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

Final Audit Report

AUDIT OF THE OFFICE OF PERSONNEL MANAGEMENT'S DISPUTED CLAIMS PROCESS FOR YEARS 2018 THROUGH 2020

Report Number 2022-CAAG-001
December 20, 2023

EXECUTIVE SUMMARY

Audit of the Office of Personnel Management's
Disputed Claims Process for years 2018 through 2020

Report No. 2022-CAAG-001 **December 20, 2023**

Why Did We Conduct the Audit?

The primary objective of our audit was to determine if the U.S. Office of Personnel Management (OPM) had sufficient internal controls, including written policies and procedures, to review and make final determinations on appealed health care claims in calendar years 2018 through 2020, as specified in 5 Code of Federal Regulations (CFR) § 890.105, 48 CFR § 1652.204-72, and the Federal Employees Health Benefits Program (FEHBP) Benefit Brochures.

What Did We Audit?

The Office of the Inspector General completed a performance audit of OPM's disputed claims process. Our audit consisted of reviews of disputed health care claims; omitted and duplicate OPM assigned disputed claims case file numbers; and policies, procedures, and internal controls for the period January 1, 2018, through December 31, 2020. We conducted our fieldwork remotely from May 5, 2022, through December 1, 2022.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

We determined that due to insufficient internal controls, OPM lacked written policies and procedures, sufficient training, and a quality assurance process when administering its disputed claims process in calendar years 2018 through 2020. As a result of the insufficient controls, we identified the following issues:

- OPM lacked controls to sufficiently define disputed claims review timeliness, communicating a 90-day review period required by 5 CFR § 890.105, 48 CFR § 1652.204-72, and a 60-day review period in the FEHBP benefit brochures, Section 3 and Section 8, which resulted in multiple timeliness and administration issues.

- Other disputed claims process issues indicated reviews and decisions were made inconsistently, in some cases conflicting with guidance from the Centers for Disease Control and Prevention and the requirements in the Consumer Bill of Rights.

- OPM did not respond timely to a Freedom of Information Act/Privacy Act of 1974 (PA) request filed on a disputed claim.

- OPM's disputed claims system transition was not compliant with the PA.

- OPM improperly disclosed an FEHBP member's personal information.

- OPM is unable to support that the disputed claims records for the scope of the audit were managed in accordance with OPM's Records Management Program.

ABBREVIATIONS

APA	**Administrative Procedure Act**
CDC	**Centers for Disease Control and Prevention**
CFR	**Code of Federal Regulations**
Contracts	**OPM's Health Insurance Carrier Contracts**
CPT	**Current Procedural Terminology**
DCOM	**Disputed Claims Operations Manual**
DCP	**Disputed Claims Procedure**
E&I	**Experimental and Investigational**
FDC	**FEHB Disputed Claims System**
FEHB	**Federal Employees Health Benefits**
FEHB Act	**Federal Employees Health Benefits Act**
FEHBAR	**Federal Employee Health Benefits Acquisition Regulations**
FEHBP	**Federal Employees Health Benefits Program**
FEIO	**Federal Employee Insurance Operations**
FOIA	**Freedom of Information Act**
FTCA	**Federal Tort Claims Act**
GAGAS	**Generally Accepted Government Auditing Standards**
GAO	**U.S. Government Accountability Office**
Green Book	**GAO's Standards for Internal Controls in the Federal Government**
HCPCS	**Healthcare Common Procedure Coding System**
HI	**Healthcare and Insurance**
HITS	**Health Insurance Tracking System**
IMR	**Independent Medical Review**
INF	**Insufficient Information**
IRO	**Independent Review Organization**
LAS	**Legal Administrative Specialist**
NARA	**National Archives and Records Administration**
NFR	**Notice of Findings and Recommendations**
OD	**Office of the Director**
OGC	**U.S. Office of Personnel Management's Office of General Counsel**
OIG	**The Office of the Inspector General**
OMB	**Office of Management and Budget**
OPM	**U.S. Office of Personnel Management**
PA	**Privacy Act of 1974**
PII	**Personally Identifiable Information**
RMP	**OPM's Record Management Program**
SORN	**System of Records Notice**
U.S.C	**United States Code**
Y Code	**OPM's Disputed Claims System(s) Generated Case ID Control**

TABLE OF CONTENTS

EXECUTIVE SUMMARY i

ABBREVIATIONS ii

I. **BACKGROUND** 1

II. **OBJECTIVE, SCOPE, AND METHODOLOGY** 2

III. **AUDIT FINDINGS AND RECOMMENDATIONS** 7

OPM'S DISPUTED CLAIMS PROCESS REVIEW 7

1. Lack of Official Policies and Procedures, Sufficient Training, and a Quality Assurance Process 12

   a. Untimely Review of Disputed Claims 14

   b. Review and Decision Letter Inconsistencies 22

   c. Other Disputed Claims Process and Tracking Issues 26

2. Conflicting Timeliness Criteria 39

3. Untimely FOIA/Privacy Act Response 42

4. Privacy Act Noncompliance and Record Management Issues 44

   a. Privacy Act Noncompliance 45

   b. Records Management Program Issues 48

EXHIBIT A Disputed Claims Cases Sample Selection Methodology

EXHIBIT B Disputed Claims Cases Sample Selection Methodology – Additional Samples

EXHIBIT C OPM Omitted Disputed Claims Cases - Sample Selection Methodology

APPENDIX OPM's February 24, 2023, Response to the Draft Report

REPORT FRAUD, WASTE, AND MISMANAGEMENT

I. BACKGROUND

The U.S. Office of Personnel Management's (OPM) Healthcare and Insurance (HI) program office is responsible for the Government-wide administration of insurance and benefit programs for Federal employees, retirees, and their families. HI includes four major groups: Office of the Actuaries, Federal Employee Insurance Operations (FEIO), Program Development and Support, and Operations and Resource Management. One of HI's responsibilities is to coordinate and administer enrollment in the Federal Employees Health Benefits Program (FEHBP) by providing operational, analytical, and systems support; policy development and implementation; actuarial analysis; and stakeholder outreach and education. The FEHBP was established by the Federal Employees Health Benefits Act (FEHB Act), (Public Law 86-382), enacted on September 28, 1959, and was created to provide health insurance benefits for Federal employees, annuitants, and eligible family members. 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).

As part of administering the FEHBP, OPM HI FEIO[1] is responsible for the review of disputed health care claims appealed to OPM by FEHBP members through the process outlined in Section 3 and Section 8 of the FEHBP benefit brochures, which are considered part of the health insurance carrier (carriers) contracts (Contracts). The FEHBP enrollee claims appeal process, commonly referred to as the disputed claims process, was added to the Contracts under the Federal Employee Health Benefits Acquisition Regulation (FEHBAR) Part 1604, and the disputed claims program is governed by 5 CFR § 890.105 and 48 CFR § 1652.204-72.

This was the first audit of OPM's disputed claims process. The preliminary results of this audit were discussed with OPM officials during the Notice of Findings and Recommendations (NFR) process and at an exit conference on December 1, 2022. We issued a draft report dated December 21, 2022, to solicit OPM's comments on the findings and recommendations. OPM'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 OPM on various dates through June 16, 2023, was also considered in preparing our final report.

[1] From this point forward, we reference OPM HI FEIO as only "OPM" when addressing issues related to the disputed claims process, unless otherwise noted.

II. OBJECTIVE, SCOPE, AND METHODOLOGY

OBJECTIVE

Our primary objective was to determine if OPM had sufficient internal controls, including written policies and procedures, in place in calendar years 2018 through 2020 to review and make final determinations on appealed claims as specified in Section 3 and Section 8 of the FEHBP benefit brochures and in accordance with 5 CFR § 890.105 and 48 CFR § 1652.204-72.

SCOPE

We conducted this performance audit in accordance with generally accepted government auditing standards (GAGAS). Those standards require that we plan and perform the audit to obtain sufficient, 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 covered calendar years 2018 through 2020. During these calendar years, OPM reported that it received 5,902 FEHBP enrollee appealed claims for the benefit years 2018 through 2020. From OPM's reported appealed (i.e., disputed) claims, we selected a sample for review (See Exhibits A and B) to test whether OPM complied with its disputed claims process and claim appeals obligations outlined in the carrier Contracts and the laws and regulations governing the FEHBP as they relate to disputed claims criteria.

Also, a selection of carriers provided additional data on FEHBP enrollee claims appealed to OPM where OPM assigned a case number (Y code) in calendar years 2018 through 2020. We reconciled the carrier data to OPM's data and documented the disputed claims cases reported by carriers that were not reported to us by OPM. We selected a separate sample of the disputed claims cases reported by carriers but not reported by OPM for review (See Exhibit C). Our testing of OPM's disputed claims processes included, but was not limited to, a review of these disputed claims sample selections and OPM's disputed claims policies and procedures.

The Office of the Inspector General's (OIG) audits of OPM programs are designed to test compliance with applicable laws, program regulations, and related criteria. These audits are also designed to provide reasonable assurance that OPM has sufficient controls, including policies and procedures, to administer the FEHBP and related programs and processes, including the disputed claims process.

In planning and conducting our audit, we obtained an understanding of OPM's internal control structure to help determine the nature, timing, and extent of our auditing procedures. Based on our testing, we identified issues involving OPM's internal controls and operations pertaining to the disputed claims process. However, since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on OPM's system of internal controls taken as a whole.

In conducting the audit, we relied to varying degrees on computer-generated disputed claims data provided by OPM. We did not verify the reliability of the data generated by the various information systems involved. However, OPM had to resubmit the data for our review multiple times due to querying errors and omitted data, which caused us to doubt its reliability. During the course of this audit, there were also several instances where OPM's responses conflicted with their own previous responses. These inconsistent statements called into question the authenticity of the narratives provided to the OIG. In light of this, we want to emphasize that all OPM employees are required to cooperate with the OIG under the Inspector General Act of 1978, and as outlined in the OPM Director's memorandum titled *Cooperation with and Reporting to the OIG* that was issued to all OPM employees on March 11, 2022.[2] We verified OPM-provided data and narrative responses with other documentary support provided by OPM, including correspondence from FEHBP members, physicians, independent medical reviewers, and the carriers. We believe that the available data was sufficient to achieve our audit objectives. Except as noted above, the audit was conducted in accordance with GAGAS, issued by the Comptroller General of the United States.

We remotely conducted our audit fieldwork from May 5, 2022, through December 1, 2022.

METHODOLOGY

We examined OPM's disputed claims support and related documentation on various disputed claims samples as a basis for validating that OPM fulfilled its obligations outlined in the FEHBP benefit brochures, 5 CFR § 890.105, and 48 CFR § 1652.204-72. Specifically, we reviewed carrier disputed claims data, OPM disputed claims data, FEHBP member appeals including disputed medical and pharmacy services, FEHBP benefit brochures, timing of notices and decisions, and any other applicable support needed to verify OPM's final decision on a disputed claim. A review of these samples enabled us to assess OPM's controls surrounding the disputed claims process, including applicable policies and procedures, and determine whether the program is administered in accordance with applicable regulations and criteria.

To gain an understanding of the internal controls over OPM's disputed claims processes as well as its disputed claims systems in effect during the audit scope, we requested OPM's disputed claims policies and procedures and reviewed applicable documents and responses that it supplied. We also interviewed appropriate OPM officials regarding the controls in place to determine whether the FEHBP member disputed claims were reviewed consistently and per the terms of 5 CFR § 890.105. Other auditing procedures were performed as necessary to meet our audit objectives. As stated above, our specific methodology in selecting our disputed claims samples is detailed in Exhibits A-C.

[2] OIG.MD.22.1

OPM's Comments on the Audit Scope:

In addition to OPM's responses to the audit findings and recommendations included in Section III of this report, OPM commented on the OIG's scope in their response to the draft report, as follows:

"There were several complexities in gathering the data the OIG requested during the audit. …

During the scope years of the audit, OPM transitioned from its Health Insurance Tracking System (HITS) to a new disputed claims system, the FEHB [Federal Employees Health Benefits] Disputed Claims System (FDC). The transition to the new system complicated OPM's response requiring data to be gathered from two different sources after HITS was decommissioned. The FDC system began development in the fall of 2018 with a minimal viable product (MVP) as is the standard in technology development. Improvements to the system were ongoing over the next two years and continue to this day, in the interest of enhanced processes and continuous quality improvement."

"There were technical issues with the system ad hoc reporting tool in FDC that were not revealed until we pulled and sent data to the OIG. Once we realized the issue, we notified the OIG and worked with our developers to ensure the requested data was correctly pulled and resubmitted to the OIG. In addition, OPM provided relevant reportable data fields to the OIG; however, there are some fields that OPM could not provide as the fields cannot be reported (e.g., case notes and dates on the auto-generated letters). These non-reportable fields cannot be queried but can be viewed in the FDC system. The OIG's analysis of only our reportable data fields was not a complete picture of the case, because elements within the system such as case notes and the audit trail holds [sic] critical information to understanding the entire case. Without this information, it resulted in numerous apparent instances of untimeliness and skewed audit findings. Since OPM could not provide the OIG with data from those non-reportable fields, we provided narrative responses to the notice of findings and recommendations (NFR) which detailed each case. The OIG has requested additional documentation/evidence to support OPM's narrative. The documentation is in the FDC system. OPM has extended several invitations to OIG to view the entire case files either in person or via a virtual FDC system walkthrough and that invitation remains open....

The [OIG] cited 70 claims cases [it] received from the carriers that OPM did not report. These cases were not missing from the OPM data file. OPM and the carriers used two different data queries. OPM queried on benefit years 2018-2020, while the carriers used date [sic] received between 2018-2020. OPM was not intentionally withholding data. OIG did not request a different data submission after they were aware the data was pulled based on benefit year. Had OPM used the same query as the carriers, then those 70 claims

would have been included in the data we provided. Also, of those 70 claims, two had incorrect Y numbers. This may have resulted from the carrier incorrectly entering/providing the Y numbers. OPM identified the correct Y numbers via a search of the member's name. These two correct Y numbers already existed in the data we had previously provided to the OIG. The evidence for this and an updated FDC data set using date received query is attached … ."

"OPM wants to clarify that the FDC system generates unique codes. More importantly, the HITS system was decommissioned [in] February 2019, mitigating the risk for any additional entry of Y codes outside of the FDC system. All that remains of HITS is one large data file not accessible to the FEHB staff. We rely on the Systems Development and Implementation team in HI's Program Development and Support (PDS) to provide data from HITS. Additionally, all duplicate Y code cases were processed and closed prior to 2022. Therefore, there is virtually no risk that data will be inappropriately communicated, incorrectly used, or insufficiently stored."

OIG Comments:

OPM's response mischaracterizes the data extracts provided during the course of the audit, which in total were submitted four separate times for FDC data and twice for HITS data. The earliest request for FDC and HITS data was submitted with the notification letter in September 2021, and included a request for all data, including "any other pertinent information that would be of benefit for our knowledge." However, as OPM noted above, it limited the data provided to what it deemed "relevant." Although the FDC data dictionary indicates there are 103 reportable fields, the largest of the four FDC data extracts contained only 21 reportable fields, which was provided in response to the draft report. Additionally, the FDC data dictionary shows that the FDC "Case Notes" are a reportable field, but it was not included in any of the four FDC data submissions. OPM's data dictionary also indicates that the "Case Note" field is not required to be populated in FDC.

We do not agree with OPM that FDC houses the source documentation to substantiate its narratives. OPM provided us with a sample of screen shots that included the FDC case list, case audit trail, and case files exclusively documented in FDC. We also met with OPM on December 8, 2022, and March 20, 2023, to discuss case data documented in FDC and OPM's interpretation of its process and related responses. What we found was the case list and audit trail do not necessarily document the dates OPM received correspondence from members, carriers, Independent Medical Reviews (IMR), etc., but instead the date applicable personnel log the data in FDC. Additionally, the case notes are representative of narratives generated by personnel working in FDC, but do not include source documentation to substantiate the narratives. OPM lacks controls over this process, and as such, case note quantity and quality is not standardized or monitored. Specifically, there is no requirement to populate the case notes, and when they are created, there is no policy to ensure the narratives are completed consistently and sufficiently supported.

We reviewed the documentation OPM provided to us throughout the audit process. During fieldwork, OPM provided the case files for all 81 FDC claims samples. Additionally, we reviewed the draft response documentation provided by OPM. The final FDC data extract was reviewed and used to update report findings as applicable. In many cases, the data substantiated prior OPM and carrier provided data, and ultimately the findings, that were previously communicated to OPM.

III. AUDIT FINDINGS AND RECOMMENDATIONS

OPM'S DISPUTED CLAIMS PROCESS REVIEW

Federal employees, retirees, and their eligible family members that elect to participate in the FEHBP are granted the opportunity to dispute claims not covered by their elected carrier as described in Section 3 and Section 8 of the FEHBP benefit brochures and codified in 5 CFR § 890.105. If the Carrier affirms its denial of the FEHBP member's claimed benefits or fails to respond to a request for reconsideration, the FEHBP member has the opportunity to appeal to OPM for review.

OPM's authority to review and make decisions on disputed claims is specified in 5 CFR § 890.105 and 48 CFR § 1652.204-72. However, we found that due to insufficient controls, OPM lacked policies and procedures, sufficient training, and a quality assurance process to define and administer its disputed claims process in the context of their own regulations and the FEHBP benefit brochures in calendar years 2018 through 2020.

We reached this conclusion by selecting and reviewing a sample of disputed claims reported by OPM. We also collected additional disputed claims data from a selection of FEHBP carriers and selected a second disputed claims sample to test OPM's reported disputed claims data and tracking (See Exhibits A through C). Since OPM lacked controls to define its disputed claims review processes, including its definition of timeliness, status update, and final decision, we referenced 5 CFR § 890.105(e)(4) in establishing the 90 consecutive day benchmark, and found that OPM's disputed claims review was frequently untimely. Further, without sufficient support, OPM elected to open, close, and review disputed claims outside the processes defined in 5 CFR § 890.105 and the FEHBP benefit brochures. Other reviews of disputed claims cases and final decisions were made inconsistently, in some cases conflicting with guidance from the Centers for Disease Control and Prevention (CDC) and requirements in the Consumer Bill of Rights.[3]

Additionally, the 60-day review period, outlined in Section 8 of the FEHBP brochures, does not align with the 90-day review period allotted in 5 CFR § 890.105, and the process of tracking and storing disputed claims case data, both in paper form and in OPM's FDC system, varied, which was not compliant with the Privacy Act of 1974 (PA) and OPM's Record Management Program (RMP). These issues are indicative of insufficient internal controls.

OPM Response:

"The authority that guides the FEHB disputed claims process is found in 5 Code of Federal Regulations (CFR) 890.105 and .107-, 48 CFR 1652.204-72, Federal Employees Health Benefits Acquisition Regulations (FEHBAR) Part 1604, and the FEHBP Carrier contracts. OPM makes final decisions with respect to disputed claims on a case-by-case basis. Even if

[3] The Advisory Commission on Consumer Protection and Quality in the Health Care Industry was appointed by President Clinton on March 26, 1997, to "advise the President on changes occurring in the health care system and recommend measures as may be necessary to promote and assure health care quality and value and protect consumers and workers in the health care system." As part of its work, the President asked the Commission to draft a Consumer Bill of Rights, which provides rights and responsibilities to each health care system consumer.

cases may appear to be similar; each medical case is unique based on unique individual circumstances, and OPM retains administrative discretion in how it adjudicates claims. Final decisions are based on the plan brochure which is the complete contractual statement of benefits available to the member, and the unique member medical circumstances including clinical history. We exercise appropriate judgement and act equitably in the best interests of the members and the FEHB Program and may exercise discretion in our enforcement of filing deadlines where equity demands."

Regarding the reported untimeliness, OPM states, "OIG's counting methodology for timeliness is constrained to consecutive day count. It is OPM's longstanding practice to uphold the health plan's denial when the member cannot or does not provide adequate information and to allow the member the opportunity to provide additional information. If OPM receives additional information, the case is re-opened and the clock begins anew. This break in counting allows time for the member to gather medical records and other information needed for their case. This works in favor of and in no way harms the member. In addition, the regulation does not restrict the review period to 90 consecutive days. OPM has authority to interpret and implement its rule on how the 90 days is counted and has appropriately excluded days when the member has been given time to gather additional information from the OPM processing time."

