DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

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

January 20, 2011

Report Number: A-06-10-00024

Ms. Melissa Halstead Rhoades
Area Director & Medicare Chief Financial Officer
TrailBlazer Health Enterprises, LLC
8330 LBJ Freeway, 11th Floor
Dallas, TX 75243

Dear Ms. Rhoades:

Enclosed is the U.S. Department of Health & 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, LLC, for the Period January 1, 2007, Through December 31, 2008*. 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, Audit Manager, at (214) 767-9202 or through email at michelle.richards@oig.hhs.gov. Please refer to report number A-06-10-00024 in all correspondence.

Sincerely,

/Patricia Wheeler/
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
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Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HIGH-DOLLAR PAYMENTS FOR MEDICARE OUTPATIENT CLAIMS PROCESSED BY TRAILBLAZER HEALTH ENTERPRISES, LLC, FOR THE PERIOD JANUARY 1, 2007, THROUGH DECEMBER 31, 2008

Daniel R. Levinson
Inspector General

January 2011
A-06-10-00024

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 Medicare contractors to process and pay Medicare Part B claims submitted by hospital outpatient departments. The Medicare contractors 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, LLC (TrailBlazer), is a Medicare contractor serving more than 3,000 Medicare providers in Colorado, New Mexico, Oklahoma, and Texas. For calendar years (CY) 2007 and 2008, TrailBlazer processed approximately 18.7 million outpatient claims, 17 of which resulted in payments of $50,000 or more (high-dollar payments).

Beginning January 3, 2006, CMS required Medicare contractors 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 Medicare contractors 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

Of the 17 high-dollar claims that TrailBlazer made to providers for outpatient services, 8 were adjusted below $50,000 prior to our review. Of the remaining nine claims, three were appropriate. However, TrailBlazer overpaid providers a total of $311,109 for the remaining six claims. Contrary to Federal guidance, providers inappropriately overstated the units of service, billed the wrong Healthcare Common Procedure Coding System code for the service rendered, or billed for services that were not rendered. In addition, TrailBlazer's process for determining the accuracy of claims suspended by the high-dollar edit was not adequate because TrailBlazer relied on the providers to make the determination.

RECOMMENDATIONS

We recommend that TrailBlazer:

- ensure that the $311,109 was refunded and

- use the results of this audit in its provider education activities.

TRAILBLAZER COMMENTS

In response to our draft report, TrailBlazer agreed with the findings and recommendations. TrailBlazer reported that the entire $311,109 had been recovered and provided evidence that it had used audit results in its ongoing provider education activities. TrailBlazer's comments are included in their entirety as the Appendix.

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TRAILBLAZER COMMENTS

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 Contractors

CMS contracts with Medicare contractors to, among other things, process and pay Medicare Part B claims submitted by hospital outpatient departments.[1] The Medicare contractors' responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Federal guidance requires Medicare contractors 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 years (CY) 2007 and 2008, Medicare contractors processed and paid more than 282 million outpatient claims, 617 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.

Medicare contractors 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, LLC

TrailBlazer Health Enterprises, LLC (TrailBlazer), is a Medicare contractor serving more than 3,000 Medicare providers in Colorado, New Mexico, Oklahoma, and Texas. For CYs 2007 and 2008, TrailBlazer processed approximately 18.7 million outpatient claims, 17 of which resulted in high-dollar payments.

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[1] Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC) between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. For purposes of this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever is applicable.

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 17 high-dollar payments for outpatient claims that TrailBlazer processed during CYs 2007 and 2008. Although the initial claim count was 26, we removed 9 claims from the review: 5 claims because they included outlier payments (additional payments that are made due to unusually high-cost services) and 4 claims because the providers were either a critical access hospital or a cancer center. These provider types have different payment rules that are based on the provider's cost.

We limited our review of TrailBlazer's internal controls to those applicable to 9 of the 17 payments (the other 8 payments were adjusted below $50,000 prior to our review) 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 nine claims obtained from the National Claims History file, but we did not assess the completeness of the file.

We conducted our audit work from November 2009 through September 2010.

