



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

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# Final Audit Report

**Subject:**

## AUDIT OF HORIZON BLUECROSS BLUESHIELD OF NEW JERSEY NEWARK, NEW JERSEY

**Report No. 1A-10-49-12-035**

**Date: February 5, 2013**

### --CAUTION--

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## AUDIT REPORT

Federal Employees Health Benefits Program  
Service Benefit Plan      Contract CS 1039  
BlueCross BlueShield Association  
Plan Code 10

Horizon BlueCross BlueShield of New Jersey  
Plan Codes 280/780  
Newark, New Jersey

REPORT NO. 1A-10-49-12-035      DATE: 02/05/13



Michael R. Esser  
Assistant Inspector General  
for Audits

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## EXECUTIVE SUMMARY

Federal Employees Health Benefits Program  
Service Benefit Plan      Contract CS 1039  
BlueCross BlueShield Association  
Plan Code 10

Horizon BlueCross BlueShield of New Jersey  
Plan Codes 280/780  
Newark, New Jersey

REPORT NO. 1A-10-49-12-035

DATE: 02 / 05 / 13

This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at Horizon BlueCross BlueShield of New Jersey (Plan), in Newark, New Jersey, questions \$230,608 in health benefit charges. The BlueCross BlueShield Association agreed (A) with these questioned charges.

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covers claim payments from January 1, 2009 through December 31, 2011 as reported in the Annual Accounting Statements. However, our review of colonoscopy claims also included claims that were paid from January 1, 2012 through April 30, 2012.

The questioned health benefit charges are summarized as follows:

- |   |                         |
|---|-------------------------|
| • <b><u>Continuous Stay Claims (A)</u></b>  | <b><u>\$140,413</u></b> |
| <p>During our review of continuous stay claims, we determined that the Plan incorrectly paid 17 groups of continuous stay claims, resulting in net overcharges of \$140,413 to the FEHBP. Specifically, the Plan overpaid 15 claim groups by \$142,873 and underpaid 2 claim groups by \$2,460.</p> |                         |

- **System and Discount Review (A)** **\$76,490**

Based on our review of a judgmental sample of 200 claims, we determined that the Plan incorrectly paid 3 claims, resulting in overcharges of \$76,490 to the FEHBP.

- **Non-Participating Provider Claims (A)** **\$13,730**

During our review of claims submitted by non-participating providers, we determined that the Plan incorrectly paid two claims, resulting in overcharges of \$13,730 to the FEHBP. Specifically, the Plan overpaid one inpatient claim by \$10,125 and one professional claim by \$3,605.

- **Colonoscopy Claims (A)** **(\$25)**

Based on our review of a judgmental sample of 40 colonoscopy claims, we determined that the Plan incorrectly paid 1 claim, resulting in an undercharge of \$25 to the FEHBP.

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## **I. INTRODUCTION AND BACKGROUND**

### **INTRODUCTION**

This final audit report details the findings, conclusions, and recommendations resulting from our limited scope audit of the Federal Employees Health Benefits Program (FEHBP) operations at Horizon BlueCross BlueShield of New Jersey (Plan). The Plan is located in Newark, New Jersey.

The audit was performed by the Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as established by the Inspector General Act of 1978, as amended.

### **BACKGROUND**

The FEHBP was established by the Federal Employees Health Benefits (FEHB) 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 has overall responsibility for administration of the FEHBP. The provisions of the FEHB Act are implemented by OPM through regulations, which are codified in Title 5, Chapter 1, Part 890 of the Code of Federal Regulations (CFR). Health insurance coverage is made available through contracts with various health insurance carriers.

The BlueCross BlueShield Association (Association), on behalf of participating BlueCross and BlueShield plans, has entered into a Government-wide Service Benefit Plan contract (CS 1039) with OPM to provide a health benefit plan authorized by the FEHB Act. The Association delegates authority to participating local BlueCross and BlueShield plans throughout the United States to process the health benefit claims of its federal subscribers. The Plan is one of approximately 64 local BlueCross and BlueShield plans participating in the FEHBP.

The Association has established a Federal Employee Program (FEP<sup>1</sup>) 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 the contract with the Association, member BlueCross and BlueShield plans, and OPM.

The Association has also established an FEP Operations Center. The activities of the FEP Operations Center are performed by CareFirst BlueCross BlueShield, located in Washington, D.C. 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.