OIG Comment:

We found OPM's statements that it "exercise[s] appropriate judgement and act[s] equitably in the best interests of the member, and the FEHB Program" and that its longstanding disputed claims process practice "works in favor of and in no way harms the member" to be inaccurate. We determined that OPM could not administer its disputed claims process consistently since there are insufficient internal controls, as defined by the United States Government Accountability Office's (GAO) Standards for Internal Controls in the Federal Government (Green Book). Specifically, the Green Book states, "Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved … ." Under the FEHBP complaint resolution process, enrollees may bring disputes concerning benefits or services to OPM for review after asking the plan to reconsider its initial denial and failing to receive a satisfactory reply. OPM seeks to determine whether the enrollee or eligible family member is entitled to the services or supplies under the terms of the contract, but lacks the documented policies, procedures, and oversight to consistently do so.

Although we identified throughout this report varying issues with OPM's disputed claims process based on our audited review, there were also two OIG Hotline cases during the audit scope that illustrate how the disputed claims process, administered without sufficient controls, can harm members.

OIG Hotline – Case 1

On July 14, 2018, an FEHBP member received a denial from their carrier for skilled nursing facility services the carrier deemed not medically necessary. The FEHBP member met the 90-day requirement and appealed to OPM for review on October 9, 2018. Documentation shows that OPM received the appeal on October 10, 2018, and sent an acknowledgement letter to the FEHBP member on October 12, 2018, containing an assigned disputed claims case number (Y code).

The next communication came from OPM on December 17, 2018, in which OPM stated it could not review the claim because the member appealed outside the 90-day time limitation. The letter did not include the assigned case number from the October 12, 2018, letter. It should also be noted that a different Customer Service Representative sent the December letter, and the date was stamped "Dec 17, 2018."

The member sent another letter to OPM on January 14, 2019, outlining the appeal and timeliness of the initial appeal. The member also requested that OPM provide the details it relied on to make its decision. Without addressing the member's requests, OPM sent another letter dated January 25, 2019, assigning a new Y code to the case. This letter did not provide the amount of time allotted for OPM's review and did not mention the original Y code assigned by OPM. Since OPM neglected to address the member's requests and concerns, the member sent another letter to OPM dated February 4, 2019.

Then, on February 13, 2019, an OPM Supervisory Legal Administrative Specialist (LAS) sent another letter stating that OPM was discontinuing its review because the member's appeal was a "late filing," noting that OPM did not receive the appeal until December 17, 2018, even though the letter noted OPM signed for the letter on October 10, 2018. Additionally, OPM stated that the appeal was not warranted because the issue that the FEHBP member had with the carrier did not have a related claim (because services were denied by the carrier due to medical necessity and therefore never provided). Per our documentation, the member sent another letter to OPM on March 26, 2019, and filed a complaint with the OIG on May 14, 2019.

In the OIG's correspondence with OPM regarding the Hotline complaint, OPM stated that it "cannot give [the OIG] a definite reason" why the original appeal was not received and recorded timely nor why there were inconsistencies in the reporting of timeliness to the member. OPM also stated that it did not perform an independent review of the appeal since under the carrier's hold harmless agreement with its providers, the provider agreed to accept the plan's medical policy ruling. It is unclear why the hold harmless agreement restricted OPM from completing its review obligations when the issue pertained to a

medical necessity determination disputed between the carrier and the member.

OPM also notified the OIG that after several calls from the member, OPM contacted the carrier and requested additional information about the claim to which the carrier responded that it processed the claim incorrectly. At that point, OPM stated that it opened another case file (the third assigned Y code) to perform an independent review, including a review from OPM's contracted Independent Review Organization (IRO), and issued a final decision to the member. Per the FDC data extracts supplied during the audit, we confirmed a final decision was recorded in FDC on July 12, 2019.

OPM did not fulfill its obligations as specified in the Consumer Bill of Rights. Specifically, the Consumer Bill of Rights provides the following: "External appeals systems should … Apply to any decision by a health plan to deny, reduce, or terminate coverage or deny payment for services based on a determination that the treatment is either experimental or investigational in nature; apply when such a decision is based on a determination that such services are not medically necessary and the amount exceeds a significant threshold or the patient's life or health is jeopardized."

The carrier based its decision on medical necessity and the member appealed timely. OPM was therefore required under 5 CFR § 890.105 to review the member's appeal when it was initially received by OPM on October 10, 2018, rather than when the carrier reported incorrect processing of the claim six months later. OPM notes throughout this report that it affords members the opportunity to supply additional information for review. OPM did not in this instance and initially denied the member a review even though the member supplied additional information substantiating the appeal date and met the regulation and FEHBP benefit brochure qualifications for review. Also, due to a lack of controls, this case had three separate Y codes assigned to it, one of which was not identified in any of the five HITS and FDC data extracts provided during the audit.

OIG Hotline – Case 2

On November 5, 2020, an FEHBP member followed the requirements and appealed to OPM for review of denied residential treatment facility benefits within the 90 days allotted them per 5 CFR § 890.105. On November 13, 2020, OPM provided an acknowledgement letter stating it would conduct its review within the "allotted 60 days" but did not specify its undocumented practice of pausing its count of accrued review days. As such, after 60 consecutive days passed with no contact from OPM, the member called and e-mailed OPM in January 2021, but did not receive a response regarding the review of their appealed claim until February 16, 2021. In that communication from OPM, the member received another FEHBP member's personal information, but no

communication regarding review of their own appealed claim. That same day, the member spoke with both the OPM case manager and supervisory LAS. The LAS inaccurately stated that OPM could not review the appealed claim because a carrier denial was not present. During further communications, the supervisory LAS found the carrier denial and sent the appealed claim to OPM's contracted IRO. The IMR from the IRO was dated March 18, 2021.

Once OPM received the contracted IMR's opinion, it is unclear what internal review was completed to arrive at the final decision communicated to the member. Specifically, OPM's final decision letter dated April 6, 2021, stated, "Medical Consultant reviewed the medical documentation received in support of the appeal. The review process examines the Plan's actions to assure that the Plan administered benefits according to the contract guidelines. The Plan's brochure represents the bilateral negotiations between the Plan and the Office of Personnel Management and is the official statement of benefits under the Federal Employees Health Benefits Program. The Plan is required to administer benefits according to the definitions, limitations and exclusions set forth in the brochure. As indicated in the 2020 Service Benefit Plan brochure under Medical Necessity, it advises, we determine whether services provided by a hospital or other covered providers is appropriate to prevent, diagnose, or treat your condition, illness, or injury. The fact that one of our covered providers has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary or covered under this Plan. The review determined that the dates in question could have been addressed at a lower level of care."

OPM's final decision letter provides no reference to the recommendation of the IMR or the fact that the IMR stated that the patient required in-person treatment, which appears to support that the appealed benefits should in fact be covered. Instead, OPM's final decision letter communicates its reliance on OPM's Medical Consultant, an internal OPM position, and OPM's interpretation of the benefit plan brochure in making its final determination.

After receiving OPM's denial of benefits, the member submitted a Freedom of Information Act (FOIA)/PA request on May 11, 2021, for all records pertaining to the denial of benefits. OPM acknowledged receipt of the FOIA/PA request on May 15, 2021. Under the FOIA, an agency is generally required to respond to a requester within 20 business days and, when denying a request in part or in full, to provide the reasons for denial. The member who made the request for records did not receive a response from OPM until September 10, 2021. The response consisted of 6 pages, withheld in part pursuant to FOIA Exemption 6. The response letter indicates that the request was only processed pursuant to the FOIA and not the Privacy Act. Moreover, OPM's letter did not

provide an estimate of the amount of information withheld.

The member appealed OPM's FOIA response on December 3, 2021. On August 23, 2022, OPM's Office of General Counsel (OGC) issued a decision remanding the FOIA/PA request for further processing and directed OPM's HI Office to send a complete file of the disputed claims case in question. On February 9, 2023, the member filed a new OIG Hotline complaint when they did not receive any responses from OPM after receiving the August 2022 appeal decision letter from OGC and requesting an update twice. The OIG forwarded this new complaint to OPM's OGC and OPM HI for review.

On October 23, 2023, OPM's HI office processed the remanded request under both FOIA and the PA and produced 2, 617 pages of responsive records, withheld in part pursuant to FOIA Exemption 6. Although not transmitted until October 23, 2023, OPM's response letter itself was dated September 27, 2023. The response letter did not provide an estimate of the amount of information withheld but did indicate that the requester had "90 days of the date of the response to your request" to file an appeal, even though the date of the letter was almost a month prior to the date the response letter and records were sent to the member, effectively shortening the member's appeal window.

These cases, in conjunction with the process issues outlined later in this report, provide ample evidence to conclude that OPM lacks sufficient controls over the disputed claims process to provide FEHBP members with a "fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them …" and to "[follow] a standard of review that promotes evidence-based decision-making and relies on objective evidence," as stipulated in the Consumer Bill of Rights. As such, without sufficient internal controls, OPM's disputed claims review cannot fulfill its function equitably and in the best interests of the FEHBP members.

1. Lack of Official Policies and Procedures, Sufficient Training, and a Quality Assurance Process

During our review of OPM's disputed claims process for calendar years 2018 through 2020, we found that OPM lacked written policies and procedures, sufficient training, and a quality assurance process to consistently administer its review processes. Specifically, OPM lacked written policies and procedures to define its disputed claims review timeliness, communicating a 90-day review period in 5 CFR § 890.105 and 48 CFR § 1652.204-72, while communicating a 60-day review period in the FEHBP benefit brochures. Additionally, we identified that OPM administered its disputed claims review and decision letter process inconsistently, and other disputed claims processes and decisions at times conflicted with CDC limitations and the Consumer Bill of Rights.

When we requested that OPM provide its policies and procedures governing the disputed claims process, we were provided a narrative that stated, "written policy and procedures start with the law (Chapter 89 of title 5 U.S.C), written regulations (5 CFR § 890.105 and 5 CFR § 890.107, FEHBAR regulations - 48 CFR § 1604.7101) and FEHBP Brochures. Standard information based on the law and these regulations are found in each brochure in Section 3 and Section 8 outlining the disputed claims procedures." Additionally, we were provided two documents, a Disputed Claims Procedure (DCP) document and the Disputed Claims Operations Manual (DCOM). OPM explained that the DCP describes the disputed claims process provided to the LAS during training. Also, OPM stated, "[t]he disputed claims manual is intended to provide operational guidance and has been used as a resource regarding the disputed claims process … ."

However, our audit showed that OPM's narrative, the DCP, and the DCOM neither provide sufficient operational guidance for the administration of the disputed claims process, nor document the laws, regulations, and related criteria in a way that addresses why and how OPM administers this process as part of the FEHBP. The DCOM itself is outdated and unofficial, having been last updated in June 2013 without having been vetted by OPM senior officials. Moreover, it does not address the new FDC system implemented in 2019 for all FEHB groups, which is particularly concerning since both internal (OPM) and external (carrier and contractor) users have access to the FDC system.

Additionally, the documents speak to procedures performed by particular job titles that have been changed and/or renamed. It is unclear if these position titles are interchangeable, but neither of the documents describe in sufficient detail responsibilities by job title throughout the disputed claims process, from receipt of the disputed claim through issuance of a final decision.

Furthermore, during the scope of the audit there was insufficient evidence to support that personnel charged with disputed claims review duties received sufficient training. OPM stated that it "has … relied upon one-on-one on-the-job training with an experienced supervisor or Chief," and that "[t]he Chiefs were allowed to utilize the 2013 version [of the DCOM] for training purposes." However, OPM did not provide any evidence of an established training program beyond its approval of the Chiefs utilizing the DCOM as training material, even though OPM itself stated the DCOM "does not reflect established HI policy against which actions should be audited or measured." The training documents supplied during fieldwork and in response to the draft report were last dated for use after the audit scope period in 2021.

We also found that OPM's disputed claims quality assurance process was not in place during the scope of the audit. Per OPM, "[i]n Fall 2020, the Deputy Associate Director of Healthcare and Insurance, issued direction to the FEHB Chiefs to implement processes for Health Insurance Specialists [HIS] to review a random sampling of the work of Legal Administrative Specialists for quality assurance purposes." When we notified OPM that

this process could not be substantiated for the scope of the audit, OPM commented that "[t]hey [the three FEHB Groups] have not recovered the staffing losses and have not resumed the work of having HIS review LAS work. In addition, except for FEHB 1, the FEHB divisions [FEHB Groups] did not have Supervisory LAS until this year [2022]."

Without official policies and procedures, sufficient training, and a quality assurance process, a standardized review process and measurement of timeliness could not be determined. Therefore, we utilized the 90-days provided in 5 CFR 890.105(e)(4) as the benchmark to measure OPM's timeliness in our review of OPM's disputed claims cases. 5 CFR 890.105 provides that within 90 days OPM must provide a final decision or a status update to FEHBP members, which takes precedence over the 60 days communicated in the FEHBP benefit brochures (see Report Section 2.). However, OPM lacks sufficient controls to define what constitutes a status update or a final decision and how those are communicated to FEHBP members. As such, we utilized a consecutive 90-day count from the date the FEHBP member appealed their disputed claim to OPM for review to measure timeliness. If OPM did not communicate its final decision to the FEHBP member within 90 consecutive days, we noted the disputed claims case as untimely reviewed by OPM.

Specifically, we reviewed a sample of 81 disputed claims where the disputed service was received by the FEHBP member during benefit years 2018 through 2020, which were judgmentally selected from OPM's FDC system and HITS (see Exhibits A and B). Additionally, we reviewed 70 disputed claims cases reported by a selection of carriers where OPM assigned a unique case identifier (Y code) in calendar years 2019 through 2020 but were not reported to us by OPM in the first three data extracts (see Exhibit C). Based on our disputed claims sample reviews, we identified the following:

a. Untimely Review of Disputed Claims

We determined that OPM continued to review 21 of the 81 disputed claim cases we sampled beyond the 90-day limit, from 99 to 467 days, before OPM notified the carrier and FEHBP member of its final decision. Of these 21 disputed claims cases, we determined 8 were untimely due to a change in authority enacted by OPM's Office of the Director (OD), which required that all OPM HI work products, including disputed claims, be reviewed by the OD. Since OPM HI lacked the authority to approve final decisions on disputed claims, they could not meet the timeliness requirements from August 2020 through December 2020.[4]

Also, for 11 of the 81 disputed claims sampled, we found that OPM elected to review the claim even though the FEHBP member filed an untimely appeal, meaning after the 90-day appeal window established in 5 CFR § 890.105 passed. Per 5 CFR § 890.105, OPM may elect to review a disputed claim case if the covered individual is "prevented

[4] HI's authority to approve final decisions was restored in February 2021. We noted December 2020 here due to audit scope limitations.

by circumstances beyond his or her control" from timely appealing their claim to OPM; however, OPM lacks policies and procedures to categorize situations that fit this criterion. As such, the claims lacked sufficient evidence to support why OPM reviewed the disputed claim after the appeal window expired.

We also identified 70 additional disputed claims cases that were reported by a selection of carriers but were not listed in the FDC and HITS data supplied to us by OPM. We issued these 70 omitted disputed claims cases to OPM for review. OPM's response indicated that the majority of the disputed claims cases were not included in the FDC and HITS data pulls because they were for benefit years 2016 and 2017, which OPM assumed were outside our scope. However, our audit scope covered disputed claims reviewed by OPM in calendar years 2018 through 2020 and was not limited by benefit year. Consequently, we evaluated the timeliness of the 70 disputed claim cases and found the issues outlined in Table I below.

Table I: Untimeliness Issues from OPM Omitted Disputed Claim Cases Review

Carrier Reviewed and Denied Claim Untimely	Member Appealed to OPM Timely	OPM reviewed the disputed claim within 90-days	16
		OPM's disputed claim review exceeded 90-days	4
	Member Appealed to OPM Untimely	OPM reviewed the disputed claim within 90-days	14
		OPM's disputed claim review exceeded 90-days	2
Carrier Reviewed and Denied Claim Timely	Member Appealed to OPM Untimely	OPM reviewed the disputed claim within 90-days	13
		OPM's disputed claim review exceeded 90-days	5
		TOTAL Untimeliness Issues:	**54**

In 4 of the 54 untimely claims cases listed in Table I, the disputed claim was so untimely that the FEHBP member's window to pursue legal action against OPM, which per 5 CFR § 890.107 is 3 years from December 31st of the year in which the disputed services were provided, had expired before OPM issued its final decision. In an additional six instances, the disputed claim was so untimely that the FEHBP member had less than one year to pursue legal action against OPM for its review and final decision on the disputed claim. The OIG finds it very troubling that substantial due process rights are being impaired by OPM's failure to hold carriers accountable to the established FEHBP disputed claims process time limitations and process disputed claims in a timely manner itself; violating FEHBP members' rights to a "fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them" as specified in the Consumer Bill of Rights.

Moreover, the untimely review of disputed claims can pose legal ramifications, and delayed review and final decisions can negatively impact the health and financial well-being of FEHBP members.

It is unclear why OPM did not hold the carriers responsible for reviewing disputed claims per the terms of the Contract and why OPM itself reviewed these claims when appealed to them outside the timeliness parameters of the disputed claims process criteria. However, insufficient internal controls, including a lack of written policies and procedures surrounding the disputed claims process appears to be the root cause.

Recommendation 1

We recommend that OPM immediately implement internal controls, including written policies and procedures, over the disputed claims process to fully define what constitutes a timely review in the context of 5 CFR § 890.105, including but not limited to:

- policies/procedures to govern the 90-day window allotted for OPM to review disputed claims;
- policies/procedures to govern how OPM will address disputed claims appealed to them when the carrier reviewed the disputed claim outside the allotted timeframe and/or the FEHBP member's window to appeal expired (either at the carrier level [FEHBP Benefit Brochures, Section 3 and Section 8, Step 1 and 2] or OPM's level [FEHBP Benefit Brochures, Section 8, Step 3 and 4]; and
- roles and responsibilities by position title of OPM personnel tasked with duties during the disputed claims process.

Recommendation 2

We recommend that 5 CFR § 890.107 be revised to align the start of FEHBP members' due process rights on the date of OPM's decision on the appeal and not the date on which the health service was provided.

OPM Response:

OPM partially concurs with the finding and recommendations and provided its position by each recommendation component. OPM begins by stating, "[It] agrees with the intent of this recommendation, that OPM have stronger internal controls and written policies and procedures. OPM has written policies and procedures in place that govern the disputed claims appeal process by Federal regulation. These written policies and procedures are contained within discrete documents that include 5 CFR 890.105 and 5 CFR 890.107, 48 CFR 1652.204-72, FEHBAR Part

1604, the FEHB Program Carrier contracts, and position descriptions of OPM personnel. OPM will combine the information from these discrete written policies and procedures into a summarized Disputed Claims Process document."

Regarding Recommendation 1, first bullet, "OPM non concurs that OPM repeatedly missed the 90-day review requirement. As previously indicated, OPM exercises its judgment and acts equitably in the best interests of the members and the FEHB Program. In instances where additional information is needed from the member, it is OPM's longstanding practice to uphold the health plan's denial when the member cannot provide adequate information and to allow the member the opportunity to provide additional information. If OPM receives the additional information, the case is re-opened and the clock begins anew. It can take time for members to gather medical records. This break in counting allows time for the member to provide the information needed and does not harm the member. It also works in favor of the FEHB Program to prevent litigation since the last opportunity a member has in the disputed claims process is a lawsuit against OPM.

In addition, the regulation does not restrict the review period to 90 consecutive days. OPM has authority to interpret and implement its rule on how the 90 days is counted. Furthermore, OPM considers the extenuating circumstances of the members when opening, closing and reviewing cases. These practices are in the best interest of our members to ensure they receive the benefits the carriers are contractually obligated to provide, which ensures appropriate contract oversight and enforcement and avoids legal risk. In addition, often extenuating circumstances are included in system case notes that were not reviewed by OIG."

OPM does not concur with the second bullet in Recommendation 1. Specifically, it stated, "[a]s indicated previously, OPM and Carriers have discretion to review claims outside of the time limit. OPM holds carriers accountable for reconsideration and disputed claims in the Contract Oversight domain of FEHB Plan Performance Assessment that ties profit to performance.

