DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF INSPECTOR GENERAL

Office of Audit Services, Region III
Public Ledger Building, Suite 316
150 S. Independence Mall West
Philadelphia, PA 19106-3499

AUG 20 2008

Report Number: A-03-08-00025

Mr. Jamie Bylotas
Director, Quality & Performance Management
Highmark Medicare Services
1800 Center Street
Camp Hill, Pennsylvania 17089

Dear Mr. Bylotas:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of High-Dollar Payments for Maryland Medicare Part B Claims Processed by TrailBlazer Health Enterprises for the Period January 1, 2003, Through December 31, 2005, (report number A-03-07-00017)."

In comments on our draft report, TrailBlazer stated that it had recovered $97,524 of the $115,042 outstanding overpayments identified by the audit and that the remaining balance of $17,518 should move to the current CMS Medicare contractor (Highmark Medicare Services) for the Maryland region. Consequently, we are providing a copy of the report for your action.

We have forwarded a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary. The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, this report will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me at (215) 861-4470, or contact Bernard Siegel, Audit Manager, at (215) 861-4484 or through e-mail at Bernard.Siegel@oig.hhs.gov. Please refer to report number A-03-08-00025 in all correspondence.

Sincerely,

Stephen Virbitsky
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Nanette Foster Reilly, Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
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Pursuant to the principles of the Freedom of Information Act 5 U.S.C § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HIGH-DOLLAR PAYMENTS FOR MARYLAND MEDICARE PART B CLAIMS PROCESSED BY TRAILBLAZER HEALTH ENTERPRISES FOR THE PERIOD JANUARY 1, 2003, THROUGH DECEMBER 31, 2005

Daniel R. Levinson
Inspector General

August 2008
A-03-07-00017

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XVIII of the Social Security Act, the Medicare program provides health insurance for people age 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS), which administers the program, contracts with carriers to process and pay Medicare Part B claims submitted by physicians and medical suppliers (providers). CMS guidance requires providers to bill accurately and to report units of service as the number of times that a service or procedure was performed.

Carriers currently use the Medicare Multi-Carrier Claims System and CMS's Common Working File to process Part B claims. These systems can detect certain improper payments during prepayment validation.

TrailBlazer Health Enterprises (TrailBlazer), a wholly owned subsidiary of BlueCross BlueShield of South Carolina, was the Medicare Part B carrier for Maryland. During calendar years (CY) 2003–05, TrailBlazer processed more than 32 million claims as the Part B carrier, 101 of which resulted in payments of $10,000 or more (high-dollar payments).

OBJECTIVE

Our objective was to determine whether TrailBlazer's high-dollar payments as the Medicare Part B carrier for Maryland were appropriate.

SUMMARY OF FINDINGS

Thirty-four of the 49 high-dollar payments, included in our detailed review, that TrailBlazer made as the carrier for Maryland were appropriate. However, TrailBlazer overpaid $145,297 for 15 payments. Two providers refunded seven of the overpayments totaling $30,255 prior to our audit. Eight overpayments totaling $115,042 remain outstanding from five providers.

TrailBlazer made the overpayments because five providers incorrectly claimed excessive units of service on eight claims, one provider billed for the wrong service on one claim, and TrailBlazer used the incorrect payment rate for six claims. In addition, the Medicare claim processing systems did not have sufficient edits in place during CYs 2003–05 to detect and prevent payments for these types of erroneous claims.

RECOMMENDATIONS

We recommend that TrailBlazer:

- recover the $115,042 in overpayments and
- consider identifying and recovering any additional overpayments made to providers for high-dollar Part B claims paid after CY 2005.

TRAILBLAZER COMMENTS

In comments on our draft report (Appendix), TrailBlazer stated that it had recovered $97,524 of the $115,042 outstanding overpayments identified by the audit and that the remaining balance of $17,518 should move to the current CMS Medicare contractor (Highmark Medicare Services) for the Maryland region.

