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-99-00-10-055

Date: June 8, 2011

--CAUTION--

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

Office of the
Inspector General

AUDIT REPORT

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

Global Coordination of Benefits
BlueCross and BlueShield Plans

REPORT NO. 1A-99-00-10-055 DATE: June 8, 2011

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UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
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EXECUTIVE SUMMARY

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This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at all BlueCross and BlueShield (BCBS) plans questions $7,742,389 in health benefit charges. The BlueCross BlueShield Association (Association) and/or BCBS plans agreed with $3,529,991 and disagreed with $4,212,398 of the questioned charges.

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covers health benefit payments from January 1, 2009 through May 31, 2010 as reported in the Annual Accounting Statements. Specifically, we identified claims incurred from October 1, 2008 through May 31, 2010 that were reimbursed from January 1, 2009 through May 31, 2010 and potentially not coordinated with Medicare. We determined that the BCBS plans did not properly coordinate 15,409 claim line payments with Medicare as required by the FEHBP contract. As a result, the FEHBP was overcharged $7,742,389. When we notified the Association of these errors on July 1, 2010, the claims were within the Medicare timely filing requirement and could be filed with Medicare for coordination of benefits.

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I. INTRODUCTION AND BACKGROUND

INTRODUCTION

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

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

BACKGROUND

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

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

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

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

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

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

Findings from our previous global coordination of benefits audit of all BCBS plans (Report No. 1A-99-00-10-009, dated March 31, 2010) for contract year 2008 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 July 1, 2010. The Association's comments offered in response to the draft report were considered in preparing our final report and are included as the Appendix to this report. Also, additional documentation provided by the Association and BCBS plans on various dates through May 11, 2011 was considered in preparing our final report.

II. OBJECTIVE, SCOPE, AND METHODOLOGY

OBJECTIVE

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

SCOPE

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

The audit covered health benefit payments from January 1, 2009 through May 31, 2010 as reported in the Annual Accounting Statements. Specifically, we identified claims incurred from October 1, 2008 through May 31, 2010 that were reimbursed from January 1, 2009 through May 31, 2010 and potentially not coordinated with Medicare.[2] Based on our claim error reports, we identified 959,979 claim lines, totaling $99,293,156 in payments, that potentially were not coordinated with Medicare. From this universe, we selected and reviewed 77,652 claim lines, totaling $33,452,198 in payments, for coordination of benefits with Medicare. When we notified the Association of these potential errors on July 1, 2010, the claims were within the Medicare timely filing requirement and could be filed with Medicare for coordination of benefits.

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] Our initial audit scope included claims incurred on or after October 1, 2008 that were reimbursed in 2009 and potentially not coordinated with Medicare. However, due to a recent change with the Medicare timely filing requirement, we changed our audit scope to include claims incurred on or after October 1, 2008 that were reimbursed from January 1, 2009 through May 31, 2010 and potentially not coordinated with Medicare. 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 Director's Office, the FEP Operations Center, and the BCBS plans. Due to time constraints, we did not verify the reliability of the data generated by the various information systems involved. However, while utilizing the computer-generated data during our audit 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 December 2010 through May 2011.

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 77,652 claim lines, totaling $33,452,198 in payments, from a universe of 959,979 claim lines, totaling $99,293,156 in payments, that potentially were not coordinated with Medicare (See Schedule A for our sample selection methodology).

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

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

III. AUDIT FINDING AND RECOMMENDATIONS

Coordination of Benefits with Medicare **$7,742,389**

The BCBS plans did not properly coordinate 15,409 claim line payments, totaling $9,661,910, 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 $7,742,389 for these claim lines.

The 2010 BlueCross and BlueShield Service Benefit Plan brochure, page 121, Primary Payer Chart, illustrates when Medicare is the primary payer. In addition, page 24 of that brochure states, "We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), regardless of whether Medicare pays."

