



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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

July 16, 2009

Report Number: A-06-08-00065

Ms. Melissa Halstead Rhoades  
Area Director & Medicare Chief Financial Officer  
TrailBlazer Health Enterprises, LLC  
8330 LBJ Freeway, 11<sup>th</sup> Floor  
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 Medicare Outpatient 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, or contact Trish Wheeler, Audit Manager, at (214) 767-6325 or through email at [Trish.Wheeler@oig.hhs.gov](mailto:Trish.Wheeler@oig.hhs.gov). Please refer to report number A-06-08-00065 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  
Kansas City, Missouri 64106  
rokcmora@cms.hhs.gov

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

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



Daniel R. Levinson  
Inspector General

July 2009  
A-06-08-00065

# *Office of Inspector General*

<http://oig.hhs.gov>

---

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

## *Office of Audit Services*

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

## *Office of Evaluation and Inspections*

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

## *Office of Investigations*

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

## *Office of Counsel to the Inspector General*

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

# *Notices*

---

**THIS REPORT IS AVAILABLE TO THE PUBLIC**  
at <http://oig.hhs.gov>

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. The Centers for Medicare & Medicaid Services (CMS), which administers the program, contracts with fiscal intermediaries to process and pay Medicare Part B claims submitted by hospital outpatient departments. The intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File to process claims. The Common Working File can detect certain improper payments during prepayment validation.

Medicare guidance requires providers to bill accurately and to report units of service as the number of times that the service or procedure was performed.

TrailBlazer Health Enterprises (TrailBlazer) is a Medicare fiscal intermediary serving more than 3,000 Medicare providers in Texas, New Mexico, Louisiana, Alaska, and Colorado. For calendar year (CY) 2005, TrailBlazer processed approximately 8.8 million outpatient claims, 25 of which resulted in payments of \$50,000 or more (high-dollar payments).

### **OBJECTIVE**

Our objective was to determine whether the high-dollar Medicare payments that TrailBlazer made to providers for outpatient services were appropriate.

### **SUMMARY OF FINDINGS**

Of the 25 high-dollar payments that TrailBlazer made to providers, 9 were appropriate. TrailBlazer overpaid providers for 16 claims, resulting in overpayments totaling \$848,640. Contrary to Federal guidance, the providers inappropriately overstated the units of service for one or more procedures in 12 of the 16 high-dollar claims and billed the wrong procedure code for 4 of the 16 high-dollar claims. TrailBlazer made the overpayments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in CY 2005 to detect these types of billing errors.

### **RECOMMENDATIONS**

We recommend that TrailBlazer:

- inform us of the status of the recovery of the \$848,640 in overpayments and
- use the results of this audit in its provider education activities.

### **TRAILBLAZER HEALTH ENTERPRISES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In its comments on our draft report, TrailBlazer agreed with the findings and recommendations.

TrailBlazer commented that, as a result of the audit, it recovered \$848,640 in overpayments. However, TrailBlazer stated that it would not be cost beneficial to review all of the claims under \$50,000 that billed the procedure codes identified in this report. TrailBlazer's comments are included in their entirety as the Appendix.

We agree with TrailBlazer's assertion that reviewing all of the claims under \$50,000 that billed the procedure codes identified in this report would not be cost beneficial. As a result, we removed this recommendation from the report.

**TABLE OF CONTENTS**

	<u>Page</u>
<b>INTRODUCTION</b> .....	1
<b>BACKGROUND</b> .....	1
Medicare Fiscal Intermediaries.....	1
Claims for Outpatient Services .....	1
TrailBlazer Health Enterprises.....	1
<b>OBJECTIVE, SCOPE, AND METHODOLOGY</b> .....	1
Objective .....	1
Scope.....	2
Methodology .....	2
<b>FINDINGS AND RECOMMENDATIONS</b> .....	2
<b>FEDERAL REQUIREMENTS</b> .....	3
<b>INAPPROPRIATE HIGH-DOLLAR PAYMENTS</b> .....	3
<b>CAUSES OF OVERPAYMENTS</b> .....	4
<b>FISCAL INTERMEDIARY PREPAYMENT EDIT</b> .....	4
<b>RECOMMENDATIONS</b> .....	4
<b>TRAILBLAZER HEALTH ENTERPRISES COMMENTS AND     OFFICE OF INSPECTOR GENERAL RESPONSE</b> .....	4
<b>OTHER MATTER</b> .....	5
<b>APPENDIX</b>	
<b>TRAILBLAZER HEALTH ENTERPRISES COMMENTS</b>	

