DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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

July 21, 2003

CIN: A-06-03-00021

Ms. Marti Mahaffey
Executive Vice President & COO
TrailBlazer Health Enterprises, LLC
8330 LBJ Freeway, Executive Center III
Dallas, Texas 75243

Dear Ms. Mahaffey:

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General report entitled "Results of Audit Work Performed at TrailBlazer Health Enterprises, LLC as Part of the Office of Inspector General's Nationwide Determination of the Fiscal Year 2002 Medicare Error Rate". The Office of Inspector General's annual determination of the Medicare error rate is required by the Chief Financial Officer's Act of 1990. This report covers Medicare claims paid by TrailBlazer during the 3-month period ended December 31, 2001. A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

TrailBlazer officials agreed with most of the recommendations included in the draft audit report and provided specific responses to the recommendations. We have incorporated TrailBlazer's written comments in the body of the report following the Other Matters section. We appreciate the cooperation given to us by TrailBlazer officials and staff throughout this audit.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action 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.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General Reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.) As such, within ten business days after the final report is issued, it will be posted on the world wide web at http://oig.hhs.gov.

To facilitate identification, please refer to CIN: A-06-03-00021 in all correspondence relating to this report.

Sincerely yours,

Gordon L. Sato

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosures – as stated

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

RESULTS OF AUDIT WORK PERFORMED AT TRAILBLAZER HEALTH ENTERPRISES, LLC AS PART OF THE OFFICE OF INSPECTOR GENERAL'S NATIONWIDE DETERMINATION OF THE FISCAL YEAR 2002 MEDICARE ERROR RATE

Inspector General

JULY 2003
A-06-03-00021

Office of Inspector General

http://oig.hhs.gov/

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

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1100 Commerce, Room 632
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Common Identification Number: A-06-03-00021

Ms. Marti Mahaffey
Executive Vice President & COO
TrailBlazer Health Enterprises, LLC
8330 LBJ Freeway, Executive Center III
Dallas, Texas 75243

Dear Ms. Mahaffey:

This audit report provides you with the results of our audit work performed at TrailBlazer Health Enterprises, LLC (TrailBlazer) as part of the Office of Inspector General's (OIG) nationwide determination of the fiscal year (FY) 2002 Medicare error rate. The OIG's annual determination of the Medicare error rate is required by the Chief Financial Officers (CFO) Act of 1990.

The objectives of the nationwide audit were to determine whether: (1) the Centers for Medicare and Medicaid Service's (CMS) FY 2002 financial statements accurately reflect its financial position; (2) CMS had an adequate internal control structure; and (3) CMS' expenditures comply with applicable laws and regulations. TrailBlazer was selected by the OIG through statistical sampling as one of the CMS Contractors to be audited as part of the FY 2002 nationwide audit. The audit period we reviewed covered the first quarter of FY 2002 (October 1, 2001 through December 31, 2001).

Our audit work at TrailBlazer was limited to: (1) identifying all of the Medicare claims paid during the FY 2002 first quarter; (2) verifying the accuracy of Medicare benefit payments and other data reported by TrailBlazer on various CMS forms; and, (3) reviewing, with assistance from the TrailBlazer medical staff and the Texas and New Mexico Quality Improvement Organizations, a statistical sample of Medicare beneficiary expenditures paid during the first quarter for compliance with Medicare requirements.

We identified several areas where TrailBlazer was not in compliance with applicable Medicare requirements. These areas resulted from TrailBlazer not:

- Reconciling the funds expended amount reported on the Monthly Contractor Financial Report (CMS 1522) to the Medicare paid claims history file;
- Maintaining an accurate outstanding check listing by removing the cleared checks from the outstanding check list in preparing the CMS 1522, and;
- Recording debit and credit memos received from the bank properly on the CMS 1522.

In addition, the medical review and OIG review of the 920 claims selected in our statistical sample identified 375 claims that did not comply with Medicare requirements, resulting in net

questioned costs totaling $93,862.90 that needs to be refunded to Medicare. Appendix I to our report includes various explanations of the data related to the claims selected in our sample.

