DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
Room 3T41
61 Forsyth Street, S.W.
Atlanta, Georgia 30303-8909

MAY 2 6 1998

CIN: A-04-98-03008

Mr. Curtis W. Lord
Vice - President, Program Safeguards
Blue Cross Blue Shield of Florida
P.O. Box 2078-F
Jacksonville, Florida 32231

Dear Mr. Lord:

We have enclosed two copies of our report on the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled, *Assist Audit of HCFA's FY 1997 Financial Statements at Blue Cross Blue Shield of Florida (BCBSFL).* Also, we forwarded a copy of this report to the action official below for his/her review and any action deemed necessary.

The HHS action official will make the final determination as to actions that need to be taken on all matters reported. We request that you respond to the 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 this final determination.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23) OIG, OAS reports issued to the Department's grantees and contractors are made available, if requested, 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 Code of Federal Regulations Part 5).

To facilitate identification please refer to Common Identification Number (CIN) A-04-98-03008 in all correspondence related to this letter.

Sincerely yours,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosure

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ASSIST AUDIT OF HCFA'S FY 1997 FINANCIAL STATEMENTS AT BLUE CROSS BLUE SHIELD OF FLORIDA

JUNE GIBBS BROWN
Inspector General

MAY 1998
A-04-98-03008

EXECUTIVE SUMMARY

BACKGROUND

The Health Care Financing Administration (HCFA), an agency of the U.S. Department of Health and Human Services (HHS), has primary responsibility for administering the Medicare program. The agency carries out most Medicare operational activities through contractors that include fiscal intermediaries, carriers, durable medical equipment regional carriers, and peer review organizations (PRO). Blue Cross and Blue Shield of Florida (BCBSFL) serves as both the fiscal intermediary and carrier for the State of Florida.

In Fiscal Year (FY) 1997, almost 39 million beneficiaries were enrolled in the Medicare program, and HCFA incurred about $207 billion nationwide in Medicare benefit payments expenses for health care services.

The Chief Financial Officers (CFO) Act of 1990 requires the head of each executive agency to annually prepare and submit to the U.S. Office of Management and Budget (OMB) financial statements that fully disclose the financial position and results of operations for all trust and revolving funds and, to the extent practical, each office, bureau, and activity of the agency which performed substantial commercial functions during the preceding FY.

The CFO Act also requires the Inspector General (IG), for each agency having an IG, to audit the financial statements in accordance with applicable generally accepted government auditing standards. The IG may select an independent external auditor to conduct the audit.

The CFO Act also requires each agency to improve its systems of financial management, accounting and internal controls to assure the issuance of reliable financial information.

OBJECTIVES

Our agency's overall audit objective is to express an opinion on HCFA's FY 1997 combined financial statements and to report on their compliance with laws and regulations. An aspect of overall work is to determine whether the Medicare fee-for-service benefit payments expenses are made in accordance with the provisions of Title XVIII and implementing regulations in Title 42 of the Code of Federal Regulations (42 CFR). Specifically we were to determine if services were: (1) furnished by certified Medicare providers to eligible beneficiaries; (2) reimbursed by Medicare contractors in accordance with Medicare laws and regulations; and (3) medically necessary, accurately coded, and sufficiently documented in the beneficiaries' medical records.

The audit procedures for this audit have been designed exclusively for Medicare fee-for-service benefit payments expenses that are claim based. A separate audit approach for non-claim based benefit payments was also developed for use by other independent auditors under contract with the Office of Inspector General (OIG). The audit is to be performed in accordance with generally accepted government auditing standards.

SUMMARY OF FINDINGS

We selected a stratified random sample of 50 beneficiaries for whom BCBSFL had adjudicated 779 claims during the second quarter of FY 1997 - our audit period. The BCBSFL paid $412,703 for these claims. With the assistance of BCBSFL and Peer Review Organization (PRO) medical review personnel we identified overpayments totaling $41,126 for these claims. The overpayments occurred for various reasons, including insufficient documentation, incorrect coding of procedures, and lack of medical necessity. A complete listing of the errors with the reasons for the errors is provided in appendices A and B to this report.

Other independent auditors under contract with the OIG identified reportable conditions with respect to electronic data processing (EDP) controls and non-claims activities and addressed recommendations in separate reports to BCBSFL.

Recommendations

We recommend that BCBSFL:

- initiate recovery of the overpayments and periodically provide us with the status of recovery actions; and

- address the recommendations made by the independent auditors with respect to EDP controls and non-claims activities and provide us a copy of such responses.

Comments by BCBSFL

In a written response to our draft report, BCBSFL agreed to seek recovery of the overpayments and keep us apprised of the results. Also BCBSFL generally agreed with the recommendations made by the independent auditors and has taken or is taking corrective actions. Further, BCBSFL suggested that our report contain descriptions of the sampling methodology employed. This methodology is being described in the nationwide report to which this report contributes. Finally, BCBSFL agreed to address the concerns that we expressed in the "Other Matters" section of the report concerning ambulatory surgical center claims and cash receipts.