OPM operates in the best interests of the enrollee and the FEHB Program. A carrier may have reason to review a dispute outside the regulatory timeframe. When a Carrier provides a reconsideration decision to an FEHB member, and the member seeks a final administrative decision, OPM reviews the appeal. OPM is the party that the enrollee may sue. A Judge may remand the case back to OPM to review a disputed claim. When this occurs, these claims are reviewed outside of the 90-day timeline. It is in the enrollee and OPM's best interest to provide a final administrative decision on whether a service is covered under the contract rather than refuse coverage due to a technicality which may not be defensible in court.

In the cases that OIG discussed under OPM's response to Bullet #1, both the carrier and OPM exercised discretion and judgement afforded by the regulations to proceed with review. We do not see anything that would indicate that either decision to proceed was arbitrary or capricious."

OPM partially concurs with the third bullet in Recommendation 1 and stated, "[t]he roles and responsibilities of each position are contained within the position descriptions. OPM agrees to strengthen our written policy and procedures and to add a link to the position descriptions in the summarized Disputed Claims Process document. However, OPM disagrees with the statement that we are not implementing internal controls regarding the roles and responsibilities of each position. The written policies and procedures already exist."

Regarding Recommendation 2, OPM states, "[it] does not agree to OIG's recommendation to revise this regulation that has been in place since 1996. This timeframe reflects our contractual statement of benefits language over many years. It is our experience that this timeframe works well and there have been no concerns from members regarding this regulation. OPM disagrees with the recommendation to change the regulation to tie the 'right to sue OPM' to the year in which the service was performed. Review time frames flow from the date of service and 3 years is ample time to file suit.

In addition, the OIG states that OPM reviewed 21 of 81 disputed claims cases outside of the 90-day limit. As previously noted, OPM has discretion to review cases outside the 90-day limit. OPM analyzed the 21 cases the OIG audited and found the following:

• OPM OIG is correct in that 9[5] of the 21 cases were reviewed beyond the 90-day limit. Between August 2020 and January 2021, OPM's authority required additional administrative review. This resulted in a backlog of cases that continued through May 2021.

• Of the remaining 12 cases – ten cases were closed for lack of information and reopened upon timely receipt of additional evidence with actual days of review period less than 90 days.

• The remaining 3 cases were also appropriately reviewed as allowed under 5 CFR 890.105(e)(1)(iii).

OIG created a counting methodology for timeliness that was constrained to a consecutive day count. It is not factoring the stoppage time when a case is closed

[5] The OIG reported 8 of the 21 cases were reviewed beyond the 90-day limit in both the draft and final reports.

while the member may gather additional information. For example, from the sample of 21 cases, OPM received a claim on 2/14/2019. It was closed on 4/16/2019, due to lack of information. The case was reopened 7/9/2019, when additional information was provided and then the case was closed on 7/18/2019. The OIG's consecutive days counting methodology considers the review of this case to be 154 days, while it is 56 days in OPM's business process. The OIG may want to consider the 84 days the case was closed. OPM is providing an audit trail report for the 21 disputed claims as supporting documentation. It includes the dates the cases were closed and re-opened. The files are attached in the Response to Draft Audit Report folder (Documentation – 21 cases). OPM invites the OIG to walkthrough the FDC system as it provides the entire case history for each disputed claim."

OIG Comments:

Although OPM states that it is in agreement with the intent of our recommendation, OPM has not provided us with any evidence that they have or intend to sufficiently remedy the current lack of internal controls. OPM's repeated referral to 5 CFR § 890.105 and 5 CFR § 890.107, 48 CFR § 1652.204-72, FEHBAR Part §1604, the FEHB Program Carrier contracts, and position descriptions of OPM personnel do not qualify as control activities as defined by GAO. Instead, the regulations define OPM's authority to carry out the disputed claims process, not how it will administer the process to meet the requirements of the regulations. While OPM states it will consolidate these "discrete documents" into a summarized Disputed Claims Process document, we recommend that in preparing this document, OPM consult the GAO's Green Book to ensure that the policies/procedures/protocols established provide an appropriate framework for how disputed claims should be processed, reviewed, and resolved. These policies/procedures/protocols should also ensure members have a fair and efficient appeal process as required by the Consumer Bill of Rights.

Additionally, while OPM may have the "authority to interpret and implement its rule on how the 90 days is counted," OPM cannot consistently and fairly apply a review timeline for disputed claims without documented policies and procedures governing the process from beginning to end, and without clearly communicating those processes to members. During our audit scope, the FEHBP benefit brochures and OPM's disputed claims correspondences with members did not include communication of OPM's interpretation of its 90-day review,[6] including its practice of closing cases while it waited for additional information and restarting its count of allowed review days at day one if OPM had previously closed and subsequently reopened the case for review. As mentioned above, since OPM has no established controls over this process sufficient

[6] The FEHBP benefit brochures state, "OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a ***final decision within 60 days*** [emphasis added]. There are no other administrative appeals."

for us to identify a standardized process to measure timeliness and repeatedly indicated that its policy and procedures were "found in 5 Code of Federal Regulations (CFR) 890.105," we utilized the 90-day time limit in 5 CFR § 890.105 to calculate OPM's timeliness when reviewing disputed claims.

Specifically, 5 CFR § 890.105(e)(4) of the regulation provides that "***Within*** [emphasis added] 90 days after receipt of the request for review, OPM ***will*** [emphasis added] either" provide a decision or notify the individual of the status of the review. The terms "within" and "will" do not provide OPM the ability to arbitrarily extend its review beyond the 90-day period. Yet in our review of the 81 claims samples, OPM could not provide sufficient evidence that status updates were provided by OPM to FEHBP members within 90-days from the original receipt of the disputed claim, where timeliness is in question. Additionally, OPM's review and responses to the disputed claims case samples indicate multiple situations where they were in fact untimely for a variety of reasons.

OPM also states that, "OPM and Carriers have discretion to review claims outside of the time limit," yet the language in 5 CFR § 890.105 does not provide that leniency. Specifically, 5 CFR § 890.105(e) states, "(1) If the covered individual seeks further review of the denied claim, the covered individual ***must*** [emphasis added] make a request to OPM to review the carrier's decision. Such a request to OPM ***must be made*** [emphasis added]: (i) Within 90 days after the date of the carrier's notice to the covered individual that the denial was affirmed; (ii) If the carrier fails to respond to the covered individual as provided in paragraph (b)(2) of this section, within 120 days after the date of the covered individual's timely request for reconsideration by the carrier; or (iii) Within 120 days after the date the carrier requests additional information from the covered individual, or the date the covered individual is notified that the carrier is requesting additional information from a provider. OPM may extend the time limit for a covered individual's request for OPM review ***when the covered individual shows*** [emphasis added] he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the request for OPM review within the time limit."

The use of the term "must" does not provide OPM the discretion to extend an FEHBP member's appeal timeframe beyond the time limits indicated in the regulation except in cases where the FEHBP member "shows" they were not notified of the time limit, or they were prevented by circumstances beyond their control from filing a timely appeal for OPM review. Since every FEHBP benefit brochure contains the FEHBP member appeal rights in Section 3 and Section 8, it is unlikely that any FEHBP member is not sufficiently notified of the time limitations. Moreover, in our review of the 81 disputed claims samples, we accounted for all documentation that OPM provided to us from its disputed claims cases. If in our review of OPM's provided documentation we found sufficient evidence that an FEHBP member was prevented by circumstances beyond

their control to appeal to OPM timely per 5 CFR § 890.105(e)(1)(iii), then those claim cases were not included in this finding.

The time limitations for a carrier to reconsider a claim, the FEHBP member to appeal that decision, and for OPM to conduct its review are quantifiable and limited as stated in 5 CFR § 890.105. As such, we utilized the CFR timeliness limitations, our 90-day benchmark, and the disputed claims data provided by the carriers to identify the 70 disputed claims cases OPM omitted from the first three FDC extracts and determined disputed claims case untimeliness as illustrated in Table I. We also reviewed the case list data and a new (fourth) FDC data extract provided in response to the draft report, which in many cases substantiated our initial findings that 54 of the 70 disputed claims cases, omitted by OPM in the prior FDC data extracts, suffered from untimeliness throughout the appeal process.

Again, the regulations provide specific time limitations and require actions in all disputed claims review process steps. However, it is clear from our reviews that OPM does not consistently adhere to or enforce the established timelines during the FEHBP disputed claims process. By agreeing to review disputed claims that were already well past the timeliness limitations of 5 CFR § 890.105(b) through (d) and the terms of the benefit brochures, OPM is condoning carriers continued surpassing of the allotted review time-period.

We also found OPM's position that it holds carriers accountable utilizing the Contract Oversight portion of the FEHB Plan Performance Assessment to be inadequate and did not align with its own guidance to carriers provided through Carrier Letters . Specifically, Carrier Letter 2015-10 states that the "Contract Oversight domains will be evaluated in the Contracting Officer's discretion … ." Also, OPM's 2020 FEHB Plan Performance Assessment Procedure Manual indicates that "OPM will notify FEHB Carriers regarding the timeframe for submitting input for Contract Oversight scoring." Neither Carrier Letter 2015-10 nor the procedure manual specifically define how OPM will hold carriers accountable for timeliness over the disputed claims process, especially considering the Contract Oversight portion of the assessment is based on OPM discretion and carrier input. Since OPM did not provide any evidence that it incorporated disputed claim untimeliness in the carrier Plan Performance Assessments and we found numerous instances of carrier untimeliness, we are left with the conclusion that either this is an ineffective means of carrier accountability or OPM did not account for carrier disputed claim process compliance in this manner.

Regarding OPM's position on Recommendation 2, we do not agree with OPM that the history of the regulation and FEHBP benefit language have any bearing on whether their use should be continued unmodified. It is evident through our audit that OPM's statement that its "timeframe works well and there have been no concerns from members regarding this regulation" fails to acknowledge that the OIG found specific

instances of harm to FEHBP members. As noted in the finding, due to the excessive untimeliness during the disputed claims process, 4 of 70 (5.71 percent) sampled members experienced such untimeliness during the disputed claims process that OPM's final decision came after the member's right to seek judicial review expired. Furthermore, OPM has taken steps to shorten the record retention period of disputed claims documents as discussed in section 3b, of this report. As such, it is imperative that OPM consider consulting GAO's Green Book in developing its policies/procedures/protocols for the disputed claims process, including an evaluation of 5 CFR § 890.105 and § 890.107 requirements to ensure that its resulting policies/procedures/protocols provide a fair and efficient external appeal process for members.

Finally, OPM repeatedly uses the phrases "in the best interests of the members" and that OPM "acts equitably;" however, allotting more review time to some disputed claims cases than others and allowing some FEHBP members more time to appeal than others, without standardized policies and procedures for doing so, is not equitable. Moreover, without sufficient controls, we do not agree with OPM's statement that it can act in the best interest of the FEHBP and its members. What is in the best interest of the FEHBP is not necessarily in the best interest of the FEHBP members. That is why it is again critical that OPM consult and utilize the guidance in GAO's Green Book to implement sufficient controls, including written policies and procedures, surrounding the disputed claims process so that OPM can timely and consistently administer the disputed claims review according to the regulations, FEHBP benefit brochures, and the requirements of the Consumer Bill of Rights.

b. Review and Decision Letter Inconsistencies

During our review of the 81 disputed claims samples, we found that OPM issued different letters to FEHBP members to communicate its final decisions. Specifically, when OPM required additional information to conduct its review, OPM issued an additional information letter to the FEHBP member. The letter indicated that if the FEHBP member did not respond within the allotted 30-days, OPM would close the disputed claims case.. However, we found that OPM's closure of the cases varied from immediately upon issuance of the additional information letter, 30 days after issuance of the additional information letter, or at some point well after the 30-day response period expired.

We also found three instances in our sample where an FEHBP member received an additional information letter, did not respond, then also received a second decision letter, which included disputed claim information, action taken by OPM, rationale for the decision, and FEHBP member due process rights. In these three cases, the second decision letter was sent months later, unduly delaying information the FEHBP member

could use to take further action on the disputed claim, and well after OPM's allotted 90-day review period.

OPM lacks policies and procedures to define its use of the additional information letter as a decision letter, instigating closure of the disputed claims case. Although 5 CFR § 890.105(e)(2) provides OPM with four allowable actions, including "(i) Request[ing] that the covered individual submit[s] additional information," it does not state that OPM can close a case if they do not receive additional information without providing a decision or a status update to the FEHBP member and/or carrier. Specifically, 5 CFR § 890.105(e)(4) grants OPM these two options: "Within 90 days after receipt of the request for review, ***OPM will either*** [emphasis added]: (i) Give written notice of its decision to the covered individual and the carrier; or (ii) Notify the individual of the status of the review. If OPM does not receive requested evidence within 15 days after expiration of the applicable time limit in paragraph (e)(3) of this section, OPM may make its decision based solely on information available to it at the time and give a written notice of its decision to the covered individual and to the carrier." However, OPM lacks policies and procedures to define its processes used to meet the terms of the regulation and did not adequately notify FEHBP members of how or when its disputed claims review would be completed.

Additionally, in our review of the 81 disputed claim samples, we found the following:

- OPM closed and reopened four cases without a documented reason, three of which were cases where an additional information letter was submitted to the FEHBP member, the case was closed before the 30-day response period expired, and there was no evidence that the FEHBP member responded.

- In 10 other cases where OPM issued additional information letters, OPM closed and reopened the cases, restarting its review time at day one, even though there is evidence that 2 of the FEHBP members responded within the 30-day response window. In 5 of these 10 cases, OPM closed and reopened the case well after the 30-day FEHBP member response window expired and there is insufficient evidence to determine that these actions were warranted.

Although some of these cases had more than one administrative issue, in total there were 14 unique cases that we found were opened, closed, reopened, and reclosed without sufficient evidence to indicate why the case modification was warranted. Additionally, there were also some identified cases in our sample where OPM did not provide enough documentation to assess issues stemming from the issuance of the additional information letters and if there was sufficient evidence to warrant reopening a case.

Ultimately, OPM's use of the additional information letter to communicate final decisions lacks sufficient controls when the letter does not unequivocally end OPM's review in cases where the member does not respond timely or OPM reopens the case for other unsupported reasons. This practice is not communicated to members and places the onus for continued disputed claim resolution back on the FEHBP members instead of OPM clearly communicating a final decision. Also, the inconsistent closure, reopening, and reclosure of disputed claims cases during or after the issuance of the additional information letter is extending the time OPM allows itself to review disputed claims and is not clearly communicated to members.

Recommendation 3

We recommend that OPM implement written policies and procedures to address the use of additional information letters in the disputed claims process.

OPM Response:

OPM partially agrees with the finding and Recommendation 3. Specifically, OPM states, "[w]hen OPM does not have sufficient information to review a disputed claims case, it sends a letter to the member requesting the information per 5 CFR § 890.105 (e)(2). The letter states that if information is not provided within 30 days, then the case is closed due to insufficient information. The letter provides the status of the claim and that without sufficient responsive information, the member's appeal will not result in a directive to the carrier to pay the claim. It is OPM's longstanding practice to not send a subsequent letter closing the claim if no additional information is received.

The OIG indicates there were inconsistencies with OPM's decision letters. Specifically, the OIG noted three instances of letters sent requesting additional information where a subsequent letter was sent closing the case. OPM acknowledges that in these instances, our practice of sending one letter was not followed. In the past year, OPM has reviewed disputed claims letters for consistency among the FEHB divisions and included standard language in template letters when we request additional information to ensure uniformity. The letters are in the process of being refined."

"We believe the additional information letter meets the requirements of 5 CFR § 890.105 (e)(4) and a second letter is not needed as OPM has the right to decide based on the available information. Our additional information requests communicate a final decision based on the file we received. See 5 CFR § 890.105(e)(2)(iv). Also, 5 CFR § 890.105(e)(4) states, 'Within 90 days after receipt of the request for review, OPM will either: (i) Give written notice of its decision to the covered individual and the carrier; or (ii) Notify the individual of the status of

the review.' The letter requesting additional information complies with (i) as the letter states that if information is not provided within 30 days, then the case is closed due to insufficient information. Therefore, the dispute is a final decision that the case is closed and OPM's failure to find for the enrollee results in a denial."

OPM also stated that "we provide contact information on the acknowledgement letter and most members call for a status."

Furthermore, "As indicated in our response to Recommendation 1, it is OPM's policy and practice to provide a decision and offer the member the opportunity to provide the additional information for over 25 years. This break in counting days allows time for the member to provide information needed for their case, including gathering medical records.

There are also procedures built within the FDC system that control opening and closing cases. For example, a case cannot be opened or closed until all the required information is entered. A case can be reopened, but a specific reason must be selected."

OPM analyzed the 81 disputed claims cases, and provided the following responses:

"The 4 cases noted as closed and reopened without a documented reason, were reopened to change the decision. …

Of the 3 cases where OPM issued information request letters to the FEHB enrollee and closed the case in FDC prior to the 30-day response window, this is our normal process. Cases are closed when the insufficient information (INF) letter is sent and while awaiting a response from the member when the case is reopened. …

Of the 8 cases that were closed and reopened well after the 30-day response window closed: 4 were reopened within the 30 days or the member called and requested more time; 2 were closed for INF but then re-opened to change the decision from INF to Decision Sustained and the cases were not reviewed after the 30-day response window; one accepted additional information after 30 days because the provider said they did not receive our April letter requesting medical records; and one was accepted late because the appeal was for a pre-service and the enrollee was still pursuing future surgery. …

Of the 2 cases where the enrollee provided additional information untimely, one case was processed timely and the other case was 8 days over the 90-day timeframe due to the member's request for additional time. Supporting

information provided from the FDC system case notes communications with the member."

OIG Comments:

OPM did not provide any evidence to substantiate its statement that "[i]n the past year, OPM has reviewed disputed claims letters for consistency among the FEHB divisions and included standard language in template letters when we request additional information to ensure uniformity." Even if OPM did implement consistent language in a decision letter, that alone does not address all applicable issues related to the inconsistent use of the letter itself, nor does it address the use of the additional information letter as a decision letter.

OPM also did not clearly indicate or provide documentation to substantiate its actions that the 14 disputed claims samples were allowable per 5 CFR § 890.105. OPM's statements that it is their practice to close cases once the additional information letter is sent and while awaiting a response from the FEHBP member or the provider could not be verified with its own actions in the samples we reviewed. As discussed in our finding, starting on page 22, there are instances where an additional information letter was issued and OPM's closure of the disputed claims case varied from immediately upon issuance of the additional information letter, 30-days after issuance of the additional information letter, or at some point well after the 30-day response period expired. OPM's response above also validates our findings on these 14 disputed claims samples as its narrative illustrates that cases were open, closed, reopened, and reclosed for a variety of reasons.

In their current form and function, and lacking any documented policies and procedures, it is unclear if OPM is utilizing the additional information letter as a final decision letter or as a status update to the member, or both. The additional information letters we reviewed over the scope of the audit did not provide the FEHBP member with sufficient information regarding the member's due process rights, OPM's requirements for reopening a case (if any), nor OPM's practice of reopening cases and restarting its review period at day one. If OPM's intent for the additional information letter was to communicate status of the review and not a final decision, it is unclear why OPM stated, "we provide contact information on the acknowledgement letter and most members call for a status." Finally, it should be noted that OPM does not consistently document the date, time, and content of member phone calls to substantiate that "most members call for a status."

c. Other Disputed Claims Process and Tracking Issues

In addition to the issues already addressed in Section 1 of the report, we identified that OPM lacked written policies and procedures for the administration of disputed claims

data in both of its data systems: the HITS and the FDC system. Additionally, we identified other disputed claims process issues during our review of the 81 disputed claims samples that indicate reviews and decisions were made inconsistently, in some cases conflicting with guidance from the CDC and requirements in the Consumer Bill of Rights. The issues stemming from a lack of sufficient policies and procedures over the disputed claims data systems and review processes are as follows:

- The documentation provided for the OIG Hotline Case 2, discussed in this report, indicated that requests and correspondence from the FEHBP member were not consistently documented when received, resulting in timeliness issues extending months after the appeal to OPM.

