



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

Final Audit Report

Subject:

**AUDIT OF INFORMATION SYSTEMS
APPLICATION CONTROLS AT
AXA ASSISTANCE
AS ADMINISTRATOR FOR THE
PANAMA CANAL AREA BENEFIT PLAN**

Report No. 1B-43-00-08-066

Date: June 18, 2009

—CAUTION—

This audit report has been distributed to Federal and Non-Federal officials who are responsible for the administration of the audited contract. This audit report may contain proprietary data which is protected by Federal law (18 U.S.C. 1905); therefore, while this audit report is available under the Freedom of Information Act, caution needs to be exercised before releasing the report to the general public.



UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

Office of the
Inspector General

Audit Report

**FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM
CONTRACT CS 1066
AXA ASSISTANCE
AS ADMINISTRATOR FOR
PANAMA CANAL AREA BENEFIT PLAN
PLAN CODE 43
PANAMA CITY, PANAMA**

Report No. 1B-43-00-08-066

Date: June 18, 2009

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

**Michael R. Esser
Assistant Inspector General
for Audits**



UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

Office of the
Inspector General

Executive Summary

**FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM
CONTRACT CS 1066
AXA ASSISTANCE
AS ADMINISTRATOR FOR
PANAMA CANAL AREA BENEFIT PLAN
PLAN CODE 43
PANAMA CITY, PANAMA**

Report No. 1B-43-00-08-066

Date: June 18, 2009

This final report discusses the results of our audit of application controls over the information systems at AXA Assistance (AXA), the administrator for the Panama Canal Area Benefit Plan.

Our audit focused on the claims processing application used to adjudicate Federal Employees Health Benefits Program (FEHBP) claims for AXA, as well as the various processes and information technology (IT) systems used to support these applications. We documented controls in place and opportunities for improvement in the area below.

Application Controls

AXA has implemented many controls in their claims adjudication process to ensure that FEHBP claims are processed accurately. However, we recommended that AXA implement several enhancements to their claims processing system as well as their claims adjudication processes to

ensure that they are processing FEHBP claims in a manner consistent with their OPM contract and other regulations. Those enhancements include:

- Improved Internal Auditor Procedures
- Implementing controls over system overrides
- Segregation of enrollment duties
- The implementation of appropriateness of care, non-covered benefit and provider-to-procedure inconsistency edits
- Improving the controls over the benefit code selection for claims processors
- The processing of U.S. claims
- Development of a Multilingual Explanation of Benefits (EOB)
- Improving the EOB information provided to members
- Development of system generated EOB remark codes

Contents

Page

Executive Summary.....	i
I. Introduction.....	1
Background.....	1
Objectives.....	1
Scope.....	1
Methodology.....	2
Compliance with Laws and Regulations.....	3
II. Audit Findings and Recommendations.....	4
Application Controls.....	4
A. Input Controls.....	4
B. Processing Controls.....	4
C. Output Controls.....	16
III. Major Contributors to This Report.....	17

Appendix: AXA Assistance's December 16, 2008 response to the draft audit report, issued October 15, 2008.

I. Introduction

This final report details the findings, conclusions, and recommendations resulting from the audit of application controls over the information systems responsible for processing Federal Employees Health Benefits Program (FEHBP) claims at AXA Assistance (AXA).

The audit was conducted pursuant to Contract CS 1066; 5 U.S.C. Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit was performed by the U.S. 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 Act (the Act), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for federal employees, annuitants, and qualified dependents. The provisions of the Act are implemented by OPM through regulations codified in Title 5, Chapter 1, Part 890 of the CFR. Health insurance coverage is made available through contracts with various carriers that provide service benefits, indemnity benefits, or comprehensive medical services.

AXA Assistance is the administrator for the Panama Canal Area Benefit Plan. Employees responsible for processing FEHBP claims for AXA are located in the Plan's facility in Panama City, Panama and Miami, Florida.

This was the OIG's first audit of application controls at AXA Assistance.

All personnel that worked with the auditors were particularly helpful and open to ideas and suggestions. They viewed the audit as an opportunity to examine practices and to make changes or improvements as necessary. Their positive attitude and helpfulness throughout the audit was greatly appreciated.

Objectives

The objective of this audit was to evaluate controls over the confidentiality, integrity, and availability of FEHBP data processed and maintained in AXA's computer systems.

This objective was accomplished by reviewing the application controls specific to AXA's claims processing systems.

Scope

Our performance audit was conducted in accordance with Government Auditing Standards issued by the Comptroller General of the United States. Accordingly, we obtained an understanding of AXA's internal controls through interviews and observations, as well as the inspection of various documents, including information technology and other organizational policies and procedures. This understanding of AXA's internal controls was used in planning the audit by determining the extent of compliance testing and other auditing procedures

necessary to verify that the internal controls were properly designed, placed in operation, and effective.

We audited the confidentiality, integrity, and availability of AXA's computer-based information system used to process FEHBP claims, and found that there are opportunities for improvement in the information systems' internal controls. These areas are detailed in the "Audit Findings and Recommendations" section of this report. Since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on AXA's system of internal controls taken as a whole.

