



July 18, 2011

Report Number: A-07-11-05013

Ms. Melissa Halstead Rhoades  
Area Director and Medicare Chief Financial Officer  
Financial Management Operations Division  
TrailBlazer Health Enterprises, LLC  
8330 LBJ Freeway, 11.2402  
Dallas, TX 75234

Dear Ms. Halstead Rhoades:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicare Fee-for-Service Payments Made by TrailBlazer Health Enterprises, LLC, for Medicare Advantage Enrollees During Calendar Years 2007 and 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 at (816) 426-3591, or contact Scott Englund, Audit Manager, at (573) 893-8338, extension 27, or through email at [Scott.Englund@oig.hhs.gov](mailto:Scott.Englund@oig.hhs.gov). Please refer to report number A-07-11-05013 in all correspondence.

Sincerely,

/Patrick J. Cogley/  
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, MO 64106

Department of Health & Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF MEDICARE  
FEE-FOR-SERVICE PAYMENTS  
MADE BY TRAILBLAZER HEALTH  
ENTERPRISES, LLC, FOR MEDICARE  
ADVANTAGE ENROLLEES  
DURING CALENDAR YEARS  
2007 AND 2008**



Daniel R. Levinson  
Inspector General

July 2011  
A-07-11-05013

# *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 Act), the Medicare program provides health insurance for people aged 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 claims submitted by hospitals. The Medicare contractors use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF) to process claims. The CWF can detect certain improper payments during prepayment validation.

The Balanced Budget Act of 1997, P.L. No. 105-33, established Medicare Part C to offer beneficiaries managed care options through the Medicare+Choice program. Section 201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 revised Medicare Part C. Among its changes, this law renamed the Medicare+Choice program the Medicare Advantage program. Medicare Advantage organizations (MA organizations) receive capitation payments from CMS to arrange and pay for all medically necessary services that are allowable in the traditional Medicare fee-for-service (FFS) program. Under Medicare Part C, Medicare beneficiaries may enroll in Medicare Advantage plans (MA plans) that are offered by MA organizations.

Pursuant to Section 1886(d) of the Act, 42 CFR § 412.1(a) established the prospective payment system (PPS) for Medicare inpatient hospital services. Under the PPS, Medicare contractors will not make Medicare FFS payments for certain inpatient services, such as bed and board, nursing services, and drugs, furnished to Medicare Advantage enrollees.

For inpatient claims, the status of the beneficiary's enrollment in an MA plan on the hospital admission date determines whether the MA organization or the Medicare contractor has payment responsibility. MA organizations have payment responsibility for claims with services that began on or after the Medicare Advantage enrollment date. Medicare contractors have payment responsibility for claims with services that began before the Medicare Advantage enrollment date.

TrailBlazer Health Enterprises, LLC (TrailBlazer), was awarded the CMS Parts A and B Medicare administrative contractors (MAC) Jurisdiction 4 contract on August 3, 2007. TrailBlazer was the fiscal intermediary prior to award of the MAC contract.

### **OBJECTIVE**

Our objective was to determine whether Medicare FFS payments made by TrailBlazer to hospitals for inpatient services furnished to Medicare Advantage enrollees complied with Federal regulations.

## **SUMMARY OF FINDINGS**

Medicare FFS payments made by TrailBlazer to hospitals for inpatient services furnished to Medicare Advantage enrollees did not always comply with Federal regulations. TrailBlazer made \$472,320 in unallowable payments for inpatient claims for beneficiaries who were enrolled in MA plans.

TrailBlazer was not able to determine the beneficiaries' enrollment status on the CWF at the time it made these payments. Additionally, in each of these cases TrailBlazer did not receive an Informational Unsolicited Response (IUR) from the CWF indicating that the beneficiary had been retroactively enrolled in an MA plan.

We determined that at the time of the payments, controls were in place to verify the beneficiaries' enrollment status, and to promptly generate IURs in cases of retroactive enrollments. These controls were adequate to stop improper FFS payments for services furnished to the vast majority of Medicare Advantage enrollees.

