DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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

Report Number: A-06-07-00056

April 10, 2008

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 Excessive Payments for Carrier Services Processed by TrailBlazer Health Enterprises for the Period January 1, 2003, through December 31, 2003." 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, within 10 business days after the final report is issued, it 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-06-07-00056 in all correspondence.

Sincerely,

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF EXCESSIVE PAYMENTS FOR CARRIER SERVICES PROCESSED BY TRAILBLAZER HEALTH ENTERPRISES FOR THE PERIOD JANUARY 1, 2003, THROUGH DECEMBER 31, 2003

Daniel R. Levinson
Inspector General

April 2008
A-06-07-00056

Office of Inspector General

http://oig.hhs.gov

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Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General 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).

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.

During calendar year (CY) 2003, TrailBlazer Health Enterprises (TrailBlazer) was the Medicare Part B carrier for about 65,000 providers in Texas, Delaware, the District of Columbia, Maryland, and parts of Virginia. TrailBlazer processed more than 48 million Part B claims, 382 of which resulted in payments of $10,000 or more (high-dollar payments).

OBJECTIVE

Our objective was to determine whether TrailBlazer's high-dollar Medicare payments to Part B providers were appropriate.

SUMMARY OF FINDINGS

Of the 382 high-dollar payments that TrailBlazer made to providers, 270 were appropriate. Of the remaining claims:

- TrailBlazer applied incorrect payment rates for procedure codes on 99 claims, resulting in net overpayments of $186,103.

- Providers incorrectly claimed excessive units of service on four claims, resulting in overpayments of $50,420.

- Providers were unable to locate any records for the beneficiaries on three claims totaling $46,903.

- We were unable to determine whether five claims were paid correctly based on available information.

- We did not review one claim because the provider had filed for bankruptcy.

In addition, the Medicare claim processing systems did not have sufficient edits in place during CY 2003 to detect and prevent payments for these types of erroneous claims.

RECOMMENDATIONS

We recommend that TrailBlazer:

- ensure that identified net overpayments, totaling $236,523, have been recovered;
- recover $46,903 for the three unsupported claims;
- identify and recover any overpayments related to system pricing errors;
- review internal controls related to updating system pricing for procedure codes;
- review internal controls related to manual processing and claim adjustment; 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 majority of our findings. However, regarding one procedure code, although TrailBlazer agreed that a processing error had occurred, it disagreed that the error had affected all of the claims processed with that code during 2003. TrailBlazer also disagreed with some of our calculations of the overpayments that occurred because TrailBlazer had applied the rates in effect when they received the claims rather than the rates in effect on the dates of service. TrailBlazer's comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We have revised our report to reflect our agreement with TrailBlazer's comments about the procedure code. Without reviewing each claim containing the procedure code billed during 2003, the effect of the error cannot be determined. We do not agree with TrailBlazer that some of the overpayment amounts that we calculated are incorrect. TrailBlazer should have used dates of service to determine the appropriate payment rates for the claims.

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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] 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 year (CY) 2003, providers nationwide submitted approximately 750 million claims to carriers. Of these, 6,682 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 2003, TrailBlazer Health Enterprises (TrailBlazer), was the Medicare Part B carrier for about 65,000 providers in Texas, Delaware, the District of Columbia, Maryland, and parts of Virginia. TrailBlazer used the Medicare Multi-Carrier Claims System to process claims. TrailBlazer processed more than 48 million Part B claims, 382 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, medically unlikely edits test claim lines for the same beneficiary, Healthcare Common Procedure Coding System 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.

OBJECTIVE, SCOPE, AND METHODOLOGY

[1]The Medicare 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

Our objective was to determine whether TrailBlazer's high-dollar Medicare payments to Part B providers were appropriate.

Scope

We reviewed the 382 high-dollar payments, totaling $8.8 million, which TrailBlazer processed during CY 2003.

We limited our review of TrailBlazer's internal controls to those applicable to the 382 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.

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 time of our fieldwork;

- 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 incorrect payments, 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 objective. 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 382 high-dollar payments that TrailBlazer made to providers, 270 were appropriate. Of the remaining claims:

- TrailBlazer applied incorrect payment rates for procedure codes on 99 claims, resulting in net overpayments of $186,103.