GLOSSARY OF ACRONYMS

ASC	Ambulatory Surgical Center
BCBSFL	Blue Cross Blue Shield of Florida
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CIN	Common Identification Number
CWF	Common Working File
EDP	Electronic Data Processing
E&Y	Ernst and Young
FI	Fiscal Intermediary
FY	Fiscal Year
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HI	Hospital Insurance
IG	Inspector General
MCM	Medicare Carriers Manual
OAS	Office of Audit Services
OIG	Office of Inspector General
OMB	Office of Management and Budget
PRO	Peer Review Organization
SMI	Supplementary Medical Insurance
SNF	Skilled Nursing Facility

INTRODUCTION

The objective of our review at BCBSFL was to test a sample of claims BCBSFL adjudicated during the second quarter of FY 1997 (January 1, 1997 through March, 1997). This quarter was 1 of 12 contractor quarters our headquarters randomly selected nationwide for review. This audit forms a part of our agency's overall audit of HCFA's FY 1997 financial statements.

BACKGROUND

Congress established Medicare under Title XVIII of the Social Security Act by enacting the Social Security Amendments of 1965. Legislated as a complement to Social Security retirement, survivors, and disability benefits, Medicare originally covered people age 65 and over. Since 1972, Congress has broadened the program to cover the disabled, those with end-stage renal disease, and certain others who elect to purchase Medicare coverage.

The HCFA, an agency of HHS, has primary responsibility for administering Medicare. This responsibility includes: formulation of policy and guidelines; contract oversight and operation; maintenance and review of utilization records; and general financing. The HCFA carries out most Medicare operational activities through contractors including fiscal intermediaries (FI), carriers, durable medical equipment regional carriers and PROs. In FY 1997, almost 39 million beneficiaries were enrolled in Medicare, and HCFA incurred about $207 billion in Medicare benefit payments expenses for health care services.

Medicare is a combination of two programs - the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) programs. Each program has its own enrollment, coverage, and financing.

HI Program

The HI program, also known as Part A, is generally provided automatically to people age 65 and to most persons who are disabled for 24 months or more who are entitled to either Social Security or Railroad Retirement benefits. Most HI enrollees do not pay any enrollment premium, but some who are otherwise unqualified for Medicare may purchase HI coverage if they also elect to purchase SMI coverage.

The HI program pays participating hospitals, skilled nursing facilities (SNF), home health agencies, and hospice providers for covered services rendered to Medicare Part A enrollees. The FIs process and pay both Part A and outpatient Part B claims.

The HI program is financed primarily through contributions from taxable earnings into the HI trust fund. Employees and employers each currently contribute through a mandatory payroll deduction of 1.45 percent of taxable earnings. Self-employed individuals currently contribute 2.90 percent of their taxable earnings.

SMI Program

The SMI program, also known as Part B, is optional and available to: almost all resident citizens age 65 and over; certain aliens age 65 and over -- even those not entitled to Part A based on eligibility for Social Security or Railroad Retirement benefits; and disabled beneficiaries entitled to Part A benefits. Almost all HI enrollees also enroll in the SMI program.

The SMI program covers physician services as well as certain non-physician services including: clinical laboratory tests; durable medical equipment (including prosthetics and orthotics); flu vaccinations; drugs which cannot be self-administered (except certain anticancer drugs); most supplies; diagnostic tests; ambulance services; some therapy services; and certain other services Part A does not cover.

The SMI program is financed through monthly beneficiary premium payments (usually deducted from Social Security benefits) along with significant contributions from general revenues of the Federal Government. Carriers process and pay Part B claims.

For both Parts A and B, beneficiaries are responsible for charges not covered by the Medicare program as well as any applicable deductibles and coinsurance. For example, Medicare usually pays 80 percent of Part B services. The beneficiary is responsible for the remaining 20 percent as well as an annual deductible.

In FY 1997, BCBSFL, as both FI and carrier, reported $8.374 billion in total funds expended on the HCFA Form 1522s for Medicare Part A and Part B. Of that amount, BCBSFL reported $2.113 billion during the second quarter. The HCFA utilizes total funds expended amounts from the HCFA Form 1522s to calculate the Medicare benefit payments expenses reported in their financial statements.

Legislative and Other Requirements

The CFO Act of 1990 requires the head of each executive agency to annually prepare and submit to the U.S. Office of Management and Budget (OMB) financial statements that fully disclose the financial position and results of operations for all trust and revolving funds, and to the extent practical, each office, bureau, and activity of the agency which performed substantial commercial functions during the preceding FY.

The CFO Act also requires the IG for each agency having an IG, to audit the financial statements in accordance with applicable generally accepted government auditing standards. The IG may select an independent external auditor to conduct the audit.

In addition, the CFO Act requires each agency to improve its systems of financial management, accounting and internal controls to assure the issuance of reliable financial information.

OBJECTIVES

Our agency's overall audit objective is to express an opinion on HCFA's FY 1997 combined financial statements and to report on their compliance with laws and regulations. One aspect of our overall work is to determine whether the Medicare fee-for-service benefit payments expenses are made in accordance with the provisions of Title XVIII and implementing regulations in Title 42 of the Code of Federal Regulations (42 CFR). Specifically, we were to perform substantive tests on claims BCBSFL adjudicated during the second quarter of FY 1997 (January 1 through March 31, 1997) for a sample of 50 beneficiaries.

Our testing was to determine if services were: (1) furnished by certified Medicare providers to eligible beneficiaries; (2) reimbursed by Medicare contractors in accordance with Medicare laws and regulations; and (3) medically necessary, accurately coded, and sufficiently documented in the beneficiaries' medical records.

