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

Final Audit Report

Audit of Claims Processing and Payment Operations at Select Anthem Blue Cross and Blue Shield Plan Sites for Contract Years 2020 through 2022

Report Number 2024-CAAG-001
August 23, 2024

EXECUTIVE SUMMARY

Audit of Claims Processing and Payment Operations at Select Anthem Blue Cross and Blue Shield Plan Sites for Contract Years 2020 through 2022

Report No. 2024-CAAG-001 **August 23, 2024**

Why Did We Conduct the Audit?

The objective of our audit was to determine whether the health benefit costs charged to the Federal Employees Health Benefits Program (FEHBP) and services provided to FEHBP members by four Anthem Blue Cross and Blue Shield (Plan) (plan codes 10,11, and 13) plan sites were in accordance with the terms of the Blue Cross and Blue Shield Association's contract with the U.S. Office of Personnel Management and the Service Benefit Plan brochures.

What Did We Audit?

The Office of the Inspector General has completed a performance audit of the FEHBP claim operations at the Plan. Specifically, we performed various claim reviews to determine if the internal controls over the claims processing systems were sufficient to ensure that claims were properly processed and paid by the Plan during contract years 2020 through 2022. Our audit work was remotely conducted by staff in the Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida areas.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

Overall, we found that the Plan's internal controls over its claims processing system, for the areas under review, were effective in ensuring that health care claims were properly processed and paid.

Therefore, we have no findings and/or recommendations as a result of our audit.

ABBREVIATIONS

5 CFR 890	**Title 5, Code of Federal Regulations, Chapter 1, Part 890**
Act	**Federal Employees Health Benefits Act**
Association	**Blue Cross and Blue Shield Association**
BCBS	**Blue Cross and Blue Shield**
Contract	**Contract CS 1039 – The contract between the Blue Cross and Blue Shield Association and the U.S. Office of Personnel Management**
FEHBP	**Federal Employees Health Benefits Program**
FEP	**Federal Employee Program**
HI	**Office of Healthcare and Insurance**
Med A	**Medicare Part A**
Med B	**Medicare Part B**
Non-Par	**Non-Participating**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
Plan	**Anthem Blue Cross and Blue Shield**
POS	**Place of Service**
SBP	**Service Benefit Plan**
U.S.C.	**United States Code**

TABLE OF CONTENTS

I. BACKGROUND

This final report details the results of our performance audit of the Federal Employees Health Benefits Program (FEHBP) claims processing and payment operations at four Anthem Blue Cross and Blue Shield (Plan) (plan codes 10, 11, and 13) plan sites for contract years 2020 through 2022. The specific plan sites included in this audit were:

- Anthem Blue Cross and Blue Shield of Virginia;
- Anthem Blue Cross Blue Shield of Connecticut;
- Anthem Blue Cross Blue Shield of Maine; and
- Anthem Blue Cross and Blue Shield of New Hampshire.

The audit was conducted pursuant to the provisions of contract CS 1039 (Contract) between the U.S. Office of Personnel Management (OPM) and the Blue Cross and Blue Shield Association (Association); Title 5, United States Code (U.S.C.), Chapter 89; and Title 5, Code of Federal Regulations, Chapter 1, Part 890 (5 CFR 890). The audit was performed by OPM's Office of the Inspector General (OIG), as authorized by the Inspector General Act of 1978, as amended (5 U.S.C. sections 401 through 424).

The FEHBP was established by the Federal Employee Health Benefits Act (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 Office of Healthcare and Insurance (HI) has overall responsibility for the administration of the FEHBP, including the publication of program regulations and agency guidance. As part of its administrative responsibilities, HI contracts with various health insurance carriers that provide service benefits, indemnity benefits, and/or comprehensive medical services. The provisions of the Act are implemented by OPM through regulations codified in 5 CFR 890.

The Association, on behalf of participating Blue Cross and Blue Shield (BCBS) plans, has entered into a government-wide Service Benefit Plan (SBP) Contract with OPM to provide a health benefit plan authorized by the Act. The Association delegates authority to member BCBS Plans throughout the United States to process the health benefit claims of its federal subscribers.

