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

SEP 2 4 2008

Report Number: A-03-07-00020

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 Virginia 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-03-07-00020 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 VIRGINIA MEDICARE PART B CLAIMS PROCESSED BY TRAILBLAZER HEALTH ENTERPRISES FOR THE PERIOD JANUARY 1, 2003, THROUGH DECEMBER 31, 2005

Daniel R. Levinson
Inspector General

September 2008
A-03-07-00020

Office of Inspector General

http://oig.hhs.gov

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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.

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 Virginia. During calendar years (CY) 2003–05, TrailBlazer processed more than 45 million claims as the Part B carrier, 343 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 Virginia were appropriate.

SUMMARY OF FINDING

Seventy-three of 88 high-dollar payments TrailBlazer made as the carrier for Virginia were appropriate. However, TrailBlazer overpaid $154,305 for 15 payments. Three providers refunded six of the overpayments totaling $59,991 prior to our audit. Five providers have not yet refunded nine overpayments totaling $94,314, including one overpayment of $38,879, adjusted prior to our audit, for which neither the provider nor Trailblazer could support that a refund had occurred. We did not contact providers for the remaining 255 payments

TrailBlazer made the overpayments because three providers incorrectly claimed excessive units of service on seven claims, and TrailBlazer used the incorrect payment rate for seven claims and the incorrect units for one claim. 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 $55,435 in overpayments,

- verify that the overpayment totaling $38,879 was returned by the provider, 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 has initiated the recovery of the outstanding overpayments identified by the audit and has implemented multiple internal controls since 2003, including in June 2005 the addition of an edit to review high-dollar Part B claims and the 2007 addition of "medically unlikely edits." It had no evidence that overpayments totaling $38,879 were recovered and it would not recover $23,993 of the $55,435 in overpayments. TrailBlazer stated these overpayments would not be recovered because the claims were processed more than 4 years ago.

OFFICE OF INSPECTOR GENERAL RESPONSE

Pursuant to 42 CFR 405.980(b)(3), ". . . . A contractor may reopen and revise its initial determination or redetermination on its own motion . . . (3) At any time if there exists reliable evidence as defined in §405.902 that the initial determination was procured by fraud or similar fault as defined in §405.902." Similar fault means "to . . . receive Medicare funds to which a person knows or should reasonably be expected to know that he or she . . . is not legally entitled. [Emphasis added.] Therefore we continue to support our recommendations.

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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 Virginia.[2] TrailBlazer used the Medicare Multi-Carrier System to process claims. During CYs 2003–05, TrailBlazer processed more than 45 million Part B claims for Virginia, 343 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 Virginia were appropriate.

Scope

We reviewed the claims history for the 343 high-dollar payments totaling $6,319,770 that TrailBlazer processed during CYs 2003–05 and selected 88 payments totaling $1,590,134 for more detailed review.[3]

We limited our review of Trailblazer's internal controls to those applicable to the 343 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 objectives, 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; and
- analyzed Common Working File data for canceled claims for which revised claims had been submitted to determine whether the initial claims were overpayments.

For our sample we selected all six payments, totaling $145,851, for which TrailBlazer had made adjustments to correct overpayments. From the remaining 337 high-dollar payments we selected a judgmental sample of 82 payments, totaling $1,444,283, including payments for all 20 claims submitted by seven providers and a representative sample of 62 of the remaining 317 payments for claims submitted by four providers that had each submitted 50 or more claims.

[3]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.

- For the six adjusted payments, we contacted TrailBlazer to determine whether the providers had refunded the overpayments.

- For two of the six adjusted payments, for which TrailBlazer did not have documentation of repayment, we contacted the providers to determine whether they had repaid the adjusted amount.

- For the 82 outstanding payments, we contacted the providers to determine whether high-dollar claims were billed correctly and, if not, why the claims were billed incorrectly.[4]

- We 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 objectives.

FINDINGS AND RECOMMENDATIONS

Seventy-three of 88 high-dollar payments TrailBlazer made as the carrier for Virginia were appropriate. However, TrailBlazer overpaid $154,305 for 15 payments. Three providers refunded six of the overpayments totaling $59,991 prior to our audit.[5] Five providers have not yet refunded nine overpayments totaling $94,314, including one overpayment of $38,879, adjusted prior to our audit, for which neither the provider nor Trailblazer could support that a refund had occurred.