We conducted our audit in accordance with Government Auditing Standards issued by the Comptroller General of the United States, financial statement audit methodologies prescribed by the General Accounting Office (GAO), and OMB Bulletin 93-06, "Audit Requirements of Federal Financial Statements." These standards require that we plan and perform our audit to obtain reasonable assurance that HCFA's financial statements are free of material misstatement and that HCFA, as well as Medicare contractors such as BCBSFL, have complied with applicable laws and regulations.

SCOPE AND METHODOLOGY

We performed our review from June 1997 to March 1998 at the BCBSFL offices in Jacksonville, Florida and the OIG offices in: Birmingham, Alabama; Atlanta, Georgia; Boston, Massachusetts; and Baltimore, Maryland. We provided BCBSFL a draft report for comments on April 13, 1998. The relevant BCBSFL comments are summarized after each finding and the comments are appended in their entirety to this report (see Appendix C).

In addition to our work, Ernst and Young, LLP (E&Y) contracted with HHS, OIG to review two areas related to our audit: (1) a follow-up to the FY 1996 review of the EDP application change development and program changes controls at the Florida Shared System (FSS) maintainer, and (2) certain financial amounts not related to claims. The results of these reviews have been reported separately to BCBSFL by E&Y.

We relied on our substantive tests of BCBSFL's adjudicated claims to determine the propriety of Medicare benefit payments expenses BCBSFL reported to HCFA. To perform our substantive tests, OIG headquarters first randomly selected 12 contractor FY quarters (primary sampling unit) for review. The second quarter of FY 1997 (January 1 through March 31, 1997) for BCBSFL was one of the quarters selected.

The BCBSFL reported a total of $2,113,273,324 expended in total Medicare funds expended on the monthly HCFA Form 1522s during the second quarter of FY 1997. Our substantive testing universe consisted of $2,055,890,389 (97 percent of the total) BCBSFL paid during the same period for 14,686,806 claims for services provided to 2,159,962 beneficiaries. The remainder of the quarterly expense amount, $57,382,935 (3 percent of the total), represented the net effect of non-claim transactions, such as cost report settlements, overpayment collections, periodic interim payments to Part A providers, etc. These amounts were audited by other independent auditors under contract with OIG.

We selected a stratified random sample of 50 beneficiaries (secondary sampling unit) from claim files BCBSFL provided containing all claims BCBSFL adjudicated during our audit period. Prior to selecting the sample of beneficiaries, we reconciled these files to: (1) BCBSFL's FI and carrier check registers; and (2) Medicare benefit expenses BCBSFL reported on the HCFA 1522s for the second quarter of FY 1997.

The BCBSFL adjudicated 779 claims for the 50 beneficiaries. The 779 claims consisted of 70 FI claims and 709 carrier claims for which BCBSFL paid a total of $412,703 ($339,980 for FI claims and $72,723 for carrier claims).

After we identified the claims for the beneficiaries in the sample, we determined that the claims were: (1) for covered services furnished by eligible providers to eligible beneficiaries; (2) were reimbursed by BCBSFL in accordance with Medicare laws and regulations, and (3) were medically necessary, recorded and documented in beneficiary medical records. To accomplish these objectives, we performed audit steps to verify:

- The providers and beneficiaries were Medicare eligible;
- The BCBSFL paid the correct amount to the providers and beneficiaries;
- Any coinsurance and deductible amounts were correct;
- Medicare was the correct primary/secondary payer;
- The BCBSFL paid only once for a service (eliminating duplicate claims); and
- The BCBSFL included all payments in the monthly HCFA Form 1522 amount for "Total Funds Expended This Month" for each month in the quarter.

We obtained assistance from the medical review staffs of BCBSFL and Florida Medical Quality Assurance, Inc., (the Florida PRO) to review the selected claims. The medical review personnel for these organizations determined if the paid claims were for services actually provided, correctly coded, medically necessary, and supported by medical records.

We used the following Medicare claim categories to report our substantive testing results:

- Hospital Inpatient - Prospective Payment System
- Hospital Inpatient - Non-Prospective Payment System
- SNF Inpatient
- Hospital and SNF Outpatient
- Ambulatory Surgery
- Part B Services Paid by Carriers such as:
  - Physician Services
  - Clinical Laboratories
  - Ambulance Services

For the claim types listed above we performed tests to ensure compliance with the Medicare laws and regulations.

FINDINGS AND RECOMMENDATIONS

We identified overpayments of $41,126 in the sample of $412,703 of Medicare benefit payments. Other independent auditors under contract with OIG identified controls that needed improvement relative to EDP and non-claim transactions.

SUBSTANTIVE TESTING RESULTS

With the assistance of BCBSFL and the Florida PRO, we identified overpayments (no underpayments were detected) totaling $41,126 ($37,230 in FI payments and $3,896 in carrier payments). See Appendix A for a listing of the dollar amounts of errors and number of errors by claim type. See Appendix B for a list of all the errors by claim and item of service within each claim along with the reason for each error.

We relied on the following criteria to identify errors.

Federal regulations require that Medicare providers maintain medical records that contain sufficient evidence to support, as applicable, admission, services furnished, diagnoses, treatment performed and continued care for claims billed.

The Social Security Act § 1862 states that no payment under Medicare Part A and Part B can be made for items and services which: (1) are not reasonable or necessary; or (2) do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member (i.e., personal comfort items).

The Medicare Carriers Manual (MCM), Part 3, § 5114 and 5114.1L, states that if the sum of the payment allowance for the separately billed tests exceeds the payment allowance for the battery that includes the tests, the carrier should make payment at the lesser amount for the battery of tests.

