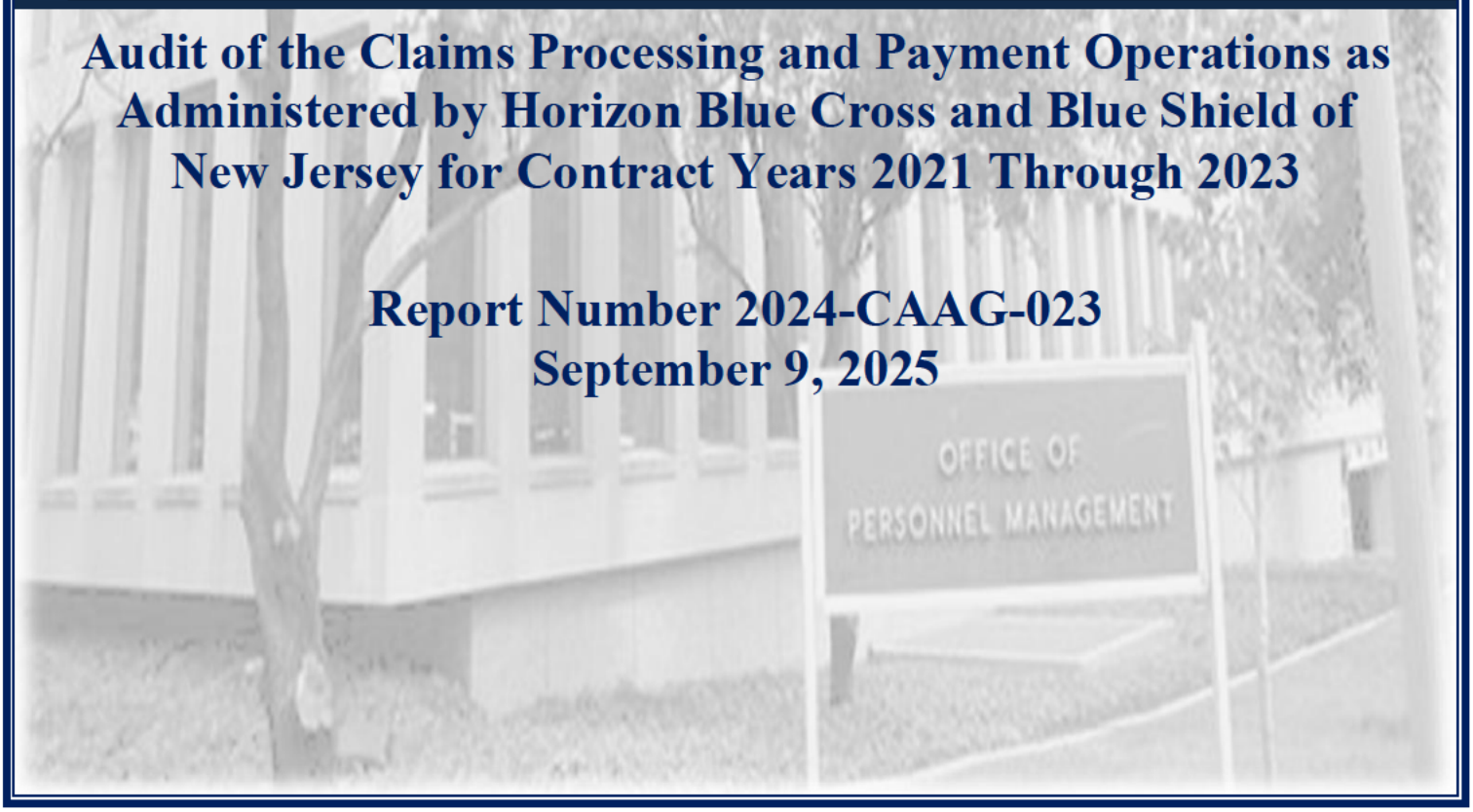
U.S. OFFICE OF PERSONNEL MANAGEMENT
OFFICE OF THE INSPECTOR GENERAL
OFFICE OF AUDITS

Final Audit Report

Audit of the Claims Processing and Payment Operations as Administered by Horizon Blue Cross and Blue Shield of New Jersey for Contract Years 2021 Through 2023

Report Number 2024-CAAG-023
September 9, 2025



EXECUTIVE SUMMARY

Audit of the Claims Processing and Payment Operations as Administered by
Horizon Blue Cross and Blue Shield of New Jersey for Contract Years 2021 Through 2023

Report No. 2024-CAAG-023 **September 9, 2025**

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 Horizon Blue Cross and Blue Shield of New Jersey (Plan) 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 related Service Benefit Plan brochures.

What Did We Audit?

The Office of the Inspector General completed a performance audit of the Plan's FEHBP claim processing and payment operations. Specifically, we performed various claim reviews to determine whether 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 2021 through 2023.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

Our audit resulted in four monetary findings, which identified potential net overcharges of $10,759,362 to the FEHBP and potential member overcharges of $254,952:

- $15,799 in overcharges to the FEHBP, $7,100 in member overcharges, and an additional estimated $10,634,756 FEHBP overcharges due to system and processor errors related to non-participating provider claims;
- $82,455 in net overcharges to the FEHBP and $247,852 in member overcharges due to processor errors, a system error, and the Plan's misinterpretation of surprise billing protections;
- $22,317 in overcharges to the FEHBP due to a system coding error and medical review not being performed for claims with unlisted procedure codes; and
- $4,035 in overcharges to the FEHBP due to payment of non-covered benefits.

Because the nearly $11 million in potential overcharges we uncovered is less than 0.5 percent of the total claims paid during the scope of our audit, we believe that the Plan's internal controls were generally effective in ensuring accurate processing and payment of health care claims.

Additionally, we identified the following two procedural issues:

- A system error that allowed non-covered procedures to be paid on facility claims by all Blue Cross and Blue Shield plans; and
- A lack of sufficient documentation, resulting in our inability to determine whether six claims were accurately paid.

Finally, we identified an area of program improvement related to messaging in the explanation of benefits issued to members.

ABBREVIATIONS

Association	**Blue Cross and Blue Shield Association**
BCBS	**Blue Cross and Blue Shield**
EOB	**Explanation of Benefits**
FAM	**Federal Employee Program Administration Manual Vol II**
FEHBP	**Federal Employees Health Benefits Program**
FEP	**Federal Employee Program**
FEPDirect	**The Association's National Claims System**
Non-Par	**Non-participating**
NSA	**No Surprises Act**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
Plan	**Horizon Blue Cross and Blue Shield of New Jersey**
QPA	**Qualifying Payment Amount**

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REPORT FRAUD, WASTE, AND MISMANAGEMENT

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 as administered by Horizon Blue Cross and Blue Shield of New Jersey (Plan), plan codes 10, 11, and 13, for contract years 2021 through 2023.

