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

Final Audit Report

Audit of Claims Processing and Payment Operations
at Highmark Blue Cross Blue Shield
for the period January 1, 2017, through August 31, 2019

Report Number 1A-10-13-20-006
December 14, 2020

EXECUTIVE SUMMARY

Audit of Claims Processing and Payment Operations at Highmark Blue Cross Blue Shield

Report No. 1A-10-13-20-006 **December 14, 2020**

Why Did We Conduct the Audit?

The objectives of our audit were to determine if the health benefit costs charged to the Federal Employees Health Benefits Program (FEHBP) and services provided to FEHBP members by Highmark Blue Cross Blue Shield (Plan) were in accordance with the terms of the Blue Cross Blue Shield Association's contract (Contract) with the U.S. Office of Personnel Management.

What Did We Audit?

The Office of the Inspector General has completed a performance audit of the FEHBP claim operations at the Plan. Our audit consisted of reviews of the claims system, provider network status, claims with amounts paid greater than covered charges, debarment, unlisted procedure codes, and a place of service claim review for the period of January 1, 2017, through August 31, 2019, at the Plan's offices in Camp Hill and Pittsburgh, Pennsylvania. We also we conducted a claims system test for the same time period. Additional audit work was completed at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida.

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Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

Our audit identified two findings that indicate the need for the Plan to strengthen its procedures and controls related to claim payments totaling $101,264. Specifically, we found the following:

- The Plan paid 25 claims incorrectly, totaling $72,308, due to provider network status issues.
  - 19 claims were overpaid by $11,755 due to the Plan's lack of formal procedures during delays in its contracting and re-credentialing process.
  - Six claims were overpaid by $60,553 as a result of the Plan's incorrect handling of claims suspended for provider network status verification.

- Two claims were overpaid by $28,956 because the Plan did not follow its procedures for the pricing of pharmaceuticals.

We also identified a program improvement area related to member notification of debarred providers on their explanation of benefits.

All other areas reviewed and not reported on here were found to be in compliance with the Contract's provisions relative to health benefit payments.

ABBREVIATIONS

5 CFR 890	**Title 5, Code of Federal Regulations, Chapter 1, Part 890**
Act	**Federal Employees Health Benefits Act**
Association	**Blue Cross Blue Shield Association**
BCBS	**Blue Cross Blue Shield**
Contract	**Contract CS 1039 – The contract between the Blue Cross Blue Shield Association and the U.S. Office of Personnel Management**
CPT	**Common Procedural Technology**
EOB	**Explanation of Benefits**
FEHBP	**Federal Employees Health Benefits Program**
FEP	**Federal Employee Program**
HCPCS	**Healthcare Common Procedure Coding System**
HIO	**Healthcare and Insurance Office**
Non-PAR	**Non-Participating (Provider)**
OBRA	**Omnibus Budget Reconciliation Act**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
PAR	**Participating (Provider)**
Plan	**Highmark Blue Cross Blue Shield**
SBP	**Service Benefit Plan**

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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 at Highmark Blue Cross Blue Shield (Plan). The auidt was performed at the Plan's headquarters in Pittsburgh, Pennsylvania, and covered claim payments made between January 1, 2017, and August 31, 2019.

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

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

The Association, on behalf of participating Blue Cross and Blue Shield (BCBS) plans, has entered into a Government-wide Service Benefit Plan (SBP) contract with OPM to provide a health benefit plan authorized by the Act. The Association delegates authority to 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 SBP. The FEP Director's Office coordinates the administration of the Contract with the Association, member BCBS plans, and OPM.

The Association has also established an FEP Operations Center. CareFirst BCBS, located in Owings Mills, Maryland, performs the activities of the FEP Operations Center. These activities include acting as fiscal intermediary between the Association and member plans, verifying subscriber eligibility, approving or disapproving the reimbursement of local plan payments of FEHBP claims (using computerized system edits), maintaining a history file of all FEHBP claims, and maintaining an accounting of all program funds.

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

Compliance with laws and regulations applicable to the FEHBP is the responsibility of the Association and Plan management. In addition, the Plan is responsible for establishing and maintaining a system of internal controls.

The most recent audit report issued that covered claim payments for the Plan was Report No. 1A-10-13-09-001 dated June 15, 2009, and covered claim payments from January 1, 2005, through December 31, 2007. All findings from the previous audit have been satisfactorily resolved.