## **INTRODUCTION**

### **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) administers the program.

#### **Medicare Fiscal Intermediaries**

CMS contracts with fiscal intermediaries to, among other things, process and pay Medicare Part B claims submitted by hospital outpatient departments. The intermediaries' responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Federal guidance provides that intermediaries must maintain adequate internal controls over automatic data processing systems to prevent increased program costs and erroneous or delayed payments.

To process providers' outpatient claims, the intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File. The Common Working File can detect certain improper payments when processing claims for prepayment validation.

In calendar year (CY) 2005, fiscal intermediaries processed and paid more than 141 million outpatient claims, 401 of which resulted in payments of \$50,000 or more (high-dollar payments). We consider such claims to be at high risk for overpayment.

#### **Claims for Outpatient Services**

Providers generate the claims for outpatient services provided to Medicare beneficiaries. Medicare guidance requires providers to bill accurately and to report units of service as the number of times that the service or procedure was performed.

#### **TrailBlazer Health Enterprises**

TrailBlazer Health Enterprises (TrailBlazer) is a Medicare fiscal intermediary serving more than 3,000 Medicare providers in Texas, New Mexico, Louisiana, Alaska, and Colorado. For calendar year (CY) 2005, TrailBlazer processed approximately 8.8 million outpatient payments, 25 of which resulted in payments of \$50,000 or more (high-dollar payments).

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether the high-dollar Medicare payments that TrailBlazer made to providers for outpatient services were appropriate.

## **Scope**

We reviewed the 25 high-dollar payments for outpatient claims that TrailBlazer processed during CY 2005. We limited our review of TrailBlazer's internal controls to those applicable to the 25 payments 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 a reasonable assurance of the authenticity and accuracy of the data in the 25 claims obtained from the National Claims History file, but we did not assess the completeness of the file.

We conducted our audit work from May 2008 through January 2009.

## **Methodology**

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;
- used CMS's National Claims History file to identify Medicare outpatient claims with high-dollar payments;
- reviewed available Common Working File claim 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;
- contacted the providers that received the high-dollar payments to determine whether the information on the claims was correct and, if not, why the claims were incorrect and whether the providers agreed that refunds were appropriate; and
- coordinated our review 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 findings and conclusions based on our audit objective.

## **FINDINGS AND RECOMMENDATIONS**

Of the 25 high-dollar payments that TrailBlazer made to providers, 9 were appropriate. TrailBlazer overpaid providers for 16 claims, resulting in overpayments totaling \$848,640. Contrary to Federal guidance, the providers inappropriately overstated the units of service for one or more procedures in 12 of the 16 high-dollar claims and billed the wrong procedure code for 4 of the 16 high-dollar claims. TrailBlazer made the overpayments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in CY 2005 to detect these types of billing errors.

## **FEDERAL REQUIREMENTS**

Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986, P.L. No. 99-509, requires hospitals to report claims for outpatient services using coding from the Healthcare Common Procedure Coding System (HCPCS). CMS's "Medicare Claims Processing Manual," Publication No. 100-04, chapter 4, section 20.4, states that the number of service units "is the number of times the service or procedure being reported was performed." In addition, chapter 1, section 80.3.2.2, of the manual states: "To be processed correctly and promptly, a bill must be completed accurately."

Section 3700 of the "Medicare Intermediary Manual" requires the fiscal intermediary to maintain adequate internal controls over Medicare automatic data processing systems to preclude increased program costs and erroneous and/or delayed payments.

## **INAPPROPRIATE HIGH-DOLLAR PAYMENTS**

TrailBlazer made overpayments totaling \$848,640 for 16 claims because five providers billed for excessive units of service or billed the wrong procedure code.