The scope of this audit was centered on the claims processing system that processes FEHBP claims for AXA, as well as the business structure and control environment in which it operates. In addition, we evaluated several areas of concern expressed to us by the Office of Personnel Management's Contracting Office. Our findings, recommendations, and conclusions are based on the status of information system general and application controls in place at AXA as of September 5, 2008.

In conducting our audit, we relied to varying degrees on computer-generated data provided by AXA. Due to time constraints, we did not verify the reliability of the data used to complete some of our audit steps, but we determined that it was adequate to achieve our audit objectives. However, when our objective was to assess computer-generated data, we completed audit steps necessary to obtain evidence that the data was valid and reliable.

We performed the audit at AXA Offices in Panama City, Panama. These on-site activities were performed in August 2008. We completed additional audit work before and after the on-site visits at our office in Washington, D.C.

Methodology

In conducting this review the OIG:

- Gathered documentation and conducted interviews; and
- Conducted various compliance tests to determine the extent to which established controls and procedures are functioning as intended.

Various laws, regulations, and industry standards were used as a guide to evaluating AXA's control structure. This criteria includes, but is not limited to, the following publications:

- Office of Management and Budget (OMB) Circular A-130, Appendix III;
- OMB Memorandum 07-16, Safeguarding Against and Responding to the Breach of Personally Identifiable Information;
- The Information Technology Governance Institute's (ITGI) CobiT: Control Objectives for Information and Related Technology, 3rd Edition;
- The General Accountability Office's (GAO) Federal Information System Controls Audit Manual;
- The National Institute of Standards and Technology's Special Publication (NIST SP) 800-12, Introduction to Computer Security;

- NIST SP 800-14, Generally Accepted Principles and Practices for Securing Information Technology Systems; and
- The Health Insurance Portability and Accountability Act of 1996, Health Insurance Reform: Security Standards; Final Rule.

Compliance with Laws and Regulations

In conducting the audit, the OIG performed tests to determine whether AXA 's practices were consistent with applicable standards. While generally compliant, with respect to the items tested, AXA was not in complete compliance with all standards as described in the "Audit Findings & Recommendations" section of this report.

II. Audit Findings and Recommendations

Application Controls

The policies and procedures that AXA has incorporated into its claims adjudication process involve several activities, some of which are supported by several computer applications. However, the scope of our application controls audit was limited to reviewing the activities related to the claims processing system.

We evaluated the input, processing, and output controls associated with AXA's [REDACTED] system. In terms of input controls, we documented the policies and procedures adopted by AXA to help ensure that: 1) there are controls over the inception of claims data into the system; 2) the data received comes from the appropriate sources; and 3) the data is entered into the claims database correctly. We also documented and reviewed AXA's methods for reconciling its processing totals against input totals and for evaluating the accuracy of their processes. For output controls, we evaluated the methods that AXA utilizes to ensure that output is distributed, safeguarded and disposed of properly.

To validate the claims processing controls, we conducted a testing exercise with AXA personnel in Panama City, Panama. This exercise involved developing a test plan that included real life situations to present to AXA personnel in the form of institutional and professional claims. All test scenarios were processed through AXA's [REDACTED] system.

The test plan included expected results for each test case. Upon conclusion of the testing exercise, we compared our expected results with the actual results obtained during the exercise.

The sections below document the opportunities for improvement we noted related to application controls.

A. Input Controls

To evaluate the input controls AXA has implemented for its [REDACTED] system, we identified all possible sources of claims coming into the system, as well as the mechanisms established by AXA to accept and process the claims. We learned that AXA:

- 1) Uses a daily log to keep track of received claims;
- 2) Documents all of the claim documentation received from a member; and
- 3) Visually verifies that paper claims are entered correctly.

These practices provide a controlled environment for receiving FEHBP data.

B. Processing Controls

AXA has adopted a practice of auditing all claims that are entered into the claims processing system. AXA maintains a pre-payment report that allows the internal auditor to review all authorized claims before approving them for payment. A backlog report is used to determine how long claims have been in the [REDACTED] system. In addition, AXA performs several internal audits throughout the year including a three percent audit and a high dollar audit.

Although we observed adequate processing controls as part of AXA's tracking mechanisms and internal auditing techniques, some of our test claims produced unexpected results. The test results indicate that certain claims processing practices at AXA should be modified to produce results consistent with the FEHBP contract and other regulations. The following sections document the findings from our limited scope audit.

1. Internal Auditor Procedures

AXA has implemented a process in which the internal auditor must approve all claims authorized by the claims adjusters before they are released for payment. During this process, the internal auditor reviews the claims that were authorized that day. The internal auditor does this by verifying the member and provider information as well as comparing the paper claim to the information entered into the system. However, AXA's internal auditor procedures do not include enough detail regarding the reviews the internal auditor performs during the approval process.

While AXA does have procedures that describe how to download the prepayment reports to spreadsheets, the procedures do not provide enough detail describing the steps the internal auditor must take to review a claim. Procedures that are not detailed would hinder other employees ability to complete a thorough review of the claims should the current internal auditor become unavailable. As a result, a major compensating control for AXA's claims processing system would be significantly weakened by the lack of information and training the new internal auditor would receive from the procedures.