The MCM Part 3, § 4824, states that because the Medicare fee schedule amount for surgical procedures includes all services that are part of a global surgery package, carriers should not pay more than the fee schedule amount when a bill is fragmented (unbundled).

Intermediary Letter 372 addresses the billing of professional services by a physician in a teaching setting when residents are involved. In essence, the physician billing for the services must have either performed the service or have been present and supervised the resident when the service was performed.

The MCM Part 3, § 5246.4, specifies that when a carrier determines that a less expensive level of service would have met the patient's medical needs or was actually furnished, the carrier must reimburse the provider for the less expensive level of service.

Recommendations

With respect to the overpayments that have been identified we recommend that BCBSFL:

- initiate recovery of the overpayments and periodically provide us with the status of recovery actions; and

Comments by BCBSFL

The BCBSFL stated that since we left the audit site additional medical records have been received which their staff has continued to review and that accordingly our list of errors prepared before these records were received does not reflect these reviews. The BCBSFL further stated that once they have validated which claims on our list are affected by these records they would initiate recovery of those overpayments that fall within the parameters of overpayment recoupment and keep us informed of their progress.

RESULTS OF WORK PERFORMED BY OTHERS

Ernst and Young LLP contracted with OIG to review two areas related to our audit: (1) a follow-up to the FY 1996 review of the EDP application change development and program changes controls at the FSS maintainer, and (2) certain financial amounts not related to claims. The results of these reviews have been reported separately by E&Y in February, 1998. In these reports to BCBSFL, E&Y made recommendations to correct noted conditions.

Recommendation

We recommend that BCBSFL address the recommendations made by E&Y in their reports and provide us with a copy of their responses.

Comments by BCBSFL

The BCBSFL stated that they had responded to the recommendations as documented in comments included in the two final reports and had taken or were taking appropriate corrective actions.

OTHER MATTERS

AMBULATORY SURGICAL CENTER CLAIMS

Our sample of claims included two ambulatory surgical center (ASC) facility claims. Services provided in ASCs normally involve two types of services - a facility component covering the charges of the facility only and a professional component covering the charges of the professionals who performed the services at the facility. When a given procedure is carried out at an ASC, both the facility and professional charges should be for the same type and level of medical care.

For one of the ASC claims, we noted that the professional fee was billed at an inappropriately higher (instead of the same) level of service than the facility fee. The facility fee bill was in our sample, but an erroneous professional fee claim was not - it was received and adjudicated by BCBSFL subsequent to our sample quarter. Because the claim for the professional fee was in error, but not a sample item, we did not include any error amount for it in our sample results. However, we did record a "compliance error" in Appendix B. We did this in order to reflect a compliance error for the claim associated with the sample item.

The discrepancy involving the professional fee claim was apparently not detected by BCBSFL because the claims were submitted at different times. The professional fee claim was received subsequent to the receipt and processing of the facility fee and there were no procedures for comparing the claims to ensure that both were the same level of care. We recommend that BCBSFL address this issue to ensure that both component claims for ASC services are paid at the appropriate rate.

Comments by BCBSFL

The BCBSFL commented that they agreed that this issue warrants further investigation and that they plan to work with their systems area to explore this issue further.

CASH RECEIPTS

As part of our audit responsibility with respect to work primarily contracted to be done by E&Y, we validated the amounts BCBSFL reported for both the number and dollar amounts of FI and carrier cash receipts for the second quarter of FY 1997.

To validate the reported amount of FI cash receipts, we obtained a listing with the number of checks received and the amount deposited for each check for the second quarter of FY 1997. We determined that the FI cash receipts involved 312 transactions and totaled $7,756,017. We did not find any discrepancies between the FI cash receipts and the reported FI cash receipts.

With respect to carrier cash receipts, BCBSFL provided us with monthly reports for the carrier deposits for the second quarter. However, this report listed only the total number of checks received and the amount deposited for each day with a monthly total (rather than individual amounts as for the FI). Therefore, in order to determine the universe of carrier checks deposited, we numbered each amount listed on the adding machine tapes that supported the amount on each daily deposit slip.

In performing this task, we found numerous instances where check amounts on the adding machine tape totals had been corrected. In most cases, the totals on the adding machine tapes had been adjusted to reflect these changes. However, in certain instances we noted the total on the tape had not been changed and neither had the deposit slip amount. Therefore, the deposit slip was incorrect. To expedite matters, we omitted the error from our universe in those instances where we were unable to correct the error noted through discussions with BCBSFL officials. We determined that the universe for carrier cash receipts numbered 13,306 transactions and totaled $5,863,383, while the reported amount was $5,870,244 - a difference of $6,861.

The total universe for FI and carrier cash receipts for BCBSFL for January 1, 1997 through March 31, 1997 numbered 13,618 transactions and totaled $13,619,399. The reported dollar amount of deposits for the FI and carrier was $13,626,260 ($7,756,017 and $5,870,243 for the FI and carrier respectively). This total differs from our sampling universe by $6,861 because of the problems regarding the carrier deposits. While the amount of error is immaterial to the total amount involved, we believe that BCBSFL should consider whether improvements are warranted, including the possibility of utilizing a more formal log to record cash receipts.

Comments by BCBSFL

The BCBSFL stated that they are currently evaluating the costs associated with logging checks individually.