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

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

For claims incurred from October 1, 2008 through May 31, 2010 and reimbursed from January 1, 2009 through May 31, 2010, we performed a computer search and identified 959,979 claim lines, totaling $99,293,156 in payments, that potentially were not coordinated with Medicare. From this universe, we selected for review a sample of 77,652 claim lines, totaling $33,452,198 in payments, to determine whether the BCBS plans complied with the contract provisions relative to coordination of benefits (COB) with Medicare. When we submitted our sample of potential COB errors to the Association on July 1, 2010, the claims were within the Medicare timely filing requirement and could be filed with Medicare for coordination of benefits.

Generally, Medicare Part A pays all covered costs for inpatient care in hospitals, skilled nursing facilities and hospice care, except for deductibles and coinsurance. For each Medicare Benefit Period, there is a one-time deductible, followed by a daily copayment beginning with the 61st day. Beginning with the 91st day of the Medicare Benefit Period, Medicare Part A benefits may be exhausted, depending on whether the patient elects to use their Lifetime Reserve Days. For the uncoordinated Medicare Part A claims, we estimate that the FEHBP was overcharged for the total claim payment amounts. When applicable, we reduced the questioned amount by the Medicare deductible and/or Medicare copayment.

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

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

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

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

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

From these six categories, we selected for review a sample of claim lines that potentially were not coordinated with Medicare (See Schedule A for our sample selection methodology). Based on our review, we identified 15,409 claim lines, totaling $9,661,910 in payments, where the FEHBP paid as the primary insurer when Medicare was the primary insurer. We estimate that the FEHBP was overcharged $7,742,389 for these claim line payments.[3]

[3] In addition, there were 9,250 claim lines, totaling $5,212,089 in payments, with COB errors that were identified by the BCBS plans before the start of our audit (i.e., July 1, 2010) and adjusted by the Association's response due date (i.e., September 30, 2010) to the draft report. Since these COB errors were identified by the BCBS plans before the start of our audit and adjusted by the Association's response due date to the draft report, we did not question these COB errors in the final report.

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

Category	Claim Lines	Amount Paid	Amount Questioned
Category A: Medicare Part A Primary for Inpatient (I/P) Facility	205	$3,578,502	$3,578,502
Category B: Medicare Part A Primary for Skilled Nursing/Home Health Care (HHC)/ Hospice Care	3,362	$723,330	$723,330
Category C: Medicare Part B Primary for Certain I/P Facility Charges	125	$1,624,895	$571,380
Category D: Medicare Part B Primary for Skilled Nursing/HHC/Hospice Care	160	$540,606	$240,833
Category E: Medicare Part B Primary for Outpatient (O/P) Facility and Professional	9,591	$2,217,746	$1,801,172
Category F: Medicare Part B Primary for O/P Facility and Professional (Participation Code F)	1,966	$976,831	$827,172
Total	15,409	$9,661,910	$7,742,389

Our audit disclosed the following for the COB errors:

- For 11,013 (71 percent) of the claim lines questioned, there was no special information on the FEP national claims system to identify Medicare as the primary payer when the claims were paid. However, when the Medicare information was subsequently added to the FEP national claims system, the BCBS plans did not review and/or adjust the patient's prior claims back to the Medicare effective dates.

- For 4,396 (29 percent) of the claim lines questioned, there was special information present on the FEP national claims system to identify Medicare as the primary payer when the claims were paid. An incorrect Medicare Payment Disposition Code was used for 74 percent of these claims. The Medicare Payment Disposition Code identifies Medicare's responsibility for payment on each charge line of a claim. Per the FEP Administrative Manual, the completion of this field is required on all claims for patients who are age 65 or older. We found that codes E, F, and N were incorrectly used. An incorrect entry in this field causes the claim line to be excluded from coordination of benefits with Medicare.

Of the $7,742,389 in questioned charges, $3,235,975 (42 percent) was identified by the BCBS plans before the start of our audit (i.e., July 1, 2010). However, since the BCBS plans had not completed the recovery process and/or adjusted these claims by the Association's response due date (i.e., September 30, 2010) to the draft report, we are continuing to question these COB errors. The remaining questioned charges of $4,506,414 (58 percent) were identified as a result of our audit.