The results of our audit were discussed with Plan and Association officials throughout the audit. We held an exit conference on July 21, 2020, and after the meeting concluded, we issued a draft report to solicit the Plan's comments to the findings. The Plan's comments offered in response to the draft report were considered in preparing our final report and are included as an appendix to this report. Additional documentation provided by the Association and the Plan on various dates through November 3, 2020, was also considered in preparing our final report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The objectives of our audit were to determine whether the Plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the Contract. Specifically, our objective was to determine whether the Plan complied with the Contract's provisions relative to health benefit payments.

SCOPE AND METHODOLOGY

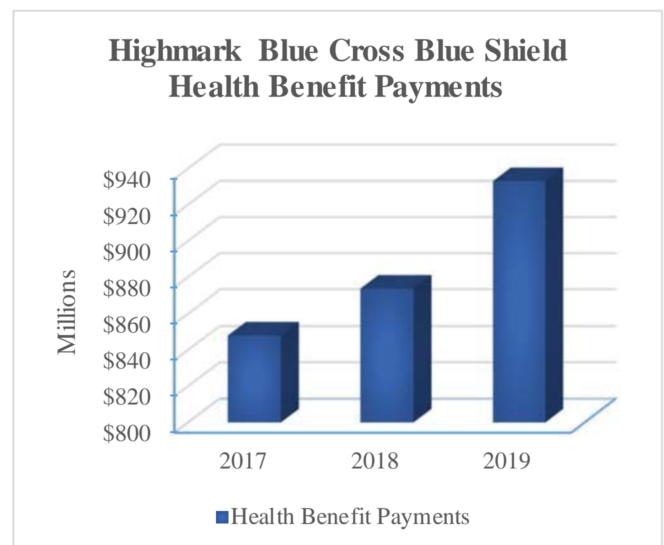
We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient and appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives.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

This performance audit included the following claim payment reviews: provider network status, claims with amounts paid greater than covered charges, debarment, unlisted procedure codes, and a place of service claim review for the period January 1, 2017, through August 31, 2019. Additionally, we conducted a claims system test for the same time period.

As part of our audit we conducted site visits at the Plan offices in Camp Hill, Pennsylvania from December 2, 2019, through December 6, 2019, and in Pittsburgh, Pennsylvania from January 27, 2020, through January 31, 2020. Additional audit fieldwork was performed at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida through July 2020.

We reviewed the Association's Government-wide SBP Annual Accounting Statements for contract years 2017 through 2019[2] and determined that the Plan paid approximately $2.65 billion in health benefit payments as they pertain to the following BCBS plan codes and coverage areas:

- 363 and 865 – Highmark BCBS – coverage includes western and northeastern Pennsylvania;
- 443 and 943 – Mountain State BCBS – coverage includes all of West Virginia; and
- 070 and 570 – BCBS of Delaware – coverage includes all of Delaware.



[2] Although the audit scope covered January 1, 2017, through August 31, 2019, the Association's Government-wide Service Benefit Plan 2019 Annual Accounting Statement reports through year-end December 31, 2019.

In planning and conducting our audit, we obtained an understanding of the Plan's internal control structure 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 Plan's internal control structure and its 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 Plan's system of internal controls taken as a whole.

We also conducted tests to determine whether the Plan had complied with the Contract, the applicable procurement regulations (i.e., Federal Acquisition Regulations and Federal Employees Health Benefits Acquisition Regulations, as appropriate), and the laws and regulations governing the FEHBP as they relate to claim payments. With the exception of those areas noted in the "Audit Findings and Recommendations" section of this audit report, we found that the Plan was in compliance with the health benefit provisions of the Contract. With respect to any areas not tested, nothing came to our attention that caused us to believe that the Plan 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, 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 to select our samples. The BCBS claims data is provided to us on a monthly basis by the FEP Operations Center, and after a series of internal steps, uploaded into our data warehouse. However, due to time constraints, we did not verify the reliability of the data generated by the BCBS plans' local claims systems. 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 the Contract's provisions relative to health benefit payments. We utilized SAS software to judgmentally select all samples reviewed. The samples that were selected and reviewed in performing the audit were not statistically based. Consequently, the results were not projected to the universe since it is unlikely that the results are representative of the universe taken as a whole.

