



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Region IX  
Office of Audit Services  
50 United Nations Plaza  
Room 171  
San Francisco, CA 94102

Report Number A-10-03-00003  
October 24, 2003

Mr. Thomas W. Colosimo  
Chief Financial Officer  
Regence BlueShield of Idaho  
P.O. Box 1106 M/S LC1E  
Lewiston, Idaho 83501

Dear Mr. Colosimo:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) Report entitled "Review of Duplicate Medicare Fee-For-Service Payments at Regence BlueShield of Idaho."

Final determination as to actions taken on all matters reported will be made by the HHS action official named on page 2 of this transmittal letter. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S. C. 552, as amended by Public Law 104-321), OIG Reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.) As such, within 10 business days after the final report is issued, it will be posted on the Internet at <http://oig.hhs.gov>.

To facilitate identification, please refer to report number A-10-03-00003 in all correspondence relating to this report. If you have any questions or need additional information, please contact Janet Tursich at (206) 615-2063 or Jim Okura at (206) 615-2069.

Sincerely,

Lori A. Ahlstrand  
Regional Inspector General  
for Audit Services

Page 2 – Mr. Thomas W. Colosimo

**Direct Reply to HHS Action Official:**

Mr. John T. Hammarlund  
Centers for Medicare & Medicaid Services  
Acting Regional Administrator, Region X  
2201 Sixth Avenue, MS- 40  
Seattle, WA 98121

cc: Paula A. McFarland, Manager  
Internal Audit for Utah and Idaho, The Regence Group

Enclosures – as stated

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF DUPLICATE MEDICARE  
FEE-FOR-SERVICE PAYMENTS AT  
REGENCE BLUESHIELD OF IDAHO**



**OCTOBER 2003  
A-10-03-00003**

# *Office of Inspector General*

<http://oig.hhs.gov/>

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The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

## *Office of Audit Services*

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

## *Office of Evaluation and Inspections*

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

## *Office of Investigations*

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties. The OI also oversees State Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

## *Office of Counsel to the Inspector General*

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the Department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

# ***Notices***

**THIS REPORT IS AVAILABLE TO THE PUBLIC  
at <http://oig.hhs.gov/>**

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services, reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.)

## **OAS FINDINGS AND OPINIONS**

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the awarding agency will make final determination on these matters.





Region IX  
Office of Audit Services  
50 United Nations Plaza  
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San Francisco, CA 94102

Report Number: A-10-03-00003  
October 24, 2003

Mr. Thomas W. Colosimo  
Chief Financial Officer  
Regence BlueShield of Idaho  
P.O. Box 1106 M/S LC1E  
Lewiston, Idaho 83501

Dear Mr. Colosimo:

This report provides you with the results of our review of Regence BlueShield of Idaho's (Regence) Medicare cost report for Calendar Year (CY) 2000. Our objectives were to determine if the costs claimed by the Health Maintenance Organization (HMO) were: (1) in accordance with the Medicare cost principles, and (2) not for services reimbursed under Medicare's fee-for-service payment system.

Generally, we found that Regence prepared the Medicare cost report in accordance with Federal regulations. However, Regence claimed costs of \$39,660 for services provided to beneficiaries under its HMO contract with Medicare that were previously reimbursed by the carrier under Medicare's fee-for-service payment system. Even though Regence had established policies and procedures to detect duplicate payments, we found that:

- claims processing procedures to detect duplicate payments were not always followed, and
- the carrier did not always notify Regence of the Medicare's fee-for-service payments.

We recommend that Regence:

- file an amended CY 2000 Medicare cost report to decrease the amount claimed by \$39,660,
- ensure that claims processing procedures to detect duplicate payments are followed, and
- work with the carrier to ensure that Regence is notified of all applicable Medicare fee-for-service payments.

In written response to our draft report, Regence concurred with our findings and recommendations. We summarized Regence's comments at the end of the FINDINGS AND RECOMMENDATIONS SECTION of the report. The complete text of Regence's comments is included as an appendix to this report.

## **INTRODUCTION**

### **BACKGROUND**

#### **Regence**

Regence, a cost-based HMO under contract with the Centers for Medicare & Medicaid Services (CMS), provided health services on a cost basis to enrolled Medicare members. Under a cost-based arrangement, CMS made an interim payment each month to Regence based on a per-capita rate for each Medicare member. The interim payments were reconciled with the HMO's annual cost report. For CY 2000, Regence claimed \$15,318,897 in reimbursable costs.

#### **Medicare Carrier**

Health providers for Regence members may also be paid by a Medicare contracted carrier. A carrier is a private company that has a contract with CMS to pay Medicare fee-for-service bills from doctors and suppliers. The carrier collects detailed information on the claims paid and forwards this information to members' HMOs, in this case Regence. This information is referred to as crossover data. Regence had procedures in place to use crossover data to ensure that Medicare claims were paid only once. Regence must receive crossover data from the carrier in order for the procedures to be effective.

