

Department of Health & 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,
2006**



Daniel R. Levinson
Inspector General

May 2010
A-06-08-00070

Office of Inspector General

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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.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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

May 18, 2010

Report Number: A-06-08-00070

Ms. Melissa Halstead Rhoades
Area Director & Medicare CFO
Financial Management Operations Division
TrailBlazer Health Enterprises, LLC
8330 LBJ Freeway, 11.2402
Dallas, TX 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, 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 at (214) 767-8414 or contact Michelle Richards, Audit Manager, at (214) 767-9202 or through email at Michelle.Richards@oig.hhs.gov. Please refer to report number A-06-08-00070 in all correspondence.

Sincerely,

/Patricia Wheeler/
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
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Kansas City, Missouri 64106
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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) 2006, TrailBlazer Health Enterprises (TrailBlazer) was the Medicare Part B carrier for providers in several States, including more than 66,000 providers in Texas. TrailBlazer processed more than 57 million Texas Medicare Part B claims, 578 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 578 high-dollar payments that TrailBlazer made to providers, 497 were appropriate. Of the remaining 81 payments, TrailBlazer incorrectly paid providers for 69 payments totaling \$429,747 and adjusted 12 payments to less than \$10,000 prior to the start of our audit.

TrailBlazer made the incorrect payments because (1) the providers made billing and documentation errors and (2) TrailBlazer made claim processing errors. In addition, the Medicare claim processing systems did not have sufficient edits in place during CY 2006 to detect and prevent payments for these types of erroneous claims.

RECOMMENDATIONS

We recommend that TrailBlazer:

- recover the \$429,747 in overpayments identified during our audit and
- consider using 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 on all but three claims. TrailBlazer stated we had calculated the three claims based on an incorrect modifier. TrailBlazer's comments are included in their entirety as the Appendix.

After reviewing TrailBlazer's explanation regarding the three claims, we concurred and revised the report where appropriate.

TrailBlazer has recovered \$381,054 in overpayments, which includes \$2,799 in claim interest, and is following CMS protocol for collecting the remaining overpayments. TrailBlazer has included in its provider education activities information related to our findings.

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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 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) 2006, providers nationwide submitted more than 800 million claims to carriers. Of these, 10,243 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 2006, TrailBlazer Health Enterprises (TrailBlazer) was the Medicare Part B carrier for providers in several States, including more than 66,000 providers in Texas. TrailBlazer processed more than 57 million Texas Medicare Part B claims, 578 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 (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.

¹ The Medicare Prescription Drug, Improvement, and 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.

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 578 high-dollar payments that TrailBlazer processed during CY 2006. TrailBlazer adjusted 12 of the payments to less than \$10,000 prior to the start of our audit. We reviewed the remaining 566 high-dollar payments, which totaled \$11,497,879.

We limited our review of TrailBlazer's internal controls to those applicable to the 566 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 November 2008 to September 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 578 high-dollar payments that TrailBlazer made to providers, 497 were appropriate. Of the remaining 81 payments, TrailBlazer incorrectly paid providers for 69 payments totaling \$429,747 and adjusted 12 payments to less than \$10,000 prior to the start of our audit.

TrailBlazer made the incorrect payments because (1) the providers made billing and documentation errors and (2) TrailBlazer made claim processing errors. In addition, the Medicare claim processing systems did not have sufficient edits in place during CY 2006 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, overutilization 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

TrailBlazer made 69 incorrect payments. For 40 claims, providers made billing and documentation errors. For 28 claims, TrailBlazer made claim processing errors. On the remaining claim, both TrailBlazer and the provider made an error. As a result, TrailBlazer overpaid the providers \$429,747.

Provider Billing and Documentation Errors

For 40 claims, providers made billing errors or were unable to provide supporting documentation. As a result, TrailBlazer overpaid the providers \$382,823.

- For 25 claims, providers billed for incorrect units of service for cancer drugs. Providers made the following additional errors on four of these claims. For two claims, providers coded the claims using incorrect procedure codes for the drugs provided. For one claim, the provider also billed incorrect units of service for the procedure code for initiating the chemotherapy infusion. For the remaining claim, a provider did not provide supporting documentation for the other line items on the claim. As a result, TrailBlazer overpaid the providers \$266,633.
- For four claims, providers billed for incorrect units of service for injectable drugs. For two of these claims, providers also coded the claims using incorrect procedure codes for the drugs provided. As a result, TrailBlazer overpaid the providers \$66,875.

- For two claims, a provider billed incorrect units of service for performing a test that measures and records the electrical activity in an individual's brain. As a result, TrailBlazer overpaid the provider \$31,404.
- For three claims, providers coded the claims using an incorrect procedure code for implantable neurostimulator pulse generators. For one of these claims, the provider also billed for a recharging system that was not compatible with the nonrechargeable pulse generator that was implanted. As a result, TrailBlazer overpaid the providers \$11,255.
- For three claims, a provider billed for incorrect units of service for hemophilia drugs. As a result, TrailBlazer overpaid the provider \$4,729.
- For one claim, a provider was unable to provide supporting records. As a result, TrailBlazer overpaid the provider \$3,404.
- For one claim, a provider made multiple billing errors. The provider billed for a procedure that was not performed, billed an incorrect procedure code for an implantable neurostimulator pulse generator, and billed for incorrect units of the patient programmer for the pulse generator. As a result, TrailBlazer underpaid the provider \$1,615.
- For one claim, the provider billed for incorrect units of service for neurostimulator electrodes. As a result, TrailBlazer overpaid the provider \$138.

