



January 20, 2012

TO: Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: /Gloria L. Jarmon/
Deputy Inspector General for Audit Services

SUBJECT: Review of Medicare Payments Exceeding Charges for Outpatient Services
Processed by TrailBlazer Health Enterprises, LLC, in Jurisdiction 4 for the Period
January 1, 2006, Through June 30, 2009 (A-06-10-00045)

Attached, for your information, is an advance copy of our final report on Medicare payments exceeding charges for outpatient services processed by TrailBlazer Health Enterprises, LLC (TrailBlazer), in Jurisdiction 4. We will issue this report to TrailBlazer within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov or Patricia Wheeler, Regional Inspector General for Audit Services, Region VI, at (214) 767-8414 or through email at Trish.Wheeler@oig.hhs.gov. Please refer to report number A-06-10-00045.

Attachment



January 27, 2012

Report Number: A-06-10-00045

Ms. Melissa Halstead Rhoades
Area Director & Medicare CFO
Financial Management Operations Division
TrailBlazer Health Enterprises, LLC
8330 LBJ Freeway, 11.2402
Dallas, TX 75243

Dear Ms. Rhoades:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by TrailBlazer Health Enterprises, LLC, in Jurisdiction 4 for the Period January 1, 2006, Through June 30, 2009*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

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

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me at (214) 767-8414, or contact Michelle Richards, Audit Manager, at (214) 767-9202 or through email at Michelle.Richards@oig.hhs.gov. Please refer to report number A-06-10-00045 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
601 East 12th Street, Room 235
Kansas City, MO 64106

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICARE PAYMENTS
EXCEEDING CHARGES FOR OUTPATIENT
SERVICES PROCESSED BY TRAILBLAZER
HEALTH ENTERPRISES, LLC,
IN JURISDICTION 4 FOR THE PERIOD
JANUARY 1, 2006, THROUGH
JUNE 30, 2009**



Daniel R. Levinson
Inspector General

January 2012
A-06-10-00045

Office of Inspector General

<http://oig.hhs.gov>

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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.

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 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 for outpatient services. 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 guidance requires providers to submit accurate claims for outpatient services. Each submitted Medicare claim contains details regarding each provided service (called a line item in this report). Providers should use the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and report units of service as the number of times that a service or procedure was performed or, if the HCPCS code is associated with a drug, the number of billable units administered, as defined by the HCPCS code description. In addition, providers should charge Medicare and other payers, such as private insurance companies, uniformly. However, Medicare uses an outpatient prospective payment system to pay certain outpatient providers. In this method of reimbursement, the Medicare payment is not based on the amount that the provider charges. Consequently, the billed charges (the prices that a provider sets for its services) generally do not affect the current Medicare prospective payment amounts. Billed charges generally exceed the amount that Medicare pays the provider. Therefore, a Medicare payment that significantly exceeds the billed charges is likely to be an overpayment.

During our audit period (January 2006 through June 2009), TrailBlazer Health Enterprises, LLC (TrailBlazer), processed approximately 261 million line items for outpatient services in Jurisdiction 4, of which 2,824 line items had (1) a Medicare line payment amount that exceeded the line billed charge amount by at least \$1,000 and (2) 3 or more units of service. On claims from the same providers, we identified an additional 1,124 line items that had (1) a Medicare line payment amount that exceeded the line billed charge amount by at least \$500 and (2) 3 or more units of service. (A single Medicare claim from a provider typically includes more than one line item. In this audit, we did not review entire claims; rather, we reviewed specific line items within the claims that met these criteria. Because the terms "payments" and "charges" generally are applied to claims, we will use "line payment amounts" and "line billed charges.") We reviewed only 3,942 of the 3,948 line items because 2 providers associated with 6 line items had closed and no longer participated in the Medicare program.

OBJECTIVE

Our objective was to determine whether certain Medicare payments in excess of charges that TrailBlazer made to providers for outpatient services were correct.

SUMMARY OF FINDINGS

Of the 3,942 selected line items for which TrailBlazer made Medicare payments to providers for outpatient services during our audit period, 373 were correct. Providers refunded overpayments on 216 line items totaling \$1,351,999 before our fieldwork. The remaining 3,353 line items were incorrect and included overpayments totaling \$11,973,119, which the providers had not refunded by the beginning of our audit.