- For seven claims, the provider billed procedure code C9205, a chemotherapy drug, for 5,700 units rather than 566 units, which was the number of units provided. The provider stated that the error occurred because the billing system's pricing tables contained an incorrect conversion factor for the procedure code. As a result of the error, TrailBlazer paid the provider \$482,338 when it should have paid \$60,907, an overpayment of \$421,431.
- For one claim, the provider billed procedure code J9305, a chemotherapy drug, for 3,000 units rather than 100 units, which was the number of units provided. The provider stated that the error occurred because of problems with the pharmacy's billing system, which were identified prior to billing. However, the provider did not correct the number of units on the claim while trying to correct the system error. As a result of the error, TrailBlazer paid the provider \$124,420 when it should have paid \$6,854, an overpayment of \$117,566.
- For three claims, the provider billed procedure code C9205, a chemotherapy drug, for 200 units for each of 12 dates of service rather than procedure code Q0137, a different chemotherapy drug, for the same number of units. The provider stated that the billing clerk misunderstood the system's error message and incorrectly chose the suggested procedure code. As a result of the error, TrailBlazer paid the provider \$184,957 when it should have paid \$17,359, an overpayment of \$167,598.
- For one claim, the provider billed procedure code J9355, a chemotherapy drug, for 2,068 units rather than 88 units, which was the number of units provided. The provider stated that the number of billing units for this drug was incorrectly entered into the billing system and attributed the incorrect number of units claimed to a clerk's misunderstanding

of conversion factors. As a result of the error, TrailBlazer paid the provider \$104,745 when it should have paid \$5,794, an overpayment of \$98,951.

- For four claims, the provider either billed for an incorrect number of units or an incorrect procedure code related to the placement of an implantable cardioverter defibrillator. For three of the claims, the provider billed procedure code C1721 for two units rather than one unit, C1722 for two units rather than one unit, and C1882 for two units rather than one unit. On the fourth claim, the provider billed procedure code 33213 for one unit rather than procedure code G0300 QR for one unit. The provider attributed the incorrect number of units and the wrong procedure code to a clerical error. As a result of the errors, TrailBlazer paid the provider \$226,119 when it should have paid \$183,025, an overpayment of \$43,094.

## **CAUSES OF OVERPAYMENTS**

The providers agreed that overpayments had occurred and that refunds were due or had already been made. The providers attributed the errors to their systems and to human errors in coding and in applying conversion factors.

In addition, during CY 2005, TrailBlazer did not have prepayment or postpayment controls to identify overpayments at the claim level, and the Common Working File prepayment editing process lacked edits to detect and prevent excessive payments. In effect, CMS relied on providers to notify the intermediaries of excessive payments and on beneficiaries to review their “Explanation of Medicare Benefits” and disclose any overpayments.<sup>1</sup>

## **FISCAL INTERMEDIARY PREPAYMENT EDIT**

On January 3, 2006, after the end of our audit period, CMS required intermediaries to implement a Fiscal Intermediary Standard System edit to suspend potentially excessive Medicare payments for prepayment review. The edit suspends high-dollar outpatient claims and requires intermediaries to determine the legitimacy of the claims.

## **RECOMMENDATIONS**

We recommend that TrailBlazer:

- inform us of the recovery status of the \$848,640 in overpayments and
- use the results of this audit in its provider education activities.

## **TRAILBLAZER HEALTH ENTERPRISES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In its comments on our draft report, TrailBlazer agreed with the findings and recommendations.

---

<sup>1</sup>The fiscal intermediary sends an “Explanation of Medicare Benefits” 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.

TrailBlazer commented that, as a result of the audit, it recovered \$848,640 in overpayments. However, TrailBlazer stated that it would not be cost beneficial to review all of the claims under \$50,000 that billed the procedure codes identified in this report. TrailBlazer's comments are included in their entirety as the Appendix.

We agree with TrailBlazer's assertion that reviewing all of the claims under \$50,000 that billed the procedure codes identified in this report would not be cost beneficial. As a result, we removed this recommendation from the report.