Other Comments by BCBSFL

The BCBSFL made a general comment suggesting that our report include more statistical information regarding the sample, such as the standard error, the coefficient of variation etc.

OIG Response to Other Comments by BCBSFL

Our review at BCBSFL contributes to a nationwide report issued by our headquarters. Information respecting the characteristics of our sample and projections etc. are a part of the nationwide reporting. Our review did not involve statistical projections for errors at BCBSFL; we only recorded the actual amounts of overpayments identified. Consequently, confidence

levels, intervals etc. while used on a nationwide basis to project sample results from aggregated totals from the various audit sites, are not relevant on an individual audit site basis where we only reported the actual dollar errors identified without making a projection for each contractor.

AUDIT OF HCFA'S FINANCIAL STATEMENTS
FOR FISCAL YEAR 1997
AT BLUE CROSS AND BLUE SHIELD OF FLORIDA
DOLLAR AMOUNT OF ERRORS BY TYPE OF CLAIM

The listing below shows the dollar amount of errors by type of claim. We calculated the percent of errors by dividing the Dollar Errors Identified by the Dollars Reviewed for each type of claim. For example, for Hospital Inpatient-PPS, dividing $36,684.14 by $304,043.79 resulted in a 12.06% error. These percentages are for informational purposes only regarding the claims in the sample. They cannot be used to derive any conclusions regarding Blue Cross Blue Shield of Florida's paid claims universe by type of claim.

TYPE OF CLAIM	DOLLARS REVIEWED	DOLLAR ERRORS IDENTIFIED	PERCENT OF ERRORS
Hospital Inpatient-PPS	$304,043.79	$36,684.14	12.06%
Hospital Inpatient-Non-PPS	$13,906.00	$ -0-	0.00%
SNF Inpatient	$13,856.05	$ -0-	0.00%
Hospital, SNF Outpatient	$5,512.42	$546.10	9.90%
Ambulatory Surgery	$2,661.97	$ -0-	0.00%
SUBTOTAL	$339,980.23	$37,230.24	10.95%
Part B	$72,722.48	$3,895.72	5.36%
TOTAL	$412,702.71	$41,125.96	9.97%

AUDIT OF HCFA'S FINANCIAL STATEMENTS
FOR FISCAL YEAR 1997
AT BLUE CROSS AND BLUE SHIELD OF FLORIDA
NUMBER OF CLAIMS WITH ERRORS BY TYPE OF CLAIM

The listing below shows the number of claims with errors by type of claim. We calculated the percent of errors by dividing the Claim Errors Identified by the Claims Reviewed for each type of claim. For example, for Hospital Inpatient - PPS, dividing 7 by 24 resulted in a 29.17% error. These percentages are for informational purposes only regarding the claims in the sample. They cannot be used to derive any conclusions regarding Blue Cross Blue Shield of Florida's paid claims universe by type of claim.

TYPE OF CLAIM	CLAIMS REVIEWED	CLAIM ERRORS IDENTIFIED	PERCENT OF ERRORS
Hospital Inpatient-PPS	24	7	29.17%
Hospital Inpatient-Non-PPS	1	0	0.00%
SNF Inpatient	4	0	0.00%
Hospital, SNF Outpatient	39	10	25.64%
Ambulatory Surgery	2	1	50.00%
SUBTOTAL	70	18	25.71%
Part B	709	66	9.31%
TOTAL	779	84	10.78%

AUDIT OF HCFA'S FINANCIAL STATEMENTS FOR FISCAL YEAR 1997 AT BLUE CROSS AND BLUE SHIELD OF FLORIDA JACKSONVILLE, FLORIDA

FISCAL INTERMEDIARY CLAIMS (BY LINE ITEM) WITH IDENTIFIED ERRORS

NO. OF CLAIMS	ICN	AMOUNT QUESTIONED	NO. OF SERVICES QUESTIONED	ERROR CODE	ERROR DESCRIPTION
1	19606602024205	0.92	1.0	21	Insufficient Documentation
1	19606602024205	22.14	3.0	21	Insufficient Documentation
1	19606602024205	3.00	1.0	21	Insufficient Documentation
1	19606602024205	11.29	1.0	21	Insufficient Documentation
1	19606602024205	4.37	1.0	21	Insufficient Documentation
1	19606602024205	3.76	1.0	21	Insufficient Documentation
1	19606602024205	8.18	1.0	21	Insufficient Documentation
1	19606602024205	33.21	1.0	21	Insufficient Documentation
1	19606602024205	9.99	1.0	21	Insufficient Documentation
1	19606602024205	25.65	1.0	21	Insufficient Documentation
2	19700103104605	1,211.63	1.0	35	Non-covered Service
3	19700712305704	58.50	1.0	21	Insufficient Documentation
3	19700712305704	5.25	1.0	21	Insufficient Documentation
3	19700712305704	11.70	1.0	21	Insufficient Documentation
4	19702002159005	0.00	1.0	21	Insufficient Documentation
4	19702002159005	0.00	1.0	21	Insufficient Documentation
4	19702002159005	24.56	1.0	21	Insufficient Documentation
4	19702002159005	0.00	1.0	21	Insufficient Documentation
5	19703002743905	4,604.72	1.0	66	Invalid Patient Admission
6	19703607081305	0.00	1.0	21	Insufficient Documentation
6	19703607081305	11.99	1.0	21	Insufficient Documentation
7	19704202688705	11.60	1.0	21	Insufficient Documentation
7	19704202688705	19.23	1.0	21	Insufficient Documentation
7	19704202688705	3.35	1.0	21	Insufficient Documentation
7	19704202688705	28.41	1.0	21	Insufficient Documentation
7	19704202688705	17.77	1.0	21	Insufficient Documentation
7	19704202688705	0.79	1.0	21	Insufficient Documentation
7	19704202688705	12.75	1.0	21	Insufficient Documentation
8	19704302506605	11.99	1.0	21	Insufficient Documentation
8	19704302506605	0.79	1.0	21	Insufficient Documentation
9	19705103612605	2,499.26	1.0	21	Insufficient Documentation
10	19705603217005	3,517.24	1.0	66	Invalid Patient Admission
11	19705702941405	2,989.19	1.0	66	Invalid Patient Admission
12	19705901780305	14.86	1.0	21	Insufficient Documentation
12	19705901780305	8.14	4.0	21	Insufficient Documentation
12	19705901780305	11.60	1.0	21	Insufficient Documentation
12	19705901780305	19.23	1.0	21	Insufficient Documentation
12	19705901780305	3.35	1.0	21	Insufficient Documentation
12	19705901780305	17.77	1.0	21	Insufficient Documentation
13	19705908555904	15.11	1.0	21	Insufficient Documentation
13	19705908555904	20.09	1.0	21	Insufficient Documentation
13	19705908555904	3.00	1.0	21	Insufficient Documentation