- OPM directed a carrier on one disputed claims case to allow benefits as an in-network benefit even though the service did not qualify as such. Per the terms of its contract with carriers, OPM and the carrier will agree upon language setting forth the benefits, exclusions, and other language of the carrier. OPM is not upholding the terms of its contract with carriers when it mandates a disputed claims case benefit be covered at terms different than those specified in the FEHBP benefit brochures.

- OPM lacks policies and procedures to identify when it should contact its IRO to seek an IMR provided by a professional appropriately credentialed with respect to the treatment being sought as designated in the Consumer Bill of Rights. On one specific case, OPM did not provide sufficient evidence to support why it did not use its IRO when evaluating appealed experimental and investigational services.

- The recommendation of the IMR was not followed by OPM on one disputed claims case, with no documented reason as to why the IMR opinion was disregarded. If OPM accepted the IMR treatment recommendation, OPM would have reversed the carrier's decision. It is unclear why OPM made a decision contrary to the IMR recommendation; however, without this documentation there is no basis to determine whether the FEHBP member was afforded an independent review of their disputed claim as specified in the Consumer Bill of Rights.

- On three disputed claims, OPM's contracted IMR recommended coverage of benefits of addictive drug usage above the CDC limits, which OPM followed, in cases where:

    - other IMRs, conducted during the carrier's reconsideration of the claim, upheld the carrier's denial on the same claims;

    - there were medical plans in place to reduce the FEHBP member's dependency to within CDC recommended limitations;

- the member was taking other prescriptions that were designated as dangerous in combination with the prescribed addictive drugs, especially in amounts over the CDC recommended limitations;

- the carriers' IMR physicians, with the same specialty as OPM's contracted IMR physicians, determined the high-risk drug was not warranted and/or recommended a treatment plan within the terms of the FEHBP benefit brochure and CDC recommended limitations; and

- the contracted physician completing the IMR may not have received all applicable prescription data for consideration, resulting in a recommendation contrary to the carrier's IMR. OPM relied on the results of the IMR and allowed drug usage above the CDC recommended limitations that was both high risk and addictive.

- There were seven medical professionals identified in our claims sample that conducted IMRs for both OPM and the carriers. Although our review of the 81 samples did not indicate that disputed claims cases were reviewed for the carrier and OPM by the same IMR, OPM lacks policies and procedures to ensure that IMRs used by the carrier are not also used by OPM on the same disputed claims case.

- We identified five like-kind cases based on the same type of denied services where OPM's final decisions for the same denied service were administered differently based on the reviewer assigned to the case.

In addition to the issues identified in our disputed claims sample review, we found that other relevant data, such as the disputed claim medical codes and OPM's decisions, are inconsistently, and in some cases inaccurately, tracked in FDC. Specifically:

- In our review of the FDC data report provided by OPM (fourth FDC data extract), we found that only 51 percent of the disputed claims case medical codes were populated in FDC. This greatly limits the ability to identify trends and systemic claim processing errors, which is a duty of the LAS as specified in the LAS's job description provided by OPM. Furthermore, it limited our ability to identify how many disputed claim cases contained relevant health benefit issues, as the medical codes were not consistently populated.

- The OIG Hotline Case 2, discussed previously in this report, illustrated multiple process issues. One issue was that OPM closed the case and noted it was withdrawn by the FEHBP member, but the FEHBP member never withdrew their request and was waiting on OPM's response for an on-going health benefit issue. When we reviewed the claim, we substantiated that the claim was incorrectly marked in FDC as "withdrawn" in the "Y Cases Decision" section of the FDC

system and the documentation did not support that the FEHBP member withdrew their claim.

Administering a disputed claim review without sufficient controls, including written policies and procedures, sufficient training, and a quality assurance program, puts OPM at risk of continued process issues and hinders OPM's ability to fulfill its obligations as the FEHBP's external appeals system as specified in the FEHBP benefit brochures, Section 3 and Section 8, and the Consumer Bill of Rights. Insufficient controls over the disputed claims process also enhances the inherent physical and financial health risk at a member level.

Recommendation 4

We recommend that OPM implement policies and procedures to standardize the review of disputed claims, provide the policies and procedures to applicable OPM personnel, and implement a plan to review and update the policies and procedures regularly.

Recommendation 5

We recommend that OPM immediately implement written policies and procedures for the administration and use of FDC to ensure:

- All FDC users are tracking disputed claim cases in the system consistently.
- Disputed claims cases are consistently opened and closed in FDC among all users.
- Disputed claim cases remain open in FDC during the 30-day FEHBP member response window, and OPM's 90-day review time frame includes the FEHBP member additional information letter process in cases where the FEHBP member responds timely.
- The date of the FEHBP member additional information letter and the FEHBP member response date (if applicable) are made reportable fields in FDC.
- FDC stores sufficient evidence to prove the FEHBP member provided new information after OPM made its decision, which warrants the reopening of the case.
- All data components, including the medical codes (Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), etc.), are populated in FDC.
- A process is established to assess FDC data trends, issues, and errors so that corrective action can be implemented timely.

Recommendation 6

We recommend that OPM implement a disputed claims process training program for new and current employees to ensure all personnel involved in the disputed claims review, regardless of assigned FEHB Group, are reviewing disputed claims timely and consistently.

Recommendation 7

We recommend that OPM implement a disputed claims quality assurance program to ensure that the disputed claims data is regularly reviewed for:

- Consistent and timely logging and addressing of FEHBP member correspondence.
- The identification of concerning trends with providers, procedures, prescriptions, etc.
- Consistent reviews of like-kind claims.
- OPM's adherence to the implemented policies and procedures.
- Consistent handling of IMR reviews, especially in cases where the carrier provided at least one IMR itself.
- Prompt identification and correction of human errors.

OPM's Response:

OPM partially agrees with the finding and some of the recommendations, as stated below.

OPM partially agrees to Recommendation 4 and stated, "OPM's written policies and procedures are contained within discrete legal documents that include 5 CFR 890.105-106, 48 CFR 1652.204-72, FEHBAR Part 1604, the FEHBP Carrier contracts, and position descriptions of OPM personnel. These documents represent OPM's policy/procedures. OPM agrees to combine the information from these discrete written policies and procedures into a summarized Disputed Claims Process document. OPM will also establish a schedule to regularly review the process for improvement."

OPM does not agree with the findings on the 81 disputed claims samples and stated, "OPM was unable to verify OIG's statements of process inconsistencies or decisions contrary the requirements. Evidence was not provided to indicate true process inconsistencies or final decisions made on disputed claims that were contrary to documented procedures, the FEHB brochure, or 5 CFR 890.105.

Final decisions are based on the contractual statement of benefits found in the plan brochure and the unique member medical circumstances, including their clinical history. Decisions are made on a case-by-case basis and there are no global decisions based on the type of service or the reviewer.

The OIG cites several disputed claim samples found issues '…included but were not limited to; inconsistent decisions on disputed claims, carrier decisions overturned contrary to the Contract and CDC guidelines, and violations of the FEHB member rights under the Consumer Bill of Rights, including a lack of evidence-based decision making and a lack of guidance specifying OPM's use of an independent medical review and the resulting professional recommendations.'

OPM disagrees with the OIG's findings except in the case where a member's information was mistakenly sent to another member. OPM investigated this incident and found it was an unfortunate human error. OPM appropriately submitted this information to OPM CyberSolutions as required and contacted the individual to ensure the inadvertent release of information was destroyed.

OPM disagrees with the statement … that OPM made decisions in conflict with guidance from the CDC. As previously stated, OPM makes decisions on a case-by-case basis based on the definition of medical necessity found in each health plan's respective brochure and there are no global decisions, even if the case appears to be a like kind case, as each case and each member and their clinical needs is unique. Furthermore, the CDC updated its 2016 guidelines in 2022 at https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm?s_cid=rr7103a1_wNew. The new guidance reflects the evolution in thinking in how opioids should be used, and the reality of how they are being used. According to the CDC, the original guidelines issued in 2016, helped further drive down opioid prescribing levels that had been in decline since 2012, as the country grappled with its legacy of overprescribing that contributed to the overdose epidemic. But critics contended the 2016 guidelines, while helping limit new prescriptions, introduced other harms by leading to unsafe dose reductions for people already on opioids and some long-term patients being cut off from medication on which they depended. A major theme of the 2022 guidelines is that people with pain need individualized care, and that prescribers need to calibrate doses and timeframes to meet each unique patient's needs, all while still trying to minimize the harms that can come with opioid use.

Regarding the disputed case claim samples the OIG reviewed, OPM stands behind its responses provided in NFR #4."

OPM's NFR #4 responses are as follows in the bulleted list:

- **"The one example OIG provided … failed to demonstrate evidence of inconsistency, lack of timeliness, or member complaint."**

- **"The four examples OIG provided … failed to provide evidence that OPM overturned carrier decisions in these cases. … It would not be appropriate to get an IMR decision in these cases. In addition, there is no requirement that OPM HI utilize the IMR in every instance where we overturn the plan. 5 CFR 890.105(e)(2)(iv) indicates that OPM has the discretion to make its decision solely based on the information the covered individual provides … ."**

- **"[OIG] failed to provide evidence that a letter was not sent to the covered individual. OPM consistently provides the member with a letter when the case is closed, even when the carrier reverses their decision."**

- **"Evidence that an IMR was not consistently sought on E&I [Experimental and Investigational] medical cases could not be verified. IMRs are not completed for contractual benefit cases and are not necessary when the carrier overturns their decision. Additionally, an IMR is consistently sought on E&I services when a complete case file is received. OPM noted that 2 of the 3 samples OIG provided did not have a complete case file and the 3rd sample was one of hundreds of Castle Bioscience cases. It was determined to be unnecessary, redundant and a waste of Government resources to perform an IMR for each Castle Bioscience case with such identical criteria where only the specific member PII [Personally Identifiable Information] changed."**

- **"[W]e want to point out that there is nothing in the law or regulations that requires OPM to adopt the opinion of the IMR. OPM must consider the whole administrative record."**

- **"[I]t is incorrect to say that an IMR 'overturned' a Carrier's denial of a claim, as IMRs do not have this authority under statute, regulation or contract. IMRs provide independent medical opinions to OPM, and OPM takes these opinions into account but is not bound by them, and must in fact make an independent decision on the FEHB disputed claim based on the entire administrative record, including but not limited to an IMR's opinion. See 5 C.F.R. §890.107 (d)(3)(providing that court review '[w]ill be limited to the record that was before OPM when it rendered its decision affirming the carrier's denial of benefits.')"**

- **"In 2020, in response to the single known instance of a conflict of interest, a log was developed to document the names of the Carrier's Physician/Medical Specialist that reviewed the medical file of the member. The log is accessible to the Nurse Consultants to reference when the IRO [Independent Review**

Organization] selects and assigns a case to a reviewer. The IRO contracts with Medical Specialists that complete reviews. When cases are assigned by the IRO to a Medical Specialist, the nurse is notified in the FDC system and acknowledges the IRO assignment. The Nurse will request a new Medical Specialist if a conflict of interest exists.

On the IRO side, the reviewer must electronically attest to having no conflict of interest with the parties involved and no prior participation in the case under review before being allowed access to the records. We understand a provision that requires this attestation is in the provider's agreement."

OPM believes the OIG misinterpreted OPM's discretion in reviewing each case, which resulted in inaccurate findings. Specifically, OPM stated, "[f]inal decisions are based on the contractual statement of benefits provided in the Plan brochure, the service in question, and the unique medical circumstances of each member and their appeal. OPM engages independent medical consultants in the medical specialty necessary for the specific diagnosis or treatment to provide OPM with opinions when cases involve medical determinations. Decisions are made on a case-by-case basis and there are no global decisions based on the type of service or the reviewer."

Additionally, OPM addressed each component of Recommendation 5 as follows:

"1. All FDC users are tracking disputed claim cases in the system consistently.

We do not concur. As the new system was being developed and transitioned, and the team members trained, there may have been some variance, but all FDC users are and have been processing disputed claims in the FDC system consistently across the FEHB groups for more than two years. The system allows some flexibilities with certain fields and actions to accommodate the differences in disputed claims cases to enhance customer service.

2. Disputed claims cases are consistently opened and closed in FDC among all users.

We do not concur. The functionality to open, close, and re-open cases was programmed to avoid constant Administrator override. It gives the LAS flexibility. Each time a closed case is addressed in FDC, by system functionality the case is re-opened. But regardless of how many times a case is opened, closed, or re-opened, the entire history of those actions are captured in an FDC audit trail.

3. Disputed claim cases remain open in FDC during the 30-day FEHBP member response window, and OPM's 90-day review time frame includes the FEHBP

member additional information letter process in cases where the FEHBP member responds timely.

We do not concur. Please see our response to Recommendation 1, 3 and 4 to avoid redundancy. OPM disagrees that cases should remain open during the 30-day member response window and that the 90-day review time should include the days included in the member's additional information letter process.

4. The date of the FEHBP member additional information letter and the FEHBP member response date (if applicable) are made reportable fields in FDC.

OPM does not concur with this statement since the date of the FEHB enrollee additional information letter is captured in the FDC system automatically when uploaded into the system. However, these dates are not captured in reportable data fields. As a result, they cannot be queried nor reported. But they can be accessed in the FDC system audit trail. Making these two date fields reportable does not align with OPM's business processes, as OPM does not use the data from these 2 date fields in our processing timeliness calculations.

5. OPM is compliant with 5 CFR § 890.105(e)(5) and documents in FDC sufficient evidence to prove the FEHBP member provided new information after OPM made its decision, which warrants the reopening of the case.

OPM does not concur. Cases are re-opened when new information is received, to make a change, or add other information to a case file. As previously indicated above in Recommendation 1, bullet 1, we exercise our judgment and act equitably in the best interests of the members and the FEHB Program. In reviewing an entire case file, including the case notes in the FDC system, OPM has the relevant information regarding reopening a case.

6. All data components, including the medical codes (Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), etc.), are populated in FDC.

OPM does not concur. CPT codes are generally not applicable to contractual cases. Medical codes, including CPT and HCPCS, are not typically provided or available to the Legal Administrative Specialist (LAS) when initially creating the disputed claim case. Making this field a requirement will add administrative burden, may delay the opening of a case and is not necessary for identifying trends.

7. A process is established to assess FDC data trends, issues, and errors so that corrective action can be implemented timely.

OPM partially concurs with this statement. The FEHB Program Managers/Chiefs have had the ability to perform ad hoc queries to monitor trends and employee performance for more than 2 years. Dashboard reports are under development for these and other purposes. The Chiefs and Health Insurance Specialists can identify trends based on the names of procedures, names of the providers, etc."

Furthermore, OPM does not agree with Recommendation 6, stating, "Supervisory Legal Administrative Specialists (LAS) provide one-on-one, on-the-job training for all new LAS with responsibility for disputed claims, including review of decision letters. In 2022, HI added Supervisory Legal Administrative Specialists in each FEHB division whose position includes training LAS. The Chief assigned will continue to train Supervisory LAS. OPM has a complete set of training materials which are being provided in separate attachments, consisting of 20 files."

Finally, OPM partially agreed with Recommendation 7 and stated, "OPM has a quality assurance process that involves the LAS, Branch Chief, and Group Chief. The Supervisory Legal Administrative Specialist (LAS) reviews the work of the LAS. The FEHB Chief reviews 100% of all directives. When necessary, the nurse consultants, the Chief Medical Officer, the Chief Pharmacy Officer or the IRO medical consultants may be engaged on clinical matters. In addition, the Chiefs have had the ability to perform ad hoc queries to monitor trends and employee performance for more than two years. Dashboard reports are being developed for trending, employee performance and other purposes. OPM looks for opportunities to improve our Quality Assurance process.

In response to each of the bullets: …

o The draft report does not provide evidence of untimely or inconsistent logging and addressing member correspondence. …

o We are developing Power BI dashboards that will show various trends. …

o As previously indicated, each member's disputed claim, their medical history and clinical picture is unique. Decisions are made on a case-by-case basis and there are no global decisions based on the type of service or the reviewer. …

o OPM agrees to strengthen our written policy and procedures. …

o Each IMR review is based on the unique set of circumstances for the disputed claim including provider specialty, medical records and clinical history. …

o OPM takes any errors seriously and immediately corrects them. OPM aims to mitigate future errors by strengthening our internal controls."

OIG Comments:

OPM responses above regarding improvements to its disputed claims processes were narratives only and were not substantiated by documentation. As such, we stand by our recommendations that OPM's disputed claims process would benefit from the implementation of stronger internal controls, including written policies and procedures, to address every step of the disputed claims process. This includes a documented process for the review and approval of addictive drugs above the CDC's recommended limitations. The lack of a documented process for OPM's review and approval of high-risk drugs, that were previously denied by appropriately credential physicians, cannot be justified by stating that the CDC's 2022 guidelines recommend that people in pain need individualized care. Instead, OPM should document its disputed claim processes, and review and update them regularly to incorporate applicable guidance from the CDC and other healthcare agencies and institutions, as applicable, to ensure consistency and compliance with the most up to date guidance when making decisions on disputed claims.

Our recommendations are substantiated by the Green Book, which sets internal control standards for government agencies like OPM, to provide reasonable assurance that operations and reporting objectives, and compliance with applicable laws and regulations, are achieved. Control activities are specifically implemented through policies and procedures and are needed to achieve effective and efficient operations and compliance with regulations, which OPM's disputed claims process lacks.

Additionally, per GAGAS, the OIG is required to gather sufficient evidence to substantiate our findings. To meet this requirement, we made numerous requests of OPM and collected applicable responses and documentation. OPM notes above that the OIG did not have the whole case file; however, we requested ALL disputed claims data related to the 81 disputed claims samples we reviewed, including documentation provided by OPM, the carriers, and the FEHBP members. If OPM was aware that not all relevant documentation was provided to the OIG for review, it had an obligation to provide such evidence, as specified in the Inspector General Act of 1978, 5 United States Code (U.S.C.) § 406, and communicated by OPM's Director to all OPM employees on March 11, 2022. Included in the OPM Director's communication was also a memorandum titled *Cooperation with and Reporting to the OIG*, which outlined OPM's responsibilities in responding to OIG requests. Throughout our audit process, OPM was given multiple opportunities to provide the requested evidence, including the Notice of Findings and Recommendations and Draft Report processes. Meetings were conducted with OPM during which OPM provided clarifying comments and documentation. However, responses to the requests and the information and documentation provided during the meetings did not change our conclusions.

Moreover, OPM's responses above confirm inconsistencies in its own processes. For instance, OPM states, "[d]ecisions are made on a case-by-case basis and there are no global decisions based on the type of service or the reviewer" but then later states that an IMR on multiple investigational and experimental services was determined to be "unnecessary, redundant and a waste of Government resources … for each [Provider] case with such identical criteria where only the specific member PII changed." This example supports our recommendation that written policies and procedures are needed to administer the disputed claims process consistently and trends can be identified by not only providers, but medical codes as well, to ensure like-kind cases are handled consistently across all three FEHB Groups.

Additionally, we have concerns with OPM's position that "CPT codes are generally not applicable to contractual cases. Medical codes, including CPT and HCPCS, are not typically provided or available to the Legal Administrative Specialist (LAS) when initially creating the disputed claim case. Making this field a requirement will add administrative burden, may delay the opening of a case and is not necessary for identifying trends."

The CPT system developed by the American Medical Association and the HCPCS produced by the Centers for Medicare and Medicaid Services provides healthcare professionals the ability to identify healthcare services in a way that can be generally understood by providers, carriers, private and government payers, and other invested parties. Healthcare claims include CPT and HCPCS coding to identify medical and pharmaceutical products, supplies, and services received by the patient. Carriers use CPT and HCPCS coding to determine whether covered individuals, including FEHBP members, received products, supplies, and services that are covered by the FEHBP benefit brochure. As such, these medical coding systems are applicable to both medical necessity and contract compliance determinations.

Since CPT and HCPCS coding is consistently present on the FEHBP member claims reviewed during the disputed claims process, we believe it is crucial that OPM implement quality assurance measures to evaluate disputed claims decisions based on these coding systems. The identification of trends using CPT and HCPCS can help OPM identify repetitive disputed claim benefits, whether medically or contractually disputed, and develop policies and procedures to direct applicable OPM personnel in their reviews of such disputed claims.