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<sup>1</sup> Throughout this report, when we refer to "FEP", we are referring to the Service Benefit Plan 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. Also, management of the Plan is responsible for establishing and maintaining a system of internal controls.

All findings from our prior audit of the Plan (Report No. 1A-10-49-09-025, dated February 12, 2010), which included claim payments from 2005 through October 31, 2008, have been satisfactorily resolved.

The results of this audit were provided to the Plan in written audit inquiries; were discussed with Plan and/or Association officials throughout the audit and at an exit conference; and were presented in detail in a draft report, dated September 28, 2012. The Association'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.

## **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 objectives were to determine whether the Plan complied with contract provisions relative to health benefit payments.

### **SCOPE**

We conducted our limited scope 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.

We reviewed the BlueCross and BlueShield FEHBP Annual Accounting Statements as they pertain to Plan codes 280 and 780 for contract years 2009 through 2011. During this period, the Plan paid approximately \$1.1 billion in health benefit charges (See Figure 1 and Schedule A). In addition, our review of colonoscopy claims also included claims that were paid from January 1, 2012 through April 30, 2012. In total, we reviewed approximately \$25 million in claim payments made from January 1, 2010 through April 30, 2012 for proper adjudication.

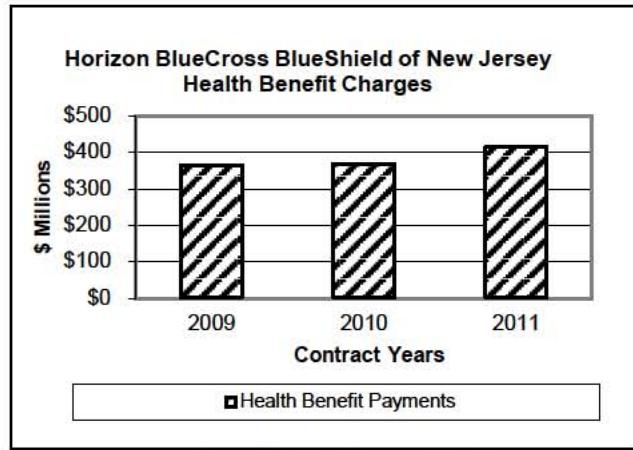


Figure 1 – Health Benefit Charges

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. This was determined to be the most effective approach to select areas of audit. For those areas selected, we primarily relied on 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 and the applicable laws and regulations governing the FEHBP as they relate to claim payments. The results of our tests indicate that, with respect to the items tested, the Plan did not fully comply with the provisions of the contract relative to claim payments. Exceptions noted in the areas reviewed are set forth in detail in the "Audit Findings and Recommendations" section of this

audit report. With respect to the items 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. Due to time constraints, we did not verify the reliability of the data generated by the various information systems involved. However, while utilizing the computer-generated data during our audit testing, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

The audit was performed at the Plan's office in Newark, New Jersey from July 23, 2012 through July 27, 2012. Audit fieldwork was also performed at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida.

## **METHODOLOGY**

We obtained an understanding of the internal controls over the Plan's claims processing system by inquiry of Plan officials.

To test the Plan's compliance with the FEHBP health benefit provisions, we selected and reviewed samples of 1,904 claims.<sup>2</sup> We used the FEHBP contract, the 2009 through 2011 Service Benefit Plan brochures, the Plan's provider agreements, and the Association's FEP administrative manual to determine the allowability of benefit payments. The results of these samples were not projected to the universe of claims.

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<sup>2</sup> See the audit findings for "Continuous Stay Claims" (1), "System and Discount Review" (2), "Non-Participating Provider Claims" (3), and "Colonoscopy Claims" (4) on pages 5 through 10 for specific details of our sample selection methodologies.

### **III. AUDIT FINDINGS AND RECOMMENDATIONS**

#### **HEALTH BENEFIT CHARGES**

##### **1. Continuous Stay Claims** **\$140,413**

During our review of continuous stay claims, we determined that the Plan incorrectly paid 17 groups of continuous stay claims, resulting in net overcharges of \$140,413 to the FEHBP. Specifically, the Plan overpaid 15 claim groups by \$142,873 and underpaid 2 claim groups by \$2,460. Continuous stay claims are two or more inpatient hospital claims with consecutive dates of service that were billed by a provider for a patient with one length of stay.

Contract CS 1039, Part II, section 2.6 states, “(a) The Carrier shall coordinate the payment of benefits under this contract with the payment of benefits under Medicare . . . (b) The Carrier shall not pay benefits . . . until it has determined whether it is the primary carrier . . .”