AUDIT OF HCFA'S FINANCIAL STATEMENTS
FOR FISCAL YEAR 1997
AT BLUE CROSS AND BLUE SHIELD OF FLORIDA
JACKSONVILLE, FLORIDA

FISCAL INTERMEDIARY CLAIMS (BY LINE ITEM) WITH IDENTIFIED ERRORS

NO. OF CLAIMS	ICN	AMOUNT QUESTIONED	NO. OF SERVICES QUESTIONED	ERROR CODE	ERROR DESCRIPTION
14	19706202776005	14.71	1.0	21	Insufficient Documentation
14	19706202776005	37.44	2.0	21	Insufficient Documentation
14	19706202776005	8.96	1.0	21	Insufficient Documentation
14	19706202776005	11.70	1.0	21	Insufficient Documentation
14	19706202776005	4.91	1.0	21	Insufficient Documentation
15	19706408200804	11.04	1.0	21	Insufficient Documentation
15	19706408200804	3.00	1.0	21	Insufficient Documentation
16	19706903122705	0.00	1.0	80	Compliance Error
16	19706903122705	0.00	1.0	80	Compliance Error
17	19707104112205	17,471.99	1.0	21	Insufficient Documentation
18	19707302366505	4,390.11	1.0	31	Incorrectly Coded
Total		37,230.24	59.0		

AUDIT OF HCFA'S FINANCIAL STATEMENTS
FOR FISCAL YEAR 1997
AT BLUE CROSS AND BLUE SHIELD OF FLORIDA
JACKSONVILLE, FLORIDA

CARRIER CLAIMS (BY LINE ITEM) WITH IDENTIFIED ERRORS

NO. OF CLAIMS	ICN	AMOUNT QUESTIONED	NO. OF SERVICES QUESTIONED	ERROR CODE	ERROR DESCRIPTION
1	0963538552500	4.06	1.0	16	No Documentation
1	0963538552500	3.79	1.0	16	No Documentation
2	4063550773900	16.49	1.0	21	Insufficient Documentation
2	4063550773900	23.07	1.0	21	Insufficient Documentation
3	4063613287300	8.28	1.0	31	Incorrectly Coded
4	4063618265300	14.44	1.0	31	Incorrectly Coded
5	4063652424200	29.62	1.0	31	Incorrectly Coded
6	4070020627200	72.33	1.0	16	No Documentation
7	4070366122500	3.59	1.0	25	Medically Unnecessary
8	4170370082900	71.91	1.0	31	Incorrectly Coded
9	4263190280901	3.00	1.0	35	Non-covered Service
9	4263190280901	28.30	1.0	35	Non-covered Service
10	5063613685100	10.28	1.0	21	Insufficient Documentation
10	5063613685100	10.28	1.0	21	Insufficient Documentation
10	5063613685100	10.28	1.0	21	Insufficient Documentation
10	5063613685100	10.28	1.0	21	Insufficient Documentation
11	5063615905200	24.01	1.0	31	Incorrectly Coded
12	5063624791800	37.28	1.0	21	Insufficient Documentation
12	5063624791800	37.28	1.0	21	Insufficient Documentation
12	5063624791800	37.28	1.0	21	Insufficient Documentation
13	5070092350900	0.00	1.0	16	No Documentation
13	5070092350900	8.80	1.0	16	No Documentation
13	5070092350900	116.08	1.0	16	No Documentation
14	5070108952300	18.34	1.0	31	Incorrectly Coded
15	5070223097100	139.04	4.0	21	Insufficient Documentation
16	5070233595800	15.13	1.0	31	Incorrectly Coded
16	5070233595800	22.54	1.0	31	Incorrectly Coded
16	5070233595800	15.13	1.0	31	Incorrectly Coded
17	5070241486300	29.50	8.0	35	Non-covered Service
17	5070241486300	231.42	1.0	35	Non-covered Service
18	5070286316700	111.81	1.0	21	Insufficient Documentation
18	5070286316700	164.16	4.0	21	Insufficient Documentation
19	5070291175800	10.38	1.0	31	Incorrectly Coded
20	5070312641000	3.00	1.0	21	Insufficient Documentation
20	5070312641000	19.01	1.0	25	Medically Unnecessary
20	5070312641000	9.96	1.0	21	Insufficient Documentation
21	5070351567200	8.52	1.0	21	Insufficient Documentation
21	5070351567200	12.03	1.0	21	Insufficient Documentation
21	5070351567200	17.22	1.0	21	Insufficient Documentation
21	5070351567200	5.58	1.0	21	Insufficient Documentation
22	5070362583000	21.35	1.0	21	Insufficient Documentation
23	5070386556100	29.27	1.0	21	Insufficient Documentation