#### **Federal Regulations**

The 42 Code of Federal Regulations (CFR) 417.532 stated that the costs incurred by the HMO to furnish services covered by Medicare are reimbursable if they are: proper and necessary; reasonable in amount; and appropriately apportioned among the HMO's Medicare enrollees, other enrollees, and nonenrolled patients.

The allowable costs were determined in accordance with the principles set forth in 42 CFR Part 417 Subpart O, the HMO Manual, the Provider Reimbursement Manual, and generally accepted accounting principles.

Chapter 17, Subchapter B, Section 300 of the HMO Manual stated that duplicate payment detection is the responsibility of the HMO.

## OBJECTIVES, SCOPE AND METHODOLOGY

We performed our audit in accordance with generally accepted government auditing standards issued by the Comptroller General. Our objectives were to determine if the costs claimed on Regence's CY 2000 Medicare cost report were:

- in accordance with the Medicare cost principles, and
- not for services reimbursed under Medicare's fee-for-service payment system.

To determine whether the costs claimed on the CY 2000 Medicare cost report were in compliance with the Medicare reimbursement regulations, we:

- verified the accuracy of the Medicare cost report,
- traced cost report data to the general ledger and supporting documentation,
- interviewed Regence officials regarding costs claimed, and
- reviewed a judgmental sample of cost categories.

To determine whether costs claimed were for services that had also been reimbursed under the Medicare fee-for-service payment system, we:

- obtained from CMS a CY 2000 database of Medicare fee-for-service paid claims for members of Regence's HealthSense 65 plan;
- obtained a database from Regence of all claims included in the Medicare cost report for CY 2000;
- compared the two databases to generate a listing of payments for beneficiaries with the same health insurance claim numbers, dates of service, and procedure codes; and
- selected a statistical random sample of 135 claims, out of the total 7,486 potential duplicate claims identified from the comparison above, to determine whether any duplicate payments existed. The results of our sample are provided in APPENDIX A.

We reviewed the internal controls related to Regence's preparation of the Medicare cost report and to its system for identifying duplicate payments. Our fieldwork was performed from January through May 2003, and included site visits to Regence's office in Lewiston, Idaho.

## FINDINGS AND RECOMMENDATIONS

Generally, we found that Regence prepared the Medicare cost report in accordance with the Federal regulations. However, we found that 15 claims, in the amount of \$2,335, were previously paid by the carrier. Based on our projection of a statistical sample, we are 95 percent confident that at least \$39,660 of costs claimed by Regence, under its HMO contract in CY 2000,



were for services previously reimbursed by the carrier under Medicare's fee-for-service payment system. These duplicate payments occurred because claims processing procedures were not always followed or the carrier did not always send crossover data to Regence.

### **CLAIMS PROCESSING PROCEDURES**

We found seven payments, totaling \$1,426, where claims processors ignored or overlooked information specifying that claims were paid as primary<sup>1</sup> by the carrier. The information was available on Regence's payment records based on crossover data provided by the carrier. However, the claims processors did not follow proper procedures to ensure that duplicate payments were not made. Regence personnel stated that a small number of claims processors were responsible for a majority of these errors.

### **CARRIER PAYMENTS**

We found eight payments, totaling \$909, where the carrier did not send Regence crossover data. A duplicate payment exists if Regence pays a claim as primary, and receives information from the carrier showing they also have paid as primary. In this instance, the control is the crossover data from the carrier. Regence's procedure is to compare all claims paid or to be paid with the crossover data. We found duplicate payments were made because the carrier did not send Regence the crossover data. This data would have indicated that the claim had already been paid by Medicare's fee-for-service payment system.

### **RECOMMENDATIONS**

We recommend that Regence:

- file an amended CY 2000 Medicare cost report to decrease the amount claimed by \$39,660,
- ensure that claims processing procedures to detect duplicate payments are followed, and
- work with the carrier to ensure that Regence is notified of all applicable Medicare fee-for-service payments.

### **REGENCE COMMENTS**

In written comments to our draft report, Regence concurred with our findings and recommendations. Regence commented that it will submit a revised CY 2000 Medicare cost report to decrease the amount claimed by \$39,660, re-train current staff on duplicate claims processing procedures and include this training for all new hire training. Also, Regence will

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<sup>1</sup> A primary payer is an insurance policy, plan, or program that pays first on a claim for medical care. This could be Medicare or other health insurance.

work with the carrier to ensure that claims that should have been received electronically are identified and processed with greater accuracy.

The complete text of Regence's comments is included as APPENDIX B to this report.

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In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions on the Act which the Department chooses to exercise. (See 45 CFR part 5.)

To facilitate identification, please refer to Report Number A-10-03-00003 in all correspondence relating to this report.

Sincerely,

A handwritten signature in black ink, appearing to read "Lori A. Ahlstrand". The signature is fluid and cursive, with a large loop at the end.