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;
- reviewed the claims to determine whether the claim payment included an outlier or if the provider was paid under different payment rules;
- 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 nine claims that we reviewed, three were appropriate. However, TrailBlazer overpaid providers a total of $311,109 for the remaining six claims. Contrary to Federal guidance, providers inappropriately overstated the units of service, billed the wrong Healthcare Common Procedure Coding System (HCPCS) code for the service rendered, or billed for services that were not rendered. In addition, TrailBlazer's process for determining the accuracy of claims suspended by the high-dollar edit was not adequate because TrailBlazer relied on the provider to make the determination.

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 Medicare contractor 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 Medicare contractors 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 Medicare contractors to determine the legitimacy of the claims.

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

Of the nine high-dollar payments identified, TrailBlazer made six incorrect payments to providers.

- For three of the incorrect payments, providers claimed incorrect numbers of units of service.

- For one incorrect payment, the provider claimed an incorrect number of units of service and used incorrect HCPCS coding.

- For one incorrect payment, the provider used incorrect HCPCS coding.

- For one incorrect payment, the provider claimed services that were not rendered.

Claims Submitted With Incorrect Numbers of Units of Service

- For 1 claim, the provider billed 1,300 units of Avastin (HCPCS code J9035), a drug used for chemotherapy, for each of 2 dates of service. The provider should have billed 100 units for each of the dates of service, which was the number of units provided. It also billed 99 units of Taxol (HCPCS code J9265), a chemotherapy drug, for 2 dates of service and 71 units for 1 date of service. The provider should have billed six units for each of the dates of service, which was the number of units provided. TrailBlazer paid the provider $150,674 when it should have paid $10,935, an overpayment of $139,739.

- For 1 claim, the provider billed 64 units of Docetaxel (HCPCS code J9170), a drug used for chemotherapy, for each of 3 dates of service. The provider should have billed eight units for each of the dates of service, which was the number of units provided. It also billed 88 units of Trastuzumab (HCPCS code J9355), a blood clotting drug, for 3 dates of service. The provider should have billed 76 units for 1 date of service and 57 units for each of the other 2 dates of service, which was the number of units provided. TrailBlazer paid the provider $72,754 when it should have paid $16,928, an overpayment of $55,826.

- For one claim, the provider billed two units of procedure code 33249, which is the insertion of a complete cardioverter-defibrillator system with leads, and procedure code 33225, which is the insertion of a left ventricular pacing lead during the insertion of a pacing cardioverter-defibrillator. The provider should have billed for one unit each of the two codes. TrailBlazer paid the provider $51,831 when it should have paid $32,038, an overpayment of $19,793.

Claim Submitted With Incorrect Number of Units of Service and Incorrect Coding

- For one claim, the provider inappropriately billed 202 units of Filigrastim, 400mcg (HCPCS code J1441), and inappropriately included other drugs administered to the beneficiary under the same HCPCS code. The provider should have billed 8 units of Filigrastim, 400mcg (HCPCS code J1441); 5 units of Filigrastim, 300mcg (HCPCS code J1440); 2 units of Neupogen (HCPCS code J0885); 9 units of Caspofungin Acetate (HCPCS code J0637); and 36 units of Zofran (HCPCS code J2405). TrailBlazer paid the provider $65,587 when it should have paid $8,525, an overpayment of $57,062.

Claim Submitted With Incorrect Code

- For one claim, the provider made two coding errors. It billed procedure code G0300 but should have billed procedure code G0298, which is the insertion of a dual chamber pacing cardioverter defibrillator pulse generator, and device code C1882 for one date of service. The device did not work properly and was replaced on a subsequent date of service. Although the provider correctly billed G0298 and C1882 on the subsequent date of service, it did not append the FB modifier, which indicates that the item was provided

without cost to the provider and not payable by Medicare, as required. TrailBlazer paid the provider $50,924 when it should have paid $30,784, an overpayment of $20,140.

Claim Submitted for Services That Were Not Rendered

- For one claim, the provider billed similar services for multiple dates of services on one claim. However, for one of the dates of service, the patient did not receive the services claimed. The provider inappropriately billed 1 unit each of intravenous infusion, initial hour (HCPCS code 90765), and intravenous infusion, additional hours (HCPCS code 90766), and 5,000 units of Cerezyme (HCPCS code J1785) for the date on which services were not received. TrailBlazer paid the provider $74,194 when it should have paid $55,645, an overpayment of $18,549.