- Providers incorrectly claimed excessive units of service on four claims, resulting in overpayments of $50,421.

- Providers were unable to locate any records for the beneficiaries on three claims, totaling $46,903.

- We were unable to determine whether five claims were paid correctly based on available information.

- We did not review one claim because the provider had filed for bankruptcy.

In addition, the Medicare claim processing systems did not have sufficient edits in place during CY 2003 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 . . . on areas where the trust fund is most at risk, i.e., highest volume and/or highest dollar codes."

The CMS "Medicare Claims Processing Manual," Publication 100-04, chapter 1, section 110, requires that providers maintain health insurance materials related to services rendered under title XVIII for the retention periods outlined in section 110.3 unless State law stipulates a longer period. Providers must keep the materials available for referencing by CMS, carriers, or Fiscal intermediaries, and Department of Health and Human Services auditors, and for bill reviewing and auditing by other specially designated components. Pursuant to section 110.3, of Publication 100-04, the retention period for clinical records is as follows: the time required by State law; 5 years from the date of discharge, when there is no requirement in State law; or, for a minor, 3 years after a resident reaches legal age under State law.

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

For 99 claims, TrailBlazer made claim-processing errors. For four claims, providers incorrectly billed excessive units of service. For three claims, providers were unable to locate any records for the beneficiaries.

TrailBlazer Processing Errors

For 99 claims, totaling $186,103 in net overpayments, TrailBlazer incorrectly processed and paid providers by applying incorrect payment rates for procedure codes:

- For 54 claims, TrailBlazer overpaid providers $130,823 because it had not updated the rate for a hemophilia drug, procedure code J7190, in the coverage policy manual. Trailblazer used the CY 2002 rate rather than the CY 2003 rate. The error affected some of the claims TrailBlazer processed with this procedure code during 2003.

- For seven claims, TrailBlazer applied the incorrect rates for hemophilia drugs, procedure codes J7190 and J7192, resulting in overpayments of $23,140. The source of the payment rates used could not be determined.

- For one claim, TrailBlazer applied an incorrect rate for procedure code E0756 and entered an incorrect number of units, resulting in a $20,668 overpayment.

- For seven claims, TrailBlazer applied incorrect rates for the hemophilia drugs, procedure codes J7192 and J7198, resulting in overpayments totaling $8,856. TrailBlazer processed these claims using a participating rate rather than a nonparticipating rate.

- For 20 claims, TrailBlazer applied an incorrect rate for a hemophilia drug, procedure code J7192, resulting in overpayments totaling $8,516. TrailBlazer used the 2004 rate applicable at the time the claims were processed rather than the CY 2003 rate applicable to the dates of service.

- For one claim, TrailBlazer applied an incorrect rate for a hemophilia drug, procedure code J7190, and entered the incorrect number of units, resulting in a $5,022 overpayment.

- For one claim, TrailBlazer applied an incorrect rate for a chemotherapy drug, procedure code J9310, resulting in a $585 overpayment. TrailBlazer used the $501 drug rate allowed in October 2003 rather than the $475 rate that applied to the September 2003 claim.

- For one claim, TrailBlazer applied an incorrect rate for the drug, procedure code J1563, resulting in a $309 overpayment. TrailBlazer used the $78 drug rate allowed in July 2003 rather than the $76 rate applicable to the June 2003 dates of service.

- For seven claims, TrailBlazer underpaid providers $11,816 because it applied incorrect rates. For two of these claims, TrailBlazer applied the incorrect rate for a hemophilia

drug, procedure code Q0187, resulting in a $219 underpayment. TrailBlazer used the $1,676 drug rate allowed in the period prior to October 2003 rather than the $1,682 rate applicable to the December 2003 service dates. For the remaining five claims, TrailBlazer did not apply the full allowable rates for the procedure codes, resulting in underpayments totaling $11,597.

TrailBlazer is attempting to identify and correct all of the claims that it paid incorrectly based on the above issues.

Provider Errors

For four overpayments, totaling $50,420, providers incorrectly billed TrailBlazer for excessive units of service:

- One provider billed 60 units of service (doses of a drug) for 1 unit delivered. The provider stated that it had updated its billing system to catch such errors. The provider identified the $14,824 overpayment but did not submit a revised claim during our fieldwork.