AUDIT OF HCFA'S FINANCIAL STATEMENTS
FOR FISCAL YEAR 1997
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JACKSONVILLE, FLORIDA

CARRIER CLAIMS (BY LINE ITEM) WITH IDENTIFIED ERRORS

NO. OF CLAIMS	ICN	AMOUNT QUESTIONED	NO. OF SERVICES QUESTIONED	ERROR CODE	ERROR DESCRIPTION
24	5070432102800	10.26	1.0	21	Insufficient Documentation
24	5070432102800	13.60	1.0	35	Non-covered Service
25	5070441431100	8.49	1.0	21	Insufficient Documentation
26	5070446896300	0.00	1.0	60	Unbundling
26	5070446896300	14.67	1.0	21	Insufficient Documentation
27	5070625123000	11.04	1.0	21	Insufficient Documentation
27	5070625123000	15.69	1.0	21	Insufficient Documentation
27	5070625123000	18.95	1.0	21	Insufficient Documentation
27	5070625123000	11.62	1.0	21	Insufficient Documentation
28	5070642967100	21.35	1.0	21	Insufficient Documentation
28	5070642967100	22.78	1.0	21	Insufficient Documentation
29	5070648666500	14.67	1.0	31	Incorrectly Coded
30	5070651401500	17.22	1.0	21	Insufficient Documentation
30	5070651401500	8.52	1.0	21	Insufficient Documentation
30	5070651401500	4.49	1.0	21	Insufficient Documentation
30	5070651401500	12.03	1.0	21	Insufficient Documentation
30	5070651401500	5.58	1.0	21	Insufficient Documentation
31	5070651930800	40.82	1.0	21	Insufficient Documentation
32	5070717042600	298.54	7.0	21	Insufficient Documentation
32	5070717042600	205.24	7.0	21	Insufficient Documentation
33	5070717042700	58.64	2.0	21	Insufficient Documentation
34	5070772221700	9.66	1.0	21	Insufficient Documentation
34	5070772221700	9.66	1.0	21	Insufficient Documentation
35	5070780496800	1.56	1.0	21	Insufficient Documentation
36	5163625884800	43.38	1.0	21	Insufficient Documentation
36	5163625884800	3.88	1.0	21	Insufficient Documentation
36	5163625884800	3.10	1.0	21	Insufficient Documentation
37	5170061390700	36.64	1.0	21	Insufficient Documentation
37	5170061390700	36.64	1.0	21	Insufficient Documentation
37	5170061390700	36.64	1.0	21	Insufficient Documentation
38	5170061411300	36.64	1.0	21	Insufficient Documentation
38	5170061411300	43.00	1.0	21	Insufficient Documentation
38	5170061411300	36.64	1.0	21	Insufficient Documentation
38	5170061411300	36.64	1.0	21	Insufficient Documentation
39	5170176284200	10.38	1.0	31	Incorrectly Coded
40	5170202313800	42.79	1.0	16	No Documentation
40	5170202313800	0.00	1.0	16	No Documentation
40	5170202313800	15.69	1.0	16	No Documentation
40	5170202313800	12.02	1.0	16	No Documentation
40	5170202313800	0.00	1.0	16	No Documentation
40	5170202313800	4.49	1.0	16	No Documentation
41	5170217680400	70.40	1.0	16	No Documentation
41	5170217680400	107.51	1.0	16	No Documentation

