DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

July 28, 2009

Report Number: A-06-08-00069

Ms. Melissa Halstead Rhoades
Area Director & Medicare CFO
Financial Management Operations Division
TrailBlazer Health Enterprises, LLC
8330 LBJ Freeway, 11.2402
Dallas, Texas 75243

Dear Ms. Rhoades:

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 Texas Medicare Part B Claims Processed by TrailBlazer Health Enterprises for the Period January 1 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 Freedom of Information Act, 5 U.S.C. § 552, OIG reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act. 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 (214) 767-8414, or contact Trish Wheeler, Audit Manager, at (214) 767-6325 or through email at Trish.Wheeler@oig.hhs.gov. Please refer to report number A-06-08-00069 in all correspondence.

Sincerely,

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Nanette Foster Reilly, Consortium Administrator
Consortium for Financial Management & Fee for Service Operations (CFMFFSO)
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
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rokcmora@cms.hhs.gov

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

Daniel R. Levinson
Inspector General

July 2009
A-06-08-00069

Office of Inspector General

http://oig.hhs.gov

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Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, Office of Inspector General reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act.

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. Prior to October 1, 2005, the Centers for Medicare & Medicaid Services (CMS), which administers the program, contracted with carriers to process and pay Medicare Part B claims submitted by physicians and medical suppliers (providers).

During calendar year (CY) 2005, TrailBlazer Health Enterprises (TrailBlazer) was the Medicare Part B carrier for providers in several States, including more than 68,000 providers in Texas. TrailBlazer processed more than 55 million Texas Medicare Part B claims, 416 of which resulted in payments of $10,000 or more (high-dollar payments).

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

OBJECTIVE

Our objective was to determine whether TrailBlazer's high-dollar Medicare payments to Part B providers in Texas were appropriate.

SUMMARY OF FINDINGS

Of the 416 high-dollar payments that TrailBlazer made to providers, 305 were appropriate. Of the remaining 111 payments, TrailBlazer incorrectly paid providers for 93 payments totaling $487,070 and adjusted 18 payments to less than $10,000 prior to the start of our audit.

TrailBlazer incorrectly paid the providers because it made claim processing errors and because the providers made billing and documentation errors. In addition, the Medicare claim processing systems did not have sufficient edits in place during CY 2005 to detect and prevent payments for these types of erroneous claims.

RECOMMENDATIONS

We recommend that TrailBlazer:

- recover the $487,070 in overpayments identified during our audit and
- consider using the results of this audit in its provider education activities.

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TRAILBLAZER HEALTH ENTERPRISES COMMENTS

In its comments on our draft report, TrailBlazer agreed with the findings and recommendations. TrailBlazer has recovered $490,076 in overpayments. In addition to the $487,070 identified during our audit, TrailBlazer recovered $1,896 returned by a provider, $964 in additional overpayments identified by TrailBlazer staff, and $146 in claim interest. TrailBlazer has included information related to our findings in its provider education activities. TrailBlazer's comments are included in their entirety as the Appendix.

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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] In addition to processing and paying claims, carriers also reviewed provider records to ensure proper payment and assist in applying safeguards against unnecessary utilization of services. To process and pay providers' claims, carriers used 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 year (CY) 2005, providers nationwide submitted more than 818 million claims to carriers. Of these, 13,402 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

During CY 2005, TrailBlazer Health Enterprises (TrailBlazer) was the Medicare Part B carrier for providers in several States, including more than 68,000 providers in Texas. TrailBlazer processed more than 55 million Texas Medicare Part B claims, 416 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," Publication 100-08, Transmittal 178, Change Request 5402, medically unlikely edits test claim lines for the same beneficiary, Healthcare Common Procedure Coding System (HCPCS) 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.

[1]The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 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.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether TrailBlazer's high-dollar Medicare payments to Part B providers in Texas were appropriate.

Scope

We identified 416 high-dollar payments that TrailBlazer processed during CY 2005. TrailBlazer adjusted 18 of the payments to less than $10,000 prior to the start of our audit. We reviewed the remaining 398 high-dollar payments, which totaled $7,976,309.

We limited our review of TrailBlazer's internal controls to those applicable to the 398 high-dollar 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 performed our audit work from September 2008 to April 2009.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- used CMS's National Claims History file to identify Medicare Part B claims with high-dollar payments;
- reviewed Medicare Multi-Carrier Claims System claim histories for claims with high-dollar payments to determine whether the claims had been canceled and superseded by revised claims or whether payments remained outstanding at the start of our audit;
- 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 with TrailBlazer, including the calculation of any payment errors.

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

Of the 416 high-dollar payments that TrailBlazer made to providers, 305 were appropriate. Of the remaining 111 payments, TrailBlazer incorrectly paid providers for 93 payments totaling $487,070 and adjusted 18 payments to less than $10,000 prior to the start of our audit.

TrailBlazer incorrectly paid the providers because it made claim processing errors and because the providers made billing and documentation errors. In addition, the Medicare claim processing systems did not have sufficient edits in place during CY 2005 to detect and prevent payments for these types of erroneous claims.

MEDICARE REQUIREMENTS

The CMS "Carriers Manual," Publication 14, part 2, section 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 . . . areas where the trust fund is most at risk, i.e., highest volume and/or highest dollar codes."

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

TrailBlazer made 93 incorrect payments, 63 because of claims processing errors and 30 because of provider errors.