Recommendation 1

We recommend that AXA expand its procedures to describe the audit process in a way that would enable a new internal auditor to adequately review authorized claims.

AXA Assistance's Response:

"AXA Assistance agrees with this audit recommendation and has expanded the existing auditor's procedure manual to include details on quality criteria and requirements that the auditor must consider prior to reviewing a claim. For example, the list of all the Plan benefits categorized by covered and non covered procedures. The procedure has been expanded to also include reviewing the provider's inconsistency and appropriateness of care until the system can be automated. Copy of auditor's procedure manual is available to OIG upon request.

It is anticipated that the gender control system capabilities will be implemented during the first quarter of 2009."

OIG Reply:

We acknowledge the steps AXA has taken to address this recommendation. As part of the audit resolution process, we recommend that AXA provide OPM's Center for

Retirement and Insurance Services (CRIS) with appropriate supporting documentation related to the controls that have been implemented.

2. Override Controls

When a claims adjuster enters a claim into the [REDACTED] system, they have the option to bypass (or override) all of the edits in the system, allowing them to process a claim without limitations. This known control deficiency was discovered during an independent audit of AXA. As a result, we requested documentation showing that this deficiency has been corrected. During our onsite visit, we were informed and were provided with screen prints of the test region to support that AXA is in the process of developing a modification for the override command that will be administered by the [REDACTED] administrator. This modification allows the administrator to enable or disable the adjuster's rights to the override command. If the command were enabled, the processor would have a maximum dollar threshold for using this command and, if the threshold were exceeded, it would go to the internal auditor for review. Finally, AXA is creating an override report that would keep track of all of the claims that were overridden.

While AXA is working on implementing controls over the override command, those controls have not been implemented in the production environment of the claims processing system. This deficiency provides claims adjusters with the ability to bypass all of the edits in the [REDACTED] system, such as duplicate and eligibility edits, thus undermining the integrity of the claims processing system. Until these controls are implemented in the [REDACTED] production environment, the adjuster's ability to use the override command without any limitations is still a significant deficiency in the [REDACTED] system.

Recommendation 2

We recommend that AXA continue working toward implementing the override controls into the [REDACTED] production environment.

AXA Assistance's Response:

"AXA Assistance agrees with this audit recommendation and the override controls were already fixed in our [REDACTED] Test environment and the Information Systems Audits Group tested the override controls during the onsite visit. Our Information Technology Department has scheduled the deployment of the new version of [REDACTED] system by end of 2008.

User limits have been created to override the claims with the deployment of the new version of [REDACTED]. The new user rights will also be introduced. We will also have the capability to detect the overridden claims through the mass approval process as well as review overridden claims for appropriateness via reporting."

OIG Reply:

We acknowledge the steps AXA has taken to address this recommendation. As part of the audit resolution process, we recommend that AXA provide OPM's CRIS with appropriate supporting documentation showing that the override controls have been implemented in production.

3. Enrollment Segregation of Duties

AXA regularly receives enrollment information from multiple sources. The processor then modifies the [REDACTED] system by either adding a new member to the system or modifying a current member's enrollment record based on the information provided.

The processor who updated the enrollment information then reconciles it with the FEHB Enrollment Reconciliation Clearinghouse (CLER) system. Enrollment reconciliation is the process of reconciling a health insurance carrier's enrollment system with the enrollment information from all of the federal government payroll offices that is located on the CLER. On a quarterly basis, the CLER system compares each carrier's enrollment database to the database provided by the payroll offices. Each carrier is required to review and resolve any discrepancies generated from the match. Typically, a health insurance carrier segregates the reconciliation process from the enrollment update process. However, AXA has the same person who adds or modifies the enrollment information also reconcile that information with CLER.

Any time a single individual has control of an entire process, the potential for fraud increases significantly. As a result, AXA is more susceptible to fraud because the enrollment processor may be able to fabricate enrollees and conceal the activity because the processor also performs the CLER reconciliation. This could potentially result in false claims being submitted and paid by AXA, thus increasing the costs to the FEHBP.

Recommendation 3

We recommend that AXA segregate the enrollment process so that more than one individual is involved in the process.

AXA Assistance's Response:

"AXA Assistance agrees with this audit recommendation and has segregated the enrollment reconciliation process with the CLER system to the Claims Team due to their high experience working in the Member Services Area. Enrollment process is handled by the Member Services Manager and the quarterly CLER reconciliation process is handled by the Claims Team."

OIG Reply:

We acknowledge the steps AXA has taken to address this recommendation. As part of the audit resolution process, we recommend that AXA provide OPM's CRIS with appropriate supporting documentation that these duties have been segregated.

4. Appropriateness of Care

We submitted six professional claims into the [REDACTED] test system to evaluate the effectiveness of the system's appropriateness of care edits. The [REDACTED] test system processed and paid all of the professional claims without deferring them for appropriateness of care edits. The six test claims included the following:

- [REDACTED];
- [REDACTED]
- [REDACTED] and
- [REDACTED].