Association's Response:

In response to the draft audit report, the Association states, "After reviewing the OIG listing of potentially uncoordinated Medicare COB claims . . . BCBSA identified $3,220,991 . . . of the questioned amount that was not coordinated with Medicare. For the time period covered by the audit, FEP reported Medicare savings in excess of $25 billion. To date Plans have recovered $1,343,596 in claim payment errors. Recovery has been initiated on the remaining overpayments and the Plans will continue to pursue these overpayments . . .

Of the $3,220,991 in claim payments that were not coordinated with Medicare, we noted the following:

- Claims processors incorrectly overrode the Medicare deferral, missed the MSN when processing the claim, claims system did not defer the claim for review or other various reasons for claims totaling $2,762,293.
- Claims were not identified by the FEP Claims System retro-active enrollment reports, Uncoordinated Medicare Application or FEP ad-hoc reports for Plan review for claims totaling $286,682; and
- Claims were identified by the FEP Claims System retro-active enrollment reports, Uncoordinated Medicare Application or FEP ad-hoc reports before the audit began but were not worked by the Plan for claims totaling $547,181.

To reduce the number and frequency of uncoordinated Medicare claims, BCBSA has implemented an action plan . . .

To timely identify uncoordinated Medicare claims before the new 12 month Medicare timely filing limit has passed, FEP is also implementing the following:

- Increase the frequency of the Uncoordinated Medicare Application update from quarterly to monthly by 4th quarter 2010;
- Issue ad hoc reports to Plans on a quarterly basis that identify claims that are not included in the Uncoordinated Medicare Application;
- Update the Uncoordinated Medicare Application for claims currently included in ad hoc reports by 2nd quarter 2011;
- Issued an Audit Alert informing the Plan of the change and the need to work with their providers to ensure that claims are timely submitted to Medicare; and
- Evaluate whether or not the quarterly Medicare match process can be moved to monthly from quarterly by 1st quarter 2011.

To the extent that claim payment errors did occur or were not identified, these payments were good faith erroneous benefit payments and fall within the context of CS 1039, Section 2.3 (g). Any benefit payments the Plans are unable to recover are allowable charges to the Program. In addition, as good faith erroneous payments, lost investment income is not applicable to these confirmed overpayments.

We contested the remaining . . . questioned uncoordinated Medicare claims as a result of the following:

- Claims totaling $5,168,042 were either adjusted before the audit started or recovery was initiated before the audit started and adjusted after the audit;
- Recovery was initiated before the audit started on claims totaling $2,991,200, but the recovery process has not been completed; . . .
- Claims totaling $491,675 were identified by the FEP Uncoordinated Medicare Application on July 7, 2010 and would have been adjusted by Plans before the Medicare timely filing limit without the OIG audit; . . .

Documentation to support the contested amounts and the initiation of overpayment recovery before the audit has been provided."

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 $7,742,389. If COB errors were identified by the BCBS plans before the start of our audit (i.e., July 1, 2010) and adjusted by the Association's response due date to the draft report (i.e., September 30, 2010), we did not question these COB errors in the final report. Based on the Association's response and the BCBS plans' additional documentation, we determined that the Association and/or plans agree with $3,529,991 and disagree with $4,212,398 of the revised questioned charges.

Although the Association agrees with $3,220,991 in its response, the BCBS plans' documentation supports concurrence with $3,529,991. For these uncontested COB errors, we disagree with the Association's comments that the payments were good faith erroneous benefit payments. When the Medicare information was subsequently added to the claims system, the BCBS plans did not review and/or adjust the patients' prior claims back to the Medicare effective dates. Since the BCBS plans did not take the proper action to immediately correct the overpayments, we do not believe the BCBS plans acted in good faith to recover these overpayments.