TrailBlazer had not taken action on these 57 improper payments prior to our fieldwork.

## **RECOMMENDATIONS**

We recommend that TrailBlazer:

- initiate overpayment recovery procedures to recoup and reimburse to the Federal Government \$472,320 of improper payments from providers and
- generate an adjustment to update or cancel the claims in order to update both the CWF and the contractor history.

## **AUDITEE COMMENTS**

In written comments on our draft report, TrailBlazer stated that it had taken actions to implement our recommendations. TrailBlazer's comments are included in their entirety as the Appendix.

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## **INTRODUCTION**

### **BACKGROUND**

Pursuant to Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people aged 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 claims submitted by hospital inpatient departments.<sup>1</sup> The Medicare contractors' responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Federal guidance provides that Medicare contractors must maintain adequate internal controls over automatic data processing systems to prevent increased program costs and erroneous or delayed payments. To process hospitals' inpatient claims, the Medicare contractors use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF) to process claims. The CWF can detect certain improper payments during prepayment validation.

#### **Medicare Advantage Program**

The Balanced Budget Act of 1997, P.L. No. 105-33, established Medicare Part C to offer beneficiaries managed care options through the Medicare+Choice program. Managed care organizations include health maintenance organizations, preferred provider organizations, provider-sponsored organizations, and private fee-for-service organizations. Section 201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 revised Medicare Part C. Among its changes, this law renamed the Medicare+Choice program the Medicare Advantage program. Medicare Advantage organizations (MA organizations) receive capitation payments from CMS to arrange and pay for all medically necessary services that are allowable in the traditional Medicare fee-for-service (FFS) program. Under Medicare Part C, Medicare beneficiaries may enroll in Medicare Advantage plans (MA plans) that are offered by MA organizations.

#### **Claims for Inpatient Services**

Pursuant to Section 1886(d) of the Act, 42 CFR § 412(a)(1) established the prospective payment system (PPS) for Medicare inpatient hospital services. Under the PPS, Medicare contractors will

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<sup>1</sup> 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.

not make Medicare FFS payments for certain inpatient services, such as bed and board, nursing services, and drugs, furnished to Medicare Advantage enrollees.

### **Claims for Inpatient Services Provided to Medicare Advantage Enrollees**

CMS is responsible for ensuring that Medicare payments are made correctly. Weekly, MA organizations transmit enrollment data to CMS, including information on when each Medicare beneficiary enrolled and/or disenrolled in his or her MA plan. CMS maintains the enrollment data on the Medicare Advantage Prescription Drug system (MARx), a system that is intended to contain data on every Medicare beneficiary enrolled in an MA plan. CMS uses the enrollment data on the MARx to update the enrollment data in the CWF, which is intended to contain eligibility information for every Medicare beneficiary.

When hospitals submit claims for inpatient service, eligibility is verified through the CWF. If the CWF indicates that the beneficiary is a member of an MA plan, the Medicare contractor should deny the claim; however, there are some exceptions. For example, a provider may be reimbursed on an FFS basis for a Medicare Advantage enrollee who elects hospice coverage or who receives a service classified as a national coverage determination.<sup>2</sup> A provider may also be reimbursed for direct graduate medical education costs, indirect medical education costs, and services to Medicare beneficiaries in clinical trials.

For inpatient claims, the status of the beneficiary's enrollment in an MA plan on the hospital admission date determines whether the MA organization or the Medicare contractor has payment responsibility. MA organizations have payment responsibility for claims with services that begin on or after the Medicare Advantage enrollment date. Medicare contractors have payment responsibility for claims with services that begin before the Medicare Advantage enrollment date.

### **Retroactive Enrollment**

A retroactive enrollment occurs when enrollment data are entered in the MARx after the beneficiary's actual enrollment date. For example, if a beneficiary enrolled in an MA plan on January 1, 2007, but the enrollment data were not entered in the MARx until January 30, 2007, the MARx would retroactively list the actual enrollment date as January 1, 2007. The actual enrollment date should then be updated in the CWF.