Contract CS 1039, Part III, section 3.2 (b)(1) states, “The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable.” In addition, Part II, section 2.3 (g) states, “If the Carrier or OPM 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 . . .”

For the period January 1, 2009 through December 31, 2011, we identified 1,270 continuous stay claim groups (representing 2,725 claims), totaling \$13,094,673 in payments. From this universe, we selected and reviewed a judgmental sample of 210 continuous stay claim groups (representing 519 claims), totaling \$8,478,149 in payments, to determine if these claims were correctly priced and paid by the Plan. Our sample included groups with cumulative claim payment amounts of \$15,000 or more. The majority of these groups contained claims with consecutive dates of service. Our sample included 12 groups with claim payment errors, totaling \$131,593 in net overcharges to the FEHBP.

Since our sample contained several claim payment errors, we expanded our testing to include all claim groups with cumulative claim payment amounts of \$12,000 or more but less than \$15,000. This expanded sample included an additional 76 continuous stay claim groups (representing 158 claims), totaling \$1,021,077 in payments. Our expanded sample included five groups with claim payment errors, totaling \$8,820 in net overcharges to the FEHBP.

In total, our review identified 17 groups of continuous stay claims with payment errors (representing 17 claim payment errors), resulting in net overcharges of \$140,413 to the FEHBP. Specifically, the Plan overpaid 15 claim groups by \$142,873 and underpaid 2 claim groups by \$2,460. These claim payment errors resulted from the following:

- The Plan priced 10 claims at incorrect per diem rates, resulting in net overcharges of \$101,952 to the FEHBP. Specifically, the Plan overpaid eight claim groups by \$104,412 and underpaid two claim groups by \$2,460.

- The Plan did not properly coordinate three claims with Medicare, resulting in overcharges of \$25,043 to the FEHBP.
- In one instance, the Plan incorrectly paid a claim where the patient's hospital stay was not authorized, resulting in an overcharge of \$7,291 to the FEHBP.
- The Plan processed three claims using the incorrect number of days, resulting in overcharges of \$6,127 to the FEHBP.

**Association's Response:**

The Association agrees with this finding. The Association states that the Plan has initiated recoveries of the overpayments. As of November 16, 2012, the Plan had recovered and returned \$81,205 of the overpayments to the FEHBP. To the extent that errors did occur, the Association also states that these payments were good faith erroneous benefit payments and fall within the context of CS 1039, Part II, section 2.3(g). Any payments the Plan is unable to recover are allowable charges to the FEHBP as long as the Plan demonstrates due diligence in the collection of these overpayments. As good faith erroneous payments, lost investment income does not apply to the claim payment errors identified in this finding.

The Association states, "The Plan has also completed causal analysis of these overpayments and has determined that the payment errors were caused by examiner[s] not following internal guidelines for the adjudication of these claims, or coding/provider billing errors. The following processes have been implemented to reduce these types of claim payment errors in the future:

- Additional training and feedback was provided to the examiners and periodic audits checks are performed to ensure . . . the quality of these claims.
- Internal systems and guidelines were reviewed to verify that the appropriate controls are in place. It was determined that based upon the number of confirmed overpayments, no new system controls are required for these types of claims.
- The Plan will continue to review the System-wide claims listings that will also include Continuous Stay Claims in 2013.

In addition, FEP will continue to include these claims types in its on-line application Claims Audit Monitoring Tool, used to timely identify and recover claims payment errors. This on-line application was made available to all Plans on October 8, 2012."

**OIG Comments:**

Based on our review of the Association's response and the Plan's supporting documentation, we revised the amount questioned from the draft report to \$140,413 for this finding.

## **Recommendation 1**

We recommend that the contracting officer disallow \$142,873 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

## **Recommendation 2**

We recommend that the contracting officer allow the Plan to charge the FEHBP \$2,460 if additional payments are made to the providers to correct the underpayment errors. However, before making any additional payment(s) to a provider, the contracting officer should require the Plan to first recover any questioned overpayment(s) for that provider.

## **Recommendation 3**

We recommend that the contracting officer have the Association verify that the Plan's corrective actions to minimize these types of claim payment errors in the future are being implemented. These corrective actions are included in the Association's response to the draft report.

## **2. System and Discount Review** **\$76,490**

The Plan incorrectly paid three claims, resulting in overcharges of \$76,490 to the FEHBP.