To further test [REDACTED] appropriateness of care edits, the OIG submitted two hospital claims that included [REDACTED] into the system. Neither of those claims encountered appropriateness of care edits as expected.

The lack of adequate appropriateness of care edits in the [REDACTED] system increases the risk of processing claims inaccurately and generating erroneous payments, increasing the costs to the FEHBP.

Recommendation 4

We recommend that AXA determine the feasibility of implementing appropriateness of care edits for all FEHBP claims in an effort to ensure that only services covered by the plan are paid.

AXA Assistance's Response:

"AXA Assistance agrees with this audit recommendation and is working toward the development of age control edits in the [REDACTED] system. System capability will be ready by January 1, 2009. Gender control edits however, will need to be expanded by the system developers ([REDACTED]). It is anticipated that the [REDACTED] capabilities will be implemented during the first quarter of 2009.

Additionally, a report has been created that highlights errors according to the rules defined for review and will be run by the Claims Department on a daily basis."

OIG Reply:

We acknowledge the steps AXA has taken to address this recommendation. As part of the audit resolution process, we recommend that AXA provide OPM's CRIS with appropriate supporting documentation related to the controls that have been implemented.

5. Non-Covered Benefits

AXA incorrectly paid two test claims for services that are not listed as covered by the Panama Canal Area Benefit Plan (PCABP) benefit brochure.

The first test case was for a claim in which the patient [REDACTED]. However, this claim should have been denied because [REDACTED] are specifically listed as a non-covered benefit in the brochure, unless the member is "[REDACTED]" [REDACTED].

The second test case was for a claim in which the patient had a procedure [REDACTED]. While [REDACTED] is not specifically excluded in the benefit brochure, it is not listed as a benefit either. The benefit brochure states that "Benefits will not be paid for services and supplies... Not specifically listed as covered."

The lack of adequate edits in the [REDACTED] system to prevent non-covered benefits from being paid increases the risk that claims can be processed inaccurately, thus generating erroneous payments and increasing the costs to the FEHBP.

Recommendation 5

We recommend that AXA implement edits that prevent the payment of non-covered benefits.

AXA Assistance's Response:

"AXA Assistance agrees with this audit recommendation and is working toward the development of edits that prevent the payment of non-covered benefits in the [REDACTED] system. System capability will be ready by January 1, 2009.

Additionally, we have expanded the existing procedure manual used by the auditor's to include details on system edits so as to track what we have added in the system. Copy of auditor's procedure manual is available to OIG upon request.

The Non Covered benefits have been added by service, to the [REDACTED] system's matrix to automatically deny. This process should reduce human errors."

OIG Reply:

We acknowledge the steps AXA has taken to address this recommendation. As part of the audit resolution process, we recommend that AXA provide OPM's CRIS with the appropriate supporting documentation related to the controls that have been implemented.

6. [REDACTED] Inconsistency

The [REDACTED] test system incorrectly paid for claims that were [REDACTED].

In one instance, the test system processed and paid a claim even though it was for a [REDACTED]. Two additional claims with [REDACTED] were processed and paid even though the fee schedules for those providers did not include [REDACTED]. We were expecting the claims

processing system to deny these claims because the services are not [REDACTED]

Paying for claims that are not [REDACTED] increases AXA's risk of processing claims inaccurately and generating erroneous payments, thus increasing the costs to the FEHBP.

Recommendation 6

We recommend that AXA implement the necessary technical controls to ensure that only services associated with [REDACTED] are paid.

AXA Assistance's Response:

"AXA Assistance agrees with this audit recommendation and is working toward the development of a [REDACTED] that will be reviewed prior to claim approvals. The report will contain [REDACTED] in which services are allowed. The report will highlight discrepancies according to the rules defined for review. It is anticipated that the reporting will be implemented during the first quarter of 2009."

OIG Reply:

We acknowledge the steps AXA has taken to address this recommendation. As part of the audit resolution process, we recommend that AXA provide OPM's CRIS with the appropriate supporting documentation related to the [REDACTED] that has been implemented.

7. Benefit Code Selection

In certain instances the claims adjuster has the ability to select the benefit that is applicable for a specific service.

During our claims testing, we submitted a claim in which the member incurred an office visit at the member's primary care physician (PCP). When the claim was entered into the [REDACTED] test system, the adjuster had the option of choosing one of the following services:

- an office visit with the PCP or
- an office visit with a specialist.

We were expecting the adjuster to select the PCP benefit resulting in a member co-payment of \$10 and the health plan being responsible for the rest of the claim. However, the adjuster mistakenly selected the specialist benefit, resulting in the member owing "50% of the Panama POS Fee schedule amount." In addition, the member was responsible for "any difference between the POS Fee schedule and the billed amount" because the member did not get a referral from the PCP to go to a specialist.

The claims adjuster should not have the opportunity to select the applicable benefit. Rather, this decision should be made by the claims processing system. If the adjuster

makes an incorrect selection, AXA would pay the incorrect benefits for a particular service.

Recommendation 7

We recommend that AXA implement the necessary technical changes to allow the [REDACTED] system to select the appropriate benefit for all services.

