0 | 73 | $3,666 | 19 | $6,799 | 94 | $44,047 | 0 | $0 | 94 | $44,047 |
| 076 | MO | WellPoint BlueCross BlueShield of Missouri | 1 | $5,932 | 85 | $6,611 | 2 | $4,539 | 1 | $2,147 | 5 | $3,551 | 33 | $7,022 | 127 | $29,802 | 0 | $0 | 127 | $29,802 |
| 078 | MN | BlueCross BlueShield of Minnesota | 4 | $52,535 | 0 | $0 | 1 | $12,456 | 0 | $0 | 101 | $54,933 | 67 | $10,548 | 173 | $130,471 | 2 | $653 | 175 | $131,125 |
| 079 | NY | Excellus BlueCross BlueShield of Central New York | 0 | $0 | 56 | $5,626 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 56 | $5,626 | 0 | $0 | 56 | $5,626 |
| 082 | KS | BlueCross BlueShield of Kansas | 0 | $0 | 9 | $1,062 | 0 | $0 | 0 | $0 | 1 | $1,316 | 0 | $0 | 10 | $2,378 | 0 | $0 | 10 | $2,378 |
| 083 | OK | BlueCross BlueShield of Oklahoma (HCSC) | 0 | $0 | 159 | $24,650 | 1 | $1,971 | 0 | $0 | 13 | $3,918 | 42 | $9,426 | 215 | $39,966 | 8 | $3,150 | 223 | $43,116 |
| 084 | NY | Excellus BlueCross BlueShield of Utica-Watertown | 1 | $1,959 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 1 | $1,959 | 0 | $0 | 1 | $1,959 |
| 085 | DC | CareFirst BlueCross BlueShield (DC Service Area) | 5 | $69,910 | 303 | $74,487 | 1 | $4,351 | 0 | $0 | 388 | $114,228 | 299 | $57,059 | 996 | $320,036 | 43 | $8,538 | 1,039 | $328,574 |
| 088 | PA | BlueCross of Northeastern Pennsylvania | 0 | $0 | 12 | $1,289 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 12 | $1,289 | 0 | $0 | 12 | $1,289 |
| 089 | DE | BlueCross BlueShield of Delaware | 0 | $0 | 117 | $13,188 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 117 | $13,188 | 0 | $0 | 117 | $13,188 |
| 092 | DC | CareFirst BlueCross BlueShield (Overseas Area) | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 0 | $0 | 16 | $23,176 | 16 | $23,176 | 0 | $0 | 16 | $23,176 |
| | | TOTALS | 80 | $1,306,092 | 3,102 | $526,570 | 31 | $107,022 | 13 | $23,266 | 4,792 | $1,270,550 | 2,753 | $1,160,285 | 10,771 | $4,393,785 | 725 | $296,854 | 11,496 | $4,690,639 |

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

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

August 31, 2012

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

**Reference:** **OPM DRAFT AUDIT REPORT**
**Tier XII Global Coordination of Benefits**
**Audit Report #1A-99-00-12-029**

Dear [redacted]:

This is in response to the above - referenced U.S. Office of Personnel Management (OPM) Draft Audit Report concerning the Global Coordination of Benefits Audit for claims paid from June 1, 2011 through March 31, 2012. Our comments concerning the findings in the report are as follows:

**Recommendation 1 and 3:**

**Coordination of Benefits with Medicare Questioned Amount** **$15,765,580**

The OPM OIG submitted their sample of potential Medicare Coordination of Benefits errors to the Blue Cross Blue Shield Association (BCBS) on April 26, 2012. The BCBS Association and/or the BCBS Plans were requested to review these potential errors and provide responses by July 31, 2012. These listings included claims incurred on or after May 15, 2011 and reimbursed from June 1, 2011 through March 31, 2012. OPM OIG identified 422,660 claim lines, totaling $49,977,166 in payments, which potentially were not coordinated with Medicare. From this universe, OPM OIG selected for review a sample of 48,559 claim lines, totaling $18,748,248 in payments with a potential overpayment of $15,765,580 to the Federal Employee Health Benefit Program (FEHBP).