As previously cited from CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. Also, the Plan must coordinate the payment of benefits under this contract with the payment of benefits under Medicare. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments.

For health benefit claims incurred from July 1, 2010 through December 31, 2011 and reimbursed from January 1, 2011 through December 31, 2011 (excluding Omnibus Budget Reconciliation Act of 1990, Omnibus Budget Reconciliation Act of 1993, and case management claims), we identified 3,545,912 claim lines, totaling \$373,736,289 in payments, where the FEHBP paid as the primary insurer. From this universe, we selected and reviewed a judgmental sample of 200 claims (representing 2,262 claim lines), totaling \$8,252,117 in payments, for the purpose of determining if the Plan adjudicated these claims properly and/or priced them according to the provider contract rates.<sup>3</sup> As part of our review, we also selected 35 participating and preferred providers, which were associated with the highest reimbursed claims in our sample, for the purpose of verifying if these providers' contract rates were accurately and timely updated in the Plan's local network pricing system.

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<sup>3</sup> We selected our sample from an OIG-generated "Place of Service Report" (SAS application) that stratified the claims by place of service (POS), such as provider's office and payment category, such as \$50 to \$99.99. We judgmentally determined the number of sample items to select from each POS stratum based on the stratum's total claim dollars paid.

Our review identified three claim payment errors, resulting in overcharges of \$76,490 to the FEHBP. These claim payment errors resulted from the following:

- The Plan did not properly coordinate two claims with Medicare, resulting in overcharges of \$76,315 to the FEHBP.
- In one instance, the Plan paid a claim using the incorrect pricing allowance, resulting in an overcharge of \$175 to the FEHBP.

**Association's Response:**

The Association agrees with this finding. The Association states that the Plan has recovered and returned these overpayments to the FEHBP. The Association also states that the Plan has implemented corrective actions to minimize these types of errors in the future.

**Recommendation 4**

We recommend that the contracting officer disallow \$76,490 for claim overcharges and verify that the Plan has returned these overcharges to the FEHBP.

**3. Non-Participating Provider Claims** **\$13,730**

During our review of claims submitted by non-participating (non-par) providers, we determined that the Plan incorrectly paid two claims, resulting in overcharges of \$13,730 to the FEHBP. Specifically, the Plan overpaid one inpatient claim by \$10,125 and one professional claim by \$3,605.

As previously cited from CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments.

The 2011 BlueCross and BlueShield Service Benefit Plan brochure, page 129, states, “Non-participating providers – We have no agreements with these providers to limit what they can bill you for their services. This means that using Non-participating providers could result in your having to pay significantly greater amounts for the services you receive.”

For the period January 1, 2009 through December 31, 2011, we performed a computer search to identify inpatient, outpatient, and professional claims that were submitted by non-par providers. In total, we identified 201,183 non-par provider claims (representing 495,782 claim lines), totaling \$52,470,375 in payments that met this search criteria. From this universe, we selected and reviewed a judgmental sample of 130 claims (representing 1,274 claim lines), totaling \$7,035,615 in payments, to determine if these claims were correctly priced by the FEP Operations Center and/or paid by the Plan.<sup>4</sup>

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<sup>4</sup> The non-par provider claims are priced by the FEP Operations Center and then paid by the Plan.

Our sample selection methodologies are summarized as follows:

- From a population of 98 non-par inpatient claims (representing 1,546 claim lines, totaling \$7,055,339 in payments), we selected and reviewed a judgmental sample of 60 claims (representing 1,204 claim lines), totaling \$6,775,241 in payments. The sample selections included the 55 highest paid claims in this population as well as 5 randomly selected claims.
- From a population of 1,040 non-par outpatient claims (representing 1,040 claim lines, totaling \$1,708,905 in payments), we selected and reviewed a judgmental sample 20 claims (representing 20 claim lines), totaling \$35,440 in payments. The sample selections included the 15 highest paid claims in this population as well as 5 randomly selected claims.
- From a population of 200,045 non-par professional claims (representing 493,196 claim lines, totaling \$43,706,131 in payments), we selected and reviewed a judgmental sample of 50 claims (representing 50 claim lines), totaling \$224,934 in payments. The sample selections included claims that were randomly selected from 10 stratified payment groups (5 from each group).