Based on the Association's response and/or the BCBS plans' documentation, the contested amount of $4,212,398 represents the following items:

- $3,235,975 of the contested amount represents COB errors where recovery efforts were initiated by the BCBS plans before the audit started. However, the plans had not recovered these overpayments and adjusted the claims by the Association's response due date to the draft report. Since these overpayments had not been recovered and returned to the FEHBP by the Association's response due date, we are continuing to question this amount in the final report.

- $941,968 of the contested amount represents COB errors that were identified by the FEP Operations Center's "FEP Uncoordinated Medicare Application" on July 7, 2010 and would have been adjusted before the Medicare timely filing limit without the OIG audit. Since these COB errors were identified after the audit started, we are continuing to question this amount in the final report.

- $29,399 of the contested amount represents COB errors where recovery efforts were initiated by the plans after the audit started even though the plans' responses state that the recoveries were initiated prior. Since the recoveries were initiated after the audit started and the overpayments had not been recovered and returned to the FEHBP by the Association's response due date, we are continuing to question this amount in the final report.

- $5,056 of the contested amount represents three non-COB errors where the BCBS of Minnesota plan agrees that these claims were duplicate payments but disagrees with the finding because the recovery efforts were initiated prior to the start of the audit. However, we verified that these recoveries were actually initiated after the audit started. Since the recoveries were initiated after the audit started and the overpayments had not been recovered and returned to the FEHBP by the Association's response due date, we are continuing to question this amount in the final report.

Recommendation 1

We recommend that the contracting officer disallow $7,742,389 for uncoordinated claim payments and verify that the BCBS plans return all amounts recovered to the FEHBP.

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.

Recommendation 3

We recommend 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.

Recommendation 4

We recommend that the contracting officer require the Association to revise and correct the procedures regarding the input of Medicare Payment Disposition Codes. We also recommend that the software used for handling claims received electronically be reviewed to verify that it creates the appropriate value for Medicare Payment Disposition Codes. These corrective actions should ensure that the FEP system will utilize the special information when it is present to properly coordinate these claims.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

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SCHEDULE A

V. SCHEDULES

Coordination of Benefits with Medicare

BlueCross and BlueShield Plans

Claims Reimbursed from January 1, 2009 through May 31, 2010

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	800	804	590	$10,745,414	all patients	800	804	590	$10,745,414	100%	$10,745,414
Category B: Medicare Part A Primary for Skilled Nursing/HHC/Hospice Care	7,119	22,898	2,062	$4,278,006	patients with cumulative claims of $1,500 or more	3,599	14,362	524	$3,495,949	100%	$3,495,949
Category C: Medicare Part B Primary for Certain Inpatient Facility Charges	280	280	261	$3,342,044	all patients	280	280	261	$3,342,044	25%	$835,511
Category D: Medicare Part B Primary for Skilled Nursing/HHC/Hospice Care	295	531	190	$1,060,807	patients with cumulative claims of $1,500 or more	228	397	141	$1,033,123	25%	$258,281
Category E: Medicare Part B Primary for Outpatient Facility and Professional	18,561	36,431	5,079	$6,976,879	patients with cumulative claims of $1,500 or more	9,161	21,727	794	$5,355,601	80%	$4,284,481
Category F: Medicare Part B Primary for Outpatient Facility and Professional (Participation Code F)	602,180	899,035	273,577	$72,890,004	patients with cumulative claims of $5,000 or more	15,486	40,082	896	$9,480,067	80%	$7,584,054
Totals	**629,235**	**959,979**		**$99,293,156**		**29,554**	**77,652**		**$33,452,198**		**$27,203,689**

Coordination of Benefits with Medicare
BlueCross and BlueShield Plans
Claims Reimbursed from January 1, 2009 through May 31, 2010