TrailBlazer made the overpayments because three providers incorrectly claimed excessive units of service on seven claims, and TrailBlazer used the incorrect payment rate for seven claims and the incorrect units for one claim. 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."

[4]We did not contact providers about the remaining 255 outstanding payments.

[5]Of the six refunded overpayments, Trailblazer had made adjustments for five.

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

TrailBlazer overpaid providers $154,305 for 15 payments, including 7 payments for the wrong number of units claimed by providers and 8 payments calculated by TrailBlazer using the incorrect payment rate or number of units.

Excessive Units Billed

For 7 of the 15 overpayments, totaling $96,551, three providers incorrectly billed TrailBlazer for excessive units of service. Prior to our audit, one provider had refunded three overpayments totaling $52,648. Providers for four claims had not refunded overpayments totaling $43,903 at the time of our audit.

- One provider billed for excessive units of service on 4 claims.
    - For one claim the provider billed 80 units of rituximab, used in treatment of leukemia and lymphoma, instead of 8 units. As a result, TrailBlazer paid the provider $29,179 when it should have paid $2,918, an overpayment of $26,261. The provider refunded the overpayment prior to our audit.
    - For one claim the provider billed 200 units of gemcitabine, a chemotherapy drug, instead of 10 units. As a result, TrailBlazer paid the provider $18,436 when it should have paid $922, an overpayment of $17,514. The provider refunded the overpayment prior to our audit.
    - For one claim the provider billed 10 units of pentostatin, a chemotherapy drug, instead of 1 unit. As a result, TrailBlazer paid the provider $14,680 when it should have paid $1,468, an overpayment of $13,212.
    - For one claim the provider billed for 299 units of chemotherapy instead of 1 unit. As a result, TrailBlazer paid the provider $8,903 when it should have paid $30, an overpayment of $8,873. The provider refunded the overpayment prior to our audit.
- One provider billed for excessive units of service on 2 claims.
    - For one claim the provider billed 30 units of alemtuzumab, used in the treatment of leukemia and lymphoma, instead of 3 units. As a result, TrailBlazer paid the provider $12,870 when it should have paid $1,287, an overpayment of $11,583.
    - For one claim the provider billed 100 units of paclitaxel, a chemotherapy drug, instead of 10 units. As a result, TrailBlazer paid the provider $11,192 when it should have paid $1,106, an overpayment of $10,086.
- One 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 $10,841 when it should have paid $1,819, an overpayment of $9,022.

Providers refunded overpayments totaling $52,648 for three of the seven claims prior to our audit. However overpayments totaling $43,903 for four claims remained outstanding. Providers attributed the incorrect billed quantity to clerical errors made by their billing staffs.

Incorrect Payment Rate or Units Used

For seven claims, TrailBlazer reimbursed providers using the incorrect payment rate for the billed services when it calculated the payment. During the processing of these seven claims, TrailBlazer calculated the payment using the incorrect fee schedule amount. For one claim, TrailBlazer reimbursed the provider for an incorrect number of units. Two providers refunded overpayments totaling $7,343 for three of the eight claims prior to our audit. One provider stated that the overpayment of $38,879 was returned to TrailBlazer as reductions to subsequent Medicare payments prior to our audit. However, neither the provider nor TrailBlazer could verify that the provider returned the overpayment. Overpayments for the remaining four claims remain outstanding.

- For six claims the provider billed for Factor VIII, an essential clotting factor for the treatment of hemophilia. TrailBlazer paid a total of $116,805 for the six claims, when it should have paid $98,062, an overpayment of $18,743. The provider refunded $7,211 for two of the six overpayments prior to our audit. Overpayments for the remaining four claims totaling $11,532 remained outstanding at the time of our audit.

- For one claim the provider billed 33,000 units of Factor IX, used in the treatment of hemophilia B. Trailblazer paid the provider $26,030, when it should have paid $25,898, an overpayment of $132. The provider refunded the overpayment prior to our audit.

- For one claim the provider billed 1 unit of leuprolide, used in the treatment of several medical conditions. TrailBlazer adjusted the claim incorrectly and paid the provider for 10 units. As a result, TrailBlazer paid the provider $43,198, when it should have paid $4,320, an overpayment of $38,879. The provider stated that the overpayment was returned to TrailBlazer as reductions to subsequent Medicare payments. However, neither the provider nor TrailBlazer could verify that the provider refunded the overpayment prior to our audit.