A copy of the final report will be provided to Highmark Medicare Services for final resolution of the two outstanding overpayments totaling $17,518 (report number A-03-08-00025).

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Pursuant to Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people age 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the program.

Medicare Part B Carriers

Prior to October 1, 2005, section 1842(a) of the Act authorized CMS to contract with carriers to process and pay Medicare Part B claims submitted by physicians and medical suppliers (providers).[1] Carriers also review provider records to ensure proper payment and assist in applying safeguards against unnecessary utilization of services. To process providers' claims, carriers currently use the Medicare Multi-Carrier Claims System and CMS's Common Working File. These systems can detect certain improper payments during prepayment validation.

CMS guidance requires providers to bill accurately and to report units of service as the number of times that a service or procedure was performed. During calendar years (CY) 2003–05, providers nationwide submitted approximately 2.3 billion claims to carriers. Of these, 29,022 claims resulted in payments of $10,000 or more (high-dollar payments). We consider such claims to be at high risk for overpayment.

TrailBlazer Health Enterprises

TrailBlazer Health Enterprises (TrailBlazer), a wholly owned subsidiary of BlueCross BlueShield of South Carolina, was the Medicare Part B carrier for Maryland.[2] TrailBlazer used the Medicare Multi-Carrier Claims System to process claims. During CYs 2003–05, TrailBlazer processed more than 32 million Part B claims for Maryland, 101 of which resulted in high-dollar payments.[3]

"Medically Unlikely Edits"

In January 2007, after our audit period, CMS required carriers to implement units-of-service edits referred to as "medically unlikely edits." These edits are designed to detect and deny unlikely Medicare claims on a prepayment basis. According to the "Medicare Program Integrity

[1]The Medicare Modernization Act of 2003, P.L. No. 108-173, which became effective on October 1, 2005, amended certain sections of the Act, including section 1842(a), to require that Medicare administrative contractors replace carriers and fiscal intermediaries by October 2011.

[2]In addition to its Dallas headquarters, TrailBlazer has offices in Denison, Texas; San Antonio, Texas; and Timonium, Maryland.

[3]On October 24, 2007, CMS named Highmark Medicare Services as the Medicare administrative contractor for jurisdiction 12, which includes Medicare Part A and B services for Pennsylvania, Maryland, New Jersey, Delaware, and the District of Columbia. CMS directed that the transition of workload from the current fiscal intermediary or carrier to the Medicare administrative contractor begin on March 5, 2008, and end by mid-December 2008.

Manual," Pub. No. 100-08, Transmittal 178, Change Request 5402, a "medically unlikely edit" tests claim lines for the same beneficiary, procedure code, date of service, and billing provider against a specified number of units of service. Carriers must deny the entire claim line when the units of service billed exceed the specified number.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether TrailBlazer's high-dollar payments as the Medicare Part B carrier for Maryland were appropriate.

Scope

We reviewed the claims history for the 101 high-dollar payments totaling $1,954,907 that TrailBlazer processed during CYs 2003–05.[4] We included 49 payments in our detailed review: 7 payments that TrailBlazer adjusted and recovered prior to our audit and 42 payments totaling $742,834 from the remaining 94 payments that TrailBlazer had not adjusted. We contacted the providers for additional billing information on the 42 claims. We did not contact providers regarding the remaining 52 payments. We limited our review of TrailBlazer's internal controls to those applicable to the 101 claims because our objective did not require an understanding of all internal controls over the submission and processing of claims. Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

We conducted our audit from February 2007 through March 2008.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;
- used CMS's National Claims History file to identify Medicare Part B claims with high-dollar payments;
- reviewed available Common Working File data for claims with high-dollar payments to determine whether the claims had been canceled and superseded by revised claims or whether the payments remained outstanding at the time of our audit;
- analyzed Common Working File data for canceled claims for which revised claims had been submitted to determine whether the initial claims were overpayments;

[4]When the Common Working File history was not available due to the age of the claim, we obtained a claim history from TrailBlazer that contained comparable information.