AXA Assistance's Response:

"AXA Assistance agrees with this audit recommendation and is working toward diminishing the benefits appearing during the claims processing by updating our [REDACTED] system, thus the system will be able to select the appropriate benefit for all services listed in our Plan. System capability will be ready by January 1, 2009."

OIG Reply:

We acknowledge the steps AXA has taken to address this recommendation. As part of the audit resolution process, we recommend that AXA provide OPM's CRIS with appropriate supporting documentation related to the controls that have been implemented.

8. Processing U.S. Claims

AXA's Panama office receives claims for services from Panamanian providers as well as U.S. providers. Once a claim is received in Panama the processor is responsible for determining if the claim is from the U.S. or Panama. If the member went to the U.S. for services, the processor is supposed to send the claim to AXA's Miami office for processing. However, if the claims adjuster does not determine that the member went to the U.S. for services then the [REDACTED] system would process and pay the claim without deferring it.

We tested this situation by submitting a claim with a U.S. provider. The test system processed and paid this claim without deferring it. We were expecting the [REDACTED] system to either suspend the claim for processor review or have the claim automatically transmitted to a claims adjuster in AXA's Miami office. The adjusters in AXA's Miami office are then responsible for processing the claim and coordinating it with Medicare, if necessary. However, if the adjusters in Panama were to process this claim they do not have the training to coordinate claims with Medicare. As a result, AXA may not be coordinating claims with other insurance carriers, resulting in increased costs to the FEHBP.

Recommendation 8

We recommend that AXA implement the necessary technical controls to ensure that U.S. claims are not processed in the Panama office.

AXA Assistance's Response:

"AXA Assistance agrees with this audit recommendation and our Member Services Department is now detecting the U.S. claims from the instant the members submit their claims and is sending the claim to AXA's Miami office for processing.

Our Claims Manager is also monitoring that U.S. claims are indeed being processed by U.S. adjustors only through a monthly productivity report."

OIG Reply:

We acknowledge the steps AXA has taken to address this recommendation. As part of the audit resolution process, we recommend that AXA provide OPM's CRIS with appropriate supporting documentation that U.S. adjustors are processing all U.S. claims.

9. Multilingual EOB

AXA only provides its members with the option of receiving an Explanation of Benefits (EOB) printed in English. While this may work for most plans, AXA's diverse group of members, most of whom live in a Spanish speaking country (Panama), would benefit from a multilingual EOB.

EOBs are an important part of FEHBP's fight against fraud as well as the disputed claims process. By developing a multilingual EOB that accommodates all their members' native languages, the health plan would be empowering their members to help AXA in their fight against fraud and abuse in the healthcare industry.

Recommendation 9

We recommend that PCABP develop an EOB that would accommodate their members' native languages (English and Spanish).

AXA Assistance's Response:

"AXA Assistance agrees with this audit recommendation, though based on past experience and specific client requirements, our central batch Explanation of Benefits (EOB) printing must be in English. Therefore, we are working toward the development of a Spanish version of the EOB to have available upon request.

A Spanish brochure called "Understanding Your Explanation of Benefits" has been created to translate EOB jargon into easy to understand plain language for members as well as to include educational information on what an EOB is and how to understand the format and language within the EOB. Please refer to Exhibit I enclosed with this communication for a sample copy of the "Understanding Your Explanation of Benefits" brochure using our current EOB format.

Additionally, at the bottom of all EOBs, a notice will be placed advising members to refer to our Member Services Department for brochure guidance on understanding your explanation of benefits or for a copy of their EOB in Spanish.

The Understanding your Explanation of Benefits brochure will be promoted to our members via our website and member newsletters, and other distribution points, including the administration offices.”

OIG Reply:

We acknowledge the steps AXA has taken to address this recommendation. As part of the audit resolution process, we recommend that CRIS verify that the “Understanding your Explanation of Benefits” brochure is made available to PCABP’s member.

10. Explanation of Benefits

After reviewing the output provided during our claims testing exercise we determined that the EOB could be confusing to members.

The output received for one of our test claims shows that the claim has an allowed amount of zero dollars (see [A] Table 1) while the insured cost is \$17.50 (see [B] Table 1), which is 50% of the POS fee schedule amount. We were expecting the EOB to show the allowed amount as the fee schedule amount allowed for this claim (see [C] Table 2). In addition, we were expecting the insured cost to equal \$37.50 (see [D] Table 2), which is 50% of the Panama POS Fee schedule amount plus the difference between the POS Fee schedule and the billed amount, instead of the \$17.50 that was displayed (see [B] Table 1) on the actual EOB.

