US OFFICE OF PERSONNEL MANAGEMENT
OFFICE OF THE INSPECTOR GENERAL
OFFICE OF AUDITS

Final Audit Report

Subject:

AUDIT OF BLUECROSS BLUESHIELD OF NEBRASKA OMAHA, NEBRASKA

Report No. 1A-10-53-08-045

Date: January 7, 2009

--CAUTION--

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

Office of the
Inspector General

AUDIT REPORT

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

BlueCross BlueShield of Nebraska
Plan Codes 260 and 760
Omaha, Nebraska

REPORT NO. 1A-10-53-08-045 DATE: January 7, 2009

Michael R. Esser
Assistant Inspector General
for Audits

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
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EXECUTIVE SUMMARY

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This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at BlueCross BlueShield of Nebraska (Plan) in Omaha, Nebraska questions $440,327 in health benefit charges. The BlueCross BlueShield Association agreed *(A)* with all questioned charges.

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covered claim payments from 2005 through 2007 as reported in the Annual Accounting Statements.

The questioned health benefit charges are summarized as follows:

- **Omnibus Budget Reconciliation Act of 1990 Review *(A)*** **$413,408**

  The Plan incorrectly paid 47 claims that were priced or potentially should have been priced under the Omnibus Budget Reconciliation Act of 1990 pricing guidelines. Specifically, the Plan overpaid 40 claims by $441,688 and underpaid 7 claims by $28,280, resulting in net overcharges of $413,408 to the FEHBP.

- **Claim Payment Errors *(A)*** **$26,919**

  The Plan incorrectly paid 76 claims, resulting in overcharges of $26,919 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 BlueCross BlueShield of Nebraska (Plan). The Plan is located in Omaha, Nebraska.

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 Center for Retirement and Insurance Services 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 63 local BlueCross and BlueShield plans participating in the FEHBP.

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 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.

[1] 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.

The findings from our previous audit of the Plan (Report No. 1A-10-53-01-010, dated January 19, 2001) for contract years 1997 through 1999 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 17, 2008. 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 260 and 760 for contract years 2005 through 2007. During this period, the Plan paid approximately $337 million in health benefit charges. Specifically, we reviewed $7.8 million in claim payments made from 2005 through 2007 for proper adjudication.

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 operation. 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. The results of our tests indicate that, with respect to the items tested, the Plan did not comply with all provisions of the contract and federal procurement regulations. 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, the Plan, and the Centers for Medicare and Medicaid Services. 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 our office in Jacksonville, Florida from June 13, 2008 through July 31, 2008.

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 553 claims.[2] We used the FEHBP contract, the Service Benefit Plan brochure, 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.

[2] See the audit findings for "Omnibus Budget Reconciliation Act of 1990 Review" (A1) and "Claim Payment Errors" (A2) on pages 5 through 10 for specific details of our sample selection methodologies.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. HEALTH BENEFIT CHARGES

1. Omnibus Budget Reconciliation Act of 1990 Review $413,408

The Plan incorrectly paid 47 claims that were priced or potentially should have been priced under the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) pricing guidelines. Specifically, the Plan overpaid 40 claims by $441,688 and underpaid 7 claims by $28,280, resulting in net overcharges of $413,408 to the FEHBP.

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." 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 diligent effort to recover an overpayment . . . ."

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 under this contract until it has determined whether it is the primary carrier . . . ."

OBRA 90 limits the benefit payments for certain inpatient hospital services provided to annuitants age 65 or older who are not covered under Medicare Part A. The FEHBP fee-for-service plans are required to limit the claim payment to the amount equivalent to the Medicare Part A payment.

Using a program developed by the Centers for Medicare and Medicaid Services to price OBRA 90 claims, we recalculated the claim payment amounts for the claims in our samples that were subject to and/or processed as OBRA 90.

The following summarizes the claim payment errors.

OBRA 90 Claim Pricing Errors

For the period 2005 through 2007, we identified 300 claims, totaling $3,724,457 in payments, that were subject to OBRA 90 pricing guidelines. From this universe, we selected and reviewed a judgmental sample of 114 claims, totaling $2,556,600 in payments, to determine if these claims were correctly priced by the FEP Operations Center and paid by the Plan. Our sample included all OBRA 90 claims with amounts paid of $10,000 or more.

Based on our review, we determined that 34 claims were paid incorrectly, resulting in net overcharges of $424,788 to the FEHBP. Specifically, the Plan overpaid 31 claims by $433,370 and underpaid 3 claims by $8,582.

The claim payment errors resulted from the following:

- The Plan inadvertently did not price 27 claims under OBRA 90, resulting in net overcharges of $382,264 to the FEHBP. Specifically, the Plan overpaid 26 claims by $387,263 and underpaid 1 claim by $4,999.