- contacted providers to determine whether high-dollar claims were billed correctly and, if not, why the claims were billed incorrectly; and

- coordinated our claim review, including the calculation of any overpayments, with TrailBlazer.

TrailBlazer recovered seven overpayments totaling $30,255 that were identified and returned by providers prior to our audit. From the remaining 94 high-dollar payments we selected a judgmental sample of 42 claims, totaling $742,834. The judgmental sample included all 12 claims submitted by nine providers and a representative sample of 30 of the remaining 82 claims submitted by two providers.[5]

We conducted this performance audit in accordance with generally accepted government auditing standards. 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 objective.

FINDINGS AND RECOMMENDATIONS

Thirty-four of the 49 high-dollar payments, included in our detailed review, that TrailBlazer made as the carrier for Maryland were appropriate. However, TrailBlazer overpaid $145,297 for 15 payments. Two providers refunded seven of the overpayments totaling $30,255 prior to our audit. Eight overpayments totaling $115,042 remain outstanding from five providers.

TrailBlazer made the overpayments because five providers incorrectly claimed excessive units of service on eight claims, one provider billed for the wrong service on one claim, and TrailBlazer used the incorrect payment rate for six claims. In addition, the Medicare claim processing systems did not have sufficient edits in place during CYs 2003–05 to detect and prevent payments for these types of erroneous claims.

MEDICARE REQUIREMENTS

The CMS "Carriers Manual," Pub. No. 14, part 2, § 5261.1, requires that carriers accurately process claims in accordance with Medicare laws, regulations, and instructions. Section 5261.3 of the manual requires carriers to effectively and continually analyze "data that identifies aberrancies, emerging trends and areas of potential abuse, overutilization or inappropriate care, and . . . on areas where the trust fund is most at risk, i.e., highest volume and/or highest dollar codes."

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

TrailBlazer overpaid providers $145,297 for 15 payments, including 9 payments billed for the wrong number of units or the wrong service and 6 payments made using the incorrect payment rate.

[5]One provider submitted 67 claims; the other provider submitted 15 claims.

Excessive Units or Wrong Service Billed

For 9 of 15 overpayments, totaling $126,171, providers incorrectly billed TrailBlazer for excessive units of service or billed for the wrong service. Providers for eight claims had not refunded overpayments totaling $115,042 at the time of our audit. One provider refunded an overpayment in the amount of $11,129.

- For one claim the provider billed 905 units of chemotherapy instead of 2 units. As a result, TrailBlazer paid the provider $36,180 when it should have paid $146, an overpayment of $36,034.

- For one claim the provider billed 350 units of octreotide, a growth inhibiting protein, instead of 350 units of oxaliplatin, a cancer treatment drug. As a result, TrailBlazer paid the provider $21,599 when it should have paid $2,366, an overpayment of $19,233.

- For two claims the provider billed 30 units of leuprolide, a cancer treatment drug, instead of 4 units. As a result, TrailBlazer paid the provider $21,432 when it should have paid $3,914, an overpayment of $17,518.

- For one claim the provider billed 300 units of bevacizumab, a cancer treatment drug, instead of 30 units. As a result, TrailBlazer paid the provider $13,704 when it should have paid $1,370, an overpayment of $12,334.

- For one claim the provider billed 9 units of pentostatin, a cancer treatment drug, instead of 1 unit. As a result, TrailBlazer paid the provider $13,470 when it should have paid $1,497, an overpayment of $11,973.

- For one claim, the provider billed for 41 units of leuprolide instead of 4 units of goserelin acetate implant, a cancer treatment drug. As a result, TrailBlazer paid the provider $12,332 when it should have paid $1,203, an overpayment of $11,129. The provider refunded the overpayment prior to our audit.

- For one claim the provider billed 42 units of docetaxel, a cancer treatment drug, instead of 2 units. As a result, TrailBlazer paid the provider $9,866 when it should have paid $470, an overpayment of $9,396.