The following specific reviews were conducted during our audit (unless otherwise stated, the samples cover the full scope of the audit, January 1, 2017, through August 31, 2019):

1. **Provider Network Status Review** – We identified all claims paid where a provider was paid both as a participating (PAR) and a non-participating (Non-PAR) provider. We identified a universe of 2,199 providers, with 1,854,361 claims paid, totaling $165,464,023, that met this criteria. We then judgmentally selected and reviewed all providers that had Non-PAR claims totaling $5,000 or more and PAR claims totaling

$10,000 or more where the provider's earliest claim paid was PAR to determine if the claims were paid at the correct network status. In all we selected 52 providers, with 81,354 claims totaling $38,506,157.

2. **Unlisted Procedure Code Review** – We identified a universe of 4,550 claim lines, totaling $4,400,953, with either unlisted or miscellaneous procedure codes. We judgmentally selected the 34 claim lines with the highest dollar amounts paid, totaling $503,145, to determine if the claim lines underwent medical review and were paid accurately.

   Based on our review of the 34 claims, we judgmentally expanded our review by choosing the 10 highest paid drug claim lines, totaling $134,504, from the original universe, where the amount paid equaled the billed charges. The objective of our expanded review was to determine if the claim lines were valid, allowable, and priced accurately.

3. **Debarred Provider Review** – We identified and reviewed all 49 claims, totaling $3,789, paid to providers listed on the OPM OIG's Administrative Sanctions Branch list of providers debarred from participation in the FEHBP to determine if the claims were appropriately paid.

4. **System Pricing, Contract, and License Review** – We identified all claims paid, segregated by Plan coverage area, where the FEHBP paid as the primary insurer and were not subject to Omnibus Budget Reconciliation Act (OBRA) of 1990 or 1993 or case management guidelines. This resulted in an overall universe of 16,935,516 claim lines, totaling $2,014,505,845.

   From each coverage area, we judgmentally selected a number of claims based on the ratio of amount paid in each place of service group. In total, we selected and reviewed 115 claim lines whose total claim amount paid (all claim lines associated with the claim) was $10,806,852 to determine if the claims were paid accurately to licensed providers according to their contract with the Plan and the SBP brochure.

5. **Amounts Paid Equal/Greater Than Billed Charges** – We identified all claims where the amount paid was greater than or equal to the billed amount (excluding Veteran Affairs and Indian Health Service providers, as well as claims subject to OBRA 90 or OBRA 93). Based on this criteria, our population consisted of 62,745 claim lines totaling $122,855,093.

   We selected and reviewed 50 claims, with 319 claim lines, totaling $7,053,093, to determine if they were paid appropriately. Specifically, we selected samples using the following criteria:

   - From all claims with amounts paid between $1,000 and $50,000, we randomly selected 27 claims, with 58 claim lines, totaling $612,662.

- We selected all claims with amounts paid of $50,000 or higher. In total, we selected 23 claims, with 261 claim lines, totaling $6,440,431.

6. **Review of Test Claims** – We created 46 test claims using fictitious subscribers and members for our test environment that closely resembled the Plan's member demographics. With our created claims, we tested the Plan and Association's claims adjudication process to validate the system's processing controls.

III. AUDIT FINDINGS AND RECOMMENDATIONS

The following audit findings and program improvement areas represent the areas identified in our audit that require corrective action by the Plan and/or Association. All other areas reviewed and not reported on here were found to be in compliance with the Contract's provisions relative to health benefit payments.

A. AUDIT FINDINGS

1. Provider Network Status Review $72,308

Our review identified 25 claims paid incorrectly, resulting in overpayments totaling $72,308.

The Plan assigned an incorrect network status to certain PAR providers causing claims to be paid incorrectly.

According to the SBP brochure, the Plan enters into contracts with facilities and physician providers (often referred to as "preferred" or "participating" providers) to provide its Standard Option members with covered services at negotiated rates as payment in full. Basic Option members receive covered benefits from preferred providers only. Facilities and physicians without contracts (Non-PAR providers) may or may not accept Plan set allowances for covered services. If a Non-PAR provider is utilized, the member is responsible not only for applicable copayment or coinsurance amounts, but also for any amount exceeding the Plan's allowance.

Therefore, amounts paid to Non-PAR providers, both by the Plan and FEHBP members, often dramatically exceed the amounts paid to preferred or participating providers as a result of the Plan's ability to negotiate allowances that are lower than the non-participating provider's billing rate.

Section 3.2(a)(4)(b)(1) of the Contract states that "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable and reasonable."