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

The FEHBP was established by the Federal Employees Health Benefits Act, Public Law 86-382, enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for federal employees, annuitants, and eligible dependents. OPM's Office of Healthcare and Insurance has overall responsibility for administration of the FEHBP, including the publication of program regulations and agency guidance. As part of its administrative responsibilities, the Office of Healthcare and Insurance contracts with various health insurance carriers that provide service benefits, indemnity benefits, and/or comprehensive medical services. The provisions of the Federal Employees Health Benefits Act are implemented by OPM through regulations codified in Title 5, United States Code, Chapter 89; and Title 5, Code of Federal Regulations, Chapter 1, Part 890.

On behalf of participating Blue Cross and Blue Shield (BCBS) plans, the Association entered a governmentwide Service Benefit Plan contract with OPM to provide a health benefit plan authorized by the Federal Employees Health Benefits Act. The Association delegates authority to participating local 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 Service Benefit Plan. The FEP Director's Office coordinates the administration of contract CS 1039 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 member plans, verifying subscriber eligibility, approving or disapproving the reimbursement of local plan payments of

[1] Throughout this report, when we refer to FEP, we are referring to the Service Benefit Plan 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.

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, as well as the terms and conditions of contract CS 1039, is the responsibility of the Association and the management of the local BCBS plans. In addition, the local BCBS plans are responsible for establishing and maintaining a system of internal controls.

The most recent audit of claims processing and payment operations at the Plan was report number 1A-10-49-12-035, dated February 5, 2013, which covered the period January 1, 2009, through December 31, 2011. Findings related to that audit were deemed obsolete and not considered as part of planning for this audit.

The results of the audit were discussed with the Association and Plan throughout the audit, including the issuance of six notices of findings and recommendations, and at an exit conference on March 26, 2025. We issued a draft report, dated April 10, 2025, to solicit the Association's comments on the findings and recommendations. The Association's response to the draft report was considered in preparing our final report and is included as an appendix to this report.

II. OBJECTIVES, 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 contract CS 1039 and the related Service Benefit Plan brochures.

Specifically, our objective was to determine whether the Plan's internal controls over its claims processing and payment operations are sufficient to ensure claims are properly processed and paid.

SCOPE AND METHODOLOGY

We conducted our performance audit in accordance with the 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.

To meet these objectives, we performed reviews related to the Plan's internal controls over its claims processing and payment operations. Specifically, we conducted reviews of the following areas to achieve our objectives for contract years 2021 through 2023:

1. **Place of Service Review** – To determine if the claims were paid accurately according to the provider contract with the Plan and the Service Benefit Plan brochure;

2. **Unlisted Procedure Codes Review** – To determine if claims that have unlisted, miscellaneous, or unclassified Current Procedural Terminology or Healthcare Common Procedure Coding System codes were priced and paid correctly in accordance with Plan policies and procedures;

3. **Procedure Code Modifier Review** – To determine if the Plan is properly applying allowance adjustments for all procedure code modifiers requiring them when pricing FEHBP claims;

4. **Non-Covered Health Care Procedures Review** – To determine if health care procedures considered non-covered, but charged to the FEHBP, were allowable;

5. **Surprise Billing Review** – To determine if claims were eligible for surprise billing protection and were paid at the correct allowance;

6. **Amount Paid Greater than Billed Charges Review** – To determine if claims that paid at more than billed charges were paid at the correct allowance per the provider's contract;

7. **Debarred Provider Review** – To determine if the Plan has sufficient policies and procedures in place to prevent payment of claims to debarred providers;

8. **Non-Covered Diagnosis Code Review** – To determine if claims with diagnosis codes considered to be non-covered, but charged to the FEHBP, were allowable, and

9. **Fraud Case Reporting Review** – To determine if the Plan is meeting the requirements of Carrier Letter 2017-13 for the reporting of fraud cases to the OPM OIG.

We conducted this audit from October 22, 2024, through March 26, 2025. We reviewed the Association's annual accounting statements and determined that approximately $2.2 billion in health benefit payments were paid to the Plan during our audit scope (contract years 2021 through 2023).

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. Based on our testing, we did not identify any significant matters involving the Association's or the Plan's internal control structures and operations. 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 complied with contract CS 1039, 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. Except for those areas noted in the "Findings and Recommendations" section of this audit report, we found that the Association and the Plan complied with the health benefit provisions of contract CS 1039. 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 us 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.

We selected various samples of claims or claim lines to determine whether the Plan complied with contract CS 1039's provisions relative to health benefit payments. We utilized statistical analysis 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 2021 through 2023):

- **Place of Service 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 935,016 claims, with a total amount paid of $1,664,710,368, incurred during contract years 2021 through 2023 grouped by the claims' assigned place of service (the location where the service was performed).

  From this resulting universe, we judgmentally selected all place of service groups with a total amount paid of $1 million or greater. From the 13 place of service groups selected, using a target sample of 100 claims, we judgmentally determined the number of claims to be reviewed from each place of service group selected based on its ratio of total amount paid among the groups selected (with a minimum of 5 selected from each group).

  We stratified each place of service group selected by 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. Based on our sampling methodology, we selected 133 claims with a total amount paid of $2,510,826.

- **Unlisted Procedure Codes Review**

  We identified a universe of 59 procedure codes and 6,741 claim lines with amounts paid totaling $29,484,547 where the procedure code utilized was identified as "unlisted," "miscellaneous," and "unclassified."

  From this universe, we judgmentally chose all procedure codes with $10,000 or greater in claim amount paid. This resulted in a sub-universe of 22 procedure codes and 6,644 claim lines with amounts paid of $29,391,376.

  From this sub-universe we judgmentally selected the four highest dollar claim lines from each procedure code, all if less than four, (including any other claim lines from the same claim with the same procedure code). This resulted in a sample of 156 claim lines with a total amount paid of $800,327.

- **Procedure Code Modifier Review**

  We identified a universe of 19 procedure code modifiers, with 50,263 claim lines (with a total amount paid of $32,763,317) that the Plan indicated would affect claim pricing. From this universe, we judgmentally selected all procedure code modifiers (eight in total) with a total amount paid of $1,000,000 or greater. Additionally, we judgmentally selected modifier QZ as it is potentially ineligible for reimbursement according to the Plan.

  From each of the procedure code modifiers selected for review, we randomly selected up to eight claims each. This selection resulted in a sample of 60 claims (72 claim lines) with a total amount paid of $65,464.