Providers refunded overpayments totaling $7,343 for three of the eight claims prior to our audit. However, overpayments totaling $11,532 for four claims remained outstanding. Because of the age of the remaining overpayment totaling $38,879, TrailBlazer stated that it would not be able to identify whether it had been refunded or collect it if it remained outstanding. TrailBlazer attributed its incorrect payments for these eight 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 $55,435 in overpayments,
- verify that the overpayment totaling $38,879 was returned by the provider, 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 has initiated the recovery of the outstanding overpayments identified by the audit and has implemented multiple internal controls since 2003, including in June 2005 the addition of an edit to review high-dollar Part B claims and the 2007 addition of "medically unlikely edits." It had no evidence that overpayments totaling $38,879 were recovered and it would not recover $23,993 of the $55,435 in overpayments. TrailBlazer stated these overpayments would not be recovered because the claims were processed more than 4 years ago[7].

OFFICE OF INSPECTOR GENERAL RESPONSE

Pursuant to 42 CFR 405.980(b)(3), ". . . . A contractor may reopen and revise its initial determination or redetermination on its own motion . . . (3) At any time if there exists reliable evidence as defined in §405.902 that the initial determination was procured by fraud or similar fault as defined in §405.902." Similar fault means "to . . . receive Medicare funds to which a person knows or should reasonably be expected to know that he or she . . . is not legally entitled. [Emphasis added.] Therefore we continue to support our recommendations.

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

[7]Pursuant to 42 CFR 405.980(b)(2).

APPENDIX

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

MEDICARE

September 19, 2008

Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region III
Public Ledger Building, Suite 316
150 South Independence Mall West
Philadelphia, PA 19106-3499

Attention: Stephen Virbitsky

Subject: OIG Draft Audit Report, "Review of High-Dollar Payments for Virginia Medicare Part B Claims Processed by TrailBlazer Health Enterprises for the period January 1, 2003, Through December 31, 2005"

Dear Mr. Virbitsky:

TrailBlazer provides the response to the subject draft audit dated August 15, 2008. In general, TrailBlazer agrees with the findings and has included responses accordingly in the attached document, "OIG Excess PMTS VA PT B 00020".

In regards to the recommendations, TrailBlazer has recovered or has issued demand letters to providers for overpayment claim amounts which were processed within the recovery time period. Overpayment claim amounts which were processed over four years ago cannot be pursued by TrailBlazer.

TrailBlazer continuously strives to prevent and identify all types of overpayments and initiates recovery actions deemed appropriate.

Please contact Ernest Lopez, Chief Financial Officer, if you have any questions regarding this response at (469) 372-0122 or by e-mail at ernest.lopez@trailblazerhealth.com.

Sincerely,

Gil R. Glover
President & Chief Operating Officer
TrailBlazer Health Enterprises, LLC

cc: Ernest Lopez, Chief Financial Officer
Kevin Bidwell, Vice President Compliance
Bernard J. Siegel, AATS Audit Manager

Enclosure

TrailBlazer Health Enterprises, LLC

Response to OIG Audit Report A-03-07-00020 for Virginia Part B

FINDINGS AND RECOMMENDATIONS

Seventy-three of 88 high-dollar payments TrailBlazer made as the carrier for Virginia were appropriate. However, TrailBlazer overpaid $154,305 for 15 payments. Three providers refunded six of the overpayments totaling $59,991 prior to our audit.[5] Five providers have not yet refunded nine overpayments totaling $94,314, including one overpayment of $38,879, adjusted prior to our audit, for which neither the provider nor TrailBlazer could support that a refund had occurred.

TrailBlazer made the overpayments because three providers incorrectly claimed excessive units of service on seven claims, and TrailBlazer used the incorrect payment rate for seven claims and the incorrect units for one claim. 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 "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 $154,305 for 15 payments, including 7 payments for the wrong number of units claimed by providers and 8 payments calculated by TrailBlazer using the incorrect payment rate or number of units.

TrailBlazer response:
Research was conducted by TrailBlazer utilizing information provided by the OIG. TrailBlazer agrees with the OIG that these 15 claims are overpaid.

Excessive Units or Wrong Service Billed

For 7 of the 15 overpayments, totaling $96,551, three providers incorrectly billed TrailBlazer for excessive units of service. Prior to our audit, one provider had refunded three overpayments totaling $52,648. Providers for four claims had not refunded overpayments totaling $43,903 at the time of our audit.