Additionally, Section 2.3(g) of the Contract states that "If the Carrier determines that a Member's claim has been paid in error for any reason … , the Carrier shall make a prompt and diligent effort to recover the erroneous payment … ."

<u>Incorrect Network Status – Delays in Provider Contracting and Credentialing</u>

The Plan's contracting and credentialing processes led to it paying 19 claims in error and resulted in overpayments of $11,755. The errors resulted from two separate, but related issues:

- We identified seven claims, totaling $7,890, which were paid as Non-PAR due to delays in the Plan's contracting process.

- We identified 12 claims, totaling $3,865, which were paid as Non-Par due to delays in the Plan's re-credentialing process.

In both of these cases, the claims were paid following long delays in its contracting or re-credentialing process while the Plan was waiting on the providers to supply it with documentation to support their state credentials. Discussion with the Plan determined that it has no written procedures in place for these possibilities, but that it normally requests the provider to not submit claims until the documentation issues causing the delays are corrected.

However, in the cases identified the delays were protracted, and the providers failed to hold their claims. Consequently, when the claims were submitted they paid as Non-PAR, as the providers' statuses were still in question, resulting in overpayments by both the FEHBP and the members.

Additionally, the Plan failed to follow its unwritten procedures to run a manual report looking for claims paid to these providers during the delays, because it assumed that the claims would be held. The claims paid in error were not identified by the Plan and were brought to its attention as a result of this audit.

As a result of not having formalized procedures in place for claims paid during protracted provider contracting and credentialing delays, the FEHBP was overcharged $11,755.

Recommendation 1

We recommend that the contracting officer direct the Association to reimburse the FEHBP $11,755 for claims overpaid as a result of delays related to provider contracting.

Association's Response:

The Association agreed with $7,890 of the recommended amount and stated that it will return the funds to the FEHBP once recovered.

OIG Comments:

The Association did not have an opportunity to respond to $3,865 of the questioned costs as that amount was not finalized until after we received the response to the draft report. However, the Association is aware of the additional issue identified.

Recommendation 2

We recommend that the contracting officer direct the Plan to institute formal (written) procedures to ensure that any claims paid during protracted contracting or re-credentialing delays are identified and corrected.

<u>Association's Response:</u>

The Association agrees with the recommendation and states they are currently working on developing procedures to ensure that claims paid during contract negotiations are identified and corrected.

<u>OIG Comments:</u>

The Association did not have an opportunity to respond to re-credentialing delays as that issue was not finalized until after we received the response to the draft report.

<u>Recommendation 3:</u>

We recommend that the Plan institute procedures to suspend payment for all claims paid to providers in protracted contracting or re-credentialing delays until the issues causing the delay are corrected.

<u>OIG Comments:</u>

The Association did not have an opportunity to respond to this recommendation because it did not appear in the draft report.

However, implementing corrective actions to address this concern is important because the Plan's internal policy to rely upon its providers to hold claims until contracting and/or credentialing issues are resolved is not going to prevent the issue from occurring. Additionally, because the Plan is not following its unwritten processes to review for claims paid when a provider's network status was incorrect in the system, suspending the claims will not only prevent potential overpayments, but it will spur the providers to work with the Plan to resolve their status issues.

<u>Claim Suspension Overrides</u>

We also identified six claims that were paid incorrectly because the Plan improperly ignored a claim system suspension to manually verify the provider's network status. As a result, the claims incorrectly paid as non-participating and the FEHBP was overcharged $60,553.

The Plan's claim system typically identifies all provider claims and can readily determine the provider's network status at the time of adjudication. However, during the scope of our audit, some provider claims required additional manual review by its processors due to a unique contract situation. As a result, these claims would suspend in the adjudication process until the processor made a determination of the provider's network status.

In the case of the six claims identified in our review, the claims properly suspended for review. However, the processor, rather than manually determining the provider's proper

status (in this case participating), overrode the suspension and the claims processed as if the provider was non-participating. The Plan was unable to determine why the error occurred.

It should be noted that the unique contracting situation noted that led to the need for the suspension of claims to determine network status is no longer in place. Claims for this provider now properly identify its provider network status at the time of claim adjudication.

Recommendation 4

We recommend that the contracting officer direct the Association to reimburse the FEHBP $60,553 for claim payment errors related to claim suspension overrides.