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

After reviewing the OIG listing of potentially uncoordinated Medicare COB claims totaling $15,765,580, the BCBS Association agrees that claims totaling $2,351,475 were paid incorrectly and identified by the audit. For the remaining $13,414,106 in claim payments, we noted the following:

- $8,589,815 in claims that were paid correctly;

- $3,086,043 in claims that were initially paid incorrectly but the error was identified and corrected before the Audit Notification date and overpayment was recovered and returned before the response was due to OPM;
- $851,335 in claims that were initially paid incorrectly but recovery was initiated on or after the Audit Notification date but before receiving the OIG sample and the overpayment was recovered and returned before the response was due to OPM;
- $886,952 claims that were initially paid incorrectly but recovery was initiated before receiving the OIG sample, however overpayment was not recovered and returned before the response was due to OPM; and

See Attachment B for the amounts associated with each of the above disagree reasons.

For claim payments that the BCBS Association agrees that the claims were paid correctly, see Attachment C.

The Association's Action Plan includes steps to include that the top 10 Plans with COB errors are following the corrective action plan. In addition, to reduce the number and frequency of uncoordinated Medicare COB claims, BCBSA has completed the following:

- Implemented an edit to defer all facility claims with Medicare B Revenue Codes where the member does not have Part A but has Part B. This was implemented in the Fourth Quarter 2011.
- Modified the Uncoordinated Medicare Application to run monthly instead of quarterly in early 2011.
- Required the top ten Plans with the highest COB findings to develop and implement action plans to improve performance and address the root causes behind erroneous Medicare COB payments. These Plans have taken steps to address operational weaknesses such as proactively working daily retroactive enrollment reports to ensure corrective action is completely timely, training for processing staff, communicating with the provider community to reinforce optimal billing practices that reduce downstream issues, and enhancing in-line auditing techniques to focus on claims with a high potential for claims payment errors.
- Modified the FEP post payment review process to match with OIG global audit claims listings where appropriate. The FEP Uncoordinated Medicare Application was updated on April 14, 2012. Based on our preliminary evaluation, we believe that changes made will address 85% of the claims questioned. Once the COB Tier 12 audit is completed, we will further evaluate the effectiveness of the changes determine next steps.
- Modified the FEP claims system to defer inpatient facility Part B charges as well as changes related to payment of Home Health and Skill Nursing Facility

Medicare claims for review and coordination. These edits were implemented in early 2012.
- Modify existing pre-payment compatibility editing to increase clarity around Medicare Payment Disposition usage. This change was implemented in Release 4 on January 1, 2012.

The following corrective actions remain in process and under review:

- Provide additional Plan guidance on mapping data from Medicare crossover claims to the correct Medicare Payment Disposition code. Because of resource limitations, this will not be implemented until 2013.
- Modify the FEP claims system to require Plans to indicate that facility claims not coordinated with Medicare Part A are supported by a Medical Denial Notice. This modification is under review and a work plan will be developed by the Third Quarter 2012 for implementation in 2013.
- Create new Explanation of Benefit Remarks to more accurately explain denials due to no Medicare coordination. The targeted implementation date is 2013.
- Modify the FEP claims system to accept Medicare denial reasons. This will allow additional editing of Medicare claims to ensure that claims are paid correctly. This modification will be further explored during 2013.

**Recommendation 2:**

OPM OIG recommended that BCBSA provide support for each COB error that is included in the sample selections and part of this preliminary finding (even if the BCBS plan initiated the overpayment recovery prior to the audit notification date and completed the recovery process by the draft report response due date).

**BCBSA Response:**

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

**Recommendation 4:**

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

**BCBSA Response:**

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

- FEP updated the Plan Administrative Manual to instruct the Plans on what to do with the Retroactive Enrollment Report.
- As part of the FEP CPR, FEP reviews Plan procedures for reviewing retroactive enrollment reports as well as tests transactions to ensure that all claims are reviewed back to the Medicare effective dates.

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

Sincerely,

[redacted]
Director, FEP Program Assurance

Attachments