



Office of Audit Services, Region III  
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JUN 19 2008

Report Number: A-03-07-00019

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 District of Columbia 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](mailto:Bernard.Siegel@oig.hhs.gov). Please refer to report number A-03-07-00019 in all correspondence.

Sincerely,

A handwritten signature in black ink, appearing to read "Stephen Virbitsky".

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 12<sup>th</sup> Street, Room 235  
Kansas City, Missouri 64106

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF HIGH-DOLLAR  
PAYMENTS FOR DISTRICT OF  
COLUMBIA 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-03-07-00019

# *Office of Inspector General*

<http://oig.hhs.gov>

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**THIS REPORT IS AVAILABLE TO THE PUBLIC**  
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## **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 the District of Columbia (the District). During calendar years (CY) 2003–05, TrailBlazer processed more than 20 million claims as the Part B carrier, 36 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 the District were appropriate.

### **SUMMARY OF FINDING**

Twenty-nine of the 36 high-dollar payments made by TrailBlazer for the District were appropriate. However, TrailBlazer overpaid providers \$89,324 for five payments. One provider refunded one of the overpayments, totaling \$36,423, prior to our audit; four overpayments, totaling \$52,901, remain outstanding.

TrailBlazer made the overpayments because two providers incorrectly claimed excessive units of service on three claims and TrailBlazer used the incorrect payment rate for 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.

We could not determine whether two payments, totaling \$33,440, were appropriate because the provider was no longer in business.

## **RECOMMENDATIONS**

We recommend that TrailBlazer:

- recover the \$52,901 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 has initiated the recovery of the outstanding overpayments identified by the audit and 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.

# TABLE OF CONTENTS

	<u>Page</u>
<b>INTRODUCTION</b> .....	1
<b>BACKGROUND</b> .....	1
Medicare Part B Carriers .....	1
TrailBlazer Health Enterprises.....	1
“Medically Unlikely Edits” .....	1
<b>OBJECTIVE, SCOPE, AND METHODOLOGY</b> .....	2
Objective .....	2
Scope.....	2
Methodology .....	2
<b>FINDING AND RECOMMENDATIONS</b> .....	3
<b>MEDICARE REQUIREMENTS</b> .....	3
<b>INAPPROPRIATE HIGH-DOLLAR PAYMENTS</b> .....	3
<b>RECOMMENDATIONS</b> .....	4
<b>TRAILBLAZER COMMENTS</b> .....	4
<b>APPENDIX</b>	
<b>TRAILBLAZER COMMENTS</b>	

## 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).<sup>1</sup> 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 the District of Columbia (the District).<sup>2</sup> During CYs 2003–05, TrailBlazer processed more than 20 million claims as the Part B carrier, 36 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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<sup>1</sup>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.

<sup>2</sup>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 the District were appropriate.

### **Scope**

We reviewed the 36 high-dollar payments, totaling \$548,565, that TrailBlazer processed during CYs 2003–05. We limited our review of TrailBlazer's internal controls to those applicable to the 36 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 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 RECOMMENDATIONS

Twenty-nine of the 36 high-dollar payments made by TrailBlazer for the District were appropriate. However, TrailBlazer overpaid providers \$89,324 for five payments. One provider refunded one of the overpayments, totaling \$36,423, prior to our audit; four overpayments, totaling \$52,901, remain outstanding.

TrailBlazer made the overpayments because two providers incorrectly claimed excessive units of service on three claims and TrailBlazer used the incorrect payment rate for 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.

For the remaining two claims, we could not determine the appropriateness of the payments, totaling \$33,440, because the provider was no longer in business

### 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 \$89,324 for five payments. For three of the five overpayments, totaling \$52,613, providers incorrectly billed TrailBlazer for excessive units of service.

- One provider billed TrailBlazer 200 units of service for a chemotherapy injection, a procedure that most commonly requires 2 units of service. The same provider also billed 500 units of service for a cancer treatment drug that is most commonly billed at 1 unit. TrailBlazer paid the provider \$30,095 for the two claims. Because the provider could not supply documentation to support the amounts billed, we questioned the entire amount paid. The provider had not refunded the overpayments at the time of our audit.
- One provider billed 71 units of service for a cancer treatment drug instead of 7 units because of a data entry error. As a result, TrailBlazer paid the provider \$24,981 when it should have paid \$2,463, an overpayment of \$22,518. The provider attributed its incorrect quantity billed to a clerical error made by its billing staff, but it had not refunded the overpayment at the time of our audit.

For the remaining two overpayments, totaling \$36,711, TrailBlazer reimbursed the provider using the incorrect payment rate for the billed service when it manually calculated the payment.