We are recommending that TrailBlazer:

- Perform a monthly reconciliation of the funds expended as reported on the CMS 1522 to the Medicare paid claims history file;

- Maintain an accurate outstanding check listing by removing the cleared checks from the outstanding check list;

- Correct the classification and reporting of debit and credit memos received from the bank;

- Take the steps needed to ensure that adjustments are made to those claims in our sample that contained errors and that the net adjustment amount of $93,862.90 is refunded to Medicare.

In their written response to our draft report, TrailBlazer officials stated that they generally agreed with our findings and have taken steps to address our recommendations. TrailBlazer officials stated that corrective actions have already been taken to: (1) ensure that monthly review procedures are in place to properly identify cleared checks and outstanding checks over one year old; (2) correct the classification and reporting of debit and credit memos on the CMS 1522; (3) identify and correct the claims in CY 2002 where the deductible was inappropriately applied; and (4) adjust and recoup the net adjustment amount of $93,862.90 due Medicare from the sample claims review. Regarding the reconciliation of the CMS 1522 to the Medicare paid claims history file, TrailBlazer officials stated that various timing differences and inconsistencies exist between the MCS financial reports and the MCS paid claims tape. These officials stated that, although they had come very close to achieving a full reconciliation, without assistance from CMS and the System Maintainer their ability to perform the required reconciliation was limited. These officials believe that a recent Change Request issued by CMS will require the System Maintainer to generate the files needed to perform a full reconciliation.

We recognize the problems currently inherent in attempting to perform the reconciliation of the CMS 1522 to the Medicare paid claims tape. However, until the Change Request is implemented, we believe that TrailBlazer should attempt to perform this reconciliation. In our opinion, even though this method may not result in a complete reconciliation it should ensure more accurate reporting of the paid claims on the CMS 1522.

The full text of TrailBlazer officials' written comments is included as Appendix II to our report.

INTRODUCTION

BACKGROUND

The CFO Act of 1990 requires each agency of the Federal Government to improve its systems of financial management, accounting, and internal controls to assure the issuance of reliable financial information. The Office of Management and Budget (OMB) Circular A-123 provides guidance to federal managers on improving the accountability and effectiveness of federal programs and operations by establishing, assessing, correcting, and reporting on management controls. The OMB Circular A-123 also requires annual reports on management controls to be submitted to the President, Congress, and OMB. The Government Management Reform Act (GMRA) of 1994 broadened the CFO Act by requiring audits of the financial statements of 24 major federal agencies, including the Department of Health and Human Services (HHS) and covering all accounts and associated activities of each office, bureau and activity of the agency.

Within HHS, CMS has responsibility for administration of the Medicare program including the preparation of financial statements that report reliable financial information covering Medicare activities on an annual basis. CMS contracts with fiscal intermediaries (FIs) and carriers nationwide to process Medicare claims and to provide CMS with various reports on the results of their Medicare operations that become an integral part of CMS' Medicare financial statement information. OIG performs an annual audit of a sample of Medicare claims processed by the FIs and carriers to determine an estimated dollar amount of the Medicare claims that have been paid in error. OIG statistically selects the FIs and carriers that will be included in the annual audit including which 3-month period or periods will be reviewed for each FI and carrier.

TrailBlazer was selected as one of the Medicare contractors to be included in the OIG's annual audit for FY 2002. TrailBlazer, under contract with CMS, serves as the Medicare Part A FI for the States of Texas, New Mexico, and Colorado and serves as the Medicare Part B Carrier for the States of Texas, Maryland, Delaware, Virginia, and the District of Columbia.

OBJECTIVES AND SCOPE

The objectives of the OIG's nationwide audit were to determine whether: (1) CMS' FY 2002 financial statements accurately reflect its financial position; (2) CMS had an adequate internal control structure; and (3) CMS' expenditures comply with applicable laws and regulations. TrailBlazer was selected by the OIG through statistical sampling as one of the CMS Contractors to be audited as part of the FY 2002 nationwide audit. The audit period we reviewed covered the first quarter of FY 2002 (October 1, 2001 through December 31, 2001).

