



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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

November 30, 2009

Report Number: A-06-08-00066

Ms. Melissa Halstead Rhoades
Area Director & Medicare Chief Financial Officer
TrailBlazer Health Enterprises, LLC
8330 LBJ Freeway, 11th 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, 2006." 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Michelle Richards, Senior Auditor, at (214) 767-9202 or through email at Michelle.Richards@oig.hhs.gov. Please refer to report number A-06-08-00066 in all correspondence.

Sincerely,

/Patricia Wheeler/
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 MEDICARE OUTPATIENT CLAIMS
PROCESSED BY TRAILBLAZER HEALTH
ENTERPRISES FOR THE PERIOD JANUARY
1 THROUGH DECEMBER 31, 2006**



Daniel R. Levinson
Inspector General

(November 2009)
A-06-08-00066

Office of Inspector General

<http://oig.hhs.gov>

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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 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, and Colorado. For calendar year (CY) 2006, TrailBlazer processed approximately 8.8 million outpatient claims, 75 of which resulted in payments of \$50,000 or more (high-dollar payments).

Beginning January 3, 2006, 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.

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

Fifty-seven of the 75 high-dollar payments that TrailBlazer made to providers for outpatient services were appropriate. Of the remaining 18 claims, TrailBlazer overpaid providers a total of \$1,091,821. Contrary to Federal guidance, the providers inappropriately overstated the units of service for one or more procedures or billed the wrong Healthcare Common Procedure Coding System code for the service rendered. Additionally, TrailBlazer's process for determining the legitimacy of the claims that were suspended by the high-dollar edit was not adequate because TrailBlazer relied on providers to make the determination.

RECOMMENDATIONS

We recommend that TrailBlazer:

- inform us of the status of the recovery of the \$1,091,821 in overpayments,

- require providers to submit supporting documentation for claims subject to the edit and review that documentation to determine if the claim is legitimate before overriding the edit, and
- use 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 and detailed its newly implemented processing guidelines for outpatient claims exceeding \$50,000. TrailBlazer commented that, as a result of the audit, it recovered \$1,092,187 in overpayments, which included additional overpayments of \$366 related to two claims. TrailBlazer's comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

Pursuant to Title XVIII of the Social Security Act, the 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 requires intermediaries to 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) 2006, fiscal intermediaries processed and paid more than 140 million outpatient claims, 328 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.

Fiscal intermediaries use 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.

TrailBlazer Health Enterprises

TrailBlazer Health Enterprises (TrailBlazer) is a Medicare fiscal intermediary serving more than 3,000 Medicare providers in Texas, New Mexico, and Colorado. For CY 2006, TrailBlazer processed about 8.8 million outpatient claims, 75 of which resulted in 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 75 high-dollar payments for outpatient claims that TrailBlazer processed during CY 2006. We limited our review of TrailBlazer's internal controls to those applicable to the 75 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 75 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 June 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;
- interviewed TrailBlazer officials and reviewed documentation regarding its implementation of the Fiscal Intermediary Standard System edit for high-dollar claims; 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

Fifty-seven of the 75 high-dollar payments that TrailBlazer made to providers for outpatient services were appropriate. For the remaining 18 claims, TrailBlazer overpaid providers a total of \$1,091,821. Contrary to Federal guidance, the providers inappropriately overstated the units of service for one or more procedures or billed the wrong Healthcare Common Procedure Coding System (HCPCS) codes for the services rendered.

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 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.

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

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

TrailBlazer made overpayments totaling \$1,091,821 for 18 claims because two providers billed for excessive units of service or billed the wrong procedure code.

- For 14 claims, a provider billed procedure code J1566, a blood product, for 49,300 units rather than 983 units, which was the number of units provided. The provider stated that the error had occurred because the billing system's pricing tables contained an incorrect conversion factor, which converts administered units to billable units, for the procedure code. As a result of the error, TrailBlazer paid the provider \$1,112,169 when it should have paid \$19,443, an overpayment of \$1,092,726.
- For four claims, a provider either billed for an incorrect number of units or billed an incorrect procedure code related to the placement of an implantable cardioverter defibrillator. For two of the claims, the provider billed procedure code G0298 rather than procedure code G0300 for one unit. On the third claim, the provider billed procedure code 33225 for two units rather than one unit. On the fourth claim, the provider billed procedure codes C1721 and 33244 for one unit each in error. The provider attributed the incorrect number of units and the wrong procedure code to clerical errors. As a result of

the errors, TrailBlazer paid the provider \$232,999 when it should have paid \$233,904, an underpayment of \$905.