SUMMARY OF QUESTIONED CHARGES

			COB Category A		COB Category B		COB Category C		COB Category D		COB Category E		COB Category F		ALL COB Categories	
Plan Site #	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
003	NM	BCBS of New Mexico	2	$6,189	0	$0	0	$0	0	$0	3	$761	0	$0	5	$6,950
005	GA	WellPoint BCBS of Georgia	12	$174,378	36	$13,748	15	$82,339	0	$0	633	$162,081	86	$17,991	782	$450,537
006	MD	CareFirst BCBS	4	$69,989	49	$11,152	8	$44,453	0	$0	121	$45,483	10	$7,320	192	$178,397
007	LA	BCBS of Louisiana	5	$35,894	0	$0	0	$0	0	$0	64	$19,475	13	$10,235	82	$65,604
009	AL	BCBS of Alabama	1	$13,100	0	$0	3	$6,194	0	$0	38	$61,410	78	$4,660	120	$85,364
010	ID	BC of Idaho Health Service	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
011	MA	BCBS of Massachusetts	0	$0	98	$8,244	2	$15,359	0	$0	133	$16,333	1	$4,624	234	$44,560
012	NY	BCBS of Western New York	0	$0	0	$0	1	$4,280	0	$0	0	$0	0	$0	1	$4,280
013	PA	Highmark BCBS	0	$0	0	$0	1	$130	0	$0	26	$3,387	0	$0	27	$3,517
015	TN	BCBS of Tennessee	4	$133,839	61	$15,397	1	$2,393	0	$0	322	$107,468	0	$0	388	$259,097
016	WY	BCBS of Wyoming	0	$0	0	$0	0	$0	0	$0	28	$13,759	0	$0	28	$13,759
017	IL	BCBS of Illinois	9	$185,004	160	$16,120	0	$0	0	$0	499	$122,057	163	$25,989	831	$349,170
021	OH	WellPoint BCBS of Ohio	9	$154,302	182	$47,874	4	$11,814	23	$52,162	65	$12,034	425	$74,693	708	$352,879
024	SC	BCBS of South Carolina	4	$35,899	0	$0	2	$6,130	1	$1,098	27	$10,565	0	$0	34	$53,692
027	NH	WellPoint BCBS of New Hampshire	3	$30,662	0	$0	2	$7,223	9	$52,145	1	$7	0	$0	15	$90,037
028	VT	BCBS of Vermont	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
029	TX	BCBS of Texas	23	$630,755	158	$13,759	17	$44,087	23	$418	1,854	$200,774	143	$33,156	2,218	$922,949
030	CO	WellPoint BCBS of Colorado	6	$59,234	129	$31,123	2	$4,438	9	$11,460	104	$13,298	7	$4,612	257	$124,165
031	IA	Wellmark BCBS of Iowa	0	$0	0	$0	0	$0	1	$1,521	69	$4,994	10	$166	80	$6,681
032	MI	BCBS of Michigan	4	$100,776	122	$17,865	5	$10,560	14	$488	2	$1,400	5	$4,285	152	$135,374
033	NC	BCBS of North Carolina	5	$70,233	423	$54,271	3	$3,657	0	$0	44	$3,751	108	$23,335	583	$155,247
034	ND	BCBS of North Dakota	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
036	PA	Capital BC	3	$24,779	39	$4,194	2	$4,571	0	$0	0	$0	0	$0	44	$33,544
037	MT	BCBS of Montana	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
038	HI	BCBS of Hawaii	0	$0	0	$0	1	$2,446	0	$0	0	$0	0	$0	1	$2,446
039	IN	WellPoint BCBS of Indiana	2	$24,611	67	$30,513	4	$61,001	3	$19,804	106	$32,867	2	$542	184	$169,338
040	MS	BCBS of Mississippi	1	$61,477	0	$0	1	$4,197	6	$3,383	131	$71,536	22	$12,518	161	$153,111
041	FL	BCBS of Florida	6	$57,322	89	$30,277	0	$0	1	$618	803	$74,776	318	$332,885	1,217	$495,878
042	MO	BCBS of Kansas City	1	$7,321	0	$0	2	$439	0	$0	104	$84,311	4	$8,305	111	$100,376
043	ID	Regence BS of Idaho	0	$0	0	$0	0	$0	0	$0	5	$250	0	$0	5	$250
044	AR	Arkansas BCBS	0	$0	0	$0	0	$0	0	$0	0	$0	1	$192	1	$192
045	KY	WellPoint BCBS of Kentucky	4	$132,200	93	$7,835	0	$0	8	$10,688	0	$0	9	$7,458	114	$158,181
047	WI	WellPoint BCBS United of Wisconsin	2	$74,912	66	$6,689	8	$56,795	3	$3,578	13	$3,013	86	$26,876	178	$171,863
048	NY	Empire BCBS	14	$250,579	89	$9,886	9	$43,207	0	$0	769	$97,934	6	$6,463	887	$408,069