OPM's response expressing that "[a] training program for Legal Administrative Specialists (LAS) has always existed in HI" could not be validated with the information provided. Additionally, the response does not address training processes in place during the scope of our audit for all applicable OPM personnel with disputed claims process duties. The training documents provided in response to the draft report were completed and implemented in 2021 but did not include any policies and procedures for

which personnel should utilize them and when and how they should be utilized. Additionally, there was one agenda document that indicated a training of LASs occurred in July 2021. However, of the 19 other "training documents" supplied for our review, 14 had effective dates in August 2021, after the LAS training was conducted. If insufficiently trained, new and current OPM employees tasked with disputed claims process duties are left without guidance on how to complete the review and make decisions. Without a centralized training program in place for all employees having disputed claims responsibilities, guidance on how to administer this process may continue to differ amongst FEHB groups.

In response to Recommendation 5, OPM asserts that all FDC users are and have been processing disputed claims in the FDC system consistently across the FEHB groups for more than two years. We cannot confirm the accuracy of this statement with our current audit, as it falls outside the scope; however, we have yet to receive any updated policies and procedures that would corroborate this statement. OPM goes on to state that it does not agree with setting controls in FDC to ensure cases are opened and closed consistently because it wants to "avoid constant administrator override," moreover, it does not believe that additional reportable fields should be added to track the additional information letter and responses. Not only do these statements conflict with OPM's assurance that all FDC users are processing claims consistently, OPM is also acknowledging that it adopted convenience in lieu of controls. This theme continues as OPM notes it would be an administrative burden to require that CPT and HCPCS codes are recorded in FDC, even though the system itself already includes applicable fields to capture the data, and some processors recorded the data in FDC during the audit scope.

OPM also states that it partially agrees that controls should be established in FDC to ensure trends, issues, and errors are identified, but does not explain how it will implement those processes. Instead, it stated, "FEHB Program Managers/Chiefs have had the ability to perform ad hoc queries to monitor trends and employee performance for more than 2 years. Dashboard reports are under development for these and other purposes. The Chiefs and Health Insurance Specialists can identify trends based on the names of procedures, names of the providers … ." Noting that relevant personnel "have had the ability" and "can" identify trends in disputed claims data does not equate to an established process where trends, issues, and errors are regularly being identified, processes revised, and proactive solutions implemented.

Furthermore, it is apparent that OPM's disputed claims process lacked sufficient quality assurance measures during the scope of the audit. Although OPM indicated that Supervisory LAS review the work of the LAS conducting the reviews, supporting documentation shows that OPM lacked a supervisory LAS in two of the three FEHB groups in contract years 2018 through 2020 and prior. Additionally, OPM states that its quality assurance is limited to the "business process" and is not a function of FDC,

which indicates there is no official tracking of supervisory review available to confirm if review of the disputed claims cases occurred before a final decision was made.

Finally, the OIG continues to receive complaints via the OIG hotline regarding OPM's untimely and inconsistent disputed claims process. During the audit process alone, we received three additional complaints. Although OPM continues to state that 5 CFR 890.105 and the FEHBP benefit brochures represent its policies and procedures, neither provide sufficient guidance for applicable OPM personnel to review and make a final decision on disputed claims. As such, OPM personnel were left with the option to make an independent decision based on their own knowledge or reference the outdated and unofficial disputed claims operation manual, which outlines processes for which OPM states they should not be held accountable. Additionally, OPM's quality assurance process was significantly lacking during the audit scope, and it is unclear what steps, if any, OPM has taken to remedy these issues.

Summary: Lack of Official Policies and Procedures

OPM should immediately establish sufficient controls, including written policies and procedures, to define how it will enforce and fulfill the disputed claims process per the terms of 5 CFR § 890.105. If OPM continues to administer the disputed claims process without implementing policies/procedures/protocols sufficient to establish an appropriate framework for how disputed claims are processed, reviewed, and resolved, it runs the risk of continued inconsistencies in the handling of cases, potential detrimental FEHBP member health outcomes, and violations of FEHBP members' rights under the Consumer Bill of Rights.

2. Conflicting Timeliness Criteria

During our review of OPM's disputed claims process, we identified conflicting criteria related to the time and content allotted for OPM to review FEHBP members' disputed claims. Specifically, 5 CFR § 890.105(e)(4), 48 CFR § 1652.204-72(e)(4), and the FEHBP carrier Contract language Section 2.8(e)(4) state, "Within **90 days** [emphasis added] after receipt of the request for review, OPM will either: (i) Give a written notice of its decision to the covered individual and the carrier; or (ii) Notify the individual of the status of the review. If OPM does not receive requested evidence within 15 days after expiration of the applicable time limit in paragraph (e)(3) of this section, OPM may make its decision based solely on information available to it at that time and give a written notice of its decision to the covered individual and to the carrier." However, Section 8, Step 4 of the FEHBP benefit brochures states, "OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within **60 days** [emphasis added]. There are no other administrative appeals."

OPM itself sets forth precedence in the carrier Contracts, Section 1.3 which specify, "Any inconsistency in this contract shall be resolved by giving precedence in the following descending order: The Act, the regulations in part 890, title 5, Code of Federal Regulations, the regulations in chapters 1 and 16, title 48, Code of Federal Regulations, and this contract." The FEHBP brochure, being Appendix A of the Contract, is last in the order of precedence. Furthermore, the courts have ruled that OPM will be ultimately held to OPM's regulations regarding the FEHBP disputed claims process. *See e.g.,* Campbell v. OPM 384 F.Supp. 2d 951, 952 (W.D. Virginia 2004).

Since legally OPM is allotted 90 days to review, make a final decision or provide a status update on a disputed claim, and notify the FEHBP member, OPM should specify the same time limitations and actions in the FEHBP benefit brochures. The FEHBP benefit brochures are the public facing communication of OPM's disputed claims process, which most members rely on to direct their actions during this process. The FEHBP benefit brochures communicate that members will receive a final decision from OPM on their disputed claim within 60 days.

Recommendation 8

We recommend that OPM update Section 8, Part 4 of the FEHBP benefit brochures to align with 5 CFR § 890.105(e)(4), 48 CFR § 1652.204-72(e)(4), and the FEHBP carrier Contract language Section 2.8(e)(4).

OPM's Response:

OPM does not agree with the finding and recommendations. Specifically, OPM stated, "'OIG found that OPM's self-imposed 60-day review period, outlined in Section 8 of the FEHBP brochures, does not align with the 90-day review period allotted in 5 CFR§ 890.105.' The regulations establish a 90-day period for OPM review and action, which includes notification. OPM's practice, since 2001, is to review disputed claims within 60 days and is within the 90-day regulatory allowance. A shorter review period benefits the members when OPM disagrees with the Plan's denial by providing the appeal decision sooner. The OIG does not indicate how processing a disputed claim case in a shorter timeframe harms the member nor does the OIG provide documented member inquiries that indicate they were confused by the longer/shorter review periods. The OIG cites a legal case, Campbell v. OPM 384 F.Supp. 2d 951, 952 (W.D. Virginia 2004), and indicates that OPM will ultimately be held to its regulations regarding the FEHB disputed claims process. The Campbell case involved the issue of medical necessity. At page 956, the Court expressly states that OPM did not act arbitrarily by failing to decide the matter within 90 days and indeed OPM did not act arbitrarily by failing to comply with the regulation stating notice of status should be given if decision is not made within 90 days. The Court

determined that the regulation grants OPM broad discretion to determine the timeframe of its review.

In another legal case, Volvo Trucks of North Amer, Inc., 367 F.3d 204, 208-209 (4th Cir 2004), the 4th Circuit Court states, '…Finally, Volvo makes the astonishing argument that in order to avoid arbitrariness and capriciousness, "an administrative agency must uniformly apply its regulations to all applicable situations." *209 Such a standard would be impossible for any agency to achieve. The inherently discretionary nature of enforcement duties means that, in the absence of an unconstitutional motive, the agency cannot be required to apply each of its regulations mechanically to every situation that falls under them.' The Court's decision allows for an agency's discretion in interpreting its regulations."

OIG Comments:

We agree that there is nothing to prevent OPM from implementing a more stringent timeliness standard than the 90-days allotted; however, it is misleading to FEHBP members to propagate a 60-day timeliness review standard in the FEHBP brochure when the courts agree that the OPM administrative appeals process is guided by language in 5 CFR § 890.105.

Pursuant to the Administrative Procedure Act (APA), courts review OPM's disputed claims decisions under the "arbitrary and capricious" standard.[7] Under this standard, the court will invalidate decisions that the court determines are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law."[8]

OPM is correct in noting that, in *Campbell*, the court held that OPM's missteps in handling a disputed claims decision did not mean that the agency's decision could be set aside under the APA. However, when upholding an agency decision under the APA's arbitrary and capricious standard, the reviewing court is not indicating that an agency's decision-making should not be improved; rather, the reviewing court is indicating that the agency's decision-making is acceptable. In fact, courts are expressly prohibited from substituting their policy judgement for that of the agency.[9] Therefore, a court is not necessarily making a determination that agency processes have produced the "best"[10] decision or even a "wise"[11] decision.

---

[7] *E.g.,* Weight Loss Healthcare Centers of Am., Inc. v. Off. of Pers. Mgmt., 655 F.3d 1202, 1207 (10th Cir. 2011).
[8] 5 U.S.C. § 706.
[9] Fed. Commc'ns Comm'n v. Prometheus Radio Project, 141 S. Ct. 1150, 1158 (2021).
[10] Cnty. of Mohave, et al., Plaintiff, v. United States Bureau of Reclamation, et al., 2023 WL 2813695, at *5 (D. Ariz. Apr. 6, 2023).
[11] Cloud Peak Energy Inc. v. United States Dep't of the Interior, 559 F. Supp. 3d 1203, 1211 (D. Wyo. 2021) (citing Olenhouse v. Commodity Credit Corp., 42 F.3d 1560, 1575 (10th Cir. 1994) (Holding that when reviewing agency action under the arbitrary-or-capricious standard, the court focuses on the decision-making process, not on its wisdom or "correctness.").

Furthermore, in various circumstances, courts have set aside OPM's disputed claims decisions as arbitrary and capricious. For instance, OPM decisions have been held to be arbitrary and capricious (and overturned) when the decision is contrary to evidence in the record,[12] contradicted (without explanation) the agency's internal medical analysis such that OPM's decision had "no rational basis",[13] or when OPM failed to review information that it had itself requested.[14] Implementing sufficient internal controls would mitigate the risk of these outcomes.

Finally, it should be noted that the arbitrary and capricious standard is used to determine if an agency's decision-making in one particular instance was reasonable. By contrast, the purpose of a performance audit under GAGAS is to examine whether government programs are properly administered to achieve their objectives and desired outcomes. Although we note throughout this report examples of cases where OPM did not make timely, consistent, and supported decisions on particular disputed claims cases, the overarching issue is that OPM does not have sufficient internal controls to administer the disputed claims process to meet its desired outcome. That extends to OPM's communication regarding the 60-day timeframe allotted to OPM for it to complete the review steps outlined in Section 8 of the FEHBP brochure.

3. Untimely FOIA/Privacy Act Response

As discussed previously in the report, the FEHBP member from OIG Hotline Case 2 submitted a FOIA/PA request for all records related to the review of their disputed claim on May 11, 2021. Under the law, federal agencies are generally required to respond to a FOIA/PA request within 20 business days. Furthermore, according to United States Department of Justice guidance, FOIA/PA processing should be expedited whenever it is demonstrated that an individual's life or personal safety would be jeopardized by the failure to process a request immediately. Despite these requirements, the FEHBP member did not receive a response from OPM until September 10, 2021. Although it is unclear what led to the delay in OPM's response, the underlying cause appears to be a lack of internal controls surrounding FOIA/PA requests.

Recommendation 9

We recommend that OPM implement internal controls to ensure that FOIA/PA requests can be met within the statutory deadlines.

[12] Mereness v. United States Off. of Pers. Mgmt., 202 F. Supp. 3d 1071, 1082 (E.D. Mo. 2016).
[13] Hewitt v. U.S. Off. of Pers. Mgmt., 390 F. Supp. 2d 685, 689–90 (N.D. Ill. 2005).
[14] Surgicore v. Off. of Pers. Mgmt., 2006 WL 733548 *5-9 (N.D. Ill. Mar. 21, 2006).

OPM's Response:

"OPM acknowledges a FOIA request not completed timely due to extenuating circumstances. OPM conducted a root cause analysis and found areas that were within our control and outside of our control and subsequently have taken steps to mitigate this issue. Lastly, OPM will add these procedures to the Disputed Claims Process document."

OIG Comments:

We have not received OPM's root cause analysis or documentation supporting the steps it has taken to mitigate this issue. Further, due to a lack of internal controls, it is apparent that OPM will not be able to meet its requirements for other FOIA/PA requests. Specifically, the following additional process issues on the OIG Hotline Case 2 FOIA/PA request (see page 10 above) were identified subsequent to the finding above, that if not appropriately addressed with sufficient controls, could impact the processing of future FOIA/PA requests:

- Although the member made the initial request under FOIA and the PA, OPM seemingly limited its original processing of the request pursuant only to FOIA. The Privacy Act allows individuals to access records about themselves, while the FOIA allows the public to access government information. Agencies should process an individuals' access requests for their own records maintained in system of records under both the Privacy Act and the FOIA, regardless of the statute(s) cited. See 5 U.S.C. § 552a(t)(1). If a request is not processed under the Privacy Act as well as the FOIA, then the release of records will be severely restricted.

- OPM's first response only consisted of 6 pages, whereas OPM's second response consisted of 2,617 pages. As a general rule, courts require agencies to conduct a search that is "reasonably calculated to uncover all relevant documents." Campbell v. SSA, 446 F. App'x 477, 480 (3d Cir. June 3, 2011). There was no ambiguity in this request, the member clearly requested "all records" pertaining to the denial of benefits. It is concerning that OPM failed to locate 2,611 pages when conducting their initial search for records resulting in an incomplete response as evident by OGC's appeal determination and OPM's second response.

- OPM's second response, processed pursuant to both FOIA and the PA, contained 2,617 pages, resulting in a voluminous amount of material for the member to review within a normal 90-day appeal window. There was no indication that OPM contacted the member in advance of the transmission of these documents, but instead submitted all documents to the member at once, even though the member had requested an update twice prior to the final remanded response. OPM's poor communication and failure to provide a prompt response is in direct contrast to the

U.S. Attorney General's FOIA Guidelines which stress that agencies "must be mindful of their obligation to work 'in a spirit of cooperation' with FOIA requesters." Furthermore, the U.S. Department of Justice, Office of Policy Information recommends in "The Importance of Good Communication with FOIA Requesters" that, "[w]hen an agency is working on a request that involves a voluminous amount of material or which involves searches in multiple locations, whenever feasible, the agency should provide the requester with interim responses rather than waiting until all records are located and processed".

- OPM's communications with the member were not transmitted to the member on the date OPM indicated on its response letters. As an example, OPM transmitted the remanded FOIA/PA request on October 23, 2023; however, OPM's response letter was dated September 27, 2023. Since OPM's response letter provided the member "within 90 days of the date of the response to your request [September 27, 2023]" to appeal, but OPM didn't send the letter until October 23, 2023, it significantly shortened the member's appeal window to less than 90-days. Per 5 U.S.C. § 552(a)(6)(A)(i), if an agency is issuing an adverse determination, the agency must afford the requester no less than 90 days from the date of the adverse determination on the request to file an appeal.

- The response letters did not include an estimate of the information withheld. When a determination is adverse, (i.e., the request is denied in full or in part), the FOIA requires the agency to provide the requester with certain additional information about the action taken on the request. 5 U.S.C. § 552(a)(6)(A)(i)(III). Agencies are required to "make a reasonable effort to estimate the volume" of any information withheld and should inform the requester of that estimate, unless doing so would harm an interest protected by an applied exemption. 5 U.S.C. § 552(a)(6)(F).

If not sufficiently addressed through a documented internal controls system, OPM will not be able to process FOIA/PA requests in compliance with applicable laws, regulations and guidance. As such, we continue to recommend that OPM consider consulting and utilizing the guidance in GAO's Green Book in developing its policies/procedures/protocols over the disputed claims process so that the framework established by this process is sufficient to address the findings and recommendations in this report.

4. Privacy Act Noncompliance and Record Management Issues

We determined that OPM's disputed claims process in calendar years 2018 through 2020 was not compliant with the requirements of the PA, as amended. Specifically, when OPM decommissioned the use of HITS and established the FDC system to document and process disputed claims, OPM did not issue a new system of records notice (SORN) as required by 5 U.S.C. 552a(e)(4), to replace the in-effect SORN Central-1. Due to insufficient controls

over the disputed claims records, OPM also inadvertently released the records of one FEHBP member to another FEHBP member without prior written consent as required by the PA.

Finally, the SORN attributable to the disputed claims process during the scope of the audit, SORN Central-1, was insufficient to meet the requirements of the disputed claim program in calendar years 2018 through 2020. For example, it does not specify the same record retention period as provided in disposition schedule NC1-146-77-01. As required by federal records management regulations, disposition schedule NC1-146-77-01 details the disposal, transfer, and retention of disputed claims records. *See e.g.,* 36 CFR§§ 1225.10, 1226.10. Also, both the disposition schedule and SORN Central-1 require that OPM permanently keep all electronic records. Per OPM's statements and a lack of documented and official policies and procedures related to disputed claims record retention, we could not verify whether OPM stored and continues to store all electronic disputed claims data permanently and if they are correctly storing and disposing of hard copy disputed claims.

a. Privacy Act Noncompliance

The Privacy Act of 1974, codified in 5 U.S.C. § 552a, established requirements for Federal agencies pertaining to the collection, storage, usage, and reporting of certain information about individuals. Additionally, the Privacy Act required the U.S. Office of Management and Budget (OMB) to develop guidelines for agencies to implement the requirements of the Privacy Act, to which OMB issued Circulars A-108 and A-130 (among other guidance). In Circular A-108, OMB states:

> "The Privacy Act, specifically 5 U.S.C. 522a(e)(4), requires agencies to publish a SORN in the *Federal Register* describing the existence and character of a new or modified system of records. A SORN is comprised of the *Federal Register* notice(s) that identifies the system of records, the purpose(s) of the system, the authority for maintenance of the records, the categories of records maintained in the system, the categories of individuals about whom records are maintained, the routine uses to which the records are subject, and additional details about the system. The requirement for agencies to publish a SORN allows the Federal Government to accomplish one of the basic objectives of the Privacy Act – fostering agency accountability through public notice. …
>
> Agencies … must also publish notice in the *Federal Register* when making significant changes to an existing system of records. As a general matter, significant changes are those that are substantive in nature and therefore warrant a revision of the SORN in order to provide notice to the public of the character of the modified system of records. The following are examples of significant changes … (2) A change that expands the types or categories of records maintained in the system. For example, a benefit system that originally included

> only earned income information that is being expanded to include unearned income information would require a revised SORN. … (7) A change to equipment configuration (either hardware or software), storage protocol, type of media, or agency procedures that expands the availability of, and thereby creates substantially greater access to, the information in the system. For example, a change in the access controls that substantially increases the accessibility of the information within the agency."

From September 2018 through February 2019, OPM underwent a system conversion where the system used to store and process disputed claims, HITS, was phased out and the FDC system was phased in. Per OPM, "[t]he new tracking system automated the process and collected additional data that the previous system could not be modified to collect." OPM confirmed that the FDC system tracks and stores significantly more data on individuals than the HITS system. Also, FDC provides access to OPM, carrier, and contractor personnel. Each of these system changes represents a significant change, which warrants the issuance of a new SORN, per OMB's guidance. As such, we determined that OPM was not compliant with the requirements of the Privacy Act, as OPM did not issue a new SORN when it was establishing the new FDC system.

Additionally, the OIG received a hotline call reporting multiple concerns with the disputed claims process, one of which was that OPM sent the FEHBP member protected health information from another FEHBP member's disputed claims case. We collected the relevant e-mails and data confirming the occurrence of this incident and substantiated that OPM did not comply with 5 U.S.C. § 552a(b) which states, "No agency shall disclose any record which is contained in a system of records by any means of communication to any person, or to another agency, except pursuant to a written request by, or with the prior written consent of, the individual to whom the record pertains … ." unless 1 of 12 criteria are met. None of the criteria were met in this scenario.