- *One provider billed for excessive units of service on 4 claims.*

    - *For one claim the provider billed 80 units of rituximab, used in treatment of leukemia and lymphoma, instead of 8 units. As a result, TrailBlazer paid the provider $29,179 when it should have paid $2,918, an overpayment of $26,261. The provider refunded the overpayment prior to the audit. (Clm Ref #20-343)*

TrailBlazer response:
Claim was system priced correctly. The over billed units generated the overpayment. Overpayment of $26,261 was recovered by offsetting against the provider's outstanding A/R.

    - *For one claim the provider billed 200 units of gemcitabine, a chemotherapy drug, instead of 10 units. As a result, TrailBlazer paid the provider $18,436 when it should have paid $922, an overpayment of $17,514. The provider refunded the overpayment prior to our audit. (Clm Ref # 20-072)*

TrailBlazer response:
Claim was system priced correctly. The over billed units generated the overpayment. Overpayment of $17,514 was refunded by the provider.

    - *For one claim the provider billed 10 units of pentostatin, a chemotherapy drug, instead of 1 unit. As a result, TrailBlazer paid the provider $14,680 when it should have paid $1,468, an overpayment of $13,212. (Clm Ref # 20-244)*

TrailBlazer response:
Claim was system priced correctly. The over billed units generated the overpayment. Overpayment of $13,123 was refunded by the provider.

    - *For one claim the provider billed for 299 units of chemotherapy instead of 1 unit. As a result, TrailBlazer paid the provider $8,903 when it should have paid $30, an overpayment of $8,873. The provider refunded the overpayment prior to our audit. (Clm Ref # 20-133)*

TrailBlazer response:
Claim was system priced correctly. The over billed units generated the overpayment. Overpayment of $8,873 was refunded by the provider.

- *One provider billed for excessive units of service on 2 claims.*

    - *For one claim the provider billed 30 units of alemtuzumab, used in the treatment of leukemia and lymphoma, instead of 3 units. As a result, TrailBlazer paid the provider $12,870 when it should have paid $1,287, an overpayment of $11,583. (Clm Ref # 20-318)*

TrailBlazer response:
Claim was system priced correctly. The over billed units generated the overpayment. However, the claim processed more than four years ago and the provider was not given prior notice that the claim was being reopened. Due to the four year limitation, TrailBlazer cannot pursue the overpayment.

- *For one claim the provider billed 100 units of paclitaxel, a chemotherapy drug, instead of 10 units. As a result, TrailBlazer paid the provider $11,192 when it should have paid $1,106, an overpayment of $10,086. (Clm Ref # 20-181)*

TrailBlazer response:
Claim was system priced correctly. The over billed units generated the overpayment. However, the claim processed more than four years ago and the provider was not given prior notice that the claim was being reopened. Due to the four year limitation, TrailBlazer cannot pursue the overpayment.

- *One provider billed for 36 mg of pegfilgrastim, used to reduce the risk of infection in chemotherapy patients, instead of 6 mg. As a result, TrailBlazer paid the provider $10,841 when it should have paid $1,819, an overpayment of $9,022. (Clm Ref # 20-258)*

TrailBlazer response:
Claim was system priced correctly. The over billed units generated the overpayment. Overpayment of $9,096 was recovered by offsetting against the provider's outstanding A/R.

Providers refunded overpayments totaling $52,648 for three of the seven claims prior to our audit. However overpayments totaling $43,903 for four claims remained outstanding. Providers attributed the incorrect billed quantity to clerical errors made by their billing staffs.

TrailBlazer response:
According to TrailBlazer's records providers refunded overpayments totaling $65,801 (Claim reference numbers 20-343, 20-072, 20.244, and 20-133). A demand letter was issued for claim reference number 20-258 and $9,096 was recovered. This results in a total of $74,896 being recovered for this group of seven claims.

Although TrailBlazer agrees with OIG that the two remaining claims (claim reference numbers 20-318 and 20-181) are overpaid, the claims processed more than four years ago and the provider was given no prior notice the claims were going to be reopened. Due to the four year limitation, TrailBlazer cannot pursue the overpayment.

Incorrect Payment Rate Used

For seven claims, TrailBlazer reimbursed providers using the incorrect payment rate for the billed services when it calculated the payment. During the processing of these seven claims, TrailBlazer calculated the payment using the incorrect fee schedule amount. For one claim, TrailBlazer reimbursed the provider for an incorrect number of units. Two providers refunded overpayments totaling $7,343 for three of the eight claims prior to our audit. One provider

stated that the overpayment of $38,879 was returned to TrailBlazer as reductions to subsequent Medicare payments prior to our audit. However, neither the provider nor TrailBlazer could verify that the provider returned the overpayment. Overpayments for the remaining four claims remain outstanding.