- One provider billed 50 units of service (doses of a chemotherapy drug) for 5 units delivered. The provider stated that it had miscalculated the doses administered. The provider identified the $13,620 overpayment but did not submit a revised claim during our fieldwork.

- One provider billed 90 units of service (doses of an oncology drug) for 60 units delivered. The provider stated that it had mistakenly entered the incorrect units and type of drug furnished. As a result, TrailBlazer paid the provider $12,604 when it should have paid $609, an overpayment of $11,994. The provider identified and refunded the overpayment during our fieldwork.

- One provider billed 40 units of service (doses of a chemotherapy drug) for 2 units delivered. The provider stated that it had mistakenly made a transposition error on the doses administered. As a result, TrailBlazer paid the provider $10,507 when it should have paid $525, an overpayment of $9,982. The provider identified and refunded the overpayment during our fieldwork.

Providers attributed the incorrect claims to clerical errors made by their billing staffs. In addition, during CY 2003, the Medicare Multi-Carrier Claims System and the CMS Common Working File did not have sufficient prepayment controls to detect inappropriate claims and prevent inappropriate high-dollar payments resulting from claims for excessive units of service. Instead, CMS relied on providers to notify carriers of overpayments and on beneficiaries to review their "Medicare Summary Notice" and disclose any provider overpayments.[2]

[2]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.

Unsupported Claims

For three claims, totaling $46,903, the providers were unable to locate any records for the beneficiaries.

RECOMMENDATIONS

We recommend that TrailBlazer:

- ensure that identified net overpayments, totaling $236,523, have been recovered;
- recover $46,903 for the three unsupported claims;
- identify and recover any overpayments related to system pricing errors;
- review internal controls related to updating system pricing for procedure codes;
- review internal controls related to manual processing and claim adjustment; and
- use the results of this audit in its provider education activities.

TRAILBLAZER HEALTH ENTERPRISES COMMENTS

In written comments on our draft report, TrailBlazer agreed with the majority of our findings. However, although TrailBlazer agreed that a processing error had occurred on claims containing procedure code J7190, it disagreed that the error had affected all of the claims processed with that code during 2003.

TrailBlazer also disagreed with some of the overpayment amounts we calculated. TrailBlazer stated that it had applied rates in effect when some claims were received rather than the rates in effect on the dates of service. At that time, TrailBlazer's system maintained two annual files and was unable to reflect quarterly rates. When drug prices increased or decreased quarterly during that year, the new prices were used to pay claims dating to the beginning of the year.

TrailBlazer cited CMS Transmittal B-03-059, which states: "CMS has historically mandated that a minimum of two pricing files be maintained for systematically pricing services. The accuracy of Medicare Part B drug pricing is, in part, dependent on the number of pricing files maintained/utilized online within carrier systems . . . . Some carrier systems maintain two online pricing files (current and one prior period) consistent with CMS guidelines."

Additionally, TrailBlazer has made changes to its internal controls and "Coverage Policy Manual" (the Manual). In June 2005, it implemented an edit to suspend claims with billed amounts in excess of $25,000.

TrailBlazer revised the Manual to ensure that it processes Medicare claims accurately. The Manual provides a link to the CMS drug pricing Web site for access to current pricing files. TrailBlazer developed an archive process that records changes made to the Manual to prevent unintended access to outdated instructions.

Finally, TrailBlazer will not be able to pursue additional overpaid claims paid during 2003 because contractors cannot reopen a Medicare claim 4 years after the initial payment determination, unless fraud is present.

TrailBlazer's comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

We have revised our report to reflect our agreement with TrailBlazer's comments about procedure code J7190. Without a review of each claim containing the code billed during 2003, the effect of the error cannot be determined.

We do not agree with TrailBlazer that some of the overpayment amounts we calculated are incorrect. TrailBlazer should have used dates of service to determine the appropriate payment rates for claims. During 2003, CMS released drug pricing files quarterly and required that at least two pricing files be maintained to ensure accurate pricing. TrailBlazer overpaid providers because it didn't maintain at least two separate pricing files, one current and one for the prior period.

