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

JUN 19 2008

Report Number: A-03-07-00018

Mr. Ernest Lopez
Chief Financial Officer
TrailBlazer Health Enterprises
8330 LBJ Freeway
Dallas, Texas 75243

Dear Mr. Lopez:

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 Delaware Medicare Part B Claims Processed by TrailBlazer Health Enterprises for the Period January 1, 2003, Through December 31, 2005." We will forward 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-03-07-00018 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

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

Daniel R. Levinson
Inspector General

June 2008
A-03-07-00018

Office of Inspector General

http://oig.hhs.gov

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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.

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 Delaware. During calendar years (CY) 2003–05, TrailBlazer processed more than 7.4 million claims as the Part B carrier, 3 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 Delaware were appropriate.

SUMMARY OF FINDING

One of the three high-dollar payments made by TrailBlazer for Delaware was appropriate. However, Trailblazer overpaid providers $39,582 for two payments. Both providers identified and refunded the overpayments prior to our audit.

Trailblazer made the overpayments because two providers incorrectly claimed excessive units of service on two 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.

RECOMMENDATION

We recommend that TrailBlazer 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 implemented multiple internal controls since 2003, including in June 2005 the addition of an edit to review high-dollar Part B claims. However, because it does not receive funding to do so, it would not identify and recover any additional overpayments for high-dollar Part B claims paid after CY 2005.

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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 Heath Enterprises

TrailBlazer Health Enterprises (TrailBlazer), a wholly owned subsidiary of BlueCross BlueShield of South Carolina, was the Medicare Part B carrier for Delaware.[2] Trailblazer used the Medicare Multi-Carrier Claims System to process claims. During CYs 2003–05, Trailblazer processed more than 7.4 million Part B claims, 3 of which resulted in high-dollar payments.

"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 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.

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[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.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We reviewed the three high-dollar payments, totaling $57,952, that TrailBlazer processed during CYs 2003–05. We limited our review of TrailBlazer's internal controls to those applicable to the three 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 through December 2007.

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 histories 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;
- 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.

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 finding and conclusions based on our audit objective.

FINDING AND RECOMMENDATION

One of the three high-dollar payments made by TrailBlazer for Delaware was appropriate. However, Trailblazer overpaid providers $39,582 for two payments. Both providers identified and refunded the overpayments prior to our audit.

Trailblazer made the overpayments because the two providers incorrectly claimed excessive units of service. 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

For the two overpayments, totaling $39,582, providers incorrectly billed TrailBlazer for excessive units of service:

- One provider billed 520 units of service for a cancer treatment drug instead of 50 units. As a result, TrailBlazer paid the provider $23,756 when it should have paid $2,279, an overpayment of $21,477.

- One provider billed 410 units of service for the technical component of a pathological examination instead of 1 unit of service for the professional component. As a result, TrailBlazer paid $18,172 instead of $67, an overpayment of $18,105.

Both providers identified and refunded the overpayment prior to our audit. Both providers attributed the excessive quantity to clerical error. One provider stated its old billing system lacked the controls to prevent incorrect quantities from being submitted. In addition, 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.[3]

[3]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.

RECOMMENDATION

We recommend that Trailblazer 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 TrailBlazer stated that it had implemented multiple internal controls since 2003, including in June 2005 the addition of an edit to review high-dollar Part B claims. However, because it does not receive funding to do so, it would not identify and recover any additional overpayments for high-dollar Part B claims paid after CY 2005. TrailBlazer's comments are included as the appendix.

APPENDIX

From: Lopez, Ernest [mailto:Ernest.Lopez@trailblazerhealth.com]
Sent: Friday, June 13, 2008 5:34 PM
To: Rodgers, Jim A (OIG/OAS)
Subject: RE: DE & DC High-Dollar Payment Draft Reports

Jim,

Here are the TrailBlazer responses to the DE and DC High-Dollar Payment draft reports. Please let me know if you have any questions.

Regards,

Ernest

TrailBlazer Health Enterprises, LLC

Response to OIG Audit Report A-03-07-00018

INAPPROPORIATE HIGH-DOLLAR PAYMENTS

For the two overpayments, totaling $39,582, providers incorrectly billed TrailBlazer for excessive units of service:

- One provider billed 520 units of service for a cancer treatment drug instead of 50 units. As a result, TrailBlazer paid the provider $23,756 when it should have paid $2,279, an overpayment of $21,477.

TrailBlazer response:
This claim was not sent to TrailBlazer for review since the provider identified and refunded the over payment prior to the audit.

- One provider billed 410 units of service for the technical component of a pathological examination instead of 1 unit of service for the professional component. As a result, TrailBlazer paid $18,172 instead of $67, an over payment of $18,105.

TrailBlazer response:
This claim was not sent to TrailBlazer for review since the provider identified and refunded the over payment prior to the audit.

Both providers indentified and refunded the overpayment prior to our audit. Both providers attributed the excessive quantity to clerical error. One provider stated its old billing system lacked the controls to prevent incorrect quantities from being submitted. In addition, during CYs 2003-2005, 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.

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, we 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. A sample of claim resolutions are audited monthly for each Claims Analyst.

RECOMMENATIONS

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

TrailBlazer response:
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. 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 worked on since CY 2005 in order to identify and recover any additional overpayments made to providers for high-dollar Part B claims paid.