- The Plan did not properly coordinate two claims with Medicate Part B, resulting in overcharges of $22,481 to the FEHBP.

- The FEP Operations Center priced one claim using the incorrect billed charges, resulting in an overcharge of $17,473 to the FEHBP.

- The FEP Operations Center priced one claim using an incorrect Medicare Diagnostic Related Group (DRG) code, resulting in an overcharge of $5,239 to the FEHBP.

- In one instance, the Plan paid a split claim incorrectly, resulting in an overcharge of $914 to the FEHBP.

- The Plan paid two claims using incorrect reimbursement rates, resulting in undercharges of $3,583 to the FEHBP.

Claims Not Priced Under OBRA 90 (Possible OBRA 90 Claims)

For the period 2005 through 2007, we identified 96 claims, totaling $508,682 in payments, that were potentially subject to OBRA 90 pricing guidelines but appeared to be priced under the Plan's standard pricing procedures. We selected all 96 claims and determined if the Plan paid these claims properly.

Based on our review, we determined that 13 claims were paid incorrectly, resulting in net undercharges of $11,380 to the FEHBP. Specifically, the Plan overpaid nine claims by $8,318 and underpaid four claims by $19,698.

The claim payment errors resulted from the following:

- The Plan incorrectly paid six split claims, resulting in overcharges of $4,823 to the FEHBP.

- The Plan paid one claim using an incorrect local pricing amount, resulting in an undercharge of $476 to the FEHBP.

- The Plan priced one claim using an incorrect reimbursement rate, resulting in an undercharge of $1,263 to the FEHBP.

- The Plan inadvertently did not price five claims under OBRA 90, resulting in net undercharges of $14,464 to the FEHBP. Specifically, the Plan overpaid three claims by $3,495 and underpaid two claims by $17,959.

Association's Response:

The Association agrees with this finding. The Association states that the Plan has initiated recoveries on the overpayments and has already returned $393,640 ($386,831 + $6,809) to the FEHBP. 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 good faith erroneous payments, lost investment income does not apply to the claim payment errors identified in this finding.

The Association states, "As a result of the audit, the Plan noted several discrepancies in the assigning of Medicare provider numbers in the local Plan database. The Plan immediately reviewed all local files containing Medicare provider numbers against a list retrieved from the local Medicare Part A contractor to ensure that the database used to accurately price OBRA 90 claims was correct. . . . Efforts will be made to periodically examine existing procedures and add additional controls where necessary."

OIG Comments:

After reviewing the Association's response and documentation provided by the Plan, we revised the amount questioned from the draft report to net overcharges of $413,408. Using the FEP Direct System, we could only verify that the Plan has returned $347,127 of the questioned overcharges to the FEHBP.

Recommendation 1

We verified that the Plan has returned $347,127 of the questioned overcharges to the FEHBP. Therefore, no further action is required for these overpayments.

Recommendation 2

We recommend that the contracting officer disallow $94,561 ($441,688 overcharges - $347,127 amount already returned) in claim overcharges, and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 3

We recommend that the contracting officer allow the Plan to charge the FEHBP $28,280 if additional payments are made to the providers to correct the underpayment errors.

Recommendation 4

Although the Association has developed a corrective action plan to reduce OBRA 90 findings, we recommend that the contracting officer instruct the Association to ensure that the Plan is following the corrective action plan.

2. Claim Payment Errors — $26,919

The Plan incorrectly paid 76 claims, resulting in overcharges of $26,919 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.

The following summarizes the claim payment errors.

Assistant Surgeon Review

For the period of 2005 through 2007, we identified 428 assistant surgeon claim groups, totaling $64,207 in potential overpayments, that may not have been paid in accordance with the Plan's assistant surgeon pricing procedures. From this universe, we selected and reviewed a judgmental sample of 172 assistant surgeon claim groups, totaling $49,888 in potential overpayments, to determine if the Plan paid these claims properly. Our sample included all assistant surgeon claim groups with potential overpayments of $100 or more. Based on our review, we determined that 70 claims were paid incorrectly, resulting in overcharges of $23,827 to the FEHBP.

The claim payment errors resulted from the following:

- The Plan inadvertently priced 39 claims incorrectly, resulting in overcharges of $14,278 to the FEHBP. In each instance, the Plan paid the claim based on the assistant surgeon pricing even though the claim did not require assistant surgeon pricing.

- The Plan incorrectly paid 18 assistant surgeon claims that were subject to Omnibus Budget Reconciliation Act of 1993 (OBRA 93) pricing guidelines, resulting in overcharges of $3,745 to the FEHBP. These errors were due to Palmetto (OBRA 93 pricing vendor) not recognizing the assistant surgeon pricing modifier and erroneously calculating the assistant surgeon fee.