Recommendation 10

We recommend that OPM implement an internal control process to monitor Privacy Act requirements, as they relate to the Disputed Claims process, so that SORNs and other Privacy Act requirements are fulfilled in a timely manner.

Recommendation 11

We recommend that OPM implement sufficient controls, including written policies and procedures, to ensure that FEHBP members' identities are verified and disputed claims records are not disclosed without consent as specified in the Privacy Act.

OPM's Response:

OPM partially agrees with the finding, but disagrees with Recommendation 11 stating, "OPM is in compliance with the Privacy Act and has published a SORN. OPM/CENTRAL-1 'Civil Service Retirement and Insurance Records' SORN applied to FEHB disputed claims from the outset of the disputed claims system until OPM/CENTRAL-27 became effective on 9/16/22. Therefore, OPM/CENTRAL-1 applied to disputed claims throughout the audit period (2018-2020).

A SORN covering OPM's Disputed Claims process and FDC was published and finalized 8/12/22. https://www.federalregister.gov/documents/2022/08/12/2022-17392/privacy-act-of-1974-system-of-records

Therefore, OPM requests that this recommendation be withdrawn."

Additionally, OPM partially agrees with Recommendation 12 stating, "OPM immediately corrects human errors when identified. Upon receiving documentation from the OIG on January 26, 2023, of the inadvertent disclosure of personally identifiable information (PII) that occurred in months prior. OPM HI investigated this incident and found it was an unfortunate human error by a LAS. OPM HI followed OPM's internal procedures to report this incident to OPM's CyberSolutions. A process exists where OIG submits OIG Hotline information to HI for review and response on an almost daily basis. OPM HI did not receive a Hotline request to review this case. OPM investigated, notified CyberSolutions and acted as soon as we were informed of the error.

OPM will update the Disputed Claims Process document to include a section on the Privacy Act, following the guidelines established by OPM's Office of Privacy and Information Management (OPIM)."

OIG Comments:

OPM began collecting additional personal data in FDC when the system was implemented in 2018 as part of its disputed claims process; however, a Privacy Impact Assessment for FDC wasn't completed until January 4, 2022, after this audit was initiated. Additionally, SORN OPM/Central-27 was published in the Federal Register August 12, 2022, during the audit's notice of findings and recommendations process. We acknowledge by publishing SORN OPM/Central-27 in the Federal Register, OPM has resolved recommendation 12. However, it is unclear why OPM delayed taking these actions when FDC began collecting the additional personal data in 2018; a lack of internal controls appears to be the root cause.

OPM also states that it "immediately corrects human error when identified," but OPM lacks appropriate quality assurance processes to ensure that human errors are proactively identified as discussed in section 1 of the report. During the scope of the audit, OPM did not have sufficient supervisory legal administrative assistants to ensure disputed claims cases received sufficient oversight prior to issuing final decisions and ensuring errors were identified and resolved. Relying solely on OIG hotline complaints and communication of those complaints to identify human error is a high risk and insufficient method of control of the disputed claims process.

As previously communicated in this report, OPM has yet to provide its proposed "Disputed Claims Process document" to us to review. Therefore, we cannot express an opinion on whether this document will sufficiently address the findings and recommendations in this report and whether the control environment established will ensure disputed claims are properly processed, reviewed, and resolved. In developing its policies/procedures/protocols over the disputed claims process, we recommend that OPM consult GAO's Green Book to ensure that an appropriate control environment is established.

b. Records Management Program Issues

Under the Federal Records Act, 44 U.S.C. 3101, *et seq.* (and corresponding regulations), federal records must be disposed of in accordance with an approved records disposition schedule. National Archives and Records Administration (NARA) regulations found in 36 CFR § 1228.24 provide, "schedules must be prepared so that each office will have standing instructions detailing the disposal, transfer, and retention of records." OPM's disputed claims process record retention period for hard copy documents was specified in disposition schedule NC1-146-77-01, under the title "Insurance," No. 4. Specifically, the schedule provided a two-year record retention period for correspondence on routine claims problems and contract interpretation and a five-year record retention period (or when administrative needs have been served) for correspondence on non-routine contract interpretation or unusual claims problems. All electronic records were to be stored permanently since they were not scheduled.

OPM SORN Central-1's, "Retention and Disposal" section specifies that "[a]ll records on a claim for retirement, life insurance, health benefits, and tax withholdings are maintained permanently in paper and/or electronic imaged format. … Requests for review of health benefits claims are maintained up to 3 years. Disposal of manual records is by shredding or burning; magnetic tapes and disc are erased."

Since the record retention periods varied between the disposition schedule NC1-146-77-01 and OPM SORN Central-1, we requested that OPM confirm its record retention policy for disputed claim records. In response, OPM provided a draft record retention

policy, which stated that claims correspondence related to the disputed claims process had a temporary storage requirement, which was "[c]ut off at the end of the calendar year in which the claim is settled. Destroy 3 years after cutoff." The draft did not specify whether this pertained to hard copy or electronic records.

In follow-up correspondence with OPM regarding the record retention for the disputed claims process during calendar years 2018 through 2020, OPM stated the following:

- "FEIO purges/destroys disputed claims files as indicated in the … draft retention schedule. Accordingly, there may or may not be paper files for purged cases after the three-year time frame. FDC maintains an electronic record of all documentation related to a disputed claim. In regard to cases tracked on the decommissioned HITS, each FEHB contract group may maintain electronic files beyond the three-year time frame in a folder on a dedicated shared drive."

- "The language in the draft record retention schedule does not reflect what is in the disputed claim regulations. We made suggested changes to OPIM [OPM's Office of Privacy and Information Management] regarding the disputed claim retention schedule to reflect what is in the disputed claim regulations at 5 CFR § 890.107 and 5 CFR § 890.105. The disputed claims records may be destroyed three years after the end of the calendar year in which the service was provided. For example, records relating to a disputed claim with dates of service in July 2018 may be destroyed after December 31, 2021. We will share any subsequent drafts or the final."

- "Please Note: paper and electronic files for HITS are to be determined on a case-by-case basis. HITS was not designed to store a large amount of documentation; therefore, documents were mostly stored electronically and/or in filing cabinets and some files have been purged per the FDC document retention period. OPM's HI will have to meet in the office to pull files for review."

- "Once the stale date is reached, we have not found reason to track what will be purged."

Based on OPM's responses, we determined that OPM had insufficient controls surrounding the retention of disputed claim data, specifically in electronic form, which is to be stored permanently. Also, OPM lacks written policies and procedures that would define disposition schedule NC1-146-77-01 terms "non-routine contract interpretations or unusual claims problems," which warrant a five-year record retention period. OPM's statements do not clearly indicate if it stored all electronic data related to disputed claims cases in its HITS system as required or if that data can be retrieved. Additionally, OPM cannot clearly indicate where this data may be stored, if at all, and the applicable format (hard copy or electronic).

Per OPM's Internal Administrative RMP, "all records in the system must be retrievable and usable for as long as the NARA approved retention period dictates. If the records will need to be retained beyond the planned life of the system in which the records are originally created or captured, the migration of records and their associated metadata to new storage media or formats must be planned and budgeted, in order to avoid loss due to media decay or technological obsolescence." *See* 36 CFR § 1236.12(b).

Additionally, the three-year draft record retention period is insufficient to meet the needs of OPM's disputed claims process as confirmed in OPM's RMP, which implemented the requirements of 36 CFR, Chapter XII, Subchapter B, Records Management. Specifically, OPM's RMP section 6.8.2 states that legal factors are to be considered when determining record retention periods. When legal factors are present, OPM's RMP recommends adopting a six-year record retention period.

Since 5 CFR § 890.107 allows FEHBP members to file against OPM in a court of law three years from December 31st of the benefit year in which the disputed claim originated, adopting a six-year record retention period would ensure relevant information was properly stored two to three years after the FEHBP member's right to file a case expired, depending on when the FEHBP member filed a lawsuit, ensuring disputed claims data is available for the court case itself.

Finally, during the system conversion from HITS to the FDC system, both systems were active and utilizing the same case numbering system (Y codes) for disputed claims appealed to OPM for review. Specifically, we found the following issues illustrated in Table II below:

Table II - Duplicated Y Codes

Issue	Y Code Count
Cases where the Y code is the same, but the disputed claim case is unique between FDC and HITS	185
Cases where the Y code is the same, but the carrier name and/or OPM's final decision are recorded differently in FDC and HITS	19
Cases where the Y code is the same, and the disputed claim case appears the same in FDC and HITS	1
TOTAL	**205**

The majority of the duplicated Y codes are attributable to unique disputed claims cases, which is noncompliant with OPM's RMP Section 7.3 requiring records to have a unique identifier. Since identifiers (Y codes) were duplicated on disputed claims cases and most disputed claims cases contain Protected Health Information/PII and are communicated between FEHBP members, OPM personnel, medical contractors, and carriers, there is an elevated risk that data will be inappropriately communicated, incorrectly used, and insufficiently stored.

Recommendation 12

We recommend that OPM evaluate the disputed claims data that relate to the decommissioned HITS and ensure that applicable paper files and electronic files are stored per the terms of 36 CFR, Chapter XII, Subchapter B, Records Management and OPM's RMP for the applicable disposition schedule.

Recommendation 13

We recommend that OPM update the record retention period, ensuring that it provides sufficient time for the processing and resolution of a disputed claim.

Recommendation 14

We recommend that OPM catalog the disputed claims cases where the same Y codes were applied to unique cases, and that OPM develop a unique record identifier for cases with the same Y code so that they can be clearly differentiated until the record retention requirements have expired.

Recommendation 15

We recommend that OPM develop written policies and procedures that define the role of the Y code in the disputed claims process and the specific case data to be utilized by applicable OPM personnel to identify unique disputed claims cases.

OPM's Response

OPM disagrees with the record retention finding and specifically stated, "The records in the decommissioned HITS system are retained pursuant to NARA Schedule Number NC1-146-77-01 INS 4(a), which relates to Healthcare and Insurance claims correspondence, correspondence with individuals or carrier representatives on the interpretation of contracts, and settlement of Federal employee claims under health benefits and life insurance plans.

The disposition schedule for 4-years record retention of Disputed Claims has been approved by OGC on 1/6/2023 and has been submitted to NARA for approval. This updated schedule applies to both paper and electronic files."

"OPM disagrees with updating the record retention policy for disputed claims to six years. Regarding record retention, OPM's Record Management (RM) program schedule currently in place has a 2-year records retention schedule. The disposition schedule was updated to 4-years record retention of Disputed Claims. It was approved by OPM Office of the General Counsel (OGC) on 1/6/2023 and

has been submitted to NARA for approval. The file containing the approved draft schedule is attached ... .

OIG's reference to OPM's Records Management Policy (RMP) section 6.8.2 alludes to the 6-year retention period to the Federal Tort Claims Act (FTCA) and other types of claims. It cannot be applied to disputed claims. OPM is governed by the FEHB Act (FEHBA) over the RMP. Claims must be made within 6 years after the event on which the claim is based. Few statutes of limitations affecting the retention of records are longer than 6 years. Transportation claims must be brought within 3 years of a given event. A 6-year period governs tort and other types of claims brought before the Court of Claims.

Disputed claims do not fall under tort. The statute of limitations under the Federal Tort Claims Act (FTCA) has no bearing on our records retention requirements. An FTCA claim cannot be brought in the context of an FEHB disputed claim for several reasons including that the FEHB Act (FEHBA) is the exclusive remedy for disputed claims.

The records in the FDC disputed claims system are retained pursuant to NARA Schedule Number NC1-146-77-01 INS 4(a), which relates to Healthcare and Insurance claims correspondence, correspondence with individuals or carrier representatives on the interpretation of contracts, and settlement of Federal employee claims under health benefits and life insurance plans. OPM disagrees with the OIG applying the disputed claims to the NARA schedule NC1-146-77-01 INS 4(b) – i.e., correspondence on non-routine contract interpretations or unusual claims problems. Disputed claims are not categorized as unusual claims problems. Thus the 5 years record retention period the OIG is positing in their findings does not apply to disputed claims."

Additionally, OPM states that Recommendation 15 is "not applicable since all the duplicate Y code cases have been processed and closed. The record retention requirements for those cases have expired. Since HITS was decommissioned in February 2019, the risk for duplicated Y codes has been mitigated and the FEHB staff do not have access to the data.

OPM did catalog the duplicate Y codes between HITS and FDC. OPM sorted all the Y codes in numerical order in both HITS and FDC and performed a cross-check that identified 239 duplicate Y codes ... ."

Regarding Recommendation 16, OPM believes, "[s]ince HITS was decommissioned in February 2019, duplicate Y numbers cannot ever re-occur. OPM does not currently plan to replace the FDC system. However, when the system is replaced, OPM will work to ensure there are no duplicate Y codes.

The Y number is automatically generated in FDC and is a unique identifier for a disputed claim. It was implemented based on the following Julian numbering scheme as directed by FEIO during development.

Y Code Number Generator Process
YRRDDDXXX
Where
Y=standard prefix for disputed claims cases
RR= two-digit year
DDD = Julian day (e.g., January 1 is 001, January 15 is 015)
XXX = the number of the case created that day (across all FEHB groups)
OPM will add this documentation to the Disputed Claims Process document."

OIG Comment:

We disagree with OPM's statement that, "[t]he records in the decommissioned HITS system are retained pursuant to NARA Schedule Number NC1-146-77-01 INS 4(a)". OPM itself notes in SORN OPM/Central-27, issued August 12, 2022, that "[t]he disputed claims and complaints records are subject to the NARA-approved records schedule NC1–146–77–01 INS 4(b) relating to Healthcare and Insurance claims correspondence, correspondence with individuals or carriers' representatives on the interpretation of contracts, and settlement of Federal employee claims under health benefits and life insurance plans." Furthermore, in response to the draft report, OPM provided correspondence that indicated disputed claims are considered non-routine matters, as such the record retention is 5-years as specified in NC1-146-77-01 INS 4(b).

OPM's noncompliance with its own disputed claims record retention policies is of great concern as it may allow for the premature disposal of disputed claims documentation needed during litigation. We do not agree that Section 6.8.2 of OPM's RMP exclusively "alludes to … the Federal Tort Claims Act (FTCA) and other types of claims." Furthermore, it is unclear what basis OPM used to reduce the in-effect record retention period of five years, specified in NC1–146–77–01 INS 4(b), to four years in the updated disposition schedule approved by OGC on January 6, 2023, and submitted to NARA for approval. A final concern is that since OPM HI and OGC appear to agree that OPM HI has some flexibility in determining how the 90 days are counted for OPM's review, the total number of days OPM ultimately takes to render a decision on a disputed claims case could take well beyond 90 consecutive days. This increased amount of time further decreases the amount of time a member has to file a claim against OPM should the member disagree with OPM's decision. Unfortunately, the time limit for a member to file suit does not share the same flexibilities that OPM's review period has. Depending upon the amount of time this process ultimately takes to

resolve a disputed claim, it is possible that the time needed could surpass OPM's revised records retention policy for these claims. Based on the above, we are concerned that the new four-year record retention period, pending NARA approval, will not be sufficient.

Since OPM has not provided evidence that the revised disposition schedule was approved by NARA, the HITS-based disputed claims cases still have a five-year retention period, which will extend into 2024 based on the decommission date of February 2019 for HITS. Additionally, if the revised disposition schedule includes the drafted four-year record retention period specified for disputed claims at NC1–146–77–01 INS 4(c), then OPM will need to update SORN OPM/Central-27 to align with the new schedule.

Regarding the duplicate Y codes, we recognize that OPM provided a catalog for our review with its draft report response. However, OPM did not assign unique identifiers to eliminate the duplications nor did OPM provide written policies and procedures for applicable OPM personnel to utilize the catalog for clear identification of unique disputed claims cases moving forward. Although HITS is decommissioned, the current record retention of HITS case files is permanent for paper files and five years for electronic files. Moreover, if NARA approves the revised disposition schedule, which contains a four-year record retention for both paper and electronic files and will be likely applied retroactively, OPM will need to have a process established to clearly identify the case files prior to appropriate disposal of the records.

As previously communicated in this report, OPM has yet to provide its proposed "Disputed Claims Process document" to us to review. Therefore, we cannot express an opinion on whether this document will sufficiently address the findings and recommendations in this report. However, we would be happy to review and comment on the document once it is finalized by OPM. We also recommend that OPM consult GAO's Green Book in developing its process document to ensure that the policies/procedures/protocols established provide an appropriate framework for how disputed claims should be processed, reviewed, and resolved.

EXHIBIT A

Disputed Claims Cases Sample Selection Methodology							
Disputed Claims Review Area	**Universe of Disputed Claims (Number)**	**Sampled Carriers (Including plan codes)**	**Total Disputed Claims by Carrier (Number)**	**Percentage of Total Disputed Claims by Carrier**	**Sample Criteria**	**Sample Number**	**Results Projected to Universe?**
OPM's FEHBP Disputed Claims (FDC) system disputed claims cases for benefit years 2018 through 2020	4473	Blue Cross Blue Shield (sampled plan codes: 10, 11)	1800	53%	Judgmentally selected 5 carriers that represent the majority of the disputed claims universe in OPM's FDC system, administered by OPM HI FEIO FEHB 1, FEHB 2, and FEHB 3. Then randomly selected 50 samples from FDC based on the percentage of total carrier disputed claims of the 5 selected carriers.	27	No
		Government Employees Health Association (sampled plan codes: 31, 34)	1005	30%		15	
		Mail Handlers Benefit Plan (sampled plan codes: 41, 45)	231	7%		3	
		Aetna (sampled plan codes: 22, JN, JS)	277	8%		4	
		United, MDIPA, HPNV (sampled plan code: JP)	58	2%		1	
		TOTAL	**3371**	**100%**		**50**	
OPM's Health Insurance Tracking System (HITS) disputed claims cases for benefit years 2018 through 2020	1429	Blue Cross Blue Shield (sampled plan codes: 10, 11)	762	70%	Judgmentally selected 5 carriers that represent the majority of the disputed claims universe in OPM's HITS, administered by OPM HI FEIO FEHB 1, FEHB 2, and FEHB 3. Then randomly selected 50 samples from HITS based on the percentage of total carrier disputed claims of the 5 selected carriers.	35	No
		Government Employees Health Association (sampled plan codes: 31, 34)	233	22%		11	
		Mail Handlers Benefit Plan (sampled plan codes: 45)	25	2%		1	
		Aetna (sampled plan codes: JN, N6)	52	5%		2	
		United, MDIPA, HPNV (sampled plan code: KT)	10	1%		1	
		TOTAL	**1082**	**100%**		**50** [15]	

[15] Of the 50 HITS samples selected in Exhibit A, OPM supplied electronic documentation for 17 of the samples. Since the remaining HITS samples could not be reviewed remotely, we selected an additional sample of 14 FDC disputed claims for review. See Exhibit B for the methodology related to the additional sample.