### **OTHER MATTER**

One provider that made high-dollar claims for 2005 responded that an error had occurred due to a mistake in the provider's pharmacy charge system tables. The provider stated that in 2004, one drug was provided with two HCPCS codes, each with a different unit definition. The HCPCS defined one procedure code as 0.5 mg per unit and the other procedure code as 5 mg per unit. The provider stated that the pharmacy had inadvertently changed its pricing tables to define both HCPCS codes as 0.5 mg. As a result, the provider overbilled all claims for procedure code C9205, a chemotherapy drug, for part of 2004 and all of 2005. TrailBlazer overpaid the provider \$855,832 for CY 2005 claims that were incorrectly billed but not identified during our review because they were not high-dollar claims. The provider submitted the corrected claims to TrailBlazer along with a refund for the estimated overpayments resulting from this error.

# **APPENDIX**



CENTERS for MEDICARE & MEDICAID SERVICES

MEDICARE

June 24, 2009

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

Report Number: A-06-08-00065

Dear Mr. Sato:

We received the May 15, 2009, draft report entitled "Review of High-Dollar Payments for Medicare Outpatient Claims Processed by TrailBlazer Health Enterprises for the Period January 1 through December 31, 2005." In the draft report, the OIG recommended that TrailBlazer:

- Inform the OIG of the status of the recovery of the \$848,640 in overpayments,
- Review claims under \$50,000 that bill the procedure codes identified in the report and correct any claims found in error, and
- Use the results of this audit in its 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 \$848,640 in overpayments.

**Review of claims under \$50,000:** TrailBlazer wishes to correct all findings identified in the audit. TrailBlazer understands the OIG is recommending the review of all 2005 claims totaling \$50,000 or less containing these particular procedures. Please confirm our understanding of the recommendation.

Typically, contractors are limited to four years from the date of the initial determination or redetermination to initiate a reopening or revise claims. A portion of claims with 2005 dates of service are purged from Fiscal Intermediary Shared System (FISS). While a shell of the claim remains, including HIC number and dates of service, detailed information is not readily available. In order to accomplish this recommendation, TrailBlazer will take the following actions:

- 1) Submit a request to the Enterprise Data Center (EDC) to retrieve **all** claims from 2005.
- 2) Run a query against the retrieved claims to identify claims containing these procedures.
- 3) Determine if the claims identified in step 2 exceed the 4-year reopening period. If they do, no additional action will be taken.

Gordon L. Sato  
June 24, 2009  
Page 2 of 2

- 4) Perform an initial analysis of the claim, which will result in either a request to the provider to verify the units of service provided for those HCPCS in 2005, or ask the provider to send medical records for a nurse review. This step will only be performed on those claims which do not exceed the 4-year reopening period.

TrailBlazer has concerns that the cost and effort involved might outweigh the potential benefits. Currently, the volume of claims involved is unknown. Therefore, TrailBlazer will wait for confirmation from the OIG of our understanding of the recommendation before beginning any of the activities outlined above. TrailBlazer will then work with the CMS Project Officer for the Jurisdiction 4 MAC to determine and implement the corrective action related to these 2005 claims.

**Provider Education Activities:** TrailBlazer Provider Outreach and Education staff will use various methods to disseminate educational information to address the issues identified in this audit, including:

- Listserv messages
- Web notices
- Face-to-face presentations

In addition, TrailBlazer maintains numerous online tools relating to outpatient services and proper claim submission on the TrailBlazer Web site, including:

- Outpatient Services manual (<http://www.trailblazerhealth.com/Publications/Training%20Manual/HospitalOutpatientManual.pdf>)
- Medicare Basics manual (<http://www.trailblazerhealth.com/Publications/Training%20Manual/MedicareBasicsManual.pdf>)
- DDE (Direct Data Entry) Claims Entry manual (<http://www.trailblazerhealth.com/Publications/Training%20Manual/GPNetClaimsEntry.pdf>)

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

Sincerely,



Melissa Halstead Rhoades  
Area Director & Medicare CFO

Cc: Virginia Adams, 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