Based on our review, we determined that two of the claims in our sample were paid incorrectly, resulting in overcharges of \$13,730 to the FEHBP. These claim payment errors resulted from the following:

- In one instance, the Plan did not use a special per diem rate, negotiated between the Plan and the non-par inpatient facility provider, when pricing the claim. As a result, the Plan overpaid this claim by \$10,125.
- In one instance, the FEP Operations Center did not properly coordinate a non-par professional claim with the member's additional insurance when pricing the claim. As a result, the Plan overpaid this claim by \$3,605.

#### **Association's Response:**

The Association agrees with this finding. The Association states that the Plan has recovered and returned these overpayments to the FEHBP. The Association also states that the Plan has implemented corrective actions to reduce these types of payment errors in the future.

#### **Recommendation 5**

We recommend that the contracting officer disallow \$13,730 for claim overcharges and verify that the Plan has returned these overcharges to the FEHBP.

#### **4. Colonoscopy Claims** (\$25)

In one instance, the Plan incorrectly paid a colonoscopy claim, resulting in an undercharge of \$25 to the FEHBP.

As previously cited from CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments.

For the period January 1, 2011 through April 30, 2012, we identified 11,118 colonoscopy claims (representing 12,696 claim lines), totaling \$4,697,253 in payments. From this universe, we selected and reviewed a judgmental sample of 40 claims (representing 85 claim lines), totaling \$83,167 in payments, to determine if these claims were correctly priced and paid by the Plan. Our sample included all colonoscopy claims with amounts paid of \$1,750 or more.

Based on our review, we determined that the Plan incorrectly paid one colonoscopy claim, resulting in an undercharge of \$25 to the FEHBP. In this instance, the Plan inadvertently applied a copayment when processing the claim, instead of paying the claim at 100 percent of the local allowance.

#### **Association's Response:**

The Plan agrees with this finding. The Association states that the Plan issued an additional payment to the provider to correct this underpayment error.

#### **Recommendation 6**

We recommend that the contracting officer verify that the Plan corrected the claim underpayment error of \$25.

#### **IV. MAJOR CONTRIBUTORS TO THIS REPORT**

##### Experience-Rated Audits Group

[REDACTED] Lead Auditor

[REDACTED], Auditor

[REDACTED], Auditor

[REDACTED], Auditor

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[REDACTED], Chief [REDACTED]

##### Information Systems Audits Group

[REDACTED], Senior Information Technology Specialist

[REDACTED], Senior Information Technology Specialist

**V. SCHEDULE A**

**HORIZON BLUECROSS BLUESHIELD OF NEW JERSEY  
NEWARK, NEW JERSEY**

**HEALTH BENEFIT CHARGES AND AMOUNTS QUESTIONED**

<b>HEALTH BENEFIT CHARGES</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>TOTAL</b>
<b>HEALTH BENEFIT CHARGES</b>				
<b>PLAN CODE 280:</b>				
CLAIM PAYMENTS	\$180,031,861	\$184,618,556	\$208,912,703	\$573,563,120
MISCELLANEOUS PAYMENTS AND CREDITS*	969,614	576,032	196,029	1,741,675
<b>PLAN CODE 780:</b>				
CLAIM PAYMENTS	183,060,431	181,522,082	204,100,678	568,683,191
MISCELLANEOUS PAYMENTS AND CREDITS*	0	0	0	0
<b>TOTAL</b>	<b>\$364,061,906</b>	<b>\$366,716,670</b>	<b>\$413,209,410</b>	<b>\$1,143,987,986</b>
<b>AMOUNTS QUESTIONED</b>				
	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>TOTAL</b>
1. CONTINUOUS STAY CLAIMS	\$22,337	\$72,604	\$45,473	\$140,413
2. SYSTEM AND DISCOUNT REVIEW	0	0	76,490	76,490
3. NON-PARTICIPATING PROVIDER CLAIMS	0	0	13,730	13,730
4. COLONOSCOPY CLAIMS	0	0	(25)	(25)
<b>TOTAL QUESTIONED CHARGES</b>	<b>\$22,337</b>	<b>\$72,604</b>	<b>\$135,668</b>	<b>\$230,608</b>

\* We did not review the miscellaneous payments and credits on this audit.