Actual Explanation of Benefits									
Billed Amount	Not Covered	Allowed Amount	Provider Discount	Ded	Coins/ Copay	Other Carrier Paid	Amount Paid	Insured Cost	Remark Code
\$55.00		\$0.00	\$20.00	\$0.00	\$17.50	\$0.00	\$17.50	\$17.50	
		[A]						[B]	

Table 1: Summary of an actual EOB from an OIG Test Claim

Expected Explanation of Benefits									
Billed Amount	Not Covered	Allowed Amount	Provider Discount	Ded	Coins/ Copay	Other Carrier Paid	Amount Paid	Insured Cost	Remark Code
\$55.00		\$35.00	\$20.00	\$0.00	\$17.50	\$0.00	\$17.50	\$37.50	1
		[C]						[D]	

Table 2: Summary of an expected EOB from an OIG Test Claim

Finally, the EOB does not provide the member with a remark code that explains why the insured’s cost was so high. In this case, we were expecting an explanation stating that the patient went to a Fee for Service provider resulting in an increased cost to the member.

AXA's EOBs are confusing because they are missing critical information. As a result, their value as a tool for informing members and preventing fraud is diminished.

Recommendation 10

We recommend that AXA implement the necessary changes to ensure the Explanation of Benefits are easy to understand by the members.

AXA Assistance's Response:

"AXA Assistance agrees with this audit recommendation and is including in the Explanation of Benefits the negotiated cost and changing the description of the allowed amount to COB allowed amount. However, it's important to clarify that the allowed amount in the claim from your claims testing exercise is the COB allowed amount and not the fee schedule amount allowed. Nevertheless, AXA Assistance will change the current "Allowed Amount" description to "COB Allowed Amount"

The system behavior would be as follows using the same test claims example as your draft report:

Table 1: Summary of an actual EOB from an OIG Test Claim Table 1

Actual Explanation of Benefits									
Billed Amount	Not Covered	Allowed Amount	Provider Discount	Ded	Coins/Copay	Other Carrier Paid	Amount Paid	Insured Cost	Remark Code
\$55.00		\$0.00	\$20.00	\$0.00	\$17.50	\$0.00	\$17.50	\$17.50	

Table 2: Summary of the revised EOB after the OIG audit recommendation IF we do have a fee schedule i.e., network providers.

Revised Explanation of Benefits										
Billed Amount	Not Covered	COB Allowed Amount	Neg Cost	Provider Discount	Ded	Coins/Copay	Other Carrier Paid	Amount Paid	Insured Cost	Remark Code
\$55.00			\$35.00	\$20.00	\$0.00	\$17.50	\$0.00	\$17.50	\$17.50	

Table 3: Summary of the revised EOB after the OIG audit recommendation IF we do not have a fee schedule i.e., U.S. providers.

Revised Explanation of Benefits										
Billed Amount	Not Covered	COB Allowed Amount	Neg Cost	Provider Discount	Ded	Coins/Copay	Other Carrier Paid	Amount Paid	Insured Cost	Remark Code
\$55.00						\$27.50		\$27.50	\$27.50	

OIG Reply:

We acknowledge the steps AXA has taken to address this recommendation. As part of the audit resolution process, we recommend that AXA provide OPM's CRIS with appropriate supporting documentation that this updated EOB has been implemented.

11. Explanation of Benefits Remark Code

Several claims that processed through the [REDACTED] test system did not include remark codes on the explanation of benefits (EOB). During our claims testing exercise, it was determined that claims adjusters have to manually adjust the claim to include the correct EOB remark code.

In one instance, a claim was denied in the system as a duplicate. The system warned the claims adjuster of a potential duplicate as well as provided the adjuster with the other claim to review. However, the system did not place a duplicate remark code on the EOB to notify the member of the reason the claim was denied.

In another instance, the claims processing system detected that the claim was submitted by a debarred provider. While the [REDACTED] system provided the adjuster with information about the debarred provider, it did not place an informational remark code indicating to the member that the provider is debarred on the EOB.

Because AXA's EOBs are incomplete, important information is not being provided to health plan members. As a result, the EOBs have limited effectiveness as tools for fighting fraud and keeping members informed.

Recommendation 11

We recommend that AXA implement the necessary technical changes to ensure the system automatically places remark codes on the explanation of benefits in an effort to provide members with more information regarding the adjudication process.

AXA Assistance's Response:

"AXA Assistance agrees with this audit recommendation. The system had a unique shared field to provide an explanation for suspensions or rejections, but it was a free text field and not a list of rejection codes to refer to. AXA Assistance is working toward the development of a dictionary of suspension and rejection reasons. The dictionary will feed a drop down list for adjustors to reference when claims are rejected or suspended, but will also have a free text field for new rejection reasons not listed. A control will be implemented that will prompt the user if a claim is rejected or suspended without providing a reason. We expect to implement these system capabilities during the first quarter of 2009.

Additionally, our prepayment report will include the reasons for rejection so we can verify that the appropriate code has been selected or if the field is used as a free format,

to confirm that this will be a unique event of rejection that will not require us to add to the rejection reason dictionary.”

OIG Reply:

We acknowledge the steps AXA has taken to address this recommendation. As part of the audit resolution process, we recommend that AXA provide OPM’s CRIS with appropriate supporting documentation related to the controls that have been implemented.

C. Output Controls

On a weekly basis, AXA’s Miami office prints the checks for the claims that were processed the previous week. The checks are then mailed to the Panama office for distribution. Once they are received in Panama, the finance manager verifies that all of the checks were received. The finance manager then delivers the checks to the member services department in the Panama office. This department then distributes the checks to both the provider and members upon request.