Finally, we agree that contractors cannot reopen Medicare claims 4 years after initial payment and therefore will not be able to pursue further potential overpayments made during 2003.

APPENDIX

TrailBlazer Health Enterprises, LLC
Response to OIG Audit Report A-06-07-00056

INAPPROPORIATE HIGH-DOLLAR PAYMENTS

For 99 claims, TrailBlazer made claim-processing errors. For four claims, providers incorrectly billed excessive units of service. For three claims, providers were unable to locate any records for the beneficiaries.

TrailBlazer Processing Errors

For 99 claims, totaling $186,103 in net overpayments, TrailBlazer incorrectly processed and paid providers by applying incorrect payment rates for procedure codes:

- For 54 claims, TrailBlazer overpaid providers $130,823 because it had not updated the rate for a hemophilia drug, procedure code J7190, in the coverage policy manual. TrailBlazer used the CY 2002 rate rather than the CY 2003 rate. The error affected all of the claims TrailBlazer processed with this procedure code during 2003.

TrailBlazer agrees with the findings for J7190. However, TrailBlazer does not agree with the last sentence which states that the error affected all of the claims processed with this procedure code during 2003. Without a review of each specific claim, the effect of the error cannot be determined.

- For seven claims, TrailBlazer applied the incorrect rate for hemophilia drugs, procedure codes J7190 and J7192, resulting in overpayments of $23,140. The source of the payment rates used could not be determined.

TrailBlazer agrees.

- For one claim, TrailBlazer applied an incorrect rate for procedure code E0756 and entered an incorrect number of units, resulting in a $20,668 overpayment.

This claim was referred to the Overpayment Department and was worked and corrected on 12-21-07.

- For seven claims, TrailBlazer applied incorrect rates for the hemophilia drugs, procedure codes J7192 and J7198, resulting in overpayments totaling $8,856. TrailBlazer processed these claims using a participating rate rather than a nonparticipating rate.

TrailBlazer agrees.

- For 20 claims, TrailBlazer applied an incorrect rate for a hemophilia drug, procedure code J7192, resulting in overpayments totaling $8,516. TrailBlazer used the 2004 rate

applicable at the time the claims were processed rather than the CY 2003 rate applicable to the dates of service.

Correspondence Control Numbers (CCNs) 454604037902135(detail # 3) and 454604037902138(detail #20) paid correctly both at $22,497.60. The original claims were denied in error. When the adjustment was made, the rate referenced in Newsletter 04-041 dated February 2004 was used (based on date of adjustment). The correct overpayment total for this section is $7,470, instead of $8,516.

In 2003, we maintained two years of pricing within the system For example, the pricing for Drugs was carried as current with an effective date of January 1, 2003 and prior with an effective date of January 1, 2002. At that time, the files in place did not have the capability to reflect more than one effective date per year. When the pricing for drugs was increased or decreased on a quarterly basis during that year, the new price was implemented and overlaid the previous pricing in place back to the beginning of the year.

See CMS Transmittal B-03-059 which indicates the following information: "CMS has historically mandated that a minimum of two pricing files be maintained for systematically pricing services. The accuracy of Medicare Part B drug pricing is, in part, dependent on the number of pricing files maintained /utilized online within carrier systems. …Some carrier systems maintain two online pricing files (current and one prior period) consistent with CMS guidelines." This transmittal created a new minimum standard which expanded the pricing file with an effective date of 1-1-2004.

- For one claim, TrailBlazer applied an incorrect rate for a hemophilia drug, procedure code J7190and entered the incorrect number of units, resulting in a $5,022 overpayment.

TrailBlazer agrees.

- For one claim, TrailBlazer applied an incorrect rate for a chemotherapy drug, procedure code J9310, resulting in a $585 overpayment. TrailBlazer used the $501 drug rate allowed in October 2003 rather than the $475 rate that applied to the September 2003 claim.

TrailBlazer disagrees. This claim was paid correctly as the Multi-Carrier System (MCS) did not have the capability to store multiple rates in 2003. In 2003, the rates in effect at the time of receipt were applied, regardless of the date of service. See information above regarding drug pricing files.