The Association has established a Federal Employee Program (FEP[1]) Director's Office in Washington, D.C. to provide centralized management for the SBP. 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. CareFirst BCBS, located in Owings Mills, Maryland, performs the activities of the FEP Operations Center. These activities include acting as fiscal intermediary between the Association and its member BCBS Plans, verifying subscriber eligibility, approving or denying the reimbursement of local plan payments

[1] Throughout this report, when we refer to FEP, we are referring to the SBP lines of business at the local BCBS Plans. When we refer to the FEHBP, we are referring to the program that provides health benefits to federal employees.

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 Association and management at the Plan. In addition, the Association and the Plan are responsible for establishing and maintaining a system of internal controls.

The most recent audit report issued that covered claim payments for the Plan sites was report number 1A-99-00-10-013, dated March 17, 2011, which covered claim payments for contract years 2008 and 2009. Any findings related to that audit were considered obsolete and not considered as part of planning for this audit. However, audit report number 2023-CAAG-001, dated November 6, 2023, which covered claim payments for contract years 2019 through 2021 for other plan sites administered by Anthem Blue Cross and Blue Shield, was considered in the planning of this audit. Due to the recent issuance of the report, the findings remain open and in the resolution process.

The results of our audit were discussed with the Association and the Plan throughout the audit and at an exit conference on June 27, 2024. As there were no findings identified during the audit, a draft report was not issued.

II. OBJECTIVE, SCOPE, AND METHODOLOGY

OBJECTIVE

The objective of our audit was to determine whether the health benefit costs charged to the FEHBP, and services provided to FEHBP members, were in accordance with the terms of the Contract and the SBP brochures.

SCOPE AND METHODOLOGY

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

This performance audit included the following reviews for contract years 2020 through 2022:

- **Place of Service (POS) Claims Review**
  To determine if the claims were paid accurately according to the provider contract with the Plan and the SBP brochure;
- **Unlisted Procedure Code Review**
  To determine if claim lines that have unlisted, miscellaneous, or unclassified current procedural terminology or healthcare common procedure coding system codes were priced and paid in accordance with Plan policies and procedures;
- **Basic Option Non-Participating (Non-Par) Claims Review**
  To determine if the non-par basic option claims identified met appropriate circumstances to pay and were not unallowable payments;
- **Non-Par Outpatient Non-Emergency Benefit Change Review**
  To determine if the Plan is paying the correct allowance for outpatient non-par/non-emergency services in accordance with a 2019 benefit change;
- **Coordination of Benefits with Medicare Review**
  To determine whether the claims identified required coordination with Medicare, and if so, were properly coordinated;
- **Procedure Code Modifiers – Financial Impact Review**
  To determine if the Plan is appropriately applying procedure code modifier price adjustments to the procedure allowance;
- **Procedure Code Modifiers – Not Eligible for Reimbursement Review**
  To determine if the Plan is appropriately processing claims with procedure code modifiers not eligible for reimbursement; and

- **Surprise Billing Review**
  To determine if claims meeting the surprise billing provisions[2], but not identified as such in the claims information, were properly identified, processed, and paid.

Our audit fieldwork was remotely performed by staff located near our offices in Washington, D.C; Cranberry Township, Pennsylvania; and Jacksonville, Florida from February 20, 2024, through June 27, 2024.

We reviewed the Association's 2020 through 2022 annual accounting statements and determined that approximately $6 billion in health benefit payments were paid to the Plan for the sites under review.

In planning and conducting our audit, we obtained an understanding of both the Association's and Plan's internal control structures to help determine the nature, timing, and extent of our auditing procedures. Our audit approach consisted mainly of substantive tests of transactions and not tests of controls. However, since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on the Association's or the Plan's system of internal controls taken as a whole.

We also conducted tests to determine whether the Association and the Plan had complied with the Contract, the applicable procurement regulations (i.e., Federal Acquisition Regulations and Federal Employees Health Benefits Acquisition Regulations, as appropriate), and the laws and regulations governing the FEHBP as they relate to claim payments. We found that the Association and the Plan complied with the health benefit provisions of the Contract. With respect to any areas not tested, nothing came to our attention that caused us to believe that they had not complied, in all material respects, with those provisions.

In conducting our audit, we relied to varying degrees on computer-generated data provided by the FEP Director's Office, the FEP Operations Center, the Association, and the Plan. Through the performance of audits and an in-house claims data reconciliation process, we have verified the reliability of the BCBS claims data in our data warehouse, which was used to identify areas to test and select our samples. The BCBS claims data is provided to the OPM OIG monthly by the FEP Operations Center, and after a series of internal steps, uploaded into our data warehouse. While utilizing the computer-generated data during our audit, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

[2] The No Surprises Act, effective January 1, 2022, protects patients from receiving surprise medical bills when they receive emergency services from out-of-network providers at in-network hospitals or from out-of-network air ambulance service providers.