- **Non-Covered Health Care Procedures Review**

  Using the Association's listing of FEP non-covered procedure codes, we identified a universe of 27 claims, with 16 non-covered procedure codes reported on 54 claim lines, with total payments of $22,522. We selected the entire universe to review.

- **Surprise Billing Review**

  We identified a universe of claims incurred and paid in 2022 and 2023 of non-participating (Non-Par) claims where the Plan was the primary payer and the claims were not an overseas claim, not subject to the Omnibus Reconciliation Acts of 1990 and 1993, not provided by government providers, 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 96,290 claims, totaling $63,029,463.

  From this overall universe, we identified sub-universes of 788 claims subject to the No Suprises Act (NSA) (these sub-universes included the following claims categories – claims related to air ambulance, emergency and non-emergency services, accidental injury, urgent care, and Allowance for Non-Par Professional Providers override codes). From each resulting sub-universe, we judgmentally selected up to 10 claims with the highest calculated remaining member liability (the difference between the reported total member liability and what the member should have paid in copayment, coinsurance, and/or deductible). In total, we selected 45 claims, totaling $205,116, for review.

  In addition, we identified a universe of 3,550 claims that were identified as paying with surprise billing protections, totaling $4,353,250. From this universe we judgmentally selected 10 claims totaling $336,534, with the highest calculated remaining subscriber liability.

- **Amount Paid Greater than Billed Charges Review**

  We identified a universe of 2,107 claims, totaling $6,521,533 in which the Plan was identified as the primary payer and the claim amount paid was greater than billed charges. From this universe we randomly selected 25 claims, totaling $259,330 to review.

- **Debarred Provider Review**

  We selected all performing providers identified in the Plan's claim data as being debarred, that were not on the OIG debarment list or payment was made outside of the grace period to review for proper payment and member notifications.

  We selected all debarred performing providers that had paid claims and were not identified by the Plan as being debarred and all debarred billing providers receiving payments to review to ensure proper debarment procedures were followed.

- **Non-Covered Diagnosis Code Review**

  We identified a universe of 18 claims, with 14 non-covered diagnosis codes reported on 52 claim lines, with total payments of $15,394 in which the Plan was the primary payer, the claim line amount paid was $100 or greater, and the sole diagnosis code on the claim line was identified as non-covered. We selected the entire universe to review.

- **Fraud Case Reporting Review**

  We reviewed all legal and/or fraud cases identified by the Plan that were not reported to the OIG Office of Investigations.

During our review, we utilized the contract CS 1039, the 2021 through 2023 Service Benefit Plan brochures, the Association's FEP Administrative Procedures Manual (FAM), the 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 amount questioned. The samples selected were not statistically based. Consequently, the results were not projected[2] to their respective universes since it is unlikely that the results are representative of the universes taken as a whole.

[2] While we do not project overpayments to respective universes based on statistical sampling, in audit finding 1 on page 8, we do estimate overpayments based on an error rate to a known subset of claims potentially paid in error.

III. FINDINGS AND RECOMMENDATIONS

1. System Error Communicating Proper Allowances $15,799

A system error for non par claims caused overcharges to the FEHBP and members.

Due to communication errors in reporting the correct allowance(s) from the Plan's local claim system to FEPDirect (the Association's national claim system), we identified nine claims with overcharges of $15,799 to the FEHBP and $7,100 to members in excess coinsurance costs. Additionally, we identified 4,805 claims that meet the criteria of this error and estimate that the impact to the FEHBP is an additional $10,634,756 in overcharges (of which an amount undeterminable by us is due to the members).

Section 3.2(b)(1) of contract CS 1039 states that the only costs chargeable to the FEHBP are those that are "actual, allowable, allocable, and reasonable." Because the Plan applied an incorrect allowance in the payment of these claims, the overpayment amounts are not chargeable to the contract.

The error identified began on or about April 1, 2022, when the Plan's processing of facility claims from Non-Par providers changed. Non-Par providers are providers that do not contract with the Plan. Prior to April 1, the Plan utilized an outside vendor (referred to hereafter as V1) to obtain its local allowance for the services provided and the claim would adjudicate with that allowance. Beginning April 1, the Plan opted to utilize two additional outside vendors (referred to hereafter as V2 and V3) that also provided negotiated rates for many of the Non-Par facility providers. Under the new processing guidelines, all Non-Par facility provider claims would first obtain an allowance from V1 (as before) and then the Plan would search through the negotiated rates of V2 and V3 to determine if either vendor had rates for the facility billing the claim. If V2 and/or V3 had better rates than V1, the claim would be adjudicated at the lower price/allowance. If V2 and V3 had no rates, it would adjudicate at the allowance from V1.

In cases where the V2 or V3 rates were best, the patients would not only benefit from reciving a lower allowance/price, but would also benefit from not being balanced billed (being held liable for the difference between the allowance and the billed charge) as would typically be the case with a Non-Par provider, due to the provider's negotiated rate/contract with V2 or V3.

Our review identified nine claims where this process did not work as intended, as either system or manual processing errors resulted in the submission of an incorrect allowance and/or identifiers to FEPDirect to facilitate processing. When this occurred, the claims were processed at the wrong allowance. This resulted not only in FEHBP overcharges, but also in the application of the incorrect member cost share. For the nine claims identified, the overcharge was $15,799 to the FEHBP and $7,100 to the members (due to potentially being balanced billed by the provider).

According to the Plan, the V1 allowance or the billed charge for some of the claims was incorrectly passed to FEPDirect due to a system error that did not recognize the lower V2 or V3

allowance. In other instances, processors incorrectly bypassed the system and processed the claim incorrectly with the V1 allowance or the billed charge when the V2 or V3 allowance was lower.

The Plan stated that it identified this error prior to our audit (in August 2022), that it began working to correct it immediately, and that it was ultimately corrected in January 2024. However, of the nine claims identified by our review, the Plan only began recovery efforts on one before our audit began. Additionally, the Plan began working on a preliminary report of claims impacted by this error in September 2024, again, after the start date of our audit.

We requested a copy of the Plan's preliminary report but did not receive it. Therefore, we performed an analysis of our claims data and identified all claims that we believe met the criteria of this error (claims with a participating provider network status of 2 and where claim amount paid equaled the billed amount). We identified a universe of 4,805 claims with a total amount paid of $15,192,508. The error rate we found in our review of the 9 claims identified was 82 percent of the total amount paid. To be conservative, we are utilizing an error rate for this finding of 70 percent of the $15,192,508, or $10,634,756, in estimated overpayments. The amount overpaid by members is undeterminable at this time.