Of the 3,353 incorrect line items:

- Providers reported incorrect number of units of service on 2,731 line items, resulting in overpayments totaling \$10,283,525.
- Providers reported a combination of incorrect units of service claimed and incorrect HCPCS codes on 275 line items, resulting in overpayments totaling \$623,087.
- Providers did not provide supporting documentation for 142 line items, resulting in overpayments totaling \$591,856.
- Providers used HCPCS codes that did not reflect the procedures performed on 178 line items, resulting in overpayments totaling \$390,127.
- Providers billed for unallowable services on 24 line items, resulting in overpayments totaling \$76,850.
- Providers incorrectly billed Medicare for three line items for other reasons, resulting in overpayments totaling \$7,674.

See Appendix A for a summary of findings by Medicare contractor.

The providers attributed the incorrect payments to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors. TrailBlazer made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place during our audit period to prevent or detect the overpayments.

RECOMMENDATIONS

We recommend that TrailBlazer:

- ensure that the \$11,973,119 in identified overpayments has been recovered,
- implement system edits that would identify claims with line items having an abnormal number of service units,

- implement system edits that identify line item payments that exceed billed charges by a prescribed amount, and
- use the results of this audit in its provider education activities.

TRAILBLAZER HEALTH ENTERPRISES, LLC, COMMENTS

In written comments on our draft report, TrailBlazer concurred with our recommendations and described corrective actions that it had taken or planned to take. Our draft report included a recommendation regarding the review and refund of 636 line item overpayments that were outstanding when the report was issued. For this recommendation, TrailBlazer stated that it had processed and recovered \$2,186,640 for the 636 line items. TrailBlazer's comments are included in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

We reviewed the adjustment information that TrailBlazer forwarded to us on the 636 outstanding line item overpayments and determined that TrailBlazer had processed and recovered \$2,208,942. In addition, we determined that three line items had been adjusted prior to our review; therefore, we are no longer reporting them as errors. For this report, we have revised our findings and our first recommendation to reflect the total amount recovered and have removed the recommendation relating to the 636 line items.

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INTRODUCTION

BACKGROUND

Pursuant to Title XVIII of the Social Security Act, the Medicare program provides health insurance for people aged 65 and over and those who are disabled or have permanent kidney disease. Part B of the Medicare program helps cover medically necessary services such as doctors' services, outpatient care, home health services, and other medical services. Part B also covers some preventive services. 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 for outpatient services.¹ 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 providers' outpatient claims, the Medicare contractors use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF). The CWF can detect certain improper payments during prepayment validation.

Claims for Outpatient Services

Medicare guidance requires providers to submit accurate claims for outpatient services. Each submitted Medicare claim contains details regarding each provided service (called a line item in this report). Providers should use the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and report units of service as the number of times that a service or procedure was performed or, if the HCPCS code is associated with a drug, the number of billable units administered, as defined by the HCPCS code description.² In addition, providers should charge Medicare and other payers, such as private insurance companies, uniformly. However, Medicare uses an outpatient prospective payment system to pay certain outpatient providers. In this method of reimbursement, the Medicare payment is not based on the amount that the provider charges. Consequently, the billed charges (the prices that a provider sets for its services) generally do not affect the current Medicare prospective payment amounts. Billed charges generally exceed the amount that Medicare pays the provider. Therefore, a Medicare payment that significantly exceeds the billed charges is likely to be an overpayment.

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. In this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever is applicable.

² HCPCS codes are used throughout the health care industry to standardize coding for medical procedures.

Chisholm Administrative Services

Chisholm Administrative Services (Chisholm) was a Medicare fiscal intermediary that served Medicare providers in Oklahoma. During part of our audit period, Chisholm processed line items for outpatient services for Oklahoma providers.