We selected various samples of claims or claim lines to determine whether the Plan complied with the Contract's provisions relative to health benefit payments. We utilized SAS (Statistical Analysis System) software to judgmentally select all samples reviewed.

The following specific reviews were conducted during our audit (unless otherwise stated, the samples covered the full scope of the audit, contract years 2020 through 2022):

1. **POS Claims Review –** We identified all claims where the FEHBP paid as the primary insurer, the claim was not subject to the Omnibus Budget Reconciliation Acts of 1990 or 1993, or case management guidelines, and the total claim amount paid was $250 or greater. This resulted in an overall universe of 2,330,171 claims, totaling $4,397,718,864, grouped by the claims' assigned POS.

   From the overall universe for each Plan site, we judgmentally selected all POS groups with an amount paid percentage and claim line percentage of greater than 1 percent (resulting in a sub-universe of 25 POS groups). With a target sample of 35 claims per Plan site, we judgmentally determined the number of claims to be reviewed from each POS group based on its percentage of amount paid (with a minimum of 5 claims to be selected from each POS group).

   Additionally, we judgmentally selected all POS groups with either an amount paid percentage or claim line percentage of greater than 1 percent (resulting in a sub-universe of eight POS groups). From each POS group selected in this manner, we judgmentally determined to select three claims.

   For the above selected sub-universes, we stratified each POS group by the total amount paid and judgmentally selected those strata where the amount paid percentage was greater than 10 percent. We randomly selected claims for review from each strata based on the amount paid percentage.

   In total, we selected 230 claims with a total amount paid of $5,037,881.

2. **Unlisted Procedure Code Review –** We identified all claim lines with "unlisted," "miscellaneous," and "not otherwise specified" procedure codes. This resulted in a universe of 80,125 claim lines, with a total amount paid of $21,418,772.

   From this universe we judgmentally selected all procedure codes with a total amount paid of $100,000 or greater for review. This resulted in a selection of 16 procedure codes, with a total amount paid of $20,119,264.

   We then selected a random sample of three claim lines for each procedure code selected. In total, we selected 48 claim lines, totaling $211,297.

3. **Basic Option Non-Par Provider Claims Review –** We identified all claims that were paid where a member had the Basic Option and visited a non-par provider for a service that is potentially not covered according to the FEHBP brochure. This resulted in a universe of 6,910 claims, totaling $3,237,097.

   From this universe, we judgmentally selected the top 10 members with the highest paid claims from each Plan site. Some members saw multiple providers and we randomly chose one claim for each member and provider they visited. In total, we selected 53 claims, totaling $890,189.

4. **Non-Par Outpatient Non-Emergency Benefit Change Review –** We identified all claims that were paid to non-par outpatient facilities for non-emergency services where the Plan was the primary payor and the billed amount equaled the allowed amount. This resulted in a universe of 941 claims from 70 providers, totaling $998,234.

   From this universe, we judgmentally selected the highest paid claim for any provider who was paid $15,000 or more. In total, we selected 15 claims, totaling $152,177.

5. **Coordination of Benefits with Medicare Review –** As part of our review, we separated the uncoordinated claims into six categories based on the place of service and whether Medicare Part A (Med A) or Part B (Med B) should have been the primary payer, as follows:

Categories A and B	Categories A and B consist of inpatient claims that should have been coordinated with Med A. If the BCBS Plans indicated that Med A benefits were exhausted, we reviewed the claims to determine whether there were any inpatient services that were payable by Med B. For these categories Med A pays all covered costs (except for deductibles and coinsurance) for inpatient care in hospitals, skilled nursing facilities, and hospice care. Consequently, in determining potential overcharges for the claim lines improperly paid in these categories, we reduced the amount paid using the applicable Medicare deductible and/or copayment.
Categories C and D	Categories C and D include inpatient claims with ancillary items that should have been coordinated with Med B. If the BCBS Plans indicated that members had Med B only, we reviewed the claims to determine whether there were any inpatient services that were payable by Med B. For these categories, Med B covers a portion of inpatient facility charges for ancillary services such as medical supplies, diagnostic tests, and clinical laboratory services, and pays 80 percent for these services after the calendar year deductible has been met. Based on our experience, ancillary items account for approximately 30 percent of the total inpatient claim payment. Consequently, in determining potential overcharges for