Carrier Claims Processing Errors

For 63 claims, TrailBlazer applied incorrect rates for various procedure codes.

- For 45 claims related to hemophilia blood clotting factors, TrailBlazer did not pay using the rate applicable to the quarter for the dates of service of the claims. As a result, TrailBlazer overpaid the providers $80,373.

- For 16 claims, TrailBlazer paid nonparticipating providers the participating rate. Providers that choose not to participate in the Medicare program receive 95 percent of the allowable amount paid to participating providers. As a result, TrailBlazer overpaid the providers $22,563.

- For one claim related to a vertebral procedure, TrailBlazer paid an incorrect rate. Additionally, the procedure was billed as a cosurgery, which should have paid at a reduced rate. As a result, TrailBlazer overpaid the provider $8,274.

- For one claim related to brachytherapy, TrailBlazer paid the submitted charges rather than the invoice purchase price. As a result, TrailBlazer overpaid the provider $5,796.

Provider Coding Errors

For one claim, a provider incorrectly coded multiple dates of service using a critical care code rather than the appropriate hospital evaluation and management codes. As a result, TrailBlazer overpaid the provider $9,747.

For one claim related to air ambulance services, a provider incorrectly coded the claim using the HCPCS codes for a rotary wing aircraft rather than the codes for a fixed wing aircraft. As a result, TrailBlazer overpaid the provider $7,589.

Provider Units-of-Service Errors

For 27 claims, providers billed for excessive units of service.

- For 21 claims, providers billed for excessive units of service for injectable drugs. For one of these claims, the medical documentation also did not support the procedure code billed on an additional line item. As a result, TrailBlazer overpaid the providers $270,766.

- For two claims, providers billed for 30 and 35 units, respectively, of radiological supervision and interpretation rather than 1 unit each, which was the amount provided. As a result, TrailBlazer overpaid the providers $27,585.

- For four claims, providers billed for excessive units of service for implantable neurostimulator devices. As a result, TrailBlazer overpaid the providers $24,949.

Provider Documentation Error

For one claim, the provider was unable to provide any supporting records. As a result, TrailBlazer overpaid the provider $29,428.

CAUSES OF INCORRECT PAYMENTS

TrailBlazer attributed its claims processing errors to human error because most of the claims were processed manually. The providers that gave a reason also attributed the incorrect claims to human error. In addition, during CY 2005, 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 incorrect payments and on beneficiaries to review their "Medicare Summary Notice" and disclose any provider errors.[2]

[2]The carrier sends a "Medicare Summary Notice" to the beneficiary after the provider files a claim for Part B service(s). The notice explains the service(s) billed, the approved amount, the Medicare payment, and the amount due from the beneficiary.

RECOMMENDATIONS

We recommend that TrailBlazer:

- recover the $487,070 in overpayments identified during our audit and
- consider using the results of this audit in its provider education activities.

TRAILBLAZER HEALTH ENTERPRISES COMMENTS

In its comments on our draft report, TrailBlazer agreed with the findings and recommendations. TrailBlazer has recovered $490,076 in overpayments. In addition to the $487,070 identified during our audit, TrailBlazer recovered $1,896 returned by a provider, $964 in additional overpayments identified by TrailBlazer staff, and $146 in claim interest. TrailBlazer has included information related to our findings in its provider education activities. TrailBlazer's comments are included in their entirety as the Appendix.

APPENDIX

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

MEDICARE

July 9, 2009

Gordon L. Sato
Regional Inspector General for Audit Services
Office of Inspector General
1100 Commerce, Room 632
Dallas, Texas 75242

Report Number: A-06-08-00069

Dear Mr. Sato:

We received the June 5, 2009, draft report entitled "Review of High-Dollar Payments for Texas Medicare Part B Claims Processed by TrailBlazer Health Enterprises, for the Period January 1 through December 31, 2005." In the draft report, the OIG recommended that TrailBlazer:

- Recover the $487,070 in overpayments identified during the audit; and
- Consider using the results of this audit in provider education activities.

Please consider the following responses to these recommendations for inclusion in the final report:

Recovery of Overpayments: As a result of this audit, TrailBlazer recovered $490,076 in overpayments. The amount collected includes:

- Overpayment amount identified by the OIG of $487,070;
- Claim interest of $146;
- Additional claim identified by TrailBlazer staff as incorrectly paid of $964; and
- Amount voluntarily returned by a provider of $1,896.

Provider Education Activities: TrailBlazer Provider Outreach and Education and Medical Review maintain numerous online job aids and other educational material associated with proper coding on the TrailBlazer Web site. Our job aid, *Tips for Preventing Coding Errors*, specifically addresses each code family.

TrailBlazer strives to continually offer provider education regarding the importance of proper documentation. The importance of appropriate medical documentation is included in each presentation during our face-to-face workshops (Welcome to Medicare, etc.) and Web-based training sessions. During our recent J4 Medicare Tour this subject was of high importance in the *Partners in Compliance* training sessions.

If you have any questions regarding our response, please contact me.

Sincerely,

Melissa Halstead Rhoades

Melissa Halstead Rhoades
Area Director & Medicare CFO

Cc: Virginia Adams, CMS Project Officer for A/B MAC Southern Program Division
Gil R. Glover, President & Chief Operating Officer
Scott J. Manning, Vice President, Financial Mgt. Operations & J4 MAC Project Manager
Kevin Bidwell, Vice President & Compliance Officer