AXA has adopted adequate policies and practices to provide guidance for the generation and distribution of system output related to the claims processing applications within the scope of this audit. These include activities such as:

- The use of a “check register” to keep track of all checks received from the Miami office;
- The use of a check log to keep track of batches of checks that were printed; and
- The use of a provider receipt to document that the provider picked up the check.

Nothing came to our attention to indicate that there are any weaknesses related to AXA’s procedures for controlling system output for FEP claim transactions.

III. Major Contributors to This Report

This audit report was prepared by the U.S. Office of Personnel Management, Office of Inspector General, Information Systems Audits Group. The following individuals participated in the audit and the preparation of this report:

- [REDACTED] Group Chief
- [REDACTED], Senior Team Leader
- [REDACTED], Auditor-in-Charge

Appendix

December 16, 2008

[REDACTED]
United States Office of Personnel Management
Office of the Inspector General
Information Systems Audits Group
Washington, DC 20415-1100

**Re: Draft Report Response for the Application Controls Audit
Report No. 1B-43-00-08-066
Carrier Code: 43**

Dear [REDACTED]:

On October 15, 2008 the U.S. Office of Personnel Management, Office of the Inspector General, Information Systems Audits Group issued a draft report for the Application Controls Audit of AXA Assistance Florida, Inc.

Our comments below are in response to the draft report detailing the results of the audit findings and recommendations of the Federal Employees Health Benefits Program operations at AXA Assistance, administrators of the Panama Canal Area Benefit Plan.

Thank you for your cooperation and consideration of this additional information. If you have any questions or need additional information please contact me directly at [REDACTED] or by email at [REDACTED]

Sincerely,

[REDACTED]
Compliance Manager

cc: [REDACTED]

PROCESSING CONTROLS

A. Auditor Procedures Recommendation

The Information Systems Audits Group recommended that AXA Assistance expand its procedures to describe the audit process in a way that would enable a new auditor to adequately review authorized claims.

AXA Assistance agrees with this audit recommendation and has expanded the existing auditor's procedure manual to include details on quality criteria and requirements that the auditor must consider prior to reviewing a claim. For example, the list of all the Plan benefits categorized by covered and non covered procedures. The procedure has been expanded to also include reviewing the provider's inconsistency and appropriateness of care until the system can be automated. Copy of auditor's procedure manual is available to OIG upon request.

It is anticipated that the gender control system capabilities will be implemented during the first quarter of 2009.

B. Override Controls Recommendation

The Information Systems Audits Group recommended that AXA Assistance continue working toward implementing the override controls into the [REDACTED] production environment.

AXA Assistance agrees with this audit recommendation and the override controls were already fixed in our [REDACTED] Test environment and the Information Systems Audits Group tested the override controls during the onsite visit. Our Information Technology Department has scheduled the deployment of the new version of [REDACTED] system by end of 2008.

User limits have been created to override the claims with the deployment of the new version of [REDACTED]. The new user rights will also be introduced. We will also have the capability to detect the overridden claims through the mass approval process as well as review overridden claims for appropriateness via reporting.

C. Enrollment Segregation of Duties Recommendation

The Information Systems Audits Group recommended that AXA Assistance segregate the enrollment process so that more than one individual is involved in the process.

AXA Assistance agrees with this audit recommendation and has segregated the enrollment reconciliation process with the CLER system to the Claims Team due to their high experience working in the Member Services Area. Enrollment process is handled by the Member Services Manager and the quarterly CLER reconciliation process is handled by the Claims Team.

D. Appropriateness of Care Recommendation

The Information Systems Audits Group recommended that AXA Assistance determine the feasibility of implementing appropriateness of care edits for all FEHBP claims in an effort to ensure that only services covered by the plan are paid.

AXA Assistance agrees with this audit recommendation and is working toward the development of age control edits in the [REDACTED] system. System capability will be ready by January 1, 2009. [REDACTED] edits however, will need to be expanded by the system developers [REDACTED]. It is anticipated that the [REDACTED] system capabilities will be implemented during the first quarter of 2009.

Additionally, a report has been created that highlights errors according to the rules defined for review and will be run by the Claims Department on a daily basis.

E. Non-Covered Benefits Recommendation

The Information Systems Audits Group recommended that AXA Assistance implement edits that prevent the payment of non-covered benefits.

AXA Assistance agrees with this audit recommendation and is working toward the development of edits that prevent the payment of non-covered benefits in the [REDACTED] system. System capability will be ready by January 1, 2009.

Additionally, we have expanded the existing procedure manual used by the auditor's to include details on system edits so as to track what we have added in the system. Copy of auditor's procedure manual is available to OIG upon request.

The Non Covered benefits have been added by service, to the [REDACTED] system's matrix to automatically deny. This process should reduce human errors.

F. [REDACTED] Recommendation

The Information Systems Audits Group recommended that AXA Assistance implement the necessary technical controls to ensure that [REDACTED] are paid.