- One provider billed TrailBlazer using an outdated procedure code. TrailBlazer converted the outdated procedure code to the wrong current procedure code. As a result, TrailBlazer paid the provider \$36,703 when it should have paid \$280, an overpayment of \$36,423. The provider refunded the overpayment prior to our audit.
- One provider billed TrailBlazer using the correct procedure code; however, TrailBlazer calculated the payment amount using an incorrect fee schedule amount. As a result, TrailBlazer paid the provider \$13,986 when it should have paid \$13,698, an overpayment of \$288. The provider had not refunded the overpayment at the time of our audit.

Trailblazer attributed its incorrect payments for these two claims to clerical errors made by its claims examiner.

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 and payment rates. Instead, CMS relied on providers to notify carriers of overpayments and on beneficiaries to review their “Medicare Summary Notice” and disclose any provider overpayments.<sup>3</sup>

## **RECOMMENDATIONS**

We recommend that TrailBlazer:

- recover the \$52,901 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 TrailBlazer stated that it has initiated the recovery of the outstanding overpayments identified by the audit and 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.

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<sup>3</sup>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**

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-03-07-00019****INAPPROPRIATE HIGH-DOLLAR PAYMENTS**

TrailBlazer overpaid providers \$89,324 for five payments. For the three of the five overpayments, totaling \$52,613, providers incorrectly billed TrailBlazer for excessive units of service.

- One provider billed Trailblazer 200 units of service for a chemotherapy injection, a procedure that most commonly requires 2 units of service. The same provider also billed 500 units of service for a cancer treatment drug that is most commonly billed at 1 unit. TrailBlazer paid the provider \$30,095 for the two claims. Because the provider could not supply documentation to support the amounts billed, we questioned the entire amount paid. The provider had not refunded the overpayments at the time of our audit.

**TrailBlazer response:**

Claim # 7628886 paid correctly according to the way it was submitted by the provider. The system priced according to the quantity billed by the provider. The office visit was filed on a previous claim and the procedure code (G0355) was a-priced according to the correct coding initiative (CCI) audit.

Claim # 14064176 paid correctly according to the way it was submitted by the provider. The system priced according to the quantity billed by the provider.

- One provider billed 71 units of service for a cancer treatment drug instead of 7 units because of a data entry error. As a result, TrailBlazer paid the provider \$24,981 when it should have paid \$2,463, an overpayment of \$22,518. The provider attributed its incorrect quantity billed to a clerical error made by its billing staff, but it had not refunded the overpayment at the time of the audit.

**TrailBlazer response:**

Claim # 674622 was priced by the system according to the quantity billed by the provider. The provider sent a voluntary refund because he should have billed for 7 units rather than 71 units. The claim was adjusted for the correct allowable 7 units (see claim # 4608009853000). The provider check number 3150 for \$22,518.43 was posted to the resulting A/R. No further action is required.

For the remaining two overpayments, totaling \$36,711, TrailBlazer reimbursed the provider using the incorrect payment rate for the billed service when it manually calculated the payment.

- One provider billed TrailBlazer using an outdated procedure code. TrailBlazer converted the outdated procedure code to the wrong current procedure code. As a result, TrailBlazer paid the provider \$36,703 when it should have paid \$280, an overpayment of \$36,423. The provider refunded the overpayment prior to our audit.

**TrailBlazer response:**

Claim # 994233 was initially denied for limited coverage. The claim was adjusted and \$36,703.20 was paid on 01/19/06 on claim # 4605332500080. A keying error was made and too much was allowed on the adjustment. A refund request was sent for the excess payment of \$36,423.29, after the provider advised us of the overpayment. The provider refunded this in a timely manner on check # 31159. However, the refund was not posted timely thus, \$36,040.09 was posted to the principal and \$383.20 was posted to interest. The posting left \$383.20 in the principal and it was withheld from the provider on 9/1/06. TrailBlazer will repay the \$383.20 to the provider.

- One provider billed TrailBlazer using the correct procedure code; however, TrailBlazer calculated the payment amount using an incorrect fee schedule amount. As a result, TrailBlazer paid the provider \$13,986 when it should have paid \$13,698, an overpayment of \$288. The provider had not refunded the overpayment at the time of our audit.

**TrailBlazer response:**

Claim # 2208595 was priced incorrectly. An overpayment of \$288.39 was voluntarily refunded on check # 219063, received on 01/23/08.

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

During CYs 2003-2005, TrailBlazer, TrailBlazer, the Medicare Multi-Carrier Claims System, and the CMS Common Working File (CWF) did not have sufficient prepayment controls to detect and prevent inappropriate payments resulting from claims for excessive units of service and payment rates. 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 Claim Analyst.

**RECOMMENATIONS**

We recommend that TrailBlazer:

- recover the \$52,901 in overpayments and
- consider identifying and recovering any additional overpayments made to providers for high-dollar Part B claims paid after CY 2005.

**TrailBlazer response:**

TrailBlazer has initiated the recovery of the outstanding overpayments identified by the audit.

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.