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 billing systems and to human errors in coding and in applying conversion factors.

Additionally, TrailBlazer's process for determining the legitimacy of the claims that were suspended by the high-dollar edit was not adequate because TrailBlazer relied on providers to make the determination. When a claim was suspended, TrailBlazer contacted providers and required them to verify the number of units billed on the claim. If the provider determined that the number of units was correct, TrailBlazer instructed the provider to indicate this in the remarks section of the claim and to resubmit it. To determine the legitimacy of the claims, TrailBlazer reviewed only the claims' remarks sections, which stated that the providers had reviewed the claims and that the claims were correct. TrailBlazer did not request any medical records from the providers. Although TrailBlazer implemented the prepayment edit, neither its system for determining the legitimacy of claims nor the Common Working File had sufficient edits in place in CY 2006 to detect billing errors related to units and HCPCS codes. Instead, TrailBlazer relied on providers to notify it of incorrect payments and on beneficiaries to review their "Explanation of Medicare Benefits" and disclose any inappropriate payments.¹

RECOMMENDATIONS

We recommend that TrailBlazer:

- inform us of the recovery status of the \$1,091,821 in overpayments,
- require providers to submit supporting documentation for claims subject to the edit and review that documentation to determine if the claim is legitimate before overriding the edit, and
- use 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 and detailed its newly implemented processing guidelines for outpatient claims exceeding \$50,000. TrailBlazer commented that, as a result of the audit, it recovered \$1,092,187 in overpayments, which included additional overpayments of \$366 related to two claims. TrailBlazer's comments are included in their entirety as the Appendix.

¹The 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.

APPENDIX



November 13, 2009

Patricia Wheeler
Regional Inspector General for Audit Services
Office of Inspector General
1100 Commerce, Room 632
Dallas, Texas 75242

Report Number: A-06-08-00066

Dear Ms. Wheeler:

We received the October 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, 2006." In the draft report, the OIG recommended that TrailBlazer:

- Inform the OIG of the status of recovery of the \$1,091,821 in overpayments;
- Require providers to submit supporting documentation for the claims subject to the edit and review that documentation to determine if the claim is legitimate before overriding the edit; and
- Use 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: TrailBlazer recovered \$1,092,187. The \$366 difference is related to two claims, which had additional recoveries of \$174 and \$192. The detail for these claims is available if needed.

Documentation Review: TrailBlazer implemented new processing guidelines for outpatient claims exceeding \$50,000. Below are the new guidelines:

- The Medical Review department will be working location SM70\$\$\$. The claims will continue to edit for reason code 37551.
- The Medical Review staff will review the claim to determine if this is the first time the claim has been received by TrailBlazer.
- If this is the first time the claim has suspended for edit 37551, the Medical Review staff will review the claim to determine the services that are receiving high dollar reimbursement.
- Once the determination has been made for the charges billed, an Additional Development Request (ADR) will be sent to the provider requesting appropriate information/medical records needed to review the services.

- All Part B of A and outpatient services claims at the threshold dollar amount of \$50,000 or greater, regardless of the services/units billed, will be ADR'd and documentation will be reviewed. An auto deny for non-receipt of medical records will be set up for records not received within the specified ADR timeframe.
- When the medical records are received by the TrailBlazer Medical Review staff, they will update the claim to indicate the medical records have arrived and the claim will be suspended in location SMF5\$\$ to be reviewed by a Medical Review nurse.
- If the medical records support the information billed on the claim, the Medical Review nurse will override the edit 37551 on claim page nine.
- If the medical records do not support the information billed on the claim, the claim will be denied indicating that the medical records do not support the services billed on the claim.

Provider Education Activities: TrailBlazer Provider Outreach and Education staff will develop and issue a Web notice and listserv message. Additionally, this will be incorporated into Web-based training.

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

Sincerely,

/s/ Melissa Halstead Rhoades

Melissa Halstead Rhoades
Area Director & Medicare CFO

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