TrailBlazer Health Enterprises, LLC

In August 2007, CMS announced that it had awarded to TrailBlazer Health Enterprises, LLC (TrailBlazer), the MAC contract for the combined administration of Medicare fee-for-service payments for Jurisdiction 4 in four States: Colorado, New Mexico, Oklahoma, and Texas.³ TrailBlazer, in its capacity as a fiscal intermediary, previously processed line items for outpatient services for Medicare providers in three of those States: Colorado, New Mexico, and Texas. Because TrailBlazer is now also responsible for Oklahoma providers, this report includes the payments for all four States. During our audit period (January 2006 through June 2009), approximately 261 million line items for outpatient services were processed in Jurisdiction 4.

We refer to Chisholm and TrailBlazer as TrailBlazer throughout this report.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether certain Medicare payments in excess of charges that TrailBlazer made to providers for outpatient services were correct.

Scope

Of the approximately 261 million line items for outpatient services that TrailBlazer processed during the period January 2006 through June 2009, 2,824 line items had (1) a Medicare line payment amount that exceeded the line billed charge amount by at least \$1,000 and (2) 3 or more units of service. On claims from the same providers, we identified an additional 1,124 line items that had (1) a Medicare line payment amount that exceeded the line billed charge amount by at least \$500 and (2) 3 or more units of service.⁴ We reviewed only 3,942 of the 3,948 line items because 2 providers associated with 6 line items had closed and no longer participated in the Medicare program.

³ Prior to the award, providers in those four States processed Medicare outpatient claims through separate, legacy fiscal intermediaries. In June 2008, TrailBlazer assumed full responsibility as the MAC for Jurisdiction 4 and is therefore responsible for collecting any overpayments and resolving the issues related to this audit.

⁴ A single Medicare claim from a provider typically includes more than one line item. In this audit, we did not review entire claims; rather, we reviewed specific line items within the claims that met these criteria. Because the terms “payments” and “charges” are generally applied to claims, we will use “line payment amounts” and “line billed charges.”

We limited our review of TrailBlazer's internal controls to those that were applicable to the selected 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 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.

Our fieldwork included contacting TrailBlazer in Dallas, Texas, and the 220 providers in Jurisdiction 4 that received the selected Medicare payments.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- used CMS's National Claims History file to identify outpatient line items billed by providers that had (1) Medicare line payment amounts that exceeded the line billed charge amounts by at least \$1,000 and (2) 3 or more units of service;
- identified additional line items from the same providers that had (1) Medicare line payment amounts that exceeded the line billed charge amounts by at least \$500 and (2) 3 or more units of service;
- identified 3,942 line items totaling approximately \$15.7 million that Medicare paid to 220 providers;⁵
- contacted the 220 providers that received Medicare payments associated with the selected line items to determine whether the information conveyed in the selected line items was correct and, if not, why the information was incorrect;
- reviewed documentation that the providers furnished to verify whether each selected line item was billed correctly;
- coordinated the calculation of overpayments with TrailBlazer; and
- discussed the results of our review with TrailBlazer officials on April 20, 2011.

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.

⁵ We did not review 216 of the 3,942 selected line items because providers refunded overpayments before our fieldwork and because payments no longer exceeded charges by at least \$500 for those line items.

FINDINGS AND RECOMMENDATIONS

Of the 3,942 selected line items for which TrailBlazer made Medicare payments to providers for outpatient services during our audit period, 373 were correct. Providers refunded overpayments on 216 line items totaling \$1,351,999 before our fieldwork. The remaining 3,353 line items were incorrect and included overpayments totaling \$11,973,119, which the providers had not refunded by the beginning of our audit.

Of the 3,353 incorrect line items:

- Providers reported incorrect number of units of service on 2,731 line items, resulting in overpayments totaling \$10,283,525.
- Providers reported a combination of incorrect units of service claimed and incorrect HCPCS codes on 275 line items, resulting in overpayments totaling \$623,087.
- Providers did not provide supporting documentation for 142 line items, resulting in overpayments totaling \$591,856.
- Providers used HCPCS codes that did not reflect the procedures performed on 178 line items, resulting in overpayments totaling \$390,127.
- Providers billed for unallowable services on 24 line items, resulting in overpayments totaling \$76,850.
- Providers incorrectly billed Medicare for three line items for other reasons, resulting in overpayments totaling \$7,674.