While our claims data allowed us to identify the potential impact to the FEHBP of the preceding issue, the complexity of the Plan's pricing process precluded us from identifying those improperly paid claims where the Plan incorrectly passed through the V1 allowance to FEPDirect when the V2 or V3 allowance was lower. However, the Plan has a responsibility, under its contract with OPM, to identify these claims and return any overpayments caused by this error to the FEHBP.

Contract CS 1039's section 2.3(g)(i) states that if a claim has been paid in error that the Plan shall make a prompt and diligent effort to recover the overpayment. Additionally, section 2.3(g)(10) states that the Plan shall return to the FEHBP uncollected overpayments when it has failed to make a prompt and diligent effort to recover the overpayments.

Below is a timeline of the system error:

System Error Milestones	**Date**
Date Error Began	April 1, 2022
Approximate Date Error Identified	August 2022
Date Audit Notification Sent	December 7, 2023
Approximate Date Error Corrected	January 2024
Date Audit Requests Initiated	July 22, 2024
Date Plan Requested Prelimiary Report of Errors	September 2024

While we do not doubt that the Plan initiated efforts to correct the system error immediately, based on the preceding timeline, we find it doubtful that the Plan has met the standard of making a prompt and diligent effort to recover the overpayments identified (both actual and estimated). The Association disagrees with this and states that "CS1039 2.3g states, Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall (1) Send a written notice of erroneous payment to the member or provider." The Association's assertion here is flawed because, except for the one claim where it began recovery efforts prior to the start of this audit, the Plan had made no efforts to recover any of the other overpayments specifically identified by our audit.

The Plan was aware of the system error in August 2022, continued to pay claims erroneously until the system error was corrected in January 2024 (16 months later), and until the claims identified in our audit were brought to its attention eight out of nine were not identified or corrected by it. A prompt and diligent effort on its part would have been making an earnest and persistent effort to both identify claims affected by a known system error and to recover the overpayments, not waiting until an outside audit (starting 25 months after the system error was known) to begin the process. Identification of the additional 4,805 claims further illustrates that little effort had been made prior to this audit.

As a result of communication errors in reporting the correct allowance(s) to the FEPDirect national claims system, the FEHBP and its members were overcharged $15,799 and $7,100, respectively. Typically, members are notified of any adjustments to their liability through an adjusted explanation of benefits (EOB), which would then prompt them to seek any reimbursement from the provider in instances where they overpaid for services. We address concerns with how these adjustments are being communicated to members in the EOB messaging program improvement section of this report. Furthermore, we estimate that the FEHBP was potentially overcharged an additional $10,634,576.

Recommendation 1

We recommend that the contracting officer disallow $15,799 in claim overcharges and direct the Association to return the funds to the FEHBP for claims paid in error due to communication errors in reporting the correct allowance(s) to the FEPDirect national claims system.

Association's Response:

The Association agrees with the recommendation and states that recovery efforts have begun and that all funds recovered will be returned to the FEHBP.

Recommendation 2

We recommend that the contracting officer direct the Association to review all 4,805 claims identified by our review as potential overcharges and to return all amounts determined to be overpaid by the FEHBP unless it can demonstrate that it made a prompt and diligent effort to

recover the overpayments as per contract CS 1039. Additionally, we recommend that the contracting officer direct the Association to submit periodic reports to it on the progress of the review and recovery efforts.

Association's Response:

The Association agrees with the recommendation and states that it has begun its review of the estimated overpayments and that it will attempt recovery of those determined to be overpayments and return all recovered amounts to the FEHBP.

Recommendation 3

We recommend that the contracting officer direct the Association to identify all claims where the V1 allowance was incorrectly passed to FEPDirect, determine any FEHBP overcharges, and return those overcharges unless it can demonstrate that it made a prompt and diligent effort to recover them as per contract CS 1039.

Association's Response:

The Association agrees with the recommendation and states that it has begun to identify the claims potentially paid in error and that it will attempt recovery of those determined to be overpayments and return all recovered amounts to the FEHBP.

2. Surprise Billing Payment Errors $82,455

Due to the Plan's incorrect application of surprise billing protections, the FEHBP was overcharged $82,455 (net) for 182 claims. Additionally, as a direct result of the errors identified, patients may have been overcharged by providers $247,852 for amounts exceeding the Plan's allowance.

The NSA, effective January 1, 2022, aims to protect patients from surprise medical bills and balance billing, particularly for emergency services and certain non-emergency services from out-of-network providers at in-network facilities. The NSA prohibits providers from billing patients for the difference between the insurance plan's payment and the provider's full charge (balance billing).

Due to processor and system errors and misinterpretations of NSA regulations, the FEHBP was overcharged $82,455 (net).

Under the NSA, cost-sharing for out-of-network services is based on the "Recognized Amount" which is the lesser of the billed charges or the qualifying payment amount (QPA). The QPA is calculated based on the median in-network payment for similar services in the same geographic region. When the Plan determines that the NSA applies to a claim it determines the Recognized Amount, enters that as the allowance for the service, marks the claim as a surprise bill in its claims system, and submits the claim to FEPDirect for further processing.

Section 3.2(b)(1) of contract CS 1039 states that the "Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable. In addition, the Carrier must: (i) on request, document and make available accounting support for the cost to justify that the cost is actual, reasonable and necessary … ."

Our review identified the following claim errors:

Error Description	Over/(Under) Payment	Potential Patient Liability Issue
System Error		
Three claims were overpaid due to a system error where the surprise billing edit code was not recognized by FEPDirect. Based on discussion with the Plan, when the first claim line on each claim was rejected, FEPDirect did not recognize the surprise billing edit codes on other lines, did not apply the QPA, and paid the claim at billed charges incorrectly.	$14,611	None
Processor Errors		
Eight claims were overpaid a net amount as a result of various processor mistakes due to incorrectly entering information in the system.	$50,335 (net)	$80,183
Incorrect Suprise Billing Determination		
163 urgent care center claims were overpaid a net amount due to the Plan utilizing a member-facing website to determine if the claims were subject to the NSA. When processors reviewed the claim deferrals for each, they followed the Benefit Policy Manual's guidance and utilized a member-facing portal, which describes the NSA and its protections. This portal made no mention of urgent care center providers, and therefore the Plan assumed they were not subject to the NSA. However, other FEP guidance found in the FAM Vol II, Chapter 19a states that out-of-network "UCC [urgent care center] providers licensed to render emergency services are eligible for Surprise Billing protections."	$17,367 (net)	$16,907
Six professional claims for emergency services were overpaid a net amount due to the Plan's incorrect assumption that a corresponding facility claim was required for the NSA to apply to the claims. However, FAM Chapter 19a makes no mention of this requirement.	$142 (net)	$6,236