EXHIBIT B

Disputed Claims Cases Sample Selection Methodology - Additional Samples					
Disputed Claims Review Area	**Universe of Disputed Claims (Number)**	**Sampled Carriers (including plan codes)**	**Sample Criteria**	**Sample Number**	**Results Projected to Universe?**
OPM's FEHBP Disputed Claims (FDC) system disputed claims cases for benefit years 2018 through 2020.	4473	Blue Cross Blue Shield (sampled plan codes: 10, 11)	Judgmentally selected 13 disputed claim cases from FDC where either OPM or the carrier indicated that the disputed medical or pharmacy benefit exceeded FEHBP brochure limitations, and the benefit was designated as an audit lead.	5	No
		Government Employees Health Association (sampled plan code: 31)		6	
		Compass Rose (sampled plan code: 42)		2	
		Blue Cross Blue Shield (sampled plan code: 11)	Judgmentally selected 1 disputed claim for review that was called in by an FEHBP member on the OPM OIG Hotline.	1	
			Total Additional FDC Samples	**14**	

EXHIBIT C

OPM Omitted Disputed Claims Cases - Sample Selection Methodology							
Disputed Claims Review Area	**Universe of Disputed Claims Cases (Number)**	**First Level Sample Criteria**	**Carriers Reporting Disputed Claims Data to OIG (including plan codes)**	**Disputed Claims Cases Reported by Carriers but not OPM**	**Second Level Sample Criteria**	**Sample Number**	**Results Projected to Universe?**
OPM's FEHBP Disputed Claims (FDC) system disputed claims cases for benefit years 2018 through 2020 as of 2/24/2022.	4763	Compared OPM's reported disputed claims cases to the disputed claims cases reported by 4 sampled carriers.	Blue Cross Blue Shield (sampled plan codes: 10, 11)	28	Disputed claims cases reported by 4 sampled carriers that were appealed to OPM in calendar years 2019 and 2020.	16	No
			Government Employees Health Association (sampled plan codes: 31, 34)	48		33	
			Mail Handlers Benefit Plan (sampled plan codes: 41, 45)	10		8	
			Aetna (sampled plan codes: 22, JN, JS)	17		13	
			TOTAL	**103**		**70**	

APPENDIX

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
1900 E Street, NW, Washington, DC 20415

Healthcare and
Insurance

DATE: February 24, 2023

MEMORANDUM FOR: MICHAEL R. ESSER
Assistant Inspector General for Audits

FROM: LAURIE E. BODENHEIMER
Associate Director, Healthcare and Insurance

SUBJECT: OPM's Response to the Draft Audit of Office of Personnel Management's Disputed Claims Process, Report Number 2022- CAAG-001, issued December 21, 2022

Thank you for providing OPM the opportunity to respond to the Office of the Inspector General (OIG) draft report, Disputed Claims Process, 2022-CAAG-001. The draft report contains 17 recommendations. We have reviewed the draft report and believe there are several misunderstandings regarding the disputed claims process that we would like to clarify in this response.

The authority that guides the FEHB disputed claims process is found in 5 Code of Federal Regulations (CFR) 890.105 and .107-, 48 CFR 1652.204-72, Federal Employees Health Benefits Acquisition Regulations (FEHBAR) Part 1604, and the FEHBP Carrier contracts. OPM makes final decisions with respect to disputed claims on a case-by-case basis. Even if cases may appear to be similar; each medical case is unique based on unique individual circumstances, and OPM retains administrative discretion in how it adjudicates claims. Final decisions are based on the plan brochure which is the complete contractual statement of benefits available to the member, and the unique member medical circumstances including clinical history. We exercise appropriate judgement and act equitably in the best interests of the members and the FEHB Program and may exercise discretion in our enforcement of filing deadlines where equity demands.

There were several complexities in gathering the data the OIG requested during the audit.

- During the scope years of the audit, OPM transitioned from its Health Insurance Tracking System (HITS) to a new disputed claims system, FEHB Disputed Claims System (FDC). The transition to the new system complicated OPM's response requiring

data to be gathered from two different sources after HITS was decommissioned. The FDC system began development in the fall of 2018 with a minimal viable product (MVP) as is the standard in technology development. Improvements to the system were ongoing over the next two years and continue to this day, in the interest of enhanced processes and continuous quality improvement.

- The Draft Report indicated, "…OPM had to resubmit the data for our review multiple times due to querying errors and missing data fields, which caused us to doubt its reliability". There were technical issues with the system ad hoc reporting tool in FDC that were not revealed until we pulled and sent data to the OIG. Once we realized the issue, we notified the OIG and worked with our developers to ensure the requested data was correctly pulled and resubmitted to the OIG. In addition, OPM provided relevant reportable data fields to the OIG; however, there are some fields that OPM could not provide as the fields cannot be reported (e.g., case notes and dates on the auto-generated letters). These non-reportable fields cannot be queried but can be viewed in the FDC system. The OIG's analysis of only our reportable data fields was not a complete picture of the case, because elements within the system such as case notes and the audit trail holds critical information to understanding the entire case. Without this information, it resulted in numerous apparent instances of untimeliness and skewed audit findings.
- Since OPM could not provide the OIG with data from those non-reportable fields, we provided narrative responses to the notice of findings and recommendations (NFR) which detailed each case. The OIG has requested additional documentation/ evidence to support OPM's narrative. The documentation is in the FDC system. OPM has extended several invitations to OIG to view the entire case files either in person or via a virtual FDC system walkthrough and that invitation remains open.

- The Draft report cited 70 claims cases the OIG received from the carriers that OPM did not report. These cases were not missing from the OPM data file. OPM and the carriers used two different data queries. OPM queried on benefit years 2018-2020, while the carriers used date received between 2018-2020. OPM was not intentionally withholding data. OIG did not request a different data submission after they were aware the data was pulled based on benefit year. Had OPM used the same query as the carriers, then those 70 claims would have been included in the data we provided. Also, of those 70 claims, two had incorrect Y numbers. This may have resulted from the carrier incorrectly entering/providing the Y numbers. OPM identified the correct Y numbers via a search of the member's name. These two correct Y numbers already existed in the data we had previously provided to the OIG. The evidence for this and an updated FDC data set using date received query is attached in the Response to Draft Audit Report folder (70 Carrier Claims, Updated Data Extract FDC 1-26-23).

The Draft report indicates that OPM's review of disputed claims cases was frequently untimely. OIG's counting methodology for timeliness is constrained to consecutive day count. It is OPM's longstanding practice to uphold the health plan's denial when the member cannot or does not provide adequate information. and to allow the member the opportunity to provide additional information. If OPM receives additional information, the case is re-opened and the clock begins anew. This break in counting allows time for the member to gather medical records and other information needed for their case. This works in favor of and in no way harms the member. In addition, the regulation does not restrict the review period to 90 consecutive days. OPM has authority to interpret and implement its rule on how the 90 days is counted and has appropriately excluded days when the member has been given time to gather additional information from the OPM processing time. OPM is providing an audit trail report and a case history report for the 54 disputed claims identified in Table 1 as supporting documentation. The files are attached in the Response to Draft Audit Report folder (Documentation – 54 cases).

The OIG expressed concerns for the risk of duplicate Y code cases; however, OPM wants to clarify that the FDC system generates unique codes. More importantly, the HITS system was decommissioned February 2019, mitigating the risk for any additional entry of Y codes outside of the FDC system. All that remains of HITS is one large data file not accessible to the FEHB staff. We rely on the Systems Development and Implementation team in HI's Program Development and Support (PDS) to provide data from HITS. Additionally, all duplicate Y code cases were processed and closed prior to 2022. Therefore, there is virtually no risk that data will be inappropriately communicated, incorrectly used, or insufficiently stored.

The OIG's common theme throughout this draft report is focused on OPM's need to strengthen its internal controls and written policies and procedures. OPM acknowledges OIG's concerns regarding our internal controls, including written policies and procedures. The OIG references strengthening internal controls and written policies and procedures in nine of the 17 recommendations in the draft report. Since Recommendations 1,3,4,5,6,10,11,13 and 17 all cover multiple areas addressed, we ask these be combined into one overall recommendation. Also, OPM notes that Recommendations 2 and 9 are similar and recommends that these two recommendations be combined into one recommendation.

Responses to your recommendations, including planned corrective actions, as appropriate, are provided below. Technical comments are included in Appendix A.

Lack of Official Policies and Procedures

Recommendation 1: We recommend that OPM immediately implement internal controls,

including written policies and procedures, over the disputed claims process to ensure it is in compliance with the time limitations specified in 5 CFR § 890.105, including but not limited to:

- policies/procedures to govern the 90-day window allotted for OPM to review disputed claims;
- policies/procedures to govern how OPM will address disputed claims appealed to them when the carrier reviewed the disputed claim outside the allotted timeframe and/or the FEHBP member's window to appeal expired (either at the carrier level [FEHBP Benefit Brochures, Section 8, Step 1 and 2] or OPM's level [FEHBP Benefit Brochures, Section 8, Step 3 and 4]; and
- roles and responsibilities by position title of OPM personnel tasked with duties during the disputed claims process.

Management Response: We partially concur.

OPM agrees with the intent of this recommendation, that OPM have stronger internal controls and written policies and procedures. OPM has written policies and procedures in place that govern the disputed claims appeal process by Federal regulation. These written policies and procedures are contained within discrete documents that include 5 CFR 890.105 and 5 CFR 890.107, 48 CFR 1652.204-72, FEHBAR Part 1604, the FEHB Program Carrier contracts, and position descriptions of OPM personnel. OPM will combine the information from these discrete written policies and procedures into a summarized Disputed Claims Process document.

The response below addresses each of the bulleted items in Recommendation 1.

Bullet #1: Policies/procedures to govern the 90-day window allotted for OPM to review disputed claims.

The draft report states, "OPM repeatedly missed the 90-day review requirement established by 5 CFR § 890.105 and without sufficient support, elected to open, close, and review disputed claims outside the parameters of 5 CFR § 890.105."

OPM non concurs that OPM repeatedly missed the 90-day review requirement. As previously indicated, OPM exercises its judgment and acts equitably in the best interests of the members and the FEHB Program. In instances where additional information is needed from the member, it is OPM's longstanding practice to uphold the health plan's denial when the member cannot provide adequate information and to allow the member the opportunity to provide additional information. If OPM receives the additional information, the case is re-opened and the clock begins anew. It can take time for members to gather medical records. This break in counting allows time for the member to provide the information needed and does

not harm the member. It also works in favor of the FEHB Program to prevent litigation since the last opportunity a member has in the disputed claims process is a lawsuit against OPM.

In addition, the regulation does not restrict the review period to 90 consecutive days. OPM has authority to interpret and implement its rule on how the 90 days is counted. Furthermore, OPM considers the extenuating circumstances of the members when opening, closing and reviewing cases. These practices are in the best interest of our members to ensure they receive the benefits the carriers are contractually obligated to provide, which ensures appropriate contract oversight and enforcement and avoids legal risk. In addition, often extenuating circumstances are included in system case notes that were not reviewed by OIG.

The draft report states, "OIG found that OPM's self-imposed 60-day review period, outlined in Section 8 of the FEHBP brochures, does not align with the 90-day review period allotted in 5 CFR§ 890.105." The regulations establish a 90-day period for OPM review and action, which includes notification. OPM's practice, since 2001, is to review disputed claims within 60 days and is within the 90-day regulatory allowance. A shorter review period benefits the members when OPM disagrees with the Plan's denial by providing the appeal decision sooner. The OIG does not indicate how processing a disputed claim case in a shorter timeframe harms the member nor does the OIG provide documented member inquiries that indicate they were confused by the longer/shorter review periods. The OIG cites a legal case, Campbell v. OPM 384 F.Supp. 2d 951, 952 (W.D. Virginia 2004), and indicates that OPM will ultimately be held to its regulations regarding the FEHB disputed claims process. The Campbell case involved the issue of medical necessity. At page 956, the Court expressly states that OPM did not act arbitrarily by failing to decide the matter within 90 days and indeed OPM did not act arbitrarily by failing to comply with the regulation stating notice of status should be given if decision is not made within 90 days. The Court determined that the regulation grants OPM broad discretion to determine the timeframe of its review.

In another legal case, Volvo Trucks of North Amer, Inc., 367 F.3d 204, 208-209 (4th Cir 2004), the 4th Circuit Court states, "…Finally, Volvo makes the astonishing argument that in order to avoid arbitrariness and capriciousness, "an administrative agency must uniformly apply its regulations to all applicable situations." *209 Such a standard would be impossible for any agency to achieve. The inherently discretionary nature of enforcement duties means that, in the absence of an unconstitutional motive, the agency cannot be required to apply each of its regulations mechanically to every situation that falls under them." The Court's decision allows for an agency's discretion in interpreting its regulations.

Bullet #2: Policies/procedures to govern how OPM will address disputed claims appealed to them when the carrier reviewed the disputed claim outside the allotted timeframe

and/or the FEHBP member's window to appeal expired (either at the carrier level [FEHBP Benefit Brochures, Section 8, Step 1 and 2] or OPM's level [FEHBP Benefit Brochures, Section 8, Step 3 and 4].

OPM does not concur. As indicated previously, OPM and Carriers have discretion to review claims outside of the time limit. OPM holds carriers accountable for reconsideration and disputed claims in the Contract Oversight domain of FEHB Plan Performance Assessment that ties profit to performance.

OPM operates in the best interests of the enrollee and the FEHB Program. A carrier may have reason to review a dispute outside the regulatory timeframe. When a Carrier provides a reconsideration decision to an FEHB member, and the member seeks a final administrative decision, OPM reviews the appeal. OPM is the party that the enrollee may sue. A Judge may remand the case back to OPM to review a disputed claim. When this occurs, these claims are a reviewed outside of the 90-day timeline. It is in the enrollee and OPM's best interest to provide a final administrative decision on whether a service is covered under the contract rather than refuse coverage due to a technicality which may not be defensible in court. In the cases that OIG discussed under OPM's response to Bullet #1, both the carrier and OPM exercised discretion and judgement afforded by the regulations to proceed with review. We do not see anything that would indicate that either decision to proceed was arbitrary or capricious.

Bullet #3: Roles and responsibilities by position title of OPM personnel tasked with duties during the disputed claims process.

OPM partially concurs. The roles and responsibilities of each position are contained within the position descriptions. OPM agrees to strengthen our written policy and procedures and to add a link to the position descriptions in the summarized Disputed Claims Process document. However, OPM disagrees with the statement that we are not implementing internal controls regarding the roles and responsibilities of each position. The written policies and procedures already exist.

Recommendation 2: We recommend that 5 CFR § 890.107 be revised to align the start of FEHBP members' due process rights to the date of OPM's decision on the appeal and not the date on which the health service was provided.

Management Response: We do not concur.

OPM does not agree to OIG's recommendation to revise this regulation that has been in place since 1996. This timeframe reflects our contractual statement of benefits language over many years. It is our experience that this timeframe works well and there have been no concerns from

members regarding this regulation. OPM disagrees with the recommendation to change the regulation to tie the "right to sue OPM" to the year in which the service was performed. Review time frames flow from the date of service and 3 years is ample time to file suit.

In addition, the OIG states that OPM reviewed 21 of 81 disputed claims cases outside of the 90-day limit. As previously noted, OPM has discretion to review cases outside the 90-day limit. OPM analyzed the 21 cases the OIG audited and found the following:

- OPM OIG is correct in that 9 of the 21 cases were reviewed beyond the 90-day limit. Between August 2020 and January 2021, OPM's authority required additional administrative review. This resulted in a backlog of cases that continued through May 2021.
- Of the remaining 12 cases – ten cases were closed for lack of information and reopened upon timely receipt of additional evidence with actual days of review period less than 90 days.
- The remaining 3 cases were also appropriately reviewed as allowed under 5 CFR 890.105(e)(1)(iii).

OIG created a counting methodology for timeliness that was constrained to a consecutive day count. It is not factoring the stoppage time when a case is closed while the member may gather additional information. For example, from the sample of 21 cases, OPM received a claim on 2/14/2019. It was closed on 4/16/2019 due to lack of information. The case was reopened 7/9/2019 when additional information was provided and then the case was closed on 7/18/2019. The OIG's consecutive days counting methodology considers the review of this case to be 154 days, while it is 56 days in OPM's business process. The OIG may want to consider the 84 days the case was closed. OPM is providing an audit trail report for the 21 disputed claims as supporting documentation. It includes the dates the cases were closed and re-opened. The files are attached in the Response to Draft Audit Report folder (Documentation – 21 cases). OPM invites the OIG to a walkthrough the FDC system as it provides the entire case history for each disputed claim.

Recommendation 3: We recommend that OPM implement written policies and procedures to address the use of additional information letters in the disputed claims process to meet the requirements specified in 5 CFR § 890.105(e)(4).

Management Response: We partially concur.

When OPM does not have sufficient information to review a disputed claims case, it sends a letter to the member requesting the information per 5 CFR § 890.105 (e)(2). The letter states

that if information is not provided within 30 days, then the case is closed due to insufficient information. The letter provides the status of the claim and that without sufficient responsive information, the member's appeal will not result in a directive to the carrier to pay the claim. It is OPM's longstanding practice to not send a subsequent letter closing the claim if no additional information is received.

The OIG indicates there were inconsistencies with OPM's decision letters. Specifically, the OIG noted three instances of letters sent requesting additional information where a subsequent letter was sent closing the case. OPM acknowledges that in these instances, our practice of sending one letter was not followed. In the past year, OPM has reviewed disputed claims letters for consistency among the FEHB divisions and included standard language in template letters when we request additional information to ensure uniformity. The letters are in the process of being refined.

The draft report indicates that OPM's practice of sending a letter to request additional information from the member and upholding the plan's denial if the information is not sent does not align with 5 CFR § 890.105 (e)(4). The draft report also indicates that this practice places the onus for continued disputed claim resolution back on the member instead of OPM. We believe the additional information letter meets the requirements of 5 CFR § 890.105 (e)(4) and a second letter is not needed as OPM has the right to decide based on the available information. Our additional information requests communicate a final decision based on the file we received. See 5 CFR § 890.105(e)(2)(iv). Also, 5 CFR § 890.105(e)(4) states, "Within 90 days after receipt of the request for review, OPM will either: (i) Give written notice of its decision to the covered individual and the carrier; or (ii) Notify the individual of the status of the review." The letter requesting additional information complies with (i) as the letter states that if information is not provided within 30 days, then the case is closed due to insufficient information. Therefore, the dispute is a final decision that the case is closed and OPM's failure to find for the enrollee results in a denial.

In addition, the draft report states that OPM did not consistently provide members with a status update regarding their case in 21 of the 81 disputed cases it reviewed. We disagree with this statement as we provide contact information on the acknowledgement letter and most members call for a status.

Redacted by the OPM-OIG. Draft Report Recommendation 4 Removed.
Intent of Recommendation 4 Is Covered by Recommendation 3.
OPM's Draft Response (below) Is Applicable to the Final Report, Recommendation 3.

Management Response: We do not concur.

As indicated in our response to Recommendation 1, it is OPM's policy and practice to provide a decision and offer the member the opportunity to provide the additional information for over 25 years. This break in counting days allows time for the member to provide information needed for their case, including gathering medical records.

There are also procedures built within the FDC system that control opening and closing cases. For example, a case cannot be opened or closed until all the required information is entered. A case can be reopened, but a specific reason must be selected.

The draft report cites various inconsistencies with the 81 disputed claim samples it reviewed. OPM analyzed these cases, and our response is below.

- The 4 cases noted as closed and reopened without a documented reason, were reopened to change the decision.
- Of the 3 cases where OPM issued information request letters to the FEHB enrollee and closed the case in FDC prior to the 30-day response window, this is our normal process. Cases are closed when the insufficient information (INF) letter is sent and while awaiting a response from the member when the case is reopened.
- Of the 8 cases that were closed and reopened well after the 30-day response window closed: 4 were reopened within the 30 days or the member called and requested more time; 2 were closed for INF but then re-opened to change the decision from INF to Decision Sustained and the cases were not reviewed after the 30-day response window; one accepted additional information after 30 days because the provider said they did not receive our April letter requesting medical records; and one was accepted late because the appeal was for a pre-service and the enrollee was still pursuing future surgery.
- Of the 2 cases where the enrollee provided additional information untimely, one case was processed timely and the other case was 8 days over the 90-day timeframe due to the member's request for additional time. Supporting information provided from the FDC system case notes communications with the member.

Recommendation 5: (Recommendation 4 in the Final Report) We recommend that OPM implement policies and procedures to govern the disputed claims process, provide the policies and procedures to applicable OPM personnel, and implement a plan to review and update the policies and procedures regularly.

Management Response: We partially concur.

OPM's written policies and procedures are contained within discrete legal documents that

include 5 CFR 890.105-106, 48 CFR 1652.204-72, FEHBAR Part 1604, the FEHBP Carrier contracts, and position descriptions of OPM personnel. These documents represent OPM's policy/procedures. OPM agrees to combine the information from these discrete written policies and procedures into a summarized Disputed Claims Process document. OPM will also establish a schedule to regularly review the process for improvement.

The draft report details several issues the OIG found in its review of 81 disputed claims cases. OPM does not concur with the OIG's findings and believes that the OIG did not have sufficient evidence to draw the conclusions indicated in the draft report. OPM was unable to verify OIG's statements of process inconsistencies or decisions contrary the requirements. Evidence was not provided to indicate true process inconsistencies or final decisions made on disputed claims that were contrary to documented procedures, the FEHB brochure, or 5 CFR § 890.105. Final decisions are based on the contractual statement of benefits found in the plan brochure and the unique member medical circumstances, including their clinical history. Decisions are made on a case- by-case basis and there are no global decisions based on the type of service or the reviewer.