See Appendix A for a summary of findings by Medicare contractor.

The providers attributed the incorrect payments to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors. TrailBlazer made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place during our audit period to prevent or detect the overpayments.

FEDERAL REQUIREMENTS

Section 1833(e) of the Social Security Act states: “No payment shall be made to any provider of services ... unless there has been furnished such information as may be necessary in order to determine the amounts due such provider ... for the period with respect to which the amounts are being paid”

CMS’s *Medicare Claims Processing Manual*, Pub. No. 100-04 (the Manual), chapter 23, section 20.3, states: “providers must use HCPCS codes ... for most outpatient services.” Chapter 25, section 75.5, of the Manual states: “when HCPCS codes are required for services,

the units are equal to the number of times the procedure/service being reported was performed.”⁶ If the provider is billing for a drug, according to chapter 17, section 70, of the Manual, “[w]here HCPCS is required, units are entered in multiples of the units shown in the HCPCS narrative description. For example, if the description for the code is 50 mg, and 200 mg are provided, units are shown as 4”

Chapter 1, section 80.3.2.2, of the Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately.”

OVERPAYMENTS FOR SELECTED LINE ITEMS

Incorrect Number of Units of Service

Providers reported incorrect number of units of service on 2,731 line items, resulting in overpayments totaling \$10,283,525. The following examples illustrate incorrect units of service:

- Seventeen providers billed for an incorrect number of service units on 1,331 line items. Rather than billing between 1 and 9 service units (the correct range for the HCPCS code associated with these line items), the providers billed between 11 and 480 service units. The providers that gave a reason stated that these errors occurred because of a data entry error or an incorrect chargemaster.⁷ As a result of these errors, TrailBlazer paid the providers \$3,218,220 when it should have paid \$154,348, a total overpayment of \$3,063,872.
- Three providers billed for an incorrect number of service units on 50 line items. Rather than billing between 10 and 44 service units (the correct range for the HCPCS code associated with these line items), the providers billed between 80 and 748 service units. One provider stated that the errors occurred because of an error in converting an administered amount to billable units, and another provider stated that its chargemaster was incorrect. As a result of these errors, TrailBlazer paid the providers \$921,183 when it should have paid \$38,285, a total overpayment of \$882,898.

Combination of Incorrect Number of Units of Service and Incorrect Healthcare Common Procedure Coding System Codes

Providers reported a combination of incorrect number of units of service claimed and incorrect HCPCS codes on 275 line items, resulting in overpayments totaling \$623,087. The following examples illustrate the combination of incorrect number of units of service claimed and incorrect HCPCS codes used:

- One provider incorrectly billed Medicare for 85 units of service for a drug used for chemotherapy treatments. The provider should have billed for four units of service for

⁶ Before CMS Transmittal 1254, Change Request 5593, dated May 25, 2007, and effective June 11, 2007, this provision was located at chapter 25, section 60.5, of the Manual.

⁷ A provider’s chargemaster contains data on every chargeable item or procedure that the provider offers.

this drug with a different HCPCS code. Similar errors occurred on a total of 32 line items submitted by this provider. As a result of these errors, TrailBlazer paid the provider \$182,409 when it should have paid \$945, an overpayment of \$181,464.

- Another provider incorrectly billed Medicare for 190 units of service for a 6-mg dose of an agent used in therapeutic stress testing. The provider should have billed for four units of service for a 30-mg dose of an agent used in diagnostic stress testing. Similar errors occurred on a total of 25 line items submitted by this provider. As a result of these errors, TrailBlazer paid the provider \$37,286 when it should have paid \$3,266, an overpayment of \$34,020.

Unsupported Services

Providers billed Medicare for 142 line items for which the providers did not provide supporting documentation. As a result, TrailBlazer paid the providers \$591,856 when it should have paid \$0, an overpayment of \$591,856.

Incorrect Healthcare Common Procedure Coding System Codes

Providers used HCPCS codes that did not reflect the procedures performed or drugs administered on 178 line items, resulting in overpayments totaling \$390,127.