Coordination of Benefits with Medicare
BlueCross and BlueShield Plans
Claims Reimbursed from January 1, 2009 through May 31, 2010

SUMMARY OF QUESTIONED CHARGES

			COB Category A		COB Category B		COB Category C		COB Category D		COB Category E		COB Category F		ALL COB Categories	
Plan Site #	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
049	NJ	Horizon BCBS of New Jersey	7	$56,974	273	$30,970	3	$8,874	14	$15,032	409	$104,466	19	$16,342	725	$232,658
050	CT	WellPoint BCBS of Connecticut	0	$0	64	$14,825	1	$13,570	0	$0	49	$2,594	1	$114	115	$31,103
052	CA	WellPoint BC of California	29	$443,162	155	$91,243	5	$27,726	4	$4,753	527	$131,230	40	$44,303	760	$742,417
053	NE	BCBS of Nebraska	2	$4,126	0	$0	0	$0	0	$0	146	$13,280	11	$849	159	$18,255
054	WV	Mountain State BCBS	0	$0	57	$6,446	0	$0	0	$0	17	$1,681	0	$0	74	$8,127
055	PA	Independence BC	2	$79,923	72	$8,102	4	$40,198	9	$20,102	55	$16,627	0	$0	142	$164,952
056	AZ	BCBS of Arizona	2	$14,253	127	$14,069	3	$2,611	4	$5,661	139	$11,162	105	$15,305	380	$63,061
058	OR	Regence BCBS of Oregon	0	$0	103	$13,202	0	$0	8	$6,378	129	$11,665	0	$0	240	$31,245
059	ME	WellPoint BCBS of Maine	0	$0	32	$6,018	0	$0	8	$8,355	22	$4,840	4	$721	66	$19,934
060	RI	BCBS of Rhode Island	0	$0	19	$16,417	0	$0	0	$0	0	$0	0	$0	19	$16,417
061	NV	WellPoint BCBS of Nevada	3	$157,318	0	$0	0	$0	2	$2,375	65	$24,011	5	$509	75	$184,213
062	VA	WellPoint BCBS of Virginia	3	$60,363	55	$16,121	2	$28,340	2	$8,450	0	$0	181	$56,429	243	$169,703
064	NY	Excellus BCBS Rochester	0	$0	0	$0	1	$2,195	0	$0	0	$0	0	$0	1	$2,195
066	UT	Regence BCBS of Utah	0	$0	151	$28,558	0	$0	0	$0	20	$5,674	0	$0	171	$34,232
067	CA	BS of California	0	$0	0	$0	0	$0	0	$0	651	$49,136	1	$48	652	$49,184
069	WA	Regence BS	0	$0	0	$0	0	$0	0	$0	34	$1,991	1	$5	35	$1,996
070	AK	BCBS of Alaska	0	$0	0	$0	0	$0	0	$0	100	$27,129	0	$0	100	$27,129
074	SD	Wellmark BCBS of South Dakota	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
075	WA	Premera BC	5	$40,591	9	$20,654	3	$7,154	0	$0	100	$11,304	2	$59	119	$79,762
076	MO	WellPoint BCBS of Missouri	3	$12,921	2	$6,182	3	$4,171	8	$12,365	52	$9,247	10	$5,641	78	$50,527
078	MN	BCBS of Minnesota	1	$14,115	0	$0	0	$0	0	$0	6	$10,169	19	$25,548	26	$49,832
079	NY	Excellus BCBS of Central New York	0	$0	0	$0	0	$0	0	$0	16	$1,696	1	$173	17	$1,869
082	KS	BCBS of Kansas	0	$0	16	$1,208	0	$0	0	$0	0	$0	0	$0	16	$1,208
083	OK	BCBS of Oklahoma	7	$61,481	0	$0	2	$1,677	0	$0	656	$99,948	30	$22,122	695	$185,228
084	NY	Excellus BCBS of Utica-Watertown	0	$0	0	$0	0	$0	0	$0	168	$16,016	5	$3,062	173	$19,078
085	DC	CareFirst BCBS	16	$293,982	366	$130,367	4	$18,427	0	$0	215	$70,605	34	$29,636	635	$543,017
088	PA	BC of Northeastern Pennsylvania	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
089	DE	BCBS of Delaware	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
092	DC	CareFirst BCBS (Overseas)	1	$5,840	0	$0	1	$723	0	$0	51	$12,977	0	$0	53	$19,540
		Totals	**205**	**$3,578,502**	**3,362**	**$723,330**	**125**	**$571,380**	**160**	**$240,833**	**9,591**	**$1,801,172**	**1,966**	**$827,172**	**15,409**	**$7,742,389**