CAUSES OF OVERPAYMENTS

The providers that gave a reason for the incorrect claims attributed the errors to insufficient internal controls or software edit programs that did not detect and prevent incorrect billing of services 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. When a claim was suspended, TrailBlazer contacted the provider and required it 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 claim, TrailBlazer reviewed only the claim's remarks section, which stated that the provider had reviewed the claim and that the claim was 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 CYs 2007 and 2008 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:

- ensure that the $311,109 was refunded and

- use the results of this audit in its provider education activities.

[1] The Medicare contractor sends an "Explanation of Medicare Benefits" notice to the beneficiary after the provider files a claim for Part B service(s). The notice explains the service(s) billed, the approved amount, the Medicare payment, and the amount due from the beneficiary.

TRAILBLAZER COMMENTS

In response to our draft report, TrailBlazer agreed with the findings and recommendations. TrailBlazer reported that the entire $311,109 had been recovered and provided evidence that it had used audit results in its ongoing provider education activities. TrailBlazer's comments are included in their entirety as the Appendix.

APPENDIX

MEDICARE

December 20, 2010

Patricia Wheeler
Regional Inspector General for Audit Services
Office of Audit Services, Region IV
1100 Commerce Street, Room 632
Dallas, TX 75242

Report Number: A-06-10-00024

Dear Ms. Wheeler:

We received the November 19, 2010, draft report entitled "Review of High-Dollar Payments for Medicare Outpatient Claims Processed by TrailBlazer Health Enterprises, LLC, for the Period January 1, 2007, Through December 31, 2008." In the draft report, the OIG recommended that TrailBlazer:

- Ensure that the $311,109 was refunded; and
- Use the results of this audit in our provider education activities.

Please consider the following responses to these recommendations for inclusion in the final report:

Recovery of Overpayments: The overpayments totaling $311,109 were recovered by TrailBlazer between December 10, 2009, and August 30, 2010. The recovery was made via the providers' remittance advice. A detail listing of the recoveries is available upon request.

Provider Education Activities: In response to OIG audit A-06-08-00066, issued on November 30, 2009, entitled "Review of High-Dollar Payments for Medicare Outpatient Claims Processed by TrailBlazer Health Enterprises for the Period January 1 through December 31, 2006", TrailBlazer published an article on our Web site regarding the results of the high-dollar payment audits. The Web article can be found at the following link: http://www.trailblazerhealth.com/Tools/Notices.aspx?DomainID=1&ID=13410.

Additionally, TrailBlazer incorporated the results of the November 2009 OIG audit in several of our on-line references for providers:

OPPS manual beginning on page 27:
http://www.trailblazerhealth.com/Publications/Training%20Manual/HosptialOutpatientManual.pdf

Documentation Tips page includes a section for drugs and biologicals:
http://www.trailblazerhealth.com/CERT/DocumentationTips/default.aspx?DomainID=1#Drugs%20and%20Biologicals

In September 2010, TrailBlazer published an additional notice regarding the billing of drugs and biologicals. The September 2010 notice can be found using the following link:
http://www.trailblazerhealth.com/Tools/Notices.aspx?DomainID=1&ID=13899

In addition to the recommendations noted in the subject audit, TrailBlazer implemented process changes related to the review and payment of outpatient claims exceeding $50,000. The process changes were detailed in our response to OIG audit A-06-08-00066 issued in November 2009. TrailBlazer believes we have taken all necessary action to address the underlying cause of the overpayments determined and recovered as noted above.

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

Sincerely,

/s/ Melissa Halstead Rhoades

Melissa Halstead Rhoades
Area Director & Medicare CFO

cc: Terry Bird, Contracting Officer Technical Rep., CMS Southern MAC Pgm. Mgmt. Division
Gil R. Glover, President & Chief Operating Officer, TrailBlazer
Scott J. Manning, Vice President, Financial Management Operations, TrailBlazer
Kevin Bidwell, Vice President & Compliance Officer, TrailBlazer