Association's Response:

The Association agrees with the recommendation and states they are in the process of initiating recoveries from the members.

2. Unlisted Procedure Code Review **$28,956**

Our unlisted procedure code review found that the Plan overpaid two claims by a total of $28,956.

The Plan did not follow its internal procedures for pricing pharmaceutical claims.

Section 3.2(a)(4)(b)(1) of the Contract states that "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable and reasonable."

Additionally, Section 2.3(g) of the Contract states that "If the Carrier determines that a Member's claim has been paid in error for any reason … , the Carrier shall make a prompt and diligent effort to recover the erroneous payment … ."

We reviewed a sample of claim lines which involved undefined or miscellaneous Common Procedural Technology (CPT) codes or Healthcare Common Procedure Coding System (HCPCS) codes to determine if the claim lines were priced correctly. These codes are used by providers when, in their determination, there is no specific CPT or HCPCS code that would apply for the procedure performed. The Plan's normal procedure is to send claims with unlisted procedure codes to a vendor for medical review. The vendor reviews the patient's complete medical file, procedures performed, and level of effort required for the procedure in determining an appropriate charge for the service, if not specified in the provider's contract.

Our review identified two claims (for HCPCS J codes – a subset of HCPCS codes used to identify injectable drugs) that were properly sent to the Plan's medical review vendor. However, in the case of pharmaceuticals, the Plan has internal pricing software which it

uses to price applicable claims based on the National Drug Code assigned to the drug. In the case of these two claims, the Plan's vendor reviewed and approved the claim and then sent it back to the Plan for price determination. However, upon return to the Plan's processor, rather than follow its normal process and price the claim in its internal system, the claims were marked by the processor to incorrectly pay at the billed charge instead.

The Plan was unable to determine why the error occurred and stated that it was paid incorrectly due to the error of two different processors. When errors of any type are identified in processing, the Plan will ask its management team to review the error with the team. When an error is isolated, like these errors, the Plan's management team will meet with the processor(s) in question to have a one-on-one education session. The Plan stated that the processors involved with the errors identified are no longer at the Plan and that this type of error is rare. Additionally, after our audit brought these claims to the Plan's attention, it stated that it has begun the recovery process.

As a result of the Plan not following proper pricing procedures, the FEHBP was overcharged $28,956.

Recommendation 5

We recommend that the contracting officer direct the Association to reimburse the FEHBP $28,956 in overcharges to the FEHBP due to manual processor errors.

Association's Response:

The Association agrees with the recommendation. It stated that it has already recovered $4,555 and has initiated recovery efforts on the remaining balance.

B. PROGRAM IMPROVEMENT AREAS

1. Debarred Providers Review — Procedural

Our debarred provider review identified two Plan processor errors which led to one immaterial claim overpayment and another procedural notification error.

The Plan's manual processes for inserting debarment EOB messages can cause improper member notifications and/or claim overpayments.

Title 5 Code of Federal Regulations section 890.1043 states that a "debarred provider is not eligible to receive payment, directly or indirectly, from FEHBP funds for items or services furnished to a covered individual on or after the effective date of the debarment."

Additionally, the OPM OIG's Guidelines for Implementation of FEHBP Debarment and Suspension Orders, Chapter 2(D) states that the "FEHBP

administrative sanctions law requires FEHBP carriers to notify enrollees who obtain items or services from a debarred/suspended provider about the healthcare provider's sanction. OPM regulations prescribe a 15-day 'grace period' after issuance of such a notice, during which time items or services furnished by the healthcare provider will continue to be covered. Therefore, prompt notice to the enrollees is essential to effective implementation of debarments and suspensions."

During our review we identified two issues related to claims paid to debarred providers. Specifically, we identified the following:

- Our review identified one claim, for an immaterial amount, that was paid in error. Originally, the Plan's claim system properly identified the provider in question as debarred. However, during the adjudication of the claim, the Plan's processor manually removed the debarment indicator to allow the claim to be paid. The Plan did not provide an explanation as to why this was done.

- We identified another error related to two claims that were paid to a debarred provider. These claims were allowable, as both were within the 15-day grace period allowed per the OPM OIG debarment guidelines. However, the Plan failed to properly notify the member on the explanation of benefits (EOB) issued with the initial claim. The notification occurred following the second visit within the grace period. The Plan stated these errors were due to its processor selecting the wrong message codes for the EOB in both instances.

