DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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

March 13, 2009

Report Number: A-06-08-00040

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, 2004." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, OIG reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act. Accordingly, this report will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Trish Wheeler, Audit Manager, at (214) 767-6325 or through e-mail at Trish.Wheeler@oig.hhs.gov. Please refer to report number A-06-08-00040 in all correspondence.

Sincerely,

Gordon L. Sato

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
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106

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, 2004

Daniel R. Levinson
Inspector General

March 2009
A-06-08-00040

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, Louisiana, Alaska, and Colorado. For calendar year (CY) 2004, TrailBlazer processed approximately 8.3 million outpatient claims, 17 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 17 high-dollar payments that TrailBlazer made to providers, five were appropriate. TrailBlazer overpaid providers for 12 claims, resulting in overpayments totaling $1,055,927. Contrary to Federal guidance, the providers inappropriately overstated the units of service in the 12 high-dollar claims for one or more procedure codes. TrailBlazer made the overpayments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in CY 2004 to detect billing errors related to units of service.

RECOMMENDATIONS

We recommend that TrailBlazer:

- inform us of the status of the recovery of the $1,055,927 in overpayments and
- use the results of this audit in its provider education activities.

TRAILBLAZER HEALTH ENTERPRISES, LLC 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 $1,055,927 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 as the Appendix.

We agree with TrailBlazer's contention that it would not be cost beneficial to review the claims under $50,000 and removed this recommendation from the report.

TABLE OF CONTENTS

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) 2004, fiscal intermediaries processed and paid more than 136 million outpatient claims, 588 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 CY 2004, TrailBlazer processed approximately 8.3 million outpatient claims, 17 of which were 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 17 high-dollar payments for outpatient claims that TrailBlazer processed during CY 2004. We limited our review of TrailBlazer's internal controls to those applicable to the 17 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 17 claims obtained from the National Claims History file, but we did not assess the completeness of the file.

We conducted our audit work from January 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 17 high-dollar payments that TrailBlazer made to providers, five were appropriate. TrailBlazer overpaid providers for 12 claims, resulting in overpayments totaling $1,055,927. Contrary to Federal guidance, the providers inappropriately overstated the units of service in the 12 high-dollar claims for one or more procedure codes. TrailBlazer made the overpayments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in CY 2004 to detect billing errors related to units of service.

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. 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 12 overpayments totaling $1,055,927 because six providers billed for excessive units of service.

- For two claims, one provider billed procedure code C9207 for 35 units per claim rather than 1 unit per claim, which was the number of units provided. The provider stated that the error in units occurred because the automated charging system applied an incorrect conversion factor, which converts administered units to billable units. As a result of the error, TrailBlazer paid the provider $216,127 when it should have paid $8,060, an overpayment of $208,067.

- For one claim, the provider billed procedure code C9205 for 800 units rather than 72 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 $67,835 when it should have paid $6,939, an overpayment of $60,896.

- For one claim, the provider billed procedure code 64573 for nine units rather than one unit, 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. As a result of the error, TrailBlazer paid the provider $89,025 when it should have paid $9,892, an overpayment of $79,133.

- For one claim, the provider billed procedure code C9205 for 500 units rather than 50 units, procedure code J1626 for 500 units rather than 10 units, and procedure code J2780 for 4 units rather than 2 units. The provider attributed the incorrect number of units claimed to a clerical error. As a result of the error, TrailBlazer paid the provider $50,134 when it should have paid $3,780, an overpayment of $46,355.

- For five claims, one provider billed procedure code J0850 for 400 units rather than 4 units for two of the claims and 300 units rather than 3 units for three of the claims. The

provider attributed the incorrect number of units to a conversion factor error. As a result of the error, TrailBlazer paid the provider $557,443 when it should have paid $9,970, an overpayment of $547,473.

- For two claims, one provider billed procedure code J1626 for 1,000 units rather than 10 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. As a result, TrailBlazer paid the provider $125,327 when it should have paid $11,324, an overpayment of $114,003.

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 software programs and to human and system errors in the application of conversion factors.

In addition, during CY 2004, 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.[1]

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 status of the recovery of the $1,055,927 in overpayments and
- use the results of this audit in its provider education activities.

TRAILBLAZER HEALTH ENTERPRISES, LLC 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 $1,055,927 in overpayments. However, TrailBlazer stated that it would not be cost beneficial to review all of the claims under

[1]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.

$50,000 that billed the procedure codes identified in this report. TrailBlazer's comments are included as the Appendix.

We agree with TrailBlazer's contention that it would not be cost beneficial to review the claims under $50,000 and removed this recommendation from the report.

OTHER MATTERS

One provider that made high-dollar claims for 2004 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 for part of 2004 and all of 2005. The provider submitted the corrected claims to TrailBlazer along with a refund for the estimated overpayments resulting from this error. The provider estimated that $96,029 was for CY 2004 TrailBlazer claims that were incorrectly billed but not identified during our review because they were not high-dollar claims.

Another provider that made high-dollar claims for 2004 responded that it had incorrectly billed an additional claim not identified in our review. The provider billed procedure code J1626 for 1,000 units rather than 10 units, which was the number of units provided. The provider stated that the billing units for this drug were incorrectly entered into the billing system. The provider was overpaid $16,686 for this claim, which we did not identify during our review because it was not a high-dollar claim.

APPENDIX

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

MEDICARE

March 6, 2009

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

Report Number: A-06-08-00040

Dear Mr. Sato:

We received the January 29, 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, 2004." In the draft report, the OIG recommended that TrailBlazer:

- Inform the OIG of the status of the recovery of the $1,055,927 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 $1,055,927.25 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 2004 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 majority of claims with 2004 dates of service are purged from 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 EDC to retrieve **all** claims from 2004.
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.
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 2004 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. Therefore, TrailBlazer will wait for confirmation of our understanding of the recommendation before beginning any of the activities outlined above.

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

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