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

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September 30, 2010

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Group Chief
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U.S. Office of Personnel Management
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Washington, DC 20415-1100

Reference: **OPM DRAFT AUDIT REPORT**
Tier X Global Coordination of Benefits
Audit Report #1A-99-00-10-055

Dear [redacted]:

This is in response to the above - referenced U.S. Office of Personnel Management (OPM) Draft Audit Report concerning the Global Coordination of Benefits Audit for claims paid from January 1, 2009 through May 31, 2010. Our comments concerning the findings in the report are as follows:

AI1. Coordination of Benefits with Medicare
Questioned Amount $27,203,689

The OPM OIG submitted their sample of potential Medicare Coordination of Benefits errors to the Blue Cross Blue Shield Association (BCBS) on July 1, 2010. The BCBS Association and/or the BCBS Plans were requested to review these potential errors and provide responses by September 30, 2010. These listings included claims incurred on or after October 1, 2008 and reimbursed from January 1, 2009 through May 31, 2010. OPM OIG identified 959,979 claim lines, totaling $99,293,156 in payments, which potentially were not coordinated with Medicare. From this universe, OPM OIG selected for review a sample of 77,652 claim lines, totaling $33,452,198 in payments with a potential overcharge of $27,203,689 to the Federal Employee Health Benefit Program.

Blue Cross Blue Shield Association (BCBSA) Response:

After reviewing the OIG listing of potentially uncoordinated Medicare COB claims totaling $27,203,689, BCBSA identified $3,220,991 or 11.8 percent of the questioned amount that was not coordinated with Medicare. For the time period covered by the

audit, FEP reported Medicare savings in excess of $25 billion. To date Plans have recovered $1,343,596 in claim payment errors. Recovery has been initiated on the remaining overpayments and the Plans will continue to pursue these overpayments as required by CS 1039, Section 2.3 (g)(l).

Of the $3,220,991 in claim payments that were not coordinated with Medicare, we noted the following:

- Claims processors incorrectly overrode the Medicare deferral, missed the MSN when processing the claim, claims system did not defer the claim for review or other various reasons for claims totaling $2,762,293.
- Claims were not identified by the FEP Claims System retro-active enrollment reports, Uncoordinated Medicare Application or FEP ad-hoc reports for Plan review for claims totaling $286,682; and
- Claims were identified by the FEP Claims System retro-active enrollment reports, Uncoordinated Medicare Application or FEP ad-hoc reports before the audit began but were not worked by the Plan for claims totaling $547,181.