Error Description	Over/(Under) Payment	Potential Patient Liability Issue
Two assistant surgeon claims were paid incorrectly due to the Plan not recognizing that non-emergency services provided by ancillary providers at an in-network facility are subject to the NSA. FAM Chapter 19a states that "claims from Non-participating professional providers for non-emergency services performed in a PPO [preferred provider organization] facility setting will be eligible for Surprise Billing protections, and the Non-participating providers must accept the QPA." The Plan stated that the NSA did not apply to either claim because they were for elective surgeries that were pre-planned. However, the NSA is clearly applicable to assistant surgeon services provided by an out-of-network provider at an in-network facility regardless of whether the services received were elective or planned. They also pointed out that for one of the claims, the patient received a notice of consent acknowledging that they were liable for any difference between the provider's billed amount and the amount received as payment from the Plan. However, FAM Chapter 19a defines assistant surgeons as "Ancillary Non-participating professional providers for non-emergency services performed in PPO facilities that are eligible for Surprise Billing protections." It goes on to state that "Ancillary Non-participating professional providers are not permitted to obtain Notice and Consent from a member."	Undetermined	$144,526

When surprise billing protections are not put in place, as is the case for these errors, the claims are paid as ordinary out-of-network claims. In these situations, the patients may have been held responsible for amounts billed by the provider that exceed the Plan's allowance, which is expressly prohibited by the NSA. Therefore, we included the column "Potential Patient Liability Issue" in the table above to highlight the potential patient overcharge by the providers.

Due to a system error, incorrect surprise billing determinations, and various processor errors, surprise billing protections were not properly applied by the Plan resulting in net FEHBP overcharges of $82,455 (overcharges of $83,565 and undercharges of $1,110). Additionally, we determined that members may have been overcharged $247,852 (due to potentially being balance billed by the provider). Typically, members are notified of this through an adjusted explanation of benefits, which would then prompt them to seek any reimbursement from the provider. We address concerns with how these adjustments are being communicated to members in the EOB messaging program improvement section of this report.

Recommendation 4

We recommend that the contracting officer disallow $83,565 in overcharges and direct the Association to return the funds to the FEHBP. To date, $60,392 has been recovered and $23,173 remains due to the FEHBP.

Association's Response:

The Plan stated that it agreed with the recommendation and will continue to attempt recovery of the remaining balance.

OIG Comments:

The OIG has confirmed a total of $60,392 has been recovered based on documentation provided by the Plan.

Recommendation 5

We recommend that the contracting officer allow $1,110 in undercharges to the FEHBP. To date, $728 in additional payments have been made and $382 remains due to providers.

Association's Response:

The Plan stated it agreed with our recommendation and that adjustments have been completed.

OIG Comments:

The OIG has confirmed that a total of $728 in adjustment payments have been made to providers and $382 remains due.

Recommendation 6

We recommend that the contracting officer ensure that the Association completes and implements the system enhancement to recognize all claim lines with the claim level surprise billing code edit.

Association's Response:

The Association stated that it "will evaluate the necessity of implementing a system enhancement to recognize all claim lines impacted by SB [surprise billing]."

OIG Comments:

While we appreciate the Association is evaluating the system enhancement, the OIG maintains this is necessary to ensure the entire claim receives surprise billing protections when qualified and members are not potentially overcharged.

Recommendation 7

We recommend the contracting officer direct the Association to require the Plan to provide thorough retraining to its processors on the proper procedures of recognizing and processing surprise billing claims.

Association's Response:

The Plan agrees with the recommendation and is developing a training program for surprise billing claims processing that it plans to implement by September.

Recommendation 8

We recommend the contracting officer direct the Association to update its Benefit Policy Manual instructions to plans to require them to use the official guidance in the FAM Chapter 19a to determine eligibility for surprise billing protections and not the member portal.

Association's Response:

The Association responded that it would evaluate updating the Benefit Policy Manual instructions and make any necessary changes by July. Additionally, the Association stated that it will issue a "For Your Information" to all Plans by August to ensure that the FAM Chapter 19a is used in processing surprise billing claims.

OIG Comments:

The OIG encourages the Association to update its Benefit Policy Manual instructions, so plans do not receive conflicting guidance on how to process claims eligible for surprise billing protections.

3. Unlisted Procedure Code Payment Errors $22,317

We identified five claim lines with overpayments totaling $22,317 by the Plan due to processor and system errors.

Specifically, we identified the following errors:

- Four claim lines with overpayments, totaling $20,064, were overridden and paid by processors without a medical review being done as required.

FAM exhibit 12C – Compatibility Edits, contains a list of unlisted procedure codes that are only eligible for coverage for certain specific medical conditions and are not acceptable unless reviewed by the Plan for consistency with the Service Benefit Plan brochure, FEP medical policy guidelines, and the local Plan policy guidelines. Plan review of medical records or available claims history must be done to support the coverage of these procedure codes.

Required medical reviews were not being performed and a system coding error led to $22,317 in overpayments by the FEHBP.

The four claim lines were appropriately deferred with the medical review procedure edit code. However, processors overrode the deferral codes and sent claims for payment without a medical review being performed. To date $12,865 of the $20,064 in overpayments has been recovered and $7,199 remains due to the FEHBP.

- One claim line, totaling $2,253, was overpaid due to a coding error identified in the Plan's processing system. To date, all $2,253 in overpayments has been recovered.

  Section 3.2(b)(1) of contract CS 1039 states that the "Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable."

  We identified one claim, totaling $2,253, that was processed and paid even though the provider's contract did not allow for payment of the claim's specific revenue and procedure code combination. The Plan's processing system should have rejected the claim line. However, the system was not properly configured to reject the unauthorized revenue and procedure code combination. The Plan stated that it has taken corrective action to prevent the system from paying claim lines that contain unauthorized revenue code and procedure code combinations in the future.

Due to processors overriding edit codes and a system configuration error, the FEHBP was overcharged $22,317.

Recommendation 9

We recommend that the contracting officer disallow $22,317 in overcharges and direct the Association to return the funds to the FEHBP. To date, the Plan has recovered $15,118, and $7,199 remains due to the FEHBP.

Association's Response:

The Association stated that it agreed with the recommendation and has recovered $15,118 to date; however, it determined that the outstanding amounts are uncollectible.

OIG Comments:

While the Association has sent the required letters and has sent the overpayment to collections, nothing is stopping the Plan from also setting up an offset on its claim system to capture the overpayment from later claim payments to the provider as is allowed per contract CS 1039.

Recommendation 10

We recommend that the contracting officer direct the Association to require the Plan to implement controls to prevent processors from overriding edit codes requiring a completed medical review and to verify when this corrective action has been completed.