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CARRIER CLAIMS (BY LINE ITEM) WITH IDENTIFIED ERRORS

NO. OF CLAIMS	ICN	AMOUNT QUESTIONED	NO. OF SERVICES QUESTIONED	ERROR CODE	ERROR DESCRIPTION
42	5170223484800	15.82	1.0	31	Incorrectly Coded
43	5170272265500	28.01	1.0	21	Insufficient Documentation
44	5170294514300	146.32	14.0	21	Insufficient Documentation
44	5170294514300	39.82	1.0	21	Insufficient Documentation
44	5170294514300	39.82	1.0	21	Insufficient Documentation
44	5170294514300	146.32	14.0	21	Insufficient Documentation
45	5170368604300	6.76	1.0	31	Incorrectly Coded
46	5170373304300	9.22	1.0	21	Insufficient Documentation
46	5170373304300	9.22	1.0	21	Insufficient Documentation
46	5170373304300	9.22	1.0	21	Insufficient Documentation
46	5170373304300	9.22	1.0	21	Insufficient Documentation
46	5170373304300	9.22	1.0	21	Insufficient Documentation
46	5170373304300	9.22	1.0	21	Insufficient Documentation
47	5170411682100	31.85	1.0	21	Insufficient Documentation
48	5170653126800	38.75	1.0	21	Insufficient Documentation
49	5170653164200	38.75	1.0	21	Insufficient Documentation
50	5170653164300	52.76	1.0	21	Insufficient Documentation
51	5170703292100	24.07	1.0	35	Non-covered Service
52	5170728304100	6.79	1.0	21	Insufficient Documentation
52	5170728304100	6.79	1.0	21	Insufficient Documentation
52	5170728304100	6.79	1.0	21	Insufficient Documentation
53	5170771810700	14.47	1.0	21	Insufficient Documentation
54	5170776412400	3.00	1.0	35	Non-covered Service
54	5170776412400	4.89	1.0	35	Non-covered Service
54	5170776412400	3.98	1.0	35	Non-covered Service
54	5170776412400	3.18	1.0	35	Non-covered Service
54	5170776412400	12.03	1.0	35	Non-covered Service
55	5170782005800	25.58	1.0	31	Incorrectly Coded
56	5170791312500	30.42	1.0	21	Insufficient Documentation
57	5170846696000	10.93	1.0	31	Incorrectly Coded
58	5263620856600	31.35	1.0	21	Insufficient Documentation
58	5263620856600	19.61	1.0	21	Insufficient Documentation
59	5270132960800	34.63	1.0	21	Insufficient Documentation
60	5270483737200	15.29	1.0	21	Insufficient Documentation
61	5270562466200	23.41	1.0	40	Service Provided by Other Provider
61	5270562466200	8.60	1.0	40	Service Provided by Other Provider
61	5270562466200	8.60	1.0	40	Service Provided by Other Provider
61	5270562466200	3.10	1.0	40	Service Provided by Other Provider
62	5270570931200	15.90	1.0	31	Incorrectly Coded
63	5270631353700	12.65	1.0	31	Incorrectly Coded

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NO. OF CLAIMS	ICN	AMOUNT QUESTIONED	NO. OF SERVICES QUESTIONED	ERROR CODE	ERROR DESCRIPTION
64	5270640225100	10.38	1.0	31	Incorrectly Coded
65	5270648770900	5.58	1.0	16	No Documentation
65	5270648770900	12.02	1.0	16	No Documentation
65	5270648770900	11.60	1.0	16	No Documentation
65	5270648770900	8.52	1.0	16	No Documentation
66	5270696180000	5.58	1.0	16	No Documentation
TOTAL		3,895.72	183.0		

532 Riverside Avenue
P. O. Box 1798
Jacksonville, Florida 32231-0014

May 11, 1998

RECEIVED
MAY 15 1998
Office of Audit Svcs.

Mr. Charles J. Curtis
Regional Inspector General
Office of Inspector General-Office of Audit Services
61 Forsyth Street, S.W. - Room 3T41
Atlanta, GA. 30303-8909

CIN: A-04-98-03008

Dear Mr. Curtis:

This is in response to your letter dated April 13, 1998 and the draft report entitled, *Assist Audit of HCFA's FY 1997 Financial Statements at Blue Cross Blue Shield of Florida (BCBSFL)*, addressed to Mr. Curtis Lord. Following are the audit report recommendations and our comments regarding the draft report:

Report Recommendation:

With respect to the overpayments that have been identified, we recommend that BCBSFL initiate recovery of the overpayments and periodically provide us with the status of recovery actions.

Comments:

The draft report reflects claims with identified errors as of March 6, 1998 (established cut off by OIG). Since that time, our staff has continued to review medical records which have come in, thus making the list of claims in error not totally accurate. Once we have validated which claims should be classified as errors and have had an opportunity to assess which ones fall within the parameters for overpayment recoupment, we will initiate recovery of the overpayments and keep you informed of our progress.

Report Recommendation:

We recommend that BCBSFL address the recommendations made by E&Y in their reports and provide us with a copy of their responses.

Comments:

Ernst and Young LLP conducted two reviews and subsequently released the following reports: *Follow-up of EDP Application Development and Program Change Controls Review Florida Shared System (FSS) at Blue Cross Blue Shield of Florida*, dated November, 1997 and *HCFA Fiscal Year 1997 Financial Statements Audit*, dated February 13, 1998. Within each report, E&Y outlined their recommendations/findings and also included our responses and where appropriate, corrective actions we have undertaken. If by chance you do not have a copy of these reports, please notify me and I will forward copies to you.

Report Recommendation:

We recommend that BCBSFL address this issue (ASC) to ensure that both component claims for ASC services are paid at the appropriate rate.

Comments:

We concur that this issue warrants further investigation and plan to work with our Systems area to explore this issue further.

Report Recommendation:

While the amount of error is immaterial to the total amount involved, we believe that BCBSFL should consider whether improvements are warranted, including the possibility of utilizing a more formal log to record cash receipts.

Comments:

The Incoming Mailroom is currently evaluating the costs associated with logging checks individually. The Incoming Mailroom receives an average of 5,323 checks monthly and due to the required time frames for deposits, we would have to increase our staffing as well as develop a PC program.

Additional comment:

We suggest the report include more statistical information regarding the sample. Sample statistics such as the standard error, the coefficient of variation, and the sample standard deviation would be helpful. The most beneficial statistics would be a confidence level and confidence interval.

Thank you for allowing us the opportunity to comment prior to the report becoming final.

Please let me know if you have any questions regarding our comments.

Sincerely,

Thomas Jarvis, Director
Government Programs Finance and Controls