The CWF generates an Informational Unsolicited Response (IUR) which provides the identifying information regarding the claim submitted for a beneficiary retroactively enrolled in an MA plan. The CWF electronically transmits the IUR to the Medicare contractor that originally processed the claim.

Upon receipt of the IUR, the Medicare contractor must initiate overpayment recovery procedures to retract the original Part A and Part B payments. The Medicare contractor must also generate

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<sup>2</sup> A national coverage determination indicates coverage for a new service that was not included in the calculation of the managed care capitation payment.

an adjustment to update or cancel the claim; this adjustment, in turn, updates both the CWF and the contractor history.

## **TrailBlazer Health Enterprises, LLC**

TrailBlazer Health Enterprises, LLC (TrailBlazer), was awarded the CMS Parts A and B Medicare administrative contractors (MAC) Jurisdiction 4 contract on August 3, 2007. TrailBlazer was the fiscal intermediary prior to award of the MAC contract.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether Medicare FFS payments made by TrailBlazer to hospitals for inpatient services furnished to Medicare Advantage enrollees complied with Federal regulations.

### **Scope**

Our audit included FFS payments made by TrailBlazer for certain inpatient services furnished to Medicare Advantage enrollees who were enrolled in MA plans nationwide for at least 1 month during calendar years (CY) 2007 and 2008. We reviewed internal controls to the extent necessary to accomplish the audit objective.

### **Methodology**

To accomplish our objective, we:

- reviewed Federal regulations related to payment liability for Medicare beneficiaries enrolled in MA plans, as well as program manuals and memorandums, issued by CMS to Medicare contractors, that provided instructions on which claims to pay;
- used the Enrollment Database to identify beneficiaries enrolled in an MA plan during CY 2007;
- obtained inpatient claims data for CYs 2007 and 2008 from the National Claims History and Standard Analytical Files for those beneficiaries enrolled in MA plans;
- identified Medicare FFS inpatient claims for services that began on or after the date that the beneficiary enrolled in the MA plan and before the beneficiary disenrolled from the MA plan;
- eliminated paid claims for enrollees who elected hospice coverage before being admitted to the hospital;
- eliminated paid claims for graduate medical education costs, indirect medical education costs, and costs associated with clinical trials;

- verified, using information in the CWF, both the eligibility of the Medicare beneficiary and the accuracy of the payment amount, and ensured that the payment had not been cancelled;
- provided TrailBlazer with detail data regarding 129 claims totaling \$1,397,402 that were potentially paid in error, and, after discussing the possible causes of claims that were potentially paid in error with TrailBlazer officials:
  - eliminated 9 improper payments totaling \$62,512 that had been cancelled and recouped prior to the start of our fieldwork and
  - eliminated 63 payments totaling \$862,570 that were properly paid; and
- discussed the results of our review with TrailBlazer officials and provided them with the details of the 57 claims for which we had identified improper payments.

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**

Medicare FFS payments made by TrailBlazer to hospitals for inpatient services furnished to Medicare Advantage enrollees did not always comply with Federal regulations. TrailBlazer made \$472,320 in unallowable payments for inpatient claims for beneficiaries who were enrolled in MA plans.

TrailBlazer was not able to determine the beneficiaries' enrollment status on the CWF at the time it made these payments. Additionally, in each of these cases TrailBlazer did not receive an IUR from the CWF indicating that the beneficiary had been retroactively enrolled in an MA plan.

We determined that at the time of the payments, controls were in place to verify the beneficiaries' enrollment status, and to promptly generate IURs in cases of retroactive enrollments. These controls were adequate to stop improper FFS payments for services furnished to the vast majority of Medicare Advantage enrollees.

TrailBlazer had not taken action on these 57 improper payments prior to our fieldwork.

