



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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

April 29, 2009

Report Number: A-06-08-00034

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:

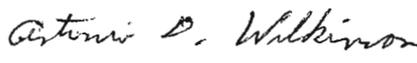
Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of High-Dollar Payments for Texas Medicare Part B Claims Processed by TrailBlazer Health Enterprises for the Period January 1 through December 31, 2004." We will forward 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 e-mail at Trish.Wheeler@oig.hhs.gov. Please refer to report number A-06-08-00034 in all correspondence.

Sincerely,


for Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

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Consortium for Financial Management & Fee for Service Operations
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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, 2004**



Daniel R. Levinson
Inspector General

April 2009
A-06-08-00034

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) 2004, TrailBlazer Health Enterprises (TrailBlazer) was the Medicare Part B carrier for providers in several States, including more than 65,000 providers in Texas. TrailBlazer processed more than 51 million Texas Medicare Part B claims, 183 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 183 high-dollar payments that TrailBlazer made to providers, 169 were appropriate. However, TrailBlazer overpaid providers \$115,836 for 13 of the remaining 14 payments. TrailBlazer adjusted the remaining claim 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 2004 to detect and prevent payments for these types of erroneous claims.

RECOMMENDATIONS

We recommend that TrailBlazer:

- recover the \$115,836 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 \$70,972 in overpayments and issued overpayment demand letters for the remaining \$44,864. TrailBlazer has included information related to our findings in their provider education activities. TrailBlazer's comments are included as the Appendix.

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TRAILBLAZER HEALTH ENTERPRISES COMMENTS	

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) 2004, providers nationwide submitted more than 787 million claims to carriers. Of these, 8,938 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 2004, TrailBlazer Health Enterprises (TrailBlazer), was the Medicare Part B carrier for providers in several States, including more than 65,000 providers in Texas. TrailBlazer processed more than 51 million Texas Medicare Part B claims, 183 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.

¹The 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 183 high-dollar payments that TrailBlazer processed during CY 2004. TrailBlazer adjusted one of the payments to less than \$10,000 prior to the start of our audit. We reviewed the remaining 182 high-dollar payments which totaled \$4,171,860. We limited our review of TrailBlazer's internal controls to those applicable to the 182 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 January 2008 to January 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 183 high-dollar payments that TrailBlazer made to providers, 169 were appropriate. However, TrailBlazer overpaid providers \$115,836 for 13 of the remaining 14 payments. TrailBlazer adjusted the remaining claim 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 2004 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, over utilization 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

Of the 13 erroneous payments identified, TrailBlazer made 3 payments to providers because of claim processing errors. TrailBlazer made the remaining 10 payments because of errors made by the providers. Providers submitted two claims with an incorrect HCPCS code, six claims with excessive units of service, and two claims without proper support.

Carrier Processing Errors

TrailBlazer incorrectly processed 3 claims.

- For one claim, TrailBlazer allowed the \$14,440 in total charges that the provider submitted for the drug Avastin. Although Avastin did not have an HCPCS code assigned during 2004, Trailblazer should have limited the payment to \$653.13 per unit. As a result of the error, TrailBlazer overpaid the provider \$6,327.
- For one claim, TrailBlazer paid the charges that the provider submitted for a therapeutic imaging agent, HCPCS code A9523. Because there was not an established payment rate for this code, TrailBlazer should have paid the amount listed on the supplier’s invoice. As a result of the error, TrailBlazer overpaid the provider \$1,808.
- For one claim, TrailBlazer priced a hemophilia drug, HCPCS code J7190, using the Medicare participating rate of \$0.87 per unit instead of the nonparticipating rate of \$0.83 per unit. As a result of the error, TrailBlazer overpaid the provider \$669.

Provider Healthcare Common Procedure Coding System Errors

For two claims related to implantable pulse generators, one provider incorrectly coded the claims using HCPCS code L8699 rather than the correct code, E0756. HCPCS code L8699 was an implantable miscellaneous code, which should have been used only if a more specific code was not available. As a result of the error, TrailBlazer overpaid the provider \$12,086.

Provider Units of Service Errors

Six providers billed for excessive units of service.

- One provider billed for 731 units of an analysis of a pacemaker system, procedure code 93731, rather than 1 unit, which was the amount provided. As a result, TrailBlazer overpaid the provider \$24,037.
- One provider billed for 200 units of a diagnostic imaging agent, HCPCS code A9500, rather than 2 units, which was the amount provided. As a result, TrailBlazer overpaid the provider \$19,361.
- One provider billed for six units of a drug injection, HCPCS code J2505, rather than one unit, which was the amount provided. As a result, TrailBlazer overpaid the provider \$10,030.
- One provider billed for 61 units of an infusion technique that is billable up to one hour, procedure code 96410, rather than 1 unit, which was the amount provided. As a result, TrailBlazer overpaid the provider \$9,346.
- One provider billed for 36 units of a chemotherapy drug, HCPCS code J9170, rather than 3 units, which was the amount provided. As a result, TrailBlazer overpaid the provider \$8030.
- One provider billed for 21,250 units of a hemophilia drug, HCPCS code J7190, rather than 21,010 units, which was the amount provided. As a result, TrailBlazer overpaid the provider \$167.

The providers identified all of these errors; the providers that gave a reason attributed the incorrect claims to human error.

In addition, during CY 2004, 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

²The 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.

Provider Documentation Errors

For two claims, the health care provider stated that the name of the attending physician was inadvertently omitted from the medical records supporting the claims, which, therefore, should not have been submitted. As a result, TrailBlazer overpaid the provider \$23,975.

RECOMMENDATIONS

We recommend that TrailBlazer:

- recover the \$115,836 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 \$70,972 in overpayments and issued overpayment demand letters for the remaining \$44,864. TrailBlazer has included information related to our findings in their provider education activities. TrailBlazer's comments are included as the Appendix.

APPENDIX



MEDICARE

April 20, 2009

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

Report Number: A-06-08-00034

Dear Mr. Sato:

We received the March 19, 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, 2004." In the draft report, the OIG recommended that TrailBlazer:

- Recover the \$115,836 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 \$70,972, which included \$160 of interest, in overpayments. Additionally, TrailBlazer issued overpayment demand letters for the remaining \$44,864. However, the remaining overpayments have not yet been collected.

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A Medicare Administrative Contractor



Gordon L. Sato
April 20, 2009
Page 2 of 2

Provider Education Activities: TrailBlazer Provider Outreach and Education staff recently developed an online job aid regarding the coding of Part B drugs and biologicals. On March 24, 2009, the job aid was distributed to providers in a general listserv. This job aid is located at the following address:

<http://www.trailblazerhealth.com/Publications/Job%20Aid/DrugsandBiologicalsCodingTips.pdf>

TrailBlazer offers “tips” regarding billing drugs and biologicals to new Part B providers during “Welcome To Medicare” seminars. These seminars cover:

- How drugs are priced as part of the fee schedules discussion; and
- How to report the quantity billed amounts are covered as part of the discussion regarding item 24(g) of the CMS 1500 claim form.

Beyond the “Welcome to Medicare” seminar, TrailBlazer continues to educate providers regarding the billing of drugs and biologicals during workshops, Web-based training seminars, and specialty training classes. TrailBlazer provides education specifically regarding the reporting of dosage and name of the drug when billing not otherwise classified drugs on Item 19 of the CMS 1500 claim form.

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

Sincerely,



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