Association's Response:

The Association agrees with the recommendation and will provide updates of corrective actions.

4. Non-Covered Benefits Charged to the FEHBP $4,035

The FEHBP was overcharged $4,035, for 9 claims, as a result of the Plan inaccurately advising a member of their benefits and by not following the proper procedures once the error was identified.

The FEHBP was charged for services that were not covered benefits.

A member reached out to the Plan's FEP customer service area to inquire about the allowability of anticipated non-emergency transportation services via wheelchair van prior to receiving the services. Both the Service Benefit Plan brochure Section 5(c) and the FAM Exhibit 2, noncovered health care procedure codes, explicitly disallows those services. The Plan's FEP customer service area incorrectly advised the member that the costs would be covered and the member proceeded with the services. Upon submission of the claims, the system correctly denied the claims as non-covered benefits. The member then contacted the Plan to inquire about the denial of the claims.

Section 12.6 of the FEP Claims and Reconsideration Handbook and Section 14.3 of the FEP Administrative Procedures Manual both direct the Plan to contact the FEP Director's Office when an overpayment results from misquoted benefits or coverage information. Based on discussions with the FEP Director's Office this step is done to determine who "should be responsible for making the member whole and the best way to process the services, so the program does not get charged."

Upon discovering that the member relied upon this incorrect benefit information to receive the unallowable services, instead of contacting the FEP Director's Office for guidance, the Plan

granted a one-time exception due to its error and the claims were paid and charged to the FEHBP.

As a result of not properly following FEP procedures when it discovered a member relied upon incorrect benefit information to receive the unallowable services, the FEHBP was improperly charged $4,035 for nine claims.

Recommendation 11

We recommend that the contracting officer disallow $4,035 in overcharges and direct the Association to return the funds to the FEHBP for payments of non-covered benefits.

Association's Response:

The Plan agrees with the recommendation and is currently completing a Special Plan Invoice to reimburse the FEHBP.

Recommendation 12

We recommend that the contracting officer direct the Association to ensure that all local plans are properly instructed on their responsibilities within Section 12.6 of the FEP Claims and Reconsideration Handbook and Section 14.3 of the FEP Administrative Procedures Manual when overpayments occur as a result of it providing a member with incorrect benefit or coverage information.

Association's Response:

The Association agrees with the recommendation and is reviewing current policies and will implement updates to the Benefit Policy Manual and FEP Administrative Procedures Manual.

5. Non-Covered Procedure Code System Error — Procedural

FEPDirect was not properly configured to reject a noncovered dental benefit resulting in an erroneous claim overpayment by the Plan.

A system error allowed non-covered procedures to be paid on facility claims.

FAM Exhibit 2 provides a listing of noncovered health care procedure codes. This listing explicitly disallows procedure codes for the application of dental sealants. Additionally, the Service Benefit Plan Brochure, Section 5(g) does not indicate coverage for dental sealants.

Our review identified one claim for a non-covered dental sealant procedure code that was paid and charged to the FEHBP. The Association indicated this was a system error. This occurred due

to this being an outpatient claim that was paid based on the reported revenue/diagnosis codes and the system did not consider the non-covered procedure code. The Association stated that it has never had logic to defer this procedure code for facility claims. It has only utilized such logic for professional claims.

We evaluated the impact of the lack of business rules for this procedure code across all BCBS plans. While the number of occurrences and dollar impact to date is minimal, the broader concern is additional noncovered benefits for facility claims can be processed and paid through local Plan systems because proper deferral business rules were not implemented by the Association.

Due to improper configuration within FEPDirect allowing a noncovered dental benefit to be allowed and paid, we identified one improperly paid claim by the Plan as well as a system issue that could potentially result in additional improper payments.

Recommendation 13

We recommend that the contracting officer direct the Association to identify all non-covered procedure codes that do not contain the proper business rule configurations for both facility and professional claims and to make those changes to its system.

Association's Response:

"The Association agrees with the recommendation and will perform an analysis of the business rule configurations for both facility and professional claims" and once complete, it will work with the FEPOC to implement necessary system enhancements to prevent future erroneous payments.

Recommendation 14

We recommend that the contracting officer direct the Association to implement policies and procedures to update FEPDirect with all required business rules and configuration updates needed whenever changes are made to the FAM Exhibit 2, to ensure that non-covered benefits are not charged to the FEHBP.

Association's Response:

"The Association agrees with the recommendation and will implement/enhance current policies and procedures to update FEPDirect with all required business rules and configuration updates needed to ensure that noncovered benefits are not charged to the FEHBP."

6. Lack of Documentation — Procedural

The Plan was unable to provide sufficient documentation to support its internal pricing methodologies for six claim samples in our place of service review. As a result, we could not complete our review and verify if the claims were priced and paid accurately.

Sufficient documentation was not available to support all claims in our review.

Section 3.2(b)(1) of contract CS 1039 states that the "Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable. In addition, the Carrier must: (i) on request, document and make available accounting support for the cost to justify that the cost is actual, reasonable and necessary … ."

Additionally, Section 1.11(a) states that we as authorized representatives of the contracting officer have the "right to inspect or evaluate the work performed or being performed under the contract, … at all reasonable times and in a manner that will not unreasonably delay the work."

Lastly, Section 1.11 (b) of contract CS 1039 states that the Plan shall maintain all records relating to its compliance with terms of the contract.

During our audit, the Plan was unable to provide all documentation requested to support its contracted pricing arrangements with providers for 6 claims out of 133 reviewed. While this number may seem small and inconsequential, the impact of this lack of documentation is important for a couple of reasons.

1. The contracts with providers serve as a formalized agreement between the two parties; and

2. The pricing (including fee schedules) included in the contracts serves as a backup for, not just the providers, but also the Plan to serve as a check to ensure that data in its claim system is correct. Without independent support outside of the claim system, there is no way to determine if the pricing within the system is correct.

The information requested as part of this audit should have been readily available and easily accessible by the Plan. It's inability to provide this information shows that its method of maintaining documentation requires improvement.

As a result of the Plan's inability to provide sufficient documentation to support its internal pricing methodologies, we could not verify that all claims reviewed were priced and paid accurately, potentially resulting in improper program payments.

Recommendation 15

We recommend that the contracting officer direct the Association to ensure that the Plan institutes policies and procedures to safeguard and have ready at hand all documentation related to provider contracts that support both the contract and pricing arrangements between it and the provider.

Association's Response:

The Association agrees with the recommendation and states that it will work with the Plan on policies and procedures that will ensure the accessibility of all documentation related to provider contracts and pricing arrangements.