Our audit work at TrailBlazer was limited to: (1) identifying all of the Medicare claims paid during the FY 2002 first quarter; (2) verifying the accuracy of Medicare benefit payments and other data reported by TrailBlazer on various CMS forms; and, (3) reviewing a statistical sample of Medicare beneficiary expenditures paid during the first quarter for compliance with Medicare laws and regulations. The statistical sample and related claims review involved the following:

- Selecting a sample of 50 Medicare beneficiaries and identifying every Medicare claim paid on their behalf during the first quarter of FY 2002;
- Requesting the providers, who submitted claims to Medicare for services to the selected beneficiaries, to submit copies of the related medical records for review by TrailBlazer's medical staff or by the Texas and New Mexico Quality Improvement Organizations (QIO) personnel; and,
- Reviewing the claims to ensure that they were appropriately paid in accordance with Medicare rules and regulations.

A large part of our audit work centered on reviewing and verifying the accuracy of the information reported by TrailBlazer on the CMS forms 1521 and 1522. In addition, we attempted to reconcile the total funds expended on the CMS 1522 to the Medicare paid claims history tape. This reconciliation was important to ensure that we had an accurate universe of Medicare paid claims from which to select our first quarter sample.

Our audit was performed in accordance with generally accepted government auditing standards. We conducted our review primarily at TrailBlazer's office in Dallas, Texas. We also performed work at the Palmetto Government Benefits Administrators office in Columbia, South Carolina, and at OIG field offices in Ft. Worth, Texas; Little Rock, Arkansas; Oklahoma City, Oklahoma; and Baton Rouge, Louisiana during the period of February 2002 through August 2002.

FINDINGS AND RECOMMENDATIONS

Our audit work disclosed several areas where TrailBlazer was not in compliance with Medicare requirements. These areas centered on the reconciliation requirements of both the CMS 1521 and CMS 1522. In addition, the medical review and OIG review of the 920 claims selected in our statistical sample identified 375 claims that did not comply with Medicare laws and regulations, resulting in net questioned costs totaling $93,862.90 that needs to be refunded to Medicare. TrailBlazer needs to take the appropriate steps to ensure that all the errors identified in the claims review are properly adjusted.

RECONCILIATION OF THE PAID CLAIMS HISTORY FILE TO THE CMS 1522

The paid claims history file contains all claim payments made by TrailBlazer during each month. CMS requires each contractor to perform a reconciliation of the Medicare paid claims history tape to the CMS 1522. This requirement is set forth in CMS Change Request (CR) #1330, effective November 1, 2000. TrailBlazer does not perform this reconciliation. Instead, TrailBlazer reconciles the system reports and registers to the CMS 1522. Reconciling to these documents does not ensure that the paid claims data reported on the CMS 1522 agrees with the Medicare paid claims history tape.

TrailBlazer processes claims under three different systems. The Part A claims are processed under the Fiscal Intermediary Standard System (FISS). The Part B claims for Texas, Maryland, Delaware, and the District of Columbia are processed under the Multi Carrier System (MCS), while Virginia claims are processed under The HCFA Part B Standard System (HPBSS). TrailBlazer provided the OIG with computerized paid claims history data for October through

December 2001, for all three systems. During our attempt to reconcile the paid claims data between the CMS 1522 and the paid claims tape, we encountered several problems. The first set of paid claims tapes for Part A that we received were blank, and the first set of paid claims tapes for Virginia contained the incorrect information. Once a correct set of paid claims tapes was received, our work disclosed that the computerized Part B claims data from MCS would not reconcile to the CMS 1522. TrailBlazer officials could not explain the differences and did not have the documentation needed to support the Medicare claim expenditures reported on the CMS 1522. The differences between the paid claims tapes and the CMS 1522 for each month in our quarter were:

- $18.92 for October
- $(1,319.03) for November
- $1,248.90 for December

One of the purposes for reconciling the CMS 1522 to the paid claims tape is to provide the OIG with assurance that the universe we select our sample from is accurate and complete. In the absence of reconciling data, the OIG used the available data on the paid claims tape to select its beneficiary sample. TrailBlazer should perform a reconciliation of the paid claims tape to the CMS 1522. This would ensure more accurate reporting of the paid claims on the CMS 1522 and should eliminate any differences in the future.