As with the unlisted procedure code finding, both of these errors were committed by separate processors who are no longer with the Plan. This finding will remain procedural due to the immaterial amount of the overpayment and the Plan's corrective actions already in place when an error like this occurs.

Although the Plan made only a small number of errors related to debarred providers, we feel it is important to stress its overall adherence to the regulations and policies surrounding them. The only errors identified in our review were the result of human error on the part of the Plan's claim processors. In the day and age of increasing technological advancement, we feel that the Plan should make all feasible attempts possible to remove the human element from the debarment process. This is not only to ensure that the FEHBP does not pay improperly, as it did on one claim identified, but because providers and facilities are also debarred from the FEHBP for a variety of reasons; in some cases, debarments are the result of a loss of medical license or criminal activity. Therefore, it is of the utmost importance that the Plan's FEHBP members are properly notified of their provider's debarment, as was not done for the two claims identified.

Recommendation 6

We recommend that the contracting officer direct the Plan to review its procedures for coding messages on its EOBs to auto-generate the messages and codes to avoid potential processor errors in the future.

Association's Response:

The Association agrees with the procedural error identified. It stated that it has addressed the issue with the processor involved. However, as this is an isolated issue it stated that no system updates are needed.

OIG Comments:

We do not agree with the Association's assertion that no system updates are needed. While this is an isolated case, it would be worthwhile if either the Plan's or the Association's claim system had the ability to auto-generate messages on EOBs for this particular issue. Any instance taken to reduce human intervention would reduce errors.

We also realize the solution has to be cost effective. Although it may require an upfront cost to program and test an auto-generated message approach, savings would be realized over the long run due to less time being needed for processor intervention and fewer improper payments made due to lack of member notification.

APPENDIX

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August 21, 2020

Advanced Claims Analysis Team
Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, Room 6400
Washington, DC 20415-11000

Reference: OPM DRAFT AUDIT REPORT
Issued: July 21, 2020 Received July 21, 2020

This is the Blue Cross and Blue Shield 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:

A. Provider Network Status Review **$68,443**

Recommendation 1

We recommend the contracting officer direct the Plan to reimburse the FEHBP $7,890 for claims overpaid as a result of delays related to provider contracting.

Plan Response

The Plan agrees to payment errors totaling $7,890 which were paid to the member. The Plan is in the process of initiating recovery from the member. Once the overpayments are recovered, the funds will be returned to the Program.

Recommendation 2

We recommend that the contracting officer direct the Plan to institute formal (written) procedures to ensure that any claims paid during protracted contracting delays are identified and corrected.

Plan Response:

The Plan agrees with the recommendation and is currently working on developing procedures to ensure that claims paid during contract negotiations are identified and corrected. The Plan will provide the procedures to OPM once written and approved. The Plan will complete the procedures by September 30, 2020.

Redacted by the OPM-OIG
Not Relevant to the Final Report

Recommendation 4:

We recommend that the contracting officer direct the Plan to reimburse the FEHBP $60,553 for claim payment errors related to claim suspension overrides.

Plan Response:

The Plan agrees to payment errors totaling $60,553 which were paid to the member. The Plan is in the process of initiating recovery from the member. Once the overpayments are recovered, the funds will be returned to the Program.

Redacted by the OPM-OIG
Not Relevant to the Final Report

B. Unlisted Procedure Code Review **$28,956**

Recommendation 5:

We recommend the contracting officer disallow $28,956 in overcharges to the FEHBP due to manual processor errors.

Plan Response:

The Plan agrees to overpayments totaling $28,956 and has recovered $4,555 via provider offset as well as sent letters regarding the outstanding balance (see Attachment 1) and $24,401 is in the recovery phase and letters have been sent to the provider (see Attachment 2).

C. Debarred Provider Review **Procedural**

Recommendation 6:

We recommend that the contracting officer direct the Plan to review its procedures for coding messages on its EOBs to auto generate the messages and codes to avoid potential processor errors in the future.

Plan Response:

The Plan agrees to the procedural error in which the guidelines were not followed by the processor. The Plan has reviewed the guidelines and determined that no updates were needed since this was an isolated case which was addressed with the processor.

Thank you for this opportunity to respond to the recommendations included in this draft report. If you have any questions, please contact me at 202.942.1285 or Elizabeth Fillinger at 202.639.1661.

Sincerely,

FEP Program Assurance

cc: OPM Contracting Officer
Highmark External Audit Services

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