Carrier Claim Processing Errors

For 28 claims, TrailBlazer made claim processing errors. As a result, TrailBlazer overpaid the providers \$46,738.

- For 26 claims, TrailBlazer made the following processing errors on claims for hemophilia blood clotting factors.² For 21 of these claims, TrailBlazer incorrectly paid nonparticipating providers the participating rate.³ For six claims, TrailBlazer did not pay the rate applicable to the quarter for the dates of service of the claims. For one claim, TrailBlazer paid the claim using an incorrect number of units of service. As a result, TrailBlazer overpaid the providers \$36,574.
- For one claim, the provider reported that it had billed for incorrect units on a claim. TrailBlazer stated that it had paid the correct units in March 2007 but had not recovered the original erroneous payment. As a result, TrailBlazer overpaid the provider \$10,197.

² Two claims had multiple errors.

³ Providers that choose not to participate in the Medicare program receive 95 percent of the allowable amount paid to participating providers.

- For one claim, TrailBlazer did not properly apply multiple-surgery special-payment rules⁴ and also paid an incorrect rate for a procedure code for supervising needle placement using a computer imaging technique. As a result, TrailBlazer underpaid the provider \$33.

Carrier Processing Error and Provider Billing Error

For one claim, TrailBlazer used an incorrect payment rate for a procedure code for implanting a neurostimulator pulse generator. In addition, the provider billed for implanting a neurostimulator electrode even though the procedure was not performed. As a result, TrailBlazer overpaid the provider \$186.

CAUSES OF INCORRECT PAYMENTS

The providers that gave a reason attributed the incorrect claims to human error. TrailBlazer also attributed its claim processing errors to human error because most of the claims were processed manually. In addition, during CY 2006, 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 incorrect 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.⁵

RECOMMENDATIONS

We recommend that TrailBlazer:

- recover the \$429,747 in overpayments identified during our audit and
- consider using the results of this audit in its provider education activities.

⁴ When certain surgical procedure codes under the Physician Fee schedule are billed, the code with the highest allowable rate should be paid 100 percent of the allowable rate; subsequent codes should be paid at 50 percent of the allowable rate.

⁵ The 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.

TRAILBLAZER HEALTH ENTERPRISES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on our draft report, TrailBlazer agreed with the findings on all but three claims. TrailBlazer stated we had calculated the three claims based on an incorrect modifier. TrailBlazer's comments are included in their entirety as the Appendix.

After reviewing TrailBlazer's explanation regarding the three claims, we concurred and revised the report where appropriate.

TrailBlazer has recovered \$381,054 in overpayments, which includes \$2,799 in claim interest, and is following CMS protocol for collecting the remaining overpayments. TrailBlazer has included in its provider education activities information related to our findings

APPENDIX



April 5, 2010

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

Report Number: A-06-08-00070

Dear Ms. Wheeler:

We received the February 26, 2010, 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, 2006." In the draft report, the OIG recommended that TrailBlazer:

- Recover the \$438,560 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 demanded \$429,778, which is net of \$5,004 underpayment adjustments made as determined by the OIG audit. As of March 31, 2010, TrailBlazer has collected \$381,054, which includes \$2,799 of interest. TrailBlazer is following CMS protocol for debt collection and referral for the remaining demanded debt totaling \$48,724.

Upon examination of the OIG findings, TrailBlazer determined the overpayment amount for three claims, totaling \$8,813, was improperly determined. The OIG calculation of the overpayment is based on the use of the 51 modifier which calculates the multiple surgery logic. The claim detail lines for these claims used the 78 modifier which is excluded from the multiple surgery pricing logic. Additionally, we determined that these three claims paid properly based on the intraop. portion of HCPCS code 36870.

The remaining difference totaling <\$31> represents immaterial differences in the overpayment calculation. The detail spreadsheet with our comments is attached to this letter.

Provider Education Activities: To provide guidance on issues relating to Part B drugs and biologicals, the TrailBlazer Web site contains specialty Web pages dedicated to these services. The TrailBlazer Provider Outreach and Education staff developed an online job aid to assist in the proper coding and quantity billing. This job aid is located at the following address:

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

In addition, the TrailBlazer Web site offers a special “Documentation Tips Page”, which includes tips for medical record documentation for Drugs and Biologicals. This Web page is located at the following address:

<http://www.trailblazerhealth.com/CERT/Medical%20Record%20Submission/DocumentationTips.aspx#Drugs%20and%20Biologicals>

TrailBlazer established Local Coverage Determinations (LCDs) for Drugs and Biologicals, Non-Chemotherapeutic and Drugs and Biologicals, Chemotherapeutic. These LCDs explain the coverage criteria for selected drugs and biologicals. TrailBlazer also established an LCD on Spinal Cord Stimulation (Dorsal Column Stimulation), which provides policy and coding guidelines associated with implantable neurostimulator pulse generators and related services. LCD information is available on the TrailBlazer Web site:

<http://www.trailblazerhealth.com/Tools/LCDs.aspx?DomainID=1>

TrailBlazer offered Chemotherapy Administration Web-based training on March 24, 2010. This training session focused on Medicare Part B chemotherapy policy and billing including hydration, therapeutic, prophylactic and diagnostic injections and infusions. This session included:

- Billing guidelines.
- Proper documentation.
- Top billing errors/rejections associated with billing these services.
- Comprehensive Error Rate Testing (CERT) findings.
- Resources.

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

Sincerely,

/s/ Melissa H. 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