**BlueCross BlueShield  
Association**

## An Association of Independent Blue Cross and Blue Shield Plans

November 21, 2012

[REDACTED], Group Chief,  
Experience-Rated Audits Group,  
U.S. Office of Personnel Management  
1900 E Street, Room 6400  
Washington, D.C. 20415-1100

Federal Employee Program  
1310 G Street, N.W.  
Washington, D.C. 20005  
202.942.1000  
Fax 202.942.1125

**Reference:** OPM FINAL AUDIT REPORT  
Horizon Blue Cross and Blue Shield of New Jersey  
Audit Report Number 1A-10-49-12-035  
(Dated September 28, 2012 and Received September 28, 2012)

Dear [REDACTED] :

This is our response to the above referenced U.S. Office of Personnel Management (OPM) Final Audit Report covering the Federal Employees' Health Benefits Program (FEHBP) for Horizon Blue Cross and Blue Shield of New Jersey. Our comments concerning the findings in this report are as follows:

## **HEALTH BENEFIT CHARGES**

## **1. Continuous Stay Claims**

**\$140,913**

The Plan agrees that 17 claim groups may have been paid incorrectly. There were 15 claim groups that resulted in overpayments totaling \$142,873 and two claim groups were underpaid by (\$2,460). For Sample # 160A totaling \$7,791, the Plan agrees that \$7,291 was paid in error and contests \$500 as the member was liable for \$500 coinsurance for services rendered.

The Plan initiated recovery efforts for these confirmed overpayments and as of November 16, 2012, the Plan has recovered and returned \$81,205 to the Program. The Plan will continue to show due diligence in its recovery efforts.

The Plan has also completed causal analysis of these overpayments and has determined that the payment errors were caused by examiner not following internal guidelines for the adjudication of these claims, or coding/ provider billing errors. The

following processes have been implemented to reduce these types of claim payment errors in the future:

- Additional training and feedback was provided to the examiners and periodic audits checks are performed to ensure enhance the quality of these claims.
- Internal systems and guidelines were reviewed to verify that the appropriate controls are in place. It was determined that based upon the number of confirmed overpayments, no new system controls are required for these types of claims.
- The Plan will continue to review the System-wide claims listings that will also include Continuous Stay Claims in 2013.

In addition, FEP will continue to include these claims types in its on-line application Claims Audit Monitoring Tool, used to timely identify and recover claim payment errors. This on-line application was made available to all Plans on October 8, 2012.

Accordingly, to the extent that errors did occur, the payments are good faith erroneous benefit payments and fall within the context of CS 1039, section 2.3(g). Any benefit payments the Plan is unable to recover are allowable charges to the Program as long as the Plan is able to demonstrate due diligence in collection of the overpayment. In addition, as good faith erroneous benefit payments; the Plan continues to initiate recovery in a timely manner for confirmed overpayments. Because these are good faith erroneous payments, they are not subject to lost investment income.

#### **4. System and Discount Review** **\$76,490**

The Plan agrees that three claim payment errors totaling \$76,490 may have been paid in error. Refund recovery efforts were initiated and as of October 9, 2012, the Plan has collected and returned \$76,490 to the Program. These overpayments were caused by manual pricing errors. The Plan has taken the following actions to minimize these types of errors in the future:

- Used the errors as training tools during recent re-fresher trainings for the claims staff. In addition, the Plan will use its quality process to continue to monitor the accuracy of these types of claims.

- Conducted random system audits to promote the efficiency of the functionality of the system in an effort to reduce the amount of human intervention required for pricing.

**5. Non-Participating Provider Claims** **\$13,730**

The Plan agrees that two claim payments totaling \$13,730 were paid incorrectly. As of October 9, 2012, all overpayments have been recovered and returned to the Program. These errors were caused by manual coding errors. In order to reduce these types of payment errors in the future the Plan has implemented the following:

- Conduct periodic coding training for claims processors; and
- Include these types of errors in the in-line quality process.
- Included these types of errors in the training tools to be used during future refresher training for claims staff.

**6. Colonoscopy Claims** **(\$25)**

The Plan agrees that one claim was underpaid by \$25 from a population of 40 claims. This error was caused by a manual coding error. As of October 9, 2012, the Plan issued the additional payment to the provider to correct this underpayment. The Plan believes that their current internal controls are sufficient to promote the accurate adjudication of these claims types and will not implement any additional controls.

We appreciate the opportunity to provide our response to each of the findings in this report and request that our comments be included in their entirety and are made a part of the Final Audit Report. If you have any questions, please contact me at 202.957.6865.

Sincerely,

*Connie Woodard*

[REDACTED], CPA  
Director, Program Assurance

cc: [REDACTED] OPM  
[REDACTED] OPM  
[REDACTED], FEP