To reduce the number and frequency of uncoordinated Medicare claims, BCBSA has implemented an action plan that includes the following:

- Monitoring of the top 10 Plans that represent 60 percent of the uncoordinated claims in this audit. Although some of these Plans have shown significant improvement over the years, additional focus will reduce the number of uncoordinated claims in future audits;
- Causal analysis of Medicare COB errors identified during the OIG audits and through FEP generated reports to implement training and system edits as needed;
- Continuous monitoring and evaluation of the Medicare COB retro-active enrollment reports to ensure that the appropriate claims are being identified for adjustment by Plans;
- Continuous evaluation of our current COB monitoring report logic to ensure that uncoordinated Medicare claims are timely identified;
- Continuous monitoring of Plans' completion of the Uncoordinated Medicare application to ensure that uncoordinated Medicare claims are addressed timely;
- Continuous review of Plan "disagree" responses to the Uncoordinated Medicare application to ensure that the Plans respond correctly;
- Implementation of an edit to defer all facility claims with Medicare B Revenue Codes where the member does not have Part A but has Part B, by fourth quarter 2010. The FEP claims system currently only identifies the claim as a "potential claim" that can be coordinated with Medicare Part B;
- Modification of FEP claims system edits for home health, hospice and skill nursing facility claims to defer the claim based upon whether the member has

Medicare, the place of service and the revenue code instead of the type of bill, by fourth quarter 2010;
- Modification of the FEP claims system to require Plans to specifically indicate that facility claims not coordinated with Medicare Part A are supported by a Medicare Denial Notice; and
- Updating of the FEP Administrative Manual to clarify Medicare coordination requirements and the use of Medicare Payment Disposition Code "F", which bypasses the FEP Claims System Medicare deferrals.

To timely identify uncoordinated Medicare claims before the new 12 month Medicare timely filing limit has passed, FEP is also implementing the following:

- Increase the frequency of the Uncoordinated Medicare Application update from quarterly to monthly by 4th quarter 2010;
- Issue ad hoc reports to Plans on a quarterly basis that identify claims that are not included in the Uncoordinated Medicare Application;
- Update the Uncoordinated Medicare Application for claims currently included in ad hoc reports by 2nd quarter 2011;
- Issued an Audit Alert informing the Plan of the change and the need to work with their providers to ensure that claims are timely submitted to Medicare; and
- Evaluate whether or not the quarterly Medicare match process can be moved to monthly from quarterly by 1st quarter 2011;

To the extent that claim payment errors did occur or were not identified, these payments were good faith erroneous benefit payments and fall within the context of CS 1039, Section 2.3 (g). Any benefit payments the Plans are unable to recover are allowable charges to the Program. In addition, as good faith erroneous payments, lost investment income is not applicable to these confirmed overpayments.

We contested the remaining $23,982,698 in questioned uncoordinated Medicare claims as a result of the following:

- Claims totaling $5,168,042 were either adjusted before the audit started or recovery was initiated before the audit started and adjusted after the audit;
- Recovery was initiated before the audit started on claims totaling $2,991,200, but the recovery process has not been completed;
- Medicare Part A or B was secondary on claims totaling $1,382,983;
- Services were not covered or denied by Medicare for claims totaling $8,831,414;
- The provider was VA, DOD, IHS or not covered by Medicare on claims totaling $1,713,266;
- Claims totaling $491,675 were identified by the FEP Uncoordinated Medicare Application on July 7, 2010 and would have been adjusted by Plans before the Medicare timely filing limit without the OIG audit;

- Claims totaling $513,118 were case managed or were contested for various other reasons; and
- Claims totaling $2,891,675 were contested for other miscellaneous reasons.

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, reason contested and amount recovered by each Plan location.

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

[redacted]
Executive Director, FEP Program Integrity

Attachment

cc: [redacted], OPM
[redacted]