- The Plan paid three claims using the incorrect assistant surgeon pricing percentage, resulting in overcharges of $2,657 to the FEHBP.

- The Plan paid six claims at incorrect allowed amounts, resulting in overcharges of $2,569 to the FEHBP.

- The Plan paid four claims without applying the multiple surgery reduction, resulting in overcharges of $578 to the FEHBP.

Amounts Paid Greater than Covered Charges

For the period 2005 through 2007, we identified 71 claims where the amounts paid were greater than the covered charges by a total of $115,573. We selected all 71 claims and determined if the Plan adjudicated these claims properly. Based on our review, we identified six claim payment errors, resulting in overcharges of $3,092 to the FEHBP.

The claim payment errors resulted from the following:

- The Plan paid two claims using incorrect local pricing methods, resulting in overcharges of $2,235 to the FEHBP.

- The Plan paid four claims using incorrect allowances, resulting in overcharges of $857 to the FEHBP.

System Review

For health benefit claims reimbursed from January 1, 2007 through December 31, 2007, we identified 782,310 claim lines, totaling $99,613,703 in payments, using a standard criteria based on our audit experience. From this universe, we selected and reviewed a judgmental sample of 100 claims (representing 874 claim lines), totaling $4,545,554 in payments, to determine if the Plan adjudicated these claims properly.[3] We identified two immaterial claim payment errors, which are not being questioned in the report.

Association's Response:

The Association agrees with this finding. The Association states that the Plan has initiated recoveries on the overpayments and has already returned $23,069 to the FEHBP. 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 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 retrained several claims auditors regarding when and how to pay Assistant Surgeon claims. This training is ongoing and as a follow up, additional quality is performed to ensure the training was successful.

[3] 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.

For the Assistant Surgeon claim errors noted during the audit, the FEPDO implemented the following:

- The OBRA '93 vendor, Palmetto, corrected pricing of the Assistant Surgeon modifier during May 2008; this should result in more accurate pricing in the future.

- A final comprehensive list that identifies all unadjusted Assistant Surgeon claims will soon be issued so that claims can be adjusted as necessary."

In addition, the Association states, "the Plan has several methods in place to identify overpayments. These methods include, but are not limited to the System Wide Claims Reports (which includes a listing of Assistant Surgeon Claims), COB claims reports and Duplicate claims reports provided by the FEP Director's Office and routine claims quality assurance audits performed by the Plan's Internal Auditors. While these measures are not absolute, they provide reasonable assurances that such items will be identified. Efforts will be made to periodically examine existing procedures and add additional controls where necessary."

OIG Comments:

Using the FEP Direct System, we could only verify that the Plan has returned $16,046 of the questioned charges to the FEHBP.

Recommendation 5

We verified that the Plan has returned $16,046 of the questioned charges to the FEHBP. No further action is required for these overpayments.

Recommendation 6

We recommend that the contracting officer disallow $10,873 ($26,919 questioned - $16,046 amount already returned) in claim overcharges, and verify that the Plan returns all amounts recovered to the FEHBP.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Experienced-Rated Audits Group

[redacted], Auditor-In-Charge

[redacted] Auditor

[redacted] Chief [redacted]

[redacted] Senior Team Leader

V. SCHEDULE A

BLUECROSS BLUESHIELD OF NEBRASKA
OMAHA, NEBRASKA

HEALTH BENEFIT CHARGES AND AMOUNTS QUESTIONED

HEALTH BENEFIT CHARGES	2005	2006	2007	TOTAL
HEALTH BENEFIT CHARGES				
PLAN CODE 260	$61,672,846	$67,992,512	$72,166,774	$201,832,132
MISCELLANEOUS PAYMENTS AND CREDITS	(14,481)	871,083	807,315	1,663,917
PLAN CODE 760	39,211,999	44,901,878	49,056,344	133,170,221
MISCELLANEOUS PAYMENTS AND CREDITS	0	0	0	0
TOTAL HEALTH BENEFIT CHARGES	$100,870,364	$113,765,473	$122,030,433	$336,666,270

AMOUNTS QUESTIONED	2005	2006	2007	TOTAL
1. OMNIBUS BUDGET RECONCILIATION ACT OF 1990 REVIEW	$205,165	$99,760	$108,483	$413,408
2. CLAIM PAYMENT ERRORS	9,568	8,008	9,343	26,919
TOTAL QUESTIONED CHARGES	$214,733	$107,768	$117,826	$440,327

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

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(Revised 12/4/08)

November 14, 2008

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Reference: **OPM DRAFT AUDIT REPORT**
BlueCross BlueShield of Nebraska
Audit Report Number 1A-10-53-08-045
(Dated and received September 17, 2008)

Dear [redacted]

This is our response to the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report covering the Federal Employees' Health Benefits Program (FEHBP) operations for BlueCross BlueShield of Nebraska. Our comments concerning the findings in the report are as follows:

B. HEALTH BENEFIT CHARGES

1. Omnibus Budget Reconciliation Act of 1990 $435,720

Specifically, the Plan overpaid 42 claims by $464,000 and underpaid seven claims by $28,280 for a net of $435,720. The breakdown is as follows:

- **OBRA '90 Claim Pricing Errors**

There were $436,618 in overpayments and $8,582 in underpayments for a net total of $428,036. The Plan contests four claims totaling $3,248 but does not contest that a net $424,788 in claim payments may have been paid in error.