7. Program Improvement – EOB Messaging

The System Error Communicating Proper Allowances and the Surprise Billing Payment Errors findings identified claim payment errors where members were potentially overcharged by providers for their cost share amounts. In these cases, when the claim was originally processed, an EOB was sent to the member indicating an amount owed to the provider. For example:

Type of Service	Submitted Charges	Plan Allowance	Remark Codes	Deduct	Coinsurance Or Copay	Medicare/ Other Ins.	What We Paid	You Owe the Provider
SURGERY ASSISTANCE	80,000.00	186.85	621		28.02		158.83	79,841.17
TOTALS:	80,000.00	186.85		0.00	28.02	0.00	158.83	79,841.17

When the error correction is processed, a new EOB is sent to the member. Nowhere on that new EOB does it say this is a revision or update of a previous EOB. It only includes a statement that the claim has been adjusted and points out the change in the benefit amount (amount paid by the Plan) and makes no mention that the amount owed by the member is now reduced (indicating that the member may have overpaid the provider). For example:

Type of Service	Submitted Charges	Plan Allowance	Remark Codes	Deduct	Coinsurance Or Copay	Medicare/ Other Ins.	What We Paid	You Owe the Provider
SURGERY ASSISTANCE	80,000.00	186.85	408 629				186.85	
TOTALS:	80,000.00	186.85		0.00	0.00	0.00	186.85	0.00

THIS CLAIM HAS BEEN ADJUSTED. THE PREVIOUS BENEFIT AMOUNT EXTENDED ON THIS CLAIM WAS $158.83. THE REVISED BENEFIT AMOUNT IS $186.85. WE ARE PROVIDING ADDITIONAL BENEFITS IN THE AMOUNT OF $28.02.

We believe that the EOB messaging is not clear and could be confusing. While the intent is to tell the member that they now owe the provider nothing, a member, who may not understand EOBs, may look at it and think "I don't owe them anything more" and not realize they may be owed a refund. Or worse, in a case where a lesser amount is shown in the "you owe the provider" area, may think they owe the provider that new amount.

We believe that in situations where the member liability changes because of a claim adjustment, the EOB messaging should clearly state the change in member liability amount (just as is currently done with the previous benefit amount extended in the example above) and that the member may owe the provider an additional amount or may be owed a refund (as the case may be). Additionally, we believe that the remittances to the providers should include similar statements. We do understand that this will require programing changes to FEPDirect, but these changes will have positive impacts on FEHB members by ensuring the appropriate cost share is paid.

While the Association and local plans do not have a responsibility in policing payments between members and providers, when a member potentially overpays a provider because of a claim payment error, every effort should be made to ensure that both parties (member and provider) are aware.

Recommendation 16

We recommend that the contracting officer work with the Association to implement modifications to EOB messaging in situations where member liability changes because of a claim adjustment to ensure that members are clearly notified of the changes in their liability.

Association's Response:

The Association disagrees with the recommendation and states that its EOBs already provide "a comprehensive summary of healthcare services, including costs, insurance payments, and member responsibilities. Therefore, no further clarification is deemed necessary."

OIG Comments:

We thank the Association for its comments. However, program improvement areas are addressed to the OPM program office and to the contracting officer directly and not to the Association or the Plan. We have discussed our concerns with EOB messaging with the program office in meetings and expressed our concerns and are confident that the issue will be worked out for the betterment of the Program.

It is still our contention that the messaging in these cases is not clear for the members. This can clearly be seen in the example EOB in our Program Improvement Area which shows an increase in the amount paid to the provider from $158.83 to $186.65. The EOB messaging on the adjusted EOB states, "THIS CLAIM HAS BEEN ADJUSTED. THE PREVIOUS BENEFIT AMOUNT EXTENDED ON THIS CLAIM WAS $158.83. THE REVISED BENEFIT AMOUNT IS $186.85. WE ARE PROVIDING ADDITIONAL BENEFITS IN THE AMOUNT OF $28.02." However, the original EOB shows that the member paid coinsurance of $28.02 and owes the provider $79,841.17. Then the revised EOB shows both the coinsurance and amount owed to the provider as blank ($0) and has

no messaging explaining this. As we state in the finding, this could be confusing to a member as it could be interpreted to mean not that they owe the provider nothing, but that they owe the provider nothing more. We believe the messaging should be enhanced to include a statement that acknowledges the change in the amount owed to the provider and that if the member has paid the provider anything more than the copay or coinsurance amount that they should seek a refund.

APPENDIX

BlueCross BlueShield
Federal Employee Program
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Washington, D.C. 20001
www.BCBS.com

May 13, 2025

Ms. Karen Eggleston
Office of the Inspector General
U.S. Office of Personnel Management
1900 E. Street, Room 6400
Washington, D.C. 20415-1100

Reference: Draft Report of Claims Processing and Payment Operations as Administered by Horizon Blue Cross and Blue Shield of New Jersey
Report Number: 2024-CAAG-023
Date Issued: April 10, 2025

Dear Ms. Eggleston:

This is the Blue Cross and Blue Shield Association's response to the above referenced U.S. Office of Personnel Management OPM Draft Audit Report covering the Federal Employees Health Benefits Program FEHBP . Our comments concerning the findings in the report are as follows:

1. System Error Communicating Proper Allowances **$10,650,555**

Recommendation 1: We recommend that the Contracting Officer CO disallow $15,799 in claim overpayments and direct the Association to return the funds to the FEHBP for claims paid in error due to communication errors in reporting the correct allowance(s) to the FEPDirect national claims system.

Plan/Association Response: The Plan agrees with the recommendation. The Plan has initiated recovery on these overpayments and any overpayments recovered will be returned to the Program.

Recommendation 2: We recommend that the CO direct the Association to review all 4,805 claims identified by our review as potential overpayments and to return all amounts determined to be overpaid by the FEHBP unless it can demonstrate that it made a prompt and diligent effort to recover the overpayments.

Plan/Association Response: The Plan agrees with the recommendation. The Plan has started its review of the claims which have an estimated total of $10,634,756 in overpayments. The Plan will initiate recover on any identified overpayments and any overpayments recovered will be returned to the Program.

Recommendation 3: We recommend that the CO direct the Association to identify all claims where the V1 allowance was incorrectly passed to FEPDirect, determine any FEHBP overpayments, and return those overpayments unless it can demonstrate that it made a prompt and diligent effort to recover them.

Plan/Association Response: The Plan agrees with the recommendation. The Association will work with the Plan to identify all claims where the V1 allowance was incorrectly used to price claims and ensure the Plan initiates recovery on all identified claim overpayments.