## **FEDERAL REQUIREMENTS**

Pursuant to 42 CFR § 412.20(e)(3), inpatient hospital services will not be paid on an FFS basis if “[t]he services are paid for by an [MA organization] ... that elects not to have CMS make payments directly to a hospital for inpatient hospital services furnished to the [MA organization’s] ... Medicare enrollees....”

CMS’s manuals instruct hospitals and Medicare contractors about the payment liability for inpatient services for Medicare Advantage enrollees. Section 408 of CMS’s *Hospital Manual* states: “If you are a PPS hospital and the patient changes his [Medicare Advantage] status during an inpatient stay, his status at admission determines liability. If he was enrolled in the [MA organization] before admission, the [MA organization] is responsible regardless of whether he disenrolled before discharge.” Section 3654.1 of CMS’s *Medicare Intermediary Manual* instructs Medicare contractors to “... not make a duplicate payment for the same services [for which] the [MA organization] has paid.”

## **IMPROPER MEDICARE FEE-FOR-SERVICE PAYMENTS**

For CYs 2007 and 2008, TrailBlazer made 57 improper payments totaling \$472,320 for inpatient claims for beneficiaries who were enrolled in MA plans. For example, one payment for \$20,367 was made for an inpatient stay beginning on May 7, 2008, for a beneficiary who was enrolled in an MA plan from November 1, 2007, to May 31, 2008.

TrailBlazer was not able to determine the beneficiaries’ enrollment status on the CWF at the time it made these payments. Additionally, in each of these cases TrailBlazer did not receive an IUR from the CWF indicating that the beneficiary had been retroactively enrolled in an MA plan. As a result, TrailBlazer was unaware that the improper payments had been made. Therefore it did not initiate overpayment recovery procedures to recoup the original payments, and it did not generate an adjustment to update or cancel the claim in order to update both the CWF and the contractor history.

We determined that at the time of the payments, controls were in place to verify the beneficiaries’ enrollment status, and to promptly generate IURs in cases of retroactive enrollments. These controls were adequate to stop improper FFS payments for services furnished to the vast majority of Medicare Advantage enrollees.

TrailBlazer had not taken action on these 57 improper payments prior to our fieldwork.

## **RECOMMENDATIONS**

We recommend that TrailBlazer:

- initiate overpayment recovery procedures to recoup and reimburse to the Federal Government \$472,320 of improper payments from providers and
- generate an adjustment to update or cancel the claims in order to update both the CWF and the contractor history.

## **AUDITEE COMMENTS**

In written comments on our draft report, TrailBlazer stated that it had taken actions to implement our recommendations. TrailBlazer's comments are included in their entirety as the Appendix.

# **APPENDIX**

## APPENDIX: AUDITEE COMMENTS



MEDICARE

July 11, 2011

Patrick J. Cogley  
Regional Inspector General for Audit Services  
Office of Inspector General  
Office of Audit Services, Region VII  
601 East 12<sup>th</sup> Street, Room 0429  
Kansas City, MO 64106

Report Number: A-07-11-05013

Dear Mr. Cogley:

We received the June 16, 2011, draft report entitled "Review of Medicare Fee-for-Service Payments Made by TrailBlazer Health Enterprises, LLC, for Medicare Advantage Enrollees During Calendar Years 2007 and 2008." In the draft report, the OIG recommended that TrailBlazer:

- Initiate overpayment recovery procedures to recoup and reimburse to the Federal Government \$472,320 of improper payments from providers, and
- Generate an adjustment to update or cancel the claims in order to update both CWF and the contractor history.

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

**Claim Cancellation and Recovery of Overpayments:** As a result of this audit and prior to issuance of the draft audit report, TrailBlazer canceled the 57 claims identified as paid in error and recovered \$472,320 in improper payments from the providers. The cancellation of the claim corrected both CWF and the claim history in the standard system. The recovery of the improper payments reduced the current claims payments made to the impacted providers, thereby reimbursing the Federal Government for the improper payments.

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. Southern MAC Program Mgmt. 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

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