As an example of incorrect HCPCS codes, for 54 line items, a provider assigned an incorrect HCPCS code to the magnetic resonance imaging contrast agents given to patients. As a result, TrailBlazer paid the provider \$52,821 when it should have paid \$2,256, an overpayment of \$50,565.

Services Not Allowable for Medicare Reimbursement

Providers incorrectly billed Medicare for 24 line items for which the services provided were not allowable for Medicare reimbursement, resulting in overpayments totaling \$76,850. For example, providers billed Medicare for 21 line items for the surgical shaping and smoothing of teeth sockets in preparation for dentures, which is not a covered procedure (*Medicare Benefit Policy Manual*, Pub. No. 100-02, chapter 15, section 150). As a result of these errors, TrailBlazer paid the providers \$49,980 when it should have paid \$0, an overpayment of \$49,980.

Other Errors

Three providers incorrectly billed Medicare for three line items for other reasons. One provider billed Medicare when it should have billed a private health insurance company first. Per the *Medicare Benefit Policy Manual*, Pub. No. 100-02, (chapter 16, section 40.3), Medicare does not make a payment for services rendered to an individual who is insured under an employer group health plan until after the individual's group health plan has paid for its portion of the services. Another provider billed Medicare directly for a service that was subject to the skilled nursing facility (SNF) consolidated billing provisions in sections 1862(a)(18) and 1842(b)(6)(E) of the Social Security Act. The provider should have billed and received payment from the SNF. The

remaining provider did not indicate on the Medicare claim that the drug it had administered to the patient was supplied to the provider free of charge. Per section 1862(a)(2) of the Social Security Act, Medicare does not pay for items or services for which the beneficiary has no legal obligation to pay. As a result of these errors, TrailBlazer paid the providers \$7,674 when it should have paid \$0, an overpayment of \$7,674.

CAUSES OF INCORRECT MEDICARE PAYMENTS

The providers attributed the incorrect payments to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors. TrailBlazer made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place to prevent or detect the overpayments. In effect, CMS relied on providers to notify the Medicare contractors of incorrect payments and on beneficiaries to review their *Medicare Summary Notice* and disclose any overpayments.⁸

On January 3, 2006, CMS required Medicare contractors to implement a Fiscal Intermediary Standard System edit to suspend potentially incorrect Medicare payments for prepayment review. As implemented, this edit suspends payments exceeding established thresholds and requires Medicare contractors to determine the legitimacy of the claims. However, the edit did not detect the errors that we found because it considers only the amount of the payment, suspends only those payments that exceed the threshold, and does not flag payments that exceed charges.

RECOMMENDATIONS

We recommend that TrailBlazer:

- ensure that the \$11,973,119 in identified overpayments has been recovered,
- implement system edits that would identify claims with line items having an abnormal number of service units,
- implement system edits that identify line item payments that exceed billed charges by a prescribed amount, and
- use the results of this audit in its provider education activities.

⁸ The Medicare contractor sends a *Medicare Summary Notice*—an explanation of benefits—to the beneficiary after the provider files a claim for services. The notice explains the services billed, the approved amount, the Medicare payment, and the amount due from the beneficiary.

TRAILBLAZER HEALTH ENTERPRISES, LLC, COMMENTS

In written comments on our draft report, TrailBlazer concurred with our recommendations and described corrective actions that it had taken or planned to take. Our draft report included a recommendation regarding the review and refund of 636 line item overpayments that were outstanding when the report was issued. For this recommendation, TrailBlazer stated that it had processed and recovered \$2,186,640 for the 636 line items. TrailBlazer's comments are included in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

We reviewed the adjustment information that TrailBlazer forwarded to us on the 636 outstanding line item overpayments and determined that TrailBlazer had processed and recovered \$2,208,942. In addition, we determined that three line items had been adjusted prior to our review; therefore, we are no longer reporting them as errors. For this report, we have revised our findings and our first recommendation to reflect the total amount recovered and have removed the recommendation relating to the 636 line items.