The OIG cites several disputed claim samples found issues "…included but were not limited to; inconsistent decisions on disputed claims, carrier decisions overturned contrary to the Contract and CDC guidelines, and violations of the FEHB member rights under the Consumer Bill of Rights, including a lack of evidence-based decision making and a lack of guidance specifying OPM's use of an independent medical review and the resulting professional recommendations."

OPM disagrees with the OIG's findings except in the case where a member's information was mistakenly sent to another member. OPM investigated this incident and found it was an unfortunate human error. OPM appropriately submitted this information to OPM CyberSolutions as required and contacted the individual to ensure the inadvertent release of information was destroyed.

OPM disagrees with the statement in the draft report that OPM made decisions in conflict with guidance from the CDC. As previously stated, OPM makes decisions on a case-by-case basis based on the definition of medical necessity found in each health plan's respective brochure and there are no global decisions, even if the case appears to be a like kind case, as each case and each member and their clinical needs is unique. Furthermore, the CDC updated its 2016 guidelines in 2022 at https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm?s_cid=rr7103a1_wNew. The new guidance reflects the evolution in thinking in how opioids should be used, and the reality of how they are being used. According to the CDC, the original guidelines issued in 2016, helped further drive down opioid prescribing levels that had been in decline since 2012, as the country grappled with its legacy of overprescribing that contributed to the overdose epidemic. But

critics contended the 2016 guidelines, while helping limit new prescriptions, introduced other harms by leading to unsafe dose reductions for people already on opioids and some long-term patients being cut off from medication on which they depended. A major theme of the 2022 guidelines is that people with pain need individualized care, and that prescribers need to calibrate doses and timeframes to meet each unique patient's needs, all while still trying to minimize the harms that can come with opioid use.

Regarding the disputed case claim samples the OIG reviewed, OPM stands behind its responses provided in NFR #4. The draft report misinterprets OPM's discretion in reviewing each case, which results in inaccurate findings. Final decisions are based on the contractual statement of benefits provided in the Plan brochure, the service in question, and the unique medical circumstances of each member and their appeal. OPM engages independent medical consultants in the medical specialty necessary for the specific diagnosis or treatment to provide OPM with opinions when cases involve medical determinations. Decisions are made on a case-by-case basis and there are no global decisions based on the type of service or the reviewer.

On the Independent Review Organization (IRO) side, the reviewer must electronically attest to having no conflict of interest with the parties involved and no prior participation in the case under review before being allowed access to the records. OPM understands a provision that requires this attestation is in the provider's agreement.

Recommendation 6: **(Recommendation 5 in the Final Report)** We recommend that OPM immediately implement controls in FDC and written policies and procedures for the administration and use of FDC to ensure:

1. All FDC users are tracking disputed claim cases in the system consistently.
2. Disputed claims cases are consistently opened and closed in FDC among all users.
3. Disputed claim cases remain open in FDC during the 30-day FEHBP member response window, and OPM's 90-day review time frame includes the FEHBP member additional information letter process in cases where the FEHBP member responds timely.
4. The date of the FEHBP member additional information letter and the FEHBP member response date (if applicable) are made reportable fields in FDC.
5. OPM is compliant with 5 CFR § 890.105(e)(5) and documents in FDC sufficient evidence to prove the FEHBP member provided new information after OPM made its decision, which warrants the reopening of the case.
6. All data components, including the medical codes (Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), etc.), are populated in FDC.
7. A process is established to assess FDC data trends, issues, and errors so that corrective action can be implemented timely.

Redacted by the OPM-OIG. Not Included in the Final Report.
Management Response: We partially concur.

Our response to each statement in the recommendation is detailed below.

1. All FDC users are tracking disputed claim cases in the system consistently.

We do not concur. As the new system was being developed and transitioned, and the team members trained, there may have been some variance, but all FDC users are and have been processing disputed claims in the FDC system consistently across the FEHB groups for more than two years. The system allows some flexibilities with certain fields and actions to accommodate the differences in disputed claims cases to enhance customer service.

2. Disputed claims cases are consistently opened and closed in FDC among all users.

We do not concur. The functionality to open, close, and re-open cases was programmed to avoid constant Administrator override. It gives the LAS flexibility. Each time a closed case is addressed in FDC, by system functionality the case is re-opened. But regardless of how many times a case is opened, closed, or re-opened, the entire history of those actions are captured in an FDC audit trail.

3. Disputed claim cases remain open in FDC during the 30-day FEHBP member response window, and OPM's 90-day review time frame includes the FEHBP member additional information letter process in cases where the FEHBP member responds timely.

We do not concur. Please see our response to Recommendation 1, 3 and 4 to avoid redundancy. OPM disagrees that cases should remain open during the 30-day member response window and that the 90-day review time should include the days included in the member's additional information letter process.

4. The date of the FEHBP member additional information letter and the FEHBP member response date (if applicable) are made reportable fields in FDC.

OPM does not concur with this statement since the date of the FEHB enrollee additional information letter is captured in the FDC system automatically when uploaded into the system. However, these dates are not captured in reportable data fields. As a result, they cannot be queried nor reported. But they can be accessed in the FDC system audit trail.
Making these two date fields reportable does not align with OPM's business processes, as OPM does not use the data from these 2 date fields in our processing timeliness calculations.

5. OPM is compliant with 5 CFR § 890.105(e)(5) and documents in FDC sufficient evidence to prove the FEHBP member provided new information after OPM made its decision, which warrants the reopening of the case.

OPM does not concur. Cases are re-opened when new information is received, to make a change or add other information to a case file. As previously indicated above in Recommendation 1, bullet 1, we exercise our judgment and act equitably in the best interests of the members and the FEHB Program. In reviewing an entire case file, including the case notes in the FDC system, OPM has the relevant information regarding reopening a case.

6. All data components, including the medical codes (Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), etc.), are populated in FDC.

OPM does not concur. CPT codes are generally not applicable to contractual cases. Medical codes, including CPT and HCPCS, are not typically provided or available to the Legal Administrative Specialist (LAS) when initially creating the disputed claim case.
Making this field a requirement will add administrative burden, may delay the opening of a case and is not necessary for identifying trends.

7. A process is established to assess FDC data trends, issues, and errors so that corrective action can be implemented timely.

OPM partially concurs with this statement. The FEHB Program Managers/Chiefs have had the ability to perform ad hoc queries to monitor trends and employee performance for more than 2 years. Dashboard reports are under development for these and other purposes. The Chiefs and Health Insurance Specialists can identify trends based on the names of procedures, names of the providers, etc.

8. Review at a sufficiently high level, including ensuring quality assurance measures are applied consistently to each disputed claims case in FDC.

OPM does not concur. This is not a system issue. Quality assurance (QA) measures are applied in the business processes, not the system. The Supervisory Legal Administrative Specialists (LAS) review disputed claims responses. The FEHB Contracting Officers review 100% of all directives. FEIO leadership is developing an additional QA process where the Health Insurance Specialists also review a sample of cases from their assigned Plans.

9. Security protocols are sufficient to address the inherent risks from all FDC users,

including internal (OPM) and external (carrier and contractor) users.

OPM does not concur. The draft report did not provide any details to indicate that security protocols were not sufficient. All OPM Systems, including the FEHB Disputed Claims (FDC) system must meet Federal Information Security Modernization Act (FISMA) requirements and standards. Compliance activities includes risk categorization, determining minimum baseline security controls, documentation of those controls, monitoring those controls on a continuous basis, and annual security reviews of core system documentation. HI meets regularly with the OCIO Information and Systems Security Office (ISSO) to ensure all required security controls are met.

Recommendation 7: (Recommendation 6 in the Final Report) We recommend that OPM implement a disputed claims process training program for new and current employees to ensure all personnel involved in the disputed claims review, regardless of assigned FEHB Group, are reviewing disputed claims timely and consistently.

Management Response: We do not concur.

Supervisory Legal Administrative Specialists (LAS) provide one-on-one, on-the-job training for all new LAS with responsibility for disputed claims, including review of decision letters. In 2022, HI added Supervisory Legal Administrative Specialists in each FEHB division whose position includes training LAS'. The Chief assigned will continue to train Supervisory LAS. OPM has a complete set of training materials which are being provided in separate attachments, consisting of 20 files. The files are in the Response to Draft Audit Report folder (Training Materials).

Recommendation 8: (Recommendation 7 in the Final Report) We recommend that OPM implement a disputed claims quality assurance program to ensure that the disputed claims data is regularly reviewed for:

- Consistent and timely logging and addressing of FEHBP member correspondence.
- The identification of concerning trends with providers, procedures, prescriptions, etc.
- Consistent reviews of like-kind claims.
- OPM's adherence to the implemented policies and procedures.
- Consistent handling of IMR reviews, especially in cases where the carrier provided at least one IMR itself.
- Prompt identification and correction of human errors.

Management Response: We partially concur.

OPM has a quality assurance process that involves the LAS, Branch Chief, and Group Chief. The Supervisory Legal Administrative Specialist (LAS) reviews the work of the LAS. The FEHB Chief reviews 100% of all directives. When necessary, the nurse consultants, the Chief Medical Officer, the Chief Pharmacy Officer or the IRO medical consultants may be engaged on clinical matters. In addition, the Chiefs have had the ability to perform ad hoc queries to monitor trends and employee performance for more than two years. Dashboard reports are being developed for trending, employee performance and other purposes. OPM looks for opportunities to improve our Quality Assurance process.

In response to each of the bullets:

- **Consistent and timely logging and addressing of FEHBP member correspondence.**
    - The draft report does not provide evidence of untimely or inconsistent logging and addressing member correspondence.
- **The identification of concerning trends with providers, procedures, prescriptions, etc.**
    - We are developing Power BI dashboards that will show various trends.
- **Consistent reviews of like-kind claims.**
    - As previously indicated, each member's disputed claim, their medical history and clinical picture is unique. Decisions are made on a case-by-case basis and there are no global decisions based on the type of service or the reviewer.
- **OPM's adherence to the implemented policies and procedures.**
    - OPM agrees to strengthen our written policy and procedures.
- **Consistent handling of IMR reviews, especially in cases where the carrier provided at least one IMR itself.**
    - Each IMR review is based on the unique set of circumstances for the disputed claim including provider specialty, medical records and clinical history.
- **Prompt identification and correction of human errors.**
    - OPM takes any errors seriously and immediately corrects them. OPM aims to mitigate future errors by strengthening our internal controls.

Conflicting Timeliness Criteria

Recommendation 9: **(Recommendation 8 in the Final Report)** We recommend that OPM update Section 8, Part 4 of the FEHBP benefit brochures to align with the 90-day review limitation specified in 5 CFR § 890.105(e)(4), 48 CFR
§ 1652.204- 72(e)(4), and the FEHBP carrier Contract language Section 2.8(e)(4).

Management Response: We do not concur.

As indicated in response to Recommendation 1, the regulations establish a 90-day period of time for OPM review and for OPM to take action, which includes notification. OPM's practice, since 2001, is to review disputed claims within 60 days, which is within the 90-day regulatory allowance.

Redacted by the OPM-OIG. Draft Report Recommendation 10 Removed. Intent of Recommendation 10 Is Covered by Other Report Recommendations.

Untimely Freedom of Information Act (FOIA)/Privacy Act (PA) Response

Recommendation 11: **(Recommendation 9 in the Final Report)** We recommend that OPM implement internal controls, including written policies and procedures, to ensure that FOIA/PA requests can be met within the statutory deadlines.

Management Response: We concur.

OPM acknowledges a FOIA request not completed timely due to extenuating circumstances. OPM conducted a root cause analysis and found areas that were within our control and outside of our control and subsequently have taken steps to mitigate this issue. Lastly, OPM will add these procedures to the Disputed Claims Process document.

Privacy Act Noncompliance and Record Management Issues

Recommendation 12: **(Recommendation 10 in the Final Report)** We recommend that OPM comply with the requirements of the Privacy Act and publish a System of Records Notice (SORN) pertaining to OPM's disputed claims process and its new FDC system.

Management Response: We do not concur.

OPM is in compliance with the Privacy Act and has published a SORN. OPM/CENTRAL-1 "Civil Service Retirement and Insurance Records" SORN applied to FEHB disputed claims from the outset of the disputed claims system until OPM/CENTRAL-27 became effective on 9/16/22. Therefore, OPM/CENTRAL-1 applied to disputed claims throughout the audit period (2018-2020).

A SORN covering OPM's Disputed Claims process and FDC was published and finalized 8/12/22. https://www.federalregister.gov/documents/2022/08/12/2022-17392/privacy-act-of-1974-system-of-records

Therefore, OPM requests that this recommendation be withdrawn.

Recommendation 13: **(Recommendation 11 in the Final Report)** We recommend that OPM implement sufficient controls, including written policies and procedures, to ensure that FEHBP members' identities are verified and disputed claims records are not disclosed without consent as specified in the Privacy Act

Management Response: We partially concur

OPM immediately corrects human errors when identified. Upon receiving documentation from the OIG on January 26, 2023, of the inadvertent disclosure of personally identifiable information (PII) that occurred in months prior. OPM HI investigated this incident and found it was an unfortunate human error by a LAS. OPM HI followed OPM's internal procedures to report this incident to OPM's CyberSolutions. A process exists where OIG submits OIG Hotline information to HI for review and response on an almost daily basis. OPM HI did not receive a Hotline request to review this case. OPM investigated, notified CyberSolutions and acted as soon as we were informed of the error.

OPM will update the Disputed Claims Process document to include a section on the Privacy Act, following the guidelines established by OPM's Office of Privacy and Information Management (OPIM).

Recommendation 14: **(Recommendation 12 in the Final Report)** We recommend that OPM evaluate the disputed claims data that relate to the decommissioned HITS and ensure that applicable paper files and electronic files are stored per the terms of 36 CFR, Chapter XII, Subchapter B, Records Management and OPM's Record Management Program (RMP) for the applicable disposition schedule.

Management Response: We do not concur.

The records in the decommissioned HITS system are retained pursuant to NARA Schedule Number NC1-146-77-01 INS 4(a), which relates to Healthcare and Insurance claims correspondence, correspondence with individuals or carrier representatives on the interpretation of contracts, and settlement of Federal employee claims under health benefits and life insurance plans.

The disposition schedule for 4-years record retention of Disputed Claims has been approved by OGC on 1/6/2023 and has been submitted to NARA for approval. This updated schedule applies

to both paper and electronic files.

Recommendation 15: **(Recommendation 13 in the Final Report)** We recommend that OPM update the record retention policy for disputed claims to six years, and update the impacted documentation (disposition schedule, SORN, etc.) as required.

Management Response: We do not concur.

OPM disagrees with updating the record retention policy for disputed claims to six years. Regarding record retention, OPM's Record Management (RM) program schedule currently in place has a 2-year records retention schedule. The disposition schedule was updated to 4-years record retention of Disputed Claims. It was approved by OPM Office of the General Counsel (OGC) on 1/6/2023 and has been submitted to NARA for approval. The file containing the approved draft schedule is attached in the Response to Draft Audit Report folder (Disputed Claims Draft Schedule HI 09292022.docx).

OIG's reference to OPM's Records Management Policy (RMP) section 6.8.2 alludes to the 6-year retention period to the Federal Tort Claims Act (FTCA) and other types of claims. It cannot be applied to disputed claims. OPM is governed by the FEHB Act (FEHBA) over the RMP. Claims must be made within 6 years after the event on which the claim is based. Few statutes of limitations affecting the retention of records are longer than 6 years. Transportation claims must be brought within 3 years of a given event. A 6-year period governs tort and other types of claims brought before the Court of Claims.

Disputed claims do not fall under tort. The statute of limitations under the Federal Tort Claims Act (FTCA) has no bearing on our records retention requirements. An FTCA claim cannot be brought in the context of an FEHB disputed claim for several reasons including that the FEHB Act (FEHBA) is the exclusive remedy for disputed claims.

The records in the FDC disputed claims system are retained pursuant to NARA Schedule Number NC1-146-77-01 INS 4(a), which relates to Healthcare and Insurance claims correspondence, correspondence with individuals or carrier representatives on the interpretation of contracts, and settlement of Federal employee claims under health benefits and life insurance plans. OPM disagrees with the OIG applying the disputed claims to the NARA schedule NC1-146-77-01 INS 4(b) – i.e., correspondence on non-routine contract interpretations or unusual claims problems. Disputed claims are not categorized as unusual claims problems. Thus the 5 years record retention period the OIG is positing in their findings does not apply to disputed claims.

Recommendation 16: **(Recommendation 14 in the Final Report)** We recommend that OPM catalog the disputed claims cases where the same Y codes were applied to unique cases, and that OPM develop a unique record identifier for cases with the same Y code so that they can be clearly differentiated until the record retention requirements have expired.

Management Response: We do not concur.

This recommendation is not applicable since all the duplicate Y code cases have been processed and closed. The record retention requirements for those cases have expired. Since HITS was decommissioned in February 2019, the risk for duplicated Y codes has been mitigated and the FEHB staff do not have access to the data.

OPM did catalog the duplicate Y codes between HITS and FDC. OPM sorted all the Y codes in numerical order in both HITS and FDC and performed a cross-check that identified 239 duplicate Y codes. The file is attached in the Response to Draft Audit Report folder (Duplicate Y Code Catalog.xlsx).

Recommendation 17: **(Recommendation 15 in the Final Report)** We recommend that OPM develop written policies and procedures that define the role of the Y code in the disputed claims process and the specific case data to be utilized by applicable OPM personnel to identify unique disputed claims cases.

Management Response: We do not concur.

Since HITS was decommissioned in February 2019, duplicate Y numbers cannot ever re-occur. OPM does not currently plan to replace the FDC system. However, when the system is replaced, OPM will work to ensure there are no duplicate Y codes.

The Y number is automatically generated in FDC and is a unique identifier for a disputed claim. It was implemented based on the following Julian numbering scheme as directed by FEIO during development.

Y Code Number Generator Process
YRRDDDXXX
Where
Y=standard prefix for disputed claims cases
RR= two-digit year
DDD = Julian day (e.g., January 1 is 001, January 15 is 015)
XXX = the number of the case created that day (across all FEHB groups)

OPM will add this documentation to the Disputed Claims Process document.

Conclusion

OPM appreciates OIG's recommendations and has devoted significant resources on this audit responding to OIG's information requests, notice of findings and recommendations, and follow up questions. OPM respectfully requests a meeting with the OIG to discuss this response and specific statements in the report that OPM does not agree with and to clarify any further misunderstandings. If you have any questions regarding our response, please contact Shakil Khandoker at Mohammed.Khandoker@opm.gov.

Technical Comments on OPM's Disputed Claims Process Draft Report, Report Number 2022-CAAG-001, issued December 21, 2022

Page 6, 1st paragraph – "We reviewed a sample of 81 disputed claims where the disputed service was received by the FEHBP member during benefit years 2018 through 2020, which were judgmentally selected from OPM's FDC system and the Health Insurance Tracking System (HITS) (see Exhibits A and B)."

OPM Comment: The 81 disputed claims provided to the OIG were ones for the 2018 through 2020 benefit years. This was not a list of disputed claims OPM received from 2018 through 2020. We believe this clarification is needed as it explains why the carriers' disputed claims were different from OPM's.

Page 6, 2nd paragraph – "Since OPM HI lacked the authority to approve final decisions on disputed claims, they could not meet the 90-day timeliness requirements from August 2020 through December 2020."

OPM Comment: December 2020 should be changed to May 2021 or later as this process was in place through January and created a backlog of items that needed to be addressed.

Report Fraud, Waste, and Mismanagement

Fraud, waste, and mismanagement in Government concerns everyone: Office of the Inspector General staff, agency employees, and the general public. We actively solicit allegations of any inefficient and wasteful practices, fraud, and mismanagement related to OPM programs and operations. You can report allegations to us in several ways:

By Internet: http://oig.opm.gov/contact/hotline

By Phone: Toll Free Number: (877) 499-7295

By Mail: Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, NW
Room 6400
Washington, DC 20415-1100