Lori A. Ahlstrand  
Regional Inspector General  
for Audit Services

# **APPENDICES**

# REGENCE BLUESHIELD OF IDAHO

## STATISTICAL SAMPLING RESULTS

	<b>POPULATION</b>	<b>SAMPLE</b>	<b>ERRORS</b>
Items:	7,486	Items: 135	Items: 15
Claims:	\$600,455	Claims: \$19,687	Claims: \$2,335

### PROJECTION OF SAMPLE RESULTS

At the 90 Percent Confidence Level

Point Estimate:	\$129,474
Lower Limit:	\$39,660
Upper Limit:	\$219,288



August 22, 2003

Lori A. Ahlstrand  
Regional Inspector General for Audit Services  
HHS OIG Region IX  
50 United Nations Plaza  
San Francisco, CA 94102

Dear Ms. Ahlstrand:

Thank you for the opportunity to provide our response to the July 31, 2003 HHS OIG draft report number A-10-03-0003, entitled "Review of Duplicate Medicare Fee-For-Service Payments at Regence BlueShield of Idaho." We are pleased with the overall audit opinion that "Generally, we found that Regence prepared the Medicare cost report in accordance with Federal regulations," and appreciate the opportunity to improve our processes, and therefore, our customer service to the Medicare program.

The audit report noted that:

- Claims processing procedures to detect duplicate payments were not always followed, and
- The carrier did not always notify Regence of Medicare's fee-for-service payments.

Further, the audit report recommended that Regence:

- File an amended CY 2000 Medicare cost report to decrease the amount claimed by \$39,660,
- Ensure that claims processing procedures to detect duplicate payments are followed, and
- Ensure that the carrier notifies Regence of all applicable Medicare fee-for-service payments.

In response to the report recommendations, Regence BlueShield of Idaho will take the following actions.

**Claims Processing Procedures:**

Regence BlueShield of Idaho will re-train current staff on duplicate claims procedures for our HealthSense 65 plan. Specific duplicate claims processing information regarding HealthSense 65 will be included in all new hire training for claims analyst and customer service representatives. All HealthSense 65 claims that are reviewed in our internal audit process will be checked for duplicate claim payments between Regence BlueShield of Idaho and Medicare Carriers and Intermediaries. If errors are detected, the claims will be returned to the claims analyst for a correction to be completed.

The Center for Medicare and Medicaid Services (CMS) is currently working with Cost Plans to develop a monthly report showing all Part B claims paid on behalf of Cost Plan beneficiaries; however, the current report still lacks enough information to provide a meaningful report. CMS is in the process of adding additional fields. Once these fields are added to the report, we anticipate that we'll be able to run this report against our claims data, and duplicate claims can be identified. Specific time frames for this report cannot be provided until the report is completed by CMS. Nancy St. Marie, Manager of Government Programs, will work with our Information Technology Department to finalize this issue as soon as possible after receipt of CMS's updated report.

**Carrier Payments:**

The audit of claims reviewed by the Office of Inspector General auditing staff was for the calendar year 2000. In 2000 HealthSense 65 eligibility was sent monthly to the Medicare Carrier, CIGNA. Regence BlueShield of Idaho subsequently changed its practice and currently submits eligibility to CIGNA weekly. With CIGNA having current eligibility information, claims are transmitted and processed with greater accuracy.

In the future, if a claim that should have been received electronically is identified, we will work with CIGNA to determine the issue. Regence BlueShield of Idaho will assure the proper steps are completed so that it will not happen in the future.

In addition to the actions outlined above, Regence BlueShield of Idaho will submit a revised CY 2000 Medicare cost report to decrease the amount claimed by \$39,660. Our revised submission will be provided to CMS by September 30, 2003. As discussed with Ms. Barbara Alford, CMS Central Office, the revised submission will not need to be re-certified since we became aware of the audit adjustment after the original submission was received by CMS.

Please feel free to contact me at (801) 333-5315 if you have any questions or need any additional information on this response. You may also contact Nancy St. Marie at (208) 798-2217.

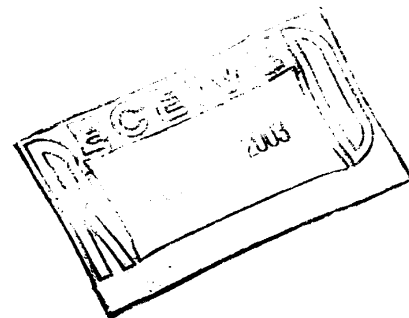
Sincerely,



Paula A. McFarland  
Manager, Internal Audit for Utah and Idaho  
The Regence Group  
2890 E. Cottonwood Parkway  
Salt Lake City, UT 84121-7035

Copy furnished:

V. Blum  
T. Colosimo  
L. Finley  
S. Simpson  
N. St. Marie  
T. Kirkpatrick, HHS OIG



## ACKNOWLEDGMENTS

This report was prepared under the direction of Lori A. Ahlstrand, Regional Inspector General for Audit Services, Region IX. Other principal Office of Audit Services staff who contributed include:

Janet Tursich, *Audit Manager*

Jim Okura, *Senior Auditor*

Teri Kirkpatrick, *Auditor-in-Charge*

Joe Beedle, *Auditor*

Technical Assistance

Larry Jacobsen, *Advanced Audit Techniques*

For information or copies of this report, please contact the Office of Inspector General's Public Affairs Office at (202) 619-1343.