APPENDIXES

APPENDIX A: FINDINGS BY MEDICARE CONTRACTOR

	Combined Totals		TrailBlazer		Chisholm	
	Overpayment	Line Items	Overpayment	Line Items	Overpayment	Line Items
Unit errors	\$10,283,525	2,731	\$9,376,193	2,329	\$907,332	402
Combination errors	623,087	275	379,082	158	244,005	117
Unsupported services	591,856	142	494,769	128	97,087	14
HCPCS ¹ errors	390,127	178	297,351	115	92,776	63
Services not allowable	76,850	24	74,883	23	1,967	1
Other errors	7,674	3	7,674	3	0	0
Total	\$11,973,119	3,353	\$10,629,952	2,756	\$1,343,167	597

¹ HCPCS = Healthcare Common Procedure Coding System.

APPENDIX B: TRAILBLAZER HEALTH ENTERPRISES, LLC, COMMENTS



MEDICARE

September 23, 2011

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

Report Number: A-06-10-00045

Dear Ms. Wheeler:

We received the August 26, 2011, draft report entitled "Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by TrailBlazer Health Enterprises, LLC, in Jurisdiction 4 for the Period January 1, 2006, Through June 30, 2009." In the draft report, the OIG recommended that TrailBlazer:

- Ensure that the \$9,764,177 in identified overpayments has been collected;
- Determine the overpayments for the 636 incorrect line item payments and recover that amount;
- Implement system edits that would identify claims with line items having an abnormal number of service units;
- Implement system edits that identify line item payments that exceed billed charges by a prescribed amount; and
- Use the results of this audit in provider education activities.

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

Recovery of Identified Overpayments: The OIG worked directly with the impacted providers to make claim adjustments prior to the issuance of the draft audit report. TrailBlazer received the listing of 3,356 claim adjustments which agreed in total to the \$9,764,177 identified overpayment. TrailBlazer verified the recovery of the identified overpayments in the standard system, FISS.

Determine and Recover Additional Overpayments: TrailBlazer received the listing of additional claims requiring adjustment as a result of this audit. The claim adjustments have been processed and resulted in recovery of additional net overpayment of \$2,186,640.

Implement System Edits – Abnormal Units of Service: TrailBlazer's Part A Claims department will conduct internal meetings to evaluate the OIG recommendation and to determine how best to capture the overbilling of units of service and to determine if appropriate system edits can be established.

TrailBlazer Health Enterprises, LLC
Executive Center III • 8330 LBJ Freeway • Dallas, TX 75243-1213
A Medicare Administrative Contractor



Patricia Wheeler
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Implement System Edits – Payments Exceed Charges: TrailBlazer's Part A Claims department will conduct internal meetings to evaluate the OIG recommendation and to determine if system edits can be established to identify when line item payments exceed billed charges.

Provider Education Activities: TrailBlazer provides a Part A Beginner's Guide to Medicare to assist providers with basic Part A information to help ensure Part A claims are submitted properly.

<http://www.trailblazerhealth.com/Publications/Training%20Manual/MedicareBasicsManual.pdf>

TrailBlazer also offers the TrailBlazer Outpatient Prospective Payment System (OPPS) manual, which includes policies, billing information, billing examples, requirements, revenue codes, form locators, initiatives and significant changes to the Medicare program.

<http://www.trailblazerhealth.com/Publications/Training%20Manual/HospitalOutpatientManual.pdf>

Part A Beginner's Guide to Medicare and OPPS training are routinely offered through Web-based training events. The PowerPoint presentations are available for download and, upon completion of these events, the recorded training sessions are posted on the TrailBlazer Web site for reference.

<http://www.trailblazerhealth.com/Education/EncoreWBTs.aspx?DomainID=1>

TrailBlazer will develop an article highlighting these OIG findings. This article will be placed on the TrailBlazer Web site, sent in listserv and added to the TrailBlazer *eBulletin* for further exposure. In addition, these findings will be addressed in future online training sessions when appropriate.

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, J4 MAC Contracting Officer's Technical Representative, CMS
Gil R. Glover, President & Chief Operating Officer, TrailBlazer
Scott J. Manning, Vice President, Financial Management Operations, TrailBlazer
Kevin Bidwell, Vice President & Compliance Officer, TrailBlazer