- For one claim the provider billed 36 mg of pegfligrastim, used to reduce the risk of infection in chemotherapy patients, instead of 6 mg. As a result, TrailBlazer paid the provider $10,265 when it should have paid $1,711, an overpayment of $8,554.

Providers attributed the incorrectly billed quantity and services to clerical errors made by their billing staffs.

Incorrect Payment Rate Used

For the remaining six claims, TrailBlazer reimbursed the provider using the incorrect payment rate for the billed services when it manually calculated the payment. The provider submitted six claims for Factor VIII, an essential clotting factor for the treatment of hemophilia. During the processing of these six claims, TrailBlazer manually calculated the payment using an incorrect fee schedule amount. TrailBlazer paid a total of $127,074 for the six claims, when it should have paid $107,948, an overpayment of $19,126. However, TrailBlazer processed multiple adjustments for these claims and the provider refunded the overpayments prior to our audit.

TrailBlazer attributed its incorrect payments for these six claims to clerical errors made by its claims examiner.

INSUFFICIENT PREPAYMENT CONTROLS

During CYs 2003–05, TrailBlazer, the Medicare Multi-Carrier Claims System, and the CMS Common Working File did not have sufficient prepayment controls to detect and prevent inappropriate payments resulting from claims for excessive units of service. Instead, CMS relied on providers to notify carriers of overpayments and on beneficiaries to review their "Medicare Summary Notice" and disclose any provider overpayments.[6]

RECOMMENDATIONS

We recommend that TrailBlazer:

- recover the $115,042 in overpayments and

- consider identifying and recovering any additional overpayments made to providers for high-dollar Part B claims paid after CY 2005.

TRAILBLAZER COMMENTS

In comments on our draft report (Appendix), TrailBlazer stated that it had recovered $97,524 of the $115,042 outstanding overpayments identified by the audit and that the remaining balance of $17,518 should move to the current CMS Medicare contractor (Highmark Medicare Services) for the Maryland region.

A copy of the final report will be provided to Highmark Medicare Services for final resolution of the two outstanding overpayments totaling $17,518 (report number A-03-08-00025).

[6]The carrier sends a "Medicare Summary Notice" to the beneficiary for each claim submitted by the provider for Part B services. The notice explains the services billed the approved amount, the Medicare payment, and the amount due from the beneficiary.

APPENDIX

Siegel, Bernard J (OIG/OAS)

From:	Lopez, Ernest [Ernest.Lopez@trailblazerhealth.com]
Sent:	Wednesday, August 13, 2008 5:52 PM
To:	Rodgers, Jim A (OIG/OAS)
Cc:	Siegel, Bernard J (OIG/OAS); BECKY.FARRIS (TAO); RENEE.COTTON (TAO); MELISSA.HALSTEAD (TAO); Cruz, Maritza (OIG/OAS)
Subject:	Response to OIG audit report A-03-07-00017 for Maryland Part B
Attachments:	OIG REVIEW Part B HIGH $ PMTS 00017 FOR MD 2003-05 (4).doc

Jim,

Attached is the TrailBlazer response to OIG audit report A-03-07-00017 for Maryland Part B. Let us know if you have any questions or require further information. Regards,

<<OIG REVIEW Part B HIGH $ PMTS 00017 FOR MD 2003-05 (4).doc>>

Ernest L. Lopez
VP & CFO
TrailBlazer Health Enterprises, LLC
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TrailBlazer Health Enterprises, LLC

Response to OIG Audit Report A-03-07-00017 for Maryland Part B

Findings and Recommendations

Thirty –four of the 49 high-dollar payments TrailBlazer made as the carrier for Maryland were appropriate. However, TrailBlazer overpaid $145,297 for 15 payments. Two providers refunded seven of the overpayments totaling $30,255 prior to our audit. Eight overpayments totaling $115,042 remain outstanding from five providers. We did not contact providers regarding the remaining 52 payments.