The Plan has returned $386,831 to the Program through November 11, 2008 and has initiated refund recovery on all remaining identified overpayments.

As a result of the audit, the Plan noted several discrepancies in the assigning of Medicare provider numbers in the local Plan database. The Plan immediately reviewed all local files containing Medicare provider numbers against a list retrieved from the local Medicare Part A contractor to ensure

that the database used to accurately price OBRA 90 claims was correct. In addition, the Plan has several methods in place to identify overpayments. These methods include, but are not limited to the System Wide Claims Reports, COB claims reports and Duplicate claims reports provided by the FEP Director's Office and routine claims quality assurance audits performed by the Plan's Internal Auditors. While these measures are not absolute, they provide reasonable assurances that such items will be identified. Efforts will be made to periodically examine existing procedures and add additional controls where necessary.

- **Claims Not Priced Under OBRA '90 (Possible OBRA '90)**

We do not contest an overpayment of $8,318 and an underpayment of $19,698 for a net underpayment of $11,380. We do contest one claim (Claim Sample #26), for $10,274 because this refund was recovered and adjusted prior to the audit. Additionally there were three claims totaling $8,790 (Claim Sample #27, 39 and 78) that when re-priced by the Operations Center OBRA '90 pricer software resulted in a different price than the price calculated by the CMS PC pricer. The Operations Center OBRA '90 pricer software is the official OPM approved source for FEP OBRA '90 pricing and must be used to determine payment. The claims were repriced with the most up-to-date version of the Operations Center OBRA '90 pricer software. Because the final updated version of the Operations Center OBRA '90 pricer was used to reprice the claims, FEP continues to believe that the pricing differences obtained by the Operations Center OBRA '90 Mainframe pricer software is the most accurate. Also, since 2005, the Operations Center updates the OBRA '90 pricing software on a quarterly basis. This has minimized pricing differences.

The Plan returned $6,809 to the Program through November 11, 2008 and has initiated refund recovery on the remaining identified overpayments.

As stated above, the Plan has several methods in place to identify overpayments. These methods include, but are not limited to the System Wide Claims Reports, COB claims reports and Duplicate claims reports provided by the FEP Director's Office and routine claims quality assurance audits performed by the Plan's Internal Auditors. While these measures are not absolute, they provide reasonable assurances that such items will be identified. Efforts will be made to periodically examine existing procedures and add additional controls where necessary. Accordingly, to the extent that errors did occur, the payments are good faith erroneous benefits 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. In addition, as good faith erroneous payments, lost investment income does not apply to the payments identified in this finding.

2. Claim Payment Errors **$26,919**

We do not contest this finding. The Plan reviewed the errors identified on the Assistant Surgeon claim list and realized that these errors could be identified as auditor errors. The Plan has retrained several claims auditors regarding when and how to pay Assistant Surgeon claims. This training is ongoing and as a follow up, additional quality is performed to ensure the training was successful.

For the Assistant Surgeon claim errors noted during the audit, the FEPDO implemented the following:

- The OBRA '93 vendor, Palmetto, corrected pricing of the Assistant Surgeon modifier during May 2008. This should result in more accurate pricing in the future.

- A final comprehensive list that identifies all unadjusted Assistant Surgeon claims will soon be issued so that claims can be adjusted as necessary.

As stated above, the Plan has several methods in place to identify overpayments. These methods include, but are not limited to the System Wide Claims Reports (which includes a listing of Assistant Surgeon Claims), COB claims reports and Duplicate claims reports provided by the FEP Director's Office and routine claims quality assurance audits performed by the Plan's Internal Auditors. While these measures are not absolute, they provide reasonable assurances that such items will be identified. Efforts will be made to periodically examine existing procedures and add additional controls where necessary. Accordingly, to the extent that errors did occur, the payments are good faith erroneous benefits 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. In addition, as good faith erroneous payments, lost investment income does not apply to the payments identified in this finding.

The Plan returned $23,069 to the Program through November 11, 2008 and has initiated refund recovery on the remaining identified overpayments.

We appreciate the opportunity to provide our response to each of the findings and request that our comments be included in their entirety as part of the Final Audit Report.

[redacted]