- For one claim, TrailBlazer applied an incorrect rate for the drug, procedure code J1563, resulting in a $309 overpayment. TrailBlazer used the $ 78 drug rate allowed July 2003 rather than the $ 76 rate applicable to the June 2003 dates of service.

TrailBlazer disagrees. This claim was paid correctly as the MCS did not have the capability to store multiple rates in 2003. In 2003, the rates in effect at the time of

receipt were applied, regardless of the date of service. See information above regarding drug pricing files.

- For seven claims, TrailBlazer underpaid providers $11,816 because it applied incorrect rates. For two of these claims, TrailBlazer applied the incorrect rate for a hemophilia drug, procedure code Q0187, resulting in a $219 underpayment. TrailBlazer used the $ 1,676 drug rate allowed in the period prior to October 2003 rather than the $ 1,682 rate applicable to the December 2003 service dates. For the remaining five claims, TrailBlazer did not apply the full allowable rates for the procedure codes, resulting in underpayments totaling $11,597.

TrailBlazer agrees.

TrailBlazer is attempting to identify and correct all of the claims that it paid incorrectly based on the above issues.

TrailBlazer will not be able to pursue the overpaid claims paid during 2003. Contractors can not reopen a Medicare claim after four years from the initial payment determination, unless fraud is present. TrailBlazer performed internal analysis of claims history and identified claims that potentially paid incorrectly during CY 2004 and CY 2005. These claims are currently being researched for validation of the overpayment by the Part B Recovery area. Claims determined to be overpayments will be adjusted and demand letters will be sent.

Provider Errors

For four overpayments, totaling $50,420, providers incorrectly billed TrailBlazer for excessive units of service:

- One provider billed 60 units of service (doses of a drug) for 1 unit delivered. The provider stated that it had updated its billing system to catch such errors. The provider identified the $14,824 overpayment but did not submit a revised claim during our fieldwork.

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Providers attributed the incorrect claims to clerical errors made by their billing staffs. In addition, during CY 2003, the Medicare Multi-Carrier Claims System and the CMS Common Working File did not have sufficient prepayment controls to detect inappropriate claims and prevent inappropriate high-dollar payments resulting from claims for excessive units of service. Instead, CMS relied on providers to notify carriers of overpayments and on beneficiaries to review their "Medicare Summary Notice" and disclose any provider overpayments.

Unsupported Claims

For three claims, totaling $46,903, the providers were unable to locate any records for the beneficiaries.

RECOMMENDATIONS

We recommend that TrailBlazer:

- ensure that identified net over payments, totaling $236,523, have been recovered;
- recover $46,903 for the three unsupported claims;
- identify and recover any overpayments related to system pricing errors;
- review internal controls related to updating system pricing for procedure codes;
- review internal controls related to manual processing and claim adjustment; and
- use the results of this audit in its provider education activities.

As stated above, TrailBlazer will not be able to pursue the overpaid claims paid during 2003. Contractors can not reopen a Medicare claim after four years from the initial payment determination, unless fraud is present. TrailBlazer performed internal analysis of claims history and identified claims that potentially paid incorrectly during CY 2004 and CY 2005. These claims are currently being researched for validation of the overpayment by the Part B Recovery area. Claims determined to be overpayments will be adjusted and demand letters will be sent. The demanded overpayments will be tracked separately, to ensure their collection and our ability to specifically report on the status of these overpayments.

Since 2003, multiple internal controls have been implemented in effort 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 Claims Analyst.

Additionally, TrailBlazer has made the following changes to our pricing internal controls and processes:

- **The drug pricing is no longer included in the Coverage Policy Manual, but rather a link to the CMS drug pricing webpage is provided. This ensures up-to-date and accurate pricing is always available to the claims staff.**
- **The policy manual now has approval controls for every change/addition. This ensures all changes/additions made to the manual are reviewed and approved.**
- **An archive process records each change and saves the change in an archive file. This prevents unintended access to outdated instructions and ensures the appropriate version is accessed.**
- **A pricing section was created which consolidates all pricing (previously interspersed throughout the manual) to one section of the policy manual. One person has responsibility for this section. This prevents problems with other pricing issues.**