2. Surprise Billing Payment Errors **$81,518**

Recommendation 4: We recommend that the CO disallow $66,075 in overcharges and direct the Association to return the funds to the FEHBP. To date, $108 has been recovered and $65,967 remains due to the FEHBP.

Plan/Association Response: The Plan agrees with the recommendation. The overpayment process has been initiated for all claims, and as of May 12, 2025, the Plan has recovered and returned a total of $60,104 to the FEP. The Plan continues to attempt to recover the remaining balance of $5,795. See Attachment 1 for all claims and Attachment 2 for supporting documentation of recoveries.

Recommendation 5: We recommend that the CO allow $611 in undercharges to the FEHBP. To date, $542 in additional payments have been made and $69 remains due to providers.

Plan/Association Response: The Plan agrees with the recommendation. For all claims with undercharges an adjustment has been completed. See Attachment 1

Recommendation 6: We recommend that the CO ensure that the Association completes and implements a system enhancement to recognize all claim lines with the claim level Surprise Billing SB code edit.

Plan/Association Response: The Association will evaluate the necessity of implementing a system enhancement to recognize all claim lines impacted by SB.

Recommendation 7: We recommend the CO direct the Association to require the Plan to provide thorough retraining to its processors on the proper procedures of recognizing and processing SB claims.

Plan/Association Response: The Plan agrees with the recommendation. The Plan is currently developing a training program for processing SB claims and expects to deliver training to processors by September 30, 2025.

Recommendation 8: We recommend the CO direct the Association to require the Plan to use the official guidance in the FAM Chapter 19a to determine eligibility for SB protections.

Plan/Association Response: The Association agrees with the recommendation and will issue a For Your Information FYI to all Plans to ensure that FAM Vol II Ch. 19a is used in processing SB claims by August 1, 2025.

Recommendation 9 Combined with Recommendation 8 in the Final Report : We recommend that the CO requires the Association to update the FEP Benefit Policy Manual BPM instructions to Plans to utilize FAM Chapter 19a to determine eligibility for SB protections and not the member portal.

Plan/Association Response: The Association will evaluate updating the BPM instructions regarding surprise billings and make any necessary changes by June 30, 2025.

Redacted by the OPM OIG
Draft Report Recommendation 10 – Dropped for the Final Report

3. Unlisted Procedure Code Payment Errors **$22,317**

Recommendation 11 Recommendation 9 in the Final Report : We recommend that the CO disallow $22,317 in overcharges and direct the Association to return the funds to the FEHBP. Of the overcharges identified, the Plan has successfully recovered $12,865 as of the date of this report.

Plan/Association Response: The Plan agrees with the recommendation. As of May 12, 2025, the Plan recovered and returned $15,118 to the Program. See Attachment 4 for a listing of claims and Attachment 5 for documentation to support recoveries. The Plan has determined the remaining amount is uncollectible. See Attachment 6 for the Overpayment Notification Letters.

Recommendation 12 Recommendation 10 in the Final Report : We recommend that the CO direct the Association to require the Plan to implement controls to prevent processors from overriding edit codes requiring a completed medical review.

Plan/Association Response: The Association agrees with the recommendation and will provide an update during the audit resolution process.

Recommendation 13 Combined with Final Report Recommendation 10 : We recommend that the CO verify the corrective action taken for the coding system error by the Plan has been completed.

Plan/Association Response: The Association agrees with the recommendation. The Association will work with the Plan to verify the corrective action and will provide an update during the audit resolution process.

4. Non-Covered Benefits Charged to the FEHBP **$4,035**

Recommendation 14: Recommendation 11 in the Final Report We recommend that the CO disallow $4,035 in overcharges and direct the Association to return the funds to the FEHBP for payments of non-covered benefits.

Plan/Association Response: The Plan agrees with the recommendation. The Plan is currently in process of completing the Special Plan Invoice to reimburse the FEHBP.

Recommendation 15: **Recommendation 12 in the Final Report** We recommend that the CO direct the Association to ensure that all local plans are properly instructed on their responsibilities within Section 12.6 of the Handbook and Section 14.3 of the APM when overpayments occur as a result of it providing a member with incorrect benefit or coverage information.

Plan/Association Response: The Association agrees with the recommendation and is reviewing the current policies to see where further instruction for the Plans is needed and will make updates to the FEP Benefit Policy Manual BPM and FEP Administrative Procedures Manual APM .

5. Non-Covered Procedure Code System Error **Procedural**

Recommendation 16: **Recommendation 13 in the Final Report** We recommend that the CO direct the Association to identify all non-covered procedure codes that do not contain the proper business rule configurations for both facility and professional claims and to make those changes to its system.

Plan/Association Response: The Association agrees with the recommendation and will perform an analysis of the business rule configurations for both facility and professional claims for the non-covered procedure codes listed in Exhibit 2 of the FAM Volume II. Once the analysis is completed, the Association will work with the FEPOC to implement necessary system enhancements to prevent future erroneous payments of non-covered procedure codes for both facility and professional claims.

Recommendation 17: **Recommendation 14 in the Final Report** We recommend that the CO direct the Association to implement policies and procedures to update FEPDirect with all required business rules and configuration updates needed whenever changes are made to the FAM Exhibit 2, to ensure that non-covered benefits are not charged to the FEHBP.

Plan/Association Response: The Association agrees with the recommendation and will implement/enhance current policies and procedures to update FEPDirect with all required business rules and configuration updates needed to ensure that noncovered benefits are not charged to the FEHBP.

6. Lack of Documentation **Procedural**

Recommendation 18: **Recommendation 15 in the Final Report** We recommend that the CO direct the Association to ensure that the Plan institutes policies and procedures to safeguard and have readily at hand all documentation related to provider contracts that support both the contract and pricing arrangements between it and the provider.

Plan/Association Response: The Association agrees and will collaborate with the Plan to implement policies ensuring all documentation related to provider contracts and pricing arrangements is safeguarded and accessible.

7. Program Improvement – EOB Messaging

Recommendation 19: (Recommendation 16 in the Final Report) We recommend that the CO work with the Association to implement modifications to EOB messaging in situations where member liability changes because of a claim adjustment to ensure that members are clearly notified of the changes in their liability.

Plan/Association Response: The Association respectfully disagrees with this recommendation. The Explanation of Benefits (EOB) document already provides a comprehensive summary of healthcare services, including costs, insurance payments, and member responsibilities. Therefore, no further clarification is deemed necessary.

Thank you for this opportunity to respond to the recommendations included in this draft report. If you have any questions, please contact me at [redacted] or [redacted] at [redacted]

Sincerely,

[redacted]

[redacted]

cc: Delon Pinto, OPM Audit Resolution and Compliance
[redacted]

Report Fraud, Waste, and Mismanagement

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