TrailBlazer made the overpayments because five providers incorrectly claimed excessive units of service on eight claims, one provider billed for the wrong service on one claim, and TrailBlazer used the incorrect payment rate for six claims. In addition, the Medicare claim processing systems did not have sufficient edits in place during CYs 2003-05 to detect and prevent payments for these types of erroneous claims.

Medicare Requirements

The CMS "Carriers Manual," Pub. No. 14, part 2, § requires that carriers accurately process claims in accordance with Medicare laws, regulations, and instructions. Section 5261.3 of the manual requires carriers to effectively and continually analyze "date that identifies aberrancies, emerging trends and areas of potential abuse, overutilization or inappropriate care, and…on areas where the trust fund is most at risk, i.e., highest volume and/or highest dollar codes."

INAPPROPORIATE HIGH-DOLLAR PAYMENTS

TrailBlazer overpaid providers $145,297 for 15 payments, including 9 payments billed for the wrong number of units or the wrong service and 6 payments made using the incorrect payment rate.

TrailBlazer response: Of the $145,297, TrailBlazer has evidence of retrieval of all but $17,518 (Claims reference 17-095 and 17-096). The outstanding payment of $17,518 should be obtained from the contractor currently handling the Maryland region due to having the history and system capability.

Excessive Units or Wrong Service Billed

For 9 of 15 overpayments, totaling $126,171, providers incorrectly billed TrailBlazer for excessive units of service or billed for the wrong service. Providers for eight claims had not refunded overpayments totaling $115,042 at the time of our audit. One provider refunded an overpayment in the amount of $11,129.

- For one claim the provider billed 905 units of chemotherapy instead of 2 units. As a result, TrailBlazer paid the provider $36,180 when it should have paid $146, an overpayment of $36,034. (Claim Reference 17-098)

TrailBlazer response: Claim system priced based on provider's submission. TrailBlazer recouped $36,057.90.

- For one claim the provider billed 350 units of octreotide, a growth inhibiting protein, instead of 350 units of oxaliplatin, a chemotherapy drug. As a result, TrailBlazer paid the provider $21,599 when it should have paid $2,366, an overpayment of $19,233. (Claim Reference 17-089)

TrailBlazer response: Claim priced correctly based on provider's submission. Provider refunded $19,291.72 on check # 1095. Contractor applied $19,212.48 and refunded $79.24 back to the provider.

- For two claims the provider billed 30 units of leuprolide, a cancer treatment drug, instead of 4 units. As a result, TrailBlazer paid the provider $21,432 when it should have paid $3,914, an overpayment of $17,518. (Claim Reference 17-095 and 17-096)

TrailBlazer response: Claims were priced correctly based on provider's submission. TrailBlazer has no history or record indicating money was recouped. The contractor currently processing Maryland region should recoup the $17,518.

- For one claim the provider billed 300 units of bevacizumab, used to inhibit tumor growth, instead of 30 units. As a result, TrailBlazer paid the provider $13,704 when it should have paid $1,370, an overpayment of $12,334. (Claim Reference 17-032)

TrailBlazer response: Claim was system priced correctly based on the provider's submission. TrailBlazer recouped $13,704.48.

- For one claim the provider billed 9 units of pentostatin, a chemotherapeutic drug, instead of 1 unit. As a result, TrailBlazer paid the provider $13,470 when it should have paid $1,497, an overpayment of $11,973. . (Claim Reference 17-080)

TrailBlazer response: Claim was system priced correctly based on provider's submission. TrailBlazer recouped $11,973.63.

- For one claim, the provider billed for 41 units of leuprolide instead of 4 units of goserelin acetate implant, used in the treatment of hormone-sensitive cancers. As a result, TrailBlazer paid the provider $12,332 when it should have paid $1,203, an overpayment of $11,129. The provider refunded the overpayment prior to our audit. (Claim Reference 17-101)

TrailBlazer response: Claim was priced correctly based on provider's submission. Provider refunded $11,129.31.