AXA Assistance agrees with this audit recommendation and is working toward the development of a [REDACTED] report that will be reviewed prior to claim approvals. The report will contain [REDACTED]. The report will highlight discrepancies according to the rules defined for review. It is anticipated that the reporting will be implemented during the first quarter of 2009.

G. Benefit Code Selection Recommendation

The Information Systems Audits Group recommended that AXA Assistance implement the necessary technical changes to allow the [REDACTED] system to select the appropriate benefit for all services.

AXA Assistance agrees with this audit recommendation and is working toward diminishing the benefits appearing during the claims processing by updating our [REDACTED] system, thus the system will be able to select the appropriate benefit for all services listed in our Plan. System capability will be ready by January 1, 2009.

H. Processing U.S. Claims Recommendation

The Information Systems Audits Group recommended that AXA Assistance implement the necessary technical controls to ensure that U.S. claims are not processed in the Panama office.

AXA Assistance agrees with this audit recommendation and our Member Services Department is now detecting the U.S. claims from the instant the members submit their claims and is sending the claim to AXA's Miami office for processing.

Our Claims Manager is also monitoring that U.S. claims are indeed being processed by U.S. adjustors only through a monthly productivity report.

I. Multilingual EOB Recommendation

The Information Systems Audits Group recommended that AXA Assistance develop an EOB that would accommodate their members' native languages (English and Spanish).

AXA Assistance agrees with this audit recommendation, though based on past experience and specific client requirements, our central batch Explanation of Benefits (EOB) printing must be in English. Therefore, we are working toward the development of a Spanish version of the EOB to have available upon request.

A Spanish brochure called "Understanding Your Explanation of Benefits" has been created to translate EOB jargon into easy to understand plain language for members as well as to include educational information on what an EOB is and how to understand the format and language within the EOB. Please refer to Exhibit I enclosed with this communication for a sample copy of the "Understanding Your Explanation of Benefits" brochure using our current EOB format.

Additionally, at the bottom of all EOBs, a notice will be placed advising members to refer to our Member Services Department for brochure guidance on understanding your explanation of benefits or for a copy of their EOB in Spanish.

The Understanding your Explanation of Benefits brochure will be promoted to our members via our website and member newsletters, and other distribution points, including the administration offices.

J. Explanation of Benefits Recommendation

The Information Systems Audits Group recommended that AXA Assistance implement the necessary changes to ensure the Explanation of Benefits is easy to understand by the members.

AXA Assistance agrees with this audit recommendation and is including in the Explanation of Benefits the negotiated cost and changing the description of the allowed amount to COB allowed amount. However, it's important to clarify that the allowed amount in the claim from your claims testing exercise is the COB allowed amount and not the fee schedule amount allowed. Nevertheless, AXA Assistance will change the current "Allowed Amount" description to "COB Allowed Amount"

The system behavior would be as follows using the same test claims example as your draft report:

Table 1: Summary of an actual EOB from an OIG Test Claim Table 1

Actual Explanation of Benefits									
Billed Amount	Not Covered	Allowed Amount	Provider Discount	Ded	Coins/Copay	Other Carrier Paid	Amount Paid	Insured Cost	Remark Code
\$55.00		\$0.00	\$20.00	\$0.00	\$17.50	\$0.00	\$17.50	\$17.50	

Table 2: Summary of the revised EOB after the OIG audit recommendation IF we do have a fee schedule i.e., network providers.

Revised Explanation of Benefits										
Billed Amount	Not Covered	COB Allowed Amount	Neg Cost	Provider Discount	Ded	Coins/Copay	Other Carrier Paid	Amount Paid	Insured Cost	Remark Code
\$55.00			\$35.00	\$20.00	\$0.00	\$17.50	\$0.00	\$17.50	\$17.50	

Table 3: Summary of the revised EOB after the OIG audit recommendation IF we do not have a fee schedule i.e., U.S. providers.

Revised Explanation of Benefits										
Billed Amount	Not Covered	COB Allowed Amount	Neg Cost	Provider Discount	Ded	Coins/Copay	Other Carrier Paid	Amount Paid	Insured Cost	Remark Code
\$55.00						\$27.50		\$27.50	\$27.50	

K. Explanation of Benefits Remark Code Recommendation

The Information Systems Audits Group recommended that AXA Assistance implement the necessary technical changes to ensure the system automatically places remark codes on the explanation of benefits in an effort to provide members with more information regarding the adjudication process.

AXA Assistance agrees with this audit recommendation. The system had a unique shared field to provide an explanation for suspensions or rejections, but it was a free text field and not a list of rejection codes to refer to. AXA Assistance is working toward the development of a dictionary of suspension and rejection reasons. The dictionary will feed a drop down list for adjustors to reference when claims are rejected or suspended, but will also have a free text field for new rejection reasons not listed. A control will be implemented that will prompt the user if a claim is rejected or suspended without providing a reason. We expect to system capabilities during the first quarter of 2009.

Additionally, our prepayment report will include the reasons for rejection so we can verify that the appropriate code has been selected or if the field is used as a free format, to confirm that this will be a unique event of rejection that will not require us to add to the rejection reason dictionary.