- *For six claims the provider billed for Factor VIII, an essential clotting factor for the treatment of hemophilia. TrailBlazer paid a total of $116,805 for the six claims, when it should have paid $98,062, an overpayment of $18,743. The provider refunded $7,211 for two of the six overpayments prior to our audit. Overpayments for the remaining four claims totaling $11,532 remained outstanding at the time of our audit. (Clms Ref #'s 20-074, 20-100, 20-101, 20-105, 20-171, and 20-253)*

TrailBlazer response:
As stated above, providers have refunded $7,211 for claim reference numbers 20-100 and 20-101. Demand letters are being issued for claim reference numbers 20-105, 20-171 and 20-253 totaling $10,702.

Claim reference number 20-074 processed more than four years ago and the provider was given no prior notice the claim was being reopened. Due to the four year limitation, TrailBlazer cannot pursue the overpayment.

- *For one claim the provider billed 33,000 units of Factor IX, used in the treatment of hemophilia B. TrailBlazer paid the provider $26,030, when it should have paid $25,898, an overpayment of $132. The provider refunded the overpayment prior to our audit. (Clm Ref # 20-207)*

TrailBlazer response:
Front-end claims a/priced incorrectly. An A/R was established for $132 and a demand letter sent to the provider.

- *For one claim the provider billed 1 unit of leuprolide, used in the treatment of several medical conditions. TrailBlazer adjusted the claim incorrectly and paid the provider for 10 units. As a result, TrailBlazer paid the provider $43,198, when it should have paid $4,320, an overpayment of $38,879. The provider stated that the overpayment was returned to TrailBlazer as reductions to subsequent Medicare payments. However, neither the provider nor TrailBlazer could verify that the provider refunded the overpayment prior to our audit. (Clm Ref # 20-317)*

TrailBlazer response:
Claim was system priced correctly. Unit billed by the provider was adjusted resulting in the overpayment. TrailBlazer has not been able to find evidence the $38,879 was recovered from the provider. However, the claim processed more than four years ago and the provider was not given prior notice the claim was being reopened. Due to the four year limitation, TrailBlazer cannot pursue the overpayment.

Providers refunded overpayments totaling $7,343 for three of the eight claims prior to our audit. However, overpayments totaling $11,532 for four claims remained outstanding. Because of the age of the remaining overpayment totaling $38,879, TrailBlazer stated that it would not be able to identify whether it had been refunded or collect it if it remained outstanding. TrailBlazer attributed its incorrect payments for these eight claims to clerical errors made by its claims examiner.

TrailBlazer response:
Providers have refunded overpayments totaling $7,343 (claim reference numbers 20-207, 20-100 and 20-101). Demand letters are being issued for overpayments totaling $10,703 (claim reference numbers 20-105, 20-171 and 20-253).

The last two claims (claim reference numbers 20-317 and 20-074) processed more than four years ago and the providers were not given prior notice the claims were being reopened. Due to the four year limitation, TrailBlazer cannot pursue the overpayment.

Insufficient Prepayment Controls

During CYs 2003-05, TrailBlazer, the Medicare Multi-Carrier Claims System, and the CMS Common Working File did not have the 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, 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 (PSC).

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 $55,435 in overpayments,*
- *verify that the overpayment totaling $38,879 was returned by the provider, and*
- *consider identifying and recovering any additional overpayments made to providers for high-dollar Part B claims paid after CY2005.*

TrailBlazer response:

- Of the $55,345 in overpayments, $22,234 has been recovered from providers and demand letters have been issued totaling $9,118.

  The remaining three claims totaling $23,993 were processed more than four years ago. Due to the four year limitation, TrailBlazer cannot pursue the overpayment.

- TrailBlazer has not been able to locate evidence the $38,879 was recovered from the provider. However, the claim processed more than four years ago and the provider was not given prior notice the claim was being reopened. Due to the four year limitation, TrailBlazer cannot pursue the overpayment.

- 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 (MUE)." These internal controls and edits are utilized in the review process described in the TrailBlazer response above.

  TrailBlazer continuously strives to prevent and identify all types of over payments and initiates recovery actions deemed appropriate.