	the claim lines improperly paid in these categories we estimated a 25 percent overcharge for the inpatient claim lines (0.30 x 0.80 = 0.24 ~ 25 percent).
Categories E and F	Categories E and F include outpatient facility and professional claims where Med B should have been the primary payer. For these categories, Med B pays 80 percent of most outpatient charges and professional claims after the calendar year deductible has been met. Consequently, in determining potential overcharges for the claim lines improperly paid in these categories we used 80 percent of the amount paid as the amount overcharged.

We identified all paid claims that potentially were not coordinated with Medicare, resulting in a universe of 23,176 claims with potential overcharges of $8,169,451.

From this universe, for each category and plan site we selected those that had a potential overpayment of $400,000 or greater (Category A, E, and F selected). This resulted in a universe of 20,803 claims with potential overcharges of $7,138,376.

From each selected category we selected patients as follows:

- Category A: Patients with a total amount paid of $50,000 or greater; and
- Category E and F: Patients with a total amount paid of $10,000 or greater.

From this resulting subset, we then judgmentally selected the highest claim amount paid for each patient (we selected the latest claim if there were multiple claims paid at the same amount). This resulted in a sample of 80 claims with potential overpayments of $2,025,113.

6. **Procedure Code Modifier – Financial Impact Review –** We identified a universe of 415,034 claim lines, totaling $104,692,318, with a procedure code modifier that has a financial impact on claim adjudication.

   From the universe identified, we randomly selected five claim lines from all procedure code modifiers that had a total amount paid of $1 million or greater and one claim line from those under $1 million. In total we selected 56 claim lines, totaling $39,697.

7. **Procedure Code Modifier – Not Eligible for Reimbursement Review –** We identified a universe of 51,821 claim lines, totaling $23,301,774, with a procedure code modifier that the Plan indicated as ineligible for reimbursement.

   From the universe identified, we judgmentally selected for review the 10 highest paid claim lines (or all if less than 10) from the following procedure code modifiers: 25, PA, PC, QS,

SG and SU. Additionally, from procedure code modifier SL, we judgmentally selected the five highest paid claim lines and also randomly selected five claim lines for review from those that paid less than $1 because of the inordinate number of low dollar claim lines identified. In total, we selected 52 claim lines, totaling $396,882.

8. **Surprise Billing Review –** We identified a universe of non-par claims incurred and paid in 2022 where the Plan was the primary payer and the claims were not an overseas claim, the claims were not subject to the Omnibus Reconciliation Acts of 1990 and 1993, the claims were not provided by government providers, the claims had no indication the claim was paid with surprise billing protections, and where the total claim amount paid was $100 or greater. This resulted in a universe of 30,456 claims, totaling $19,130,691.

   From this overall universe, we identified sub-universes of claims subject to the No Surprises Act (identifying claims with corresponding coding related to emergency and non-emergency services, accidental injury, and urgent care). From each resulting universe we selected the three highest paid claims not paid at billed charges from each Plan site.

Claim Type	Sub-Universe Claims	Sub-Universe Total Amt Paid	Sample Claims	Sample Total Amt Paid
Emergency Services - Professional	711	$153,522	21	$13,127
Emergency Services - Facility	33	$101,053	5	$47,593
Non-Emergency Services - Professional	247	$65,915	21	$15,193
Accidental Injury – with accidental injury diagnosis codes	52	$10,592	8	$4,023
Accidental Injury – without accidental injury diagnosis codes	224	$141,567	17	$23,854
Urgent Care Professional	272	$149,870	12	$20,265

During our review, we utilized the Contract, the 2020 through 2022 SBP brochures, the Association's FEP Administrative Procedures and Benefit Policy Manual, and various manuals and other documents provided by the Plan and the Association to determine compliance with program requirements, as well as deriving any amounts questioned. The samples selected were not statistically based. Consequently, the results were not projected to their respective universes since it is unlikely that the results are representative of the universes taken as a whole.

III. AUDIT RESULTS

Overall, we found that the Plan's internal controls over its claims processing system, for the areas under review, were effective in ensuring that healthcare claims were properly processed and paid.

Therefore, we have no findings and/or recommendations as a result of our audit.

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