- For one claim the provider billed 42 units of docetaxel, a chemotherapy medication, instead of 2 units. As a result, TrailBlazer paid the provider $9,866 when it should have paid $470, an overpayment of $9,396. (Claim Reference 17-094)

TrailBlazer response: Claim system priced correctly based on provider's submission. Provider submitted a voluntary refund of $9,866.20 on check # 9878.

- For one claim the provider billed 36 mg of pegfligrastim, used to reduce the risk of infection in chemotherapy patients, instead of 6 mg. As a result, TrailBlazer paid the provider $10,265 when it should have paid $1,711, an overpayment of $8,554. (Claim Reference 17-033)

TrailBlazer response: Claim system priced correctly based on provider's submission. TrailBlazer recouped $8,590.55.

Providers attributed the incorrectly billed quantity and services to clerical errors made by their billing staffs.

Incorrect Payment Rate Used

For the remaining six claims, TrailBlazer reimbursed the provider using the incorrect payment rate for the billed services when it manually calculated the payment. The provider submitted six claims for Factor VIII, an essential clotting factor for the treatment of hemophilia. During the processing of these six claims, TrailBlazer manually calculated the payment using an incorrect fee schedule amount. TrailBlazer paid a total $127,074 for the six claims, when it should have paid $107,948, an overpayment of $19,126. However, TrailBlazer processed multiple adjustments for these claims and the provider refunded the overpayments prior to our audit.

TrailBlazer attributed its incorrect payments for these six claims to clerical errors made by its claims examiner.

TrailBlazer response: TrailBlazer agrees with the OIG assessment. Payment has been recouped for these claims.

Insufficient Prepayment Controls

During CYs 2003-05, TrailBlazer, The Medicare Multi-Carrier Claims System, and the CMS Common Working File did not have sufficient prepayment controls to detect and prevent inappropriate payments resulting from claims for excessive units of service.

Instead, CMS relied on providers to notify carriers of overpayments and on beneficiaries to review their "Medicare summary Notice" and disclose any provider overpayments.5

TrailBlazer response:
Since 2003, multiple internal controls have been implemented in efforts to ensure the accurate processing of manually priced as well as high dollar claims. Claims requiring manual pricing are now segregated and are only resolved by specialized staff.

In June of 2005, TrailBlazer implemented an edit to suspend claims with billed amounts in excess of $25,000. These high dollar suspensions are resolved by lead claims staff. Designated high dollar claims are logged and reviewed for reasonability. If inaccuracy or fraud is suspected, or trends detected, claims are referred to management or medical staff for further review. Any potential fraud that is identified is immediately referred to the Payment Safeguard Contractor.

In addition, beginning January, 2007, CMS quarterly releases for "Medically Unlikely Edits" (MUE) are implemented as scheduled. MUE edits based on unit of service, as in six of the seven found in error, are developed by CMS and issued in a quarterly release for implementation by the MAC. The edit tests claim lines for the same beneficiary, procedure code, date of service, and billing provider against a specified number of units of service. Carriers must deny the entire claim line when the units of service billed exceed the specified number. A sample of claims resolutions are audited monthly for each Claim Analyst.

RECOMMENATIONS

We recommend that TrailBlazer:

- recover the $115,042 in overpayments and
- consider identifying and recovering any additional overpayments made to providers for high-dollar Part B claims paid after CY2005.

TrailBlazer response:
TrailBlazer has recovered the outstanding overpayments identified by this audit, other than the $17,518.00 described earlier in the report. This final recovery should move to the Maryland region's current contractor.

As stated above, multiple internal controls have been implemented since 2003, including in June 2005 the addition of the high dollar edit to provide an additional review for high dollar claims and the 2007 addition of "medically unlikely edits." These internal controls and edits are utilized in the review process described in the TrailBlazer response above. TrailBlazer is not funded nor staffed to re-open and review every high dollar claim processed since CY 2005 in order to identify and recover any additional overpayments made to providers for high-dollar Part B claims paid.