RECONCILIATION OF THE CMS 1521 AND 1522 TO SYSTEM REPORTS

The Contractor Draws on Letter of Credit (CMS 1521) and the CMS 1522 are prepared by TrailBlazer on a monthly basis. The reports are designed to provide a reconciliation of Medicare program cash benefit payments to the records maintained by CMS, TrailBlazer and TrailBlazer's bank. Information reported through the CMS 1522 is derived from internal contractor reports including benefit payments, periodic interim payments, pass through payments, cost report final settlements, manual checks issued and other miscellaneous adjustments.

TrailBlazer provided the OIG with copies of the CMS 1521 and 1522 with all supporting documentation for the period October through December 2001. Our analysis of the CMS 1521 did not disclose any problems. However, our analysis of the CMS 1522 and the related supporting data disclosed that TrailBlazer did not:

- Maintain an accurate outstanding check listing; and,
- Record debit and credit memos properly.

Outstanding Checks

Accurate reporting to CMS requires the verification of beginning and ending cash balances reported on the CMS 1522. To verify these balances, we requested a detailed list of outstanding checks from TrailBlazer. Upon review, we determined that TrailBlazer's system had checks listed as outstanding while the bank's records showed these checks as cleared. According to TrailBlazer officials, there was a system error in August 2001 where the checks issued file did

not match the checks issued file sent to the bank. As a result, checks that had cleared the bank were still showing as outstanding. As of August 2002, TrailBlazer had not made an adjustment to the outstanding check listing.

Debit and Credit Memos

We determined that the CMS 1522 contained sections where debit and credit memos were improperly listed. Specifically, TrailBlazer netted debit memos against credit memos from the bank statements and recorded them as credit memos on the CMS 1522. In addition, some credit memos were coded as debit memos on the CMS 1522. TrailBlazer officials explained that the spreadsheets used to reconcile and categorize its bank statements were not devised correctly to treat debit and credit memos consistently. They also stated that the resulting error amount was immaterial; thus, they would not resubmit the CMS 1522 but would correct the spreadsheets so that all debit and credit memos were treated consistently. However, as of June 2002 the problem had not been corrected.

REVIEW OF EXPENDITURES

The random sample of 50 beneficiaries selected for review had a total of 920 claim transactions paid during the FY 2002 first quarter. The 920 transactions included 107 Part A claim transactions comprised of 30 inpatient transactions and 77 outpatient transactions. The remaining 813 transactions were Part B. The total amount paid for the sampled claims was $388,065.44 and was comprised of $221,785.32 of Part A inpatient claims, $63,360.11 of Part B of A outpatient claims, and $102,920.01 of Part B outpatient claims. The sample claims were selected from a universe of approximately $3.4 billion in paid claims.

The medical review and OIG review of the 920 claims selected in our statistical sample identified 375 claims that did not comply with Medicare laws and regulations, resulting in net questioned costs totaling $93,862.90 that needs to be refunded to Medicare. We are recommending that TrailBlazer make the appropriate adjustments resulting from the medical review of the Medicare claims included in our sample.

Medical Records Review

All of the providers, who performed services related to the sampled claims, provided copies of the applicable medical record for use during the medical review of the sample claims. The documentation from the providers was reviewed for elements such as medical necessity, accurate coding, and sufficient documentation. QIO reviewed inpatient hospital claims. QIOs involved in the review were the Texas Medical Foundation and the New Mexico Medical Review Association. TrailBlazer's medical review staff reviewed claims relating to services for skilled nursing facilities (SNF), Part B of A outpatient services, and all Part B services. After reviewing the providers' medical records, both the QIO and TrailBlazer's medical review staff identified problems with the validity of some of the sample claims. The results of these reviews are discussed below.

QIO Medical Review

The QIOs reviewed 19 inpatient claims (18 Prospective Payment System (PPS) and 1 Non-PPS) and identified 7 inpatient claims with errors. The effect of these errors was a net overpayment of $10,275.04 to the providers. The circumstances surrounding these claims were as follows:

- One claim was an invalid inpatient admission because the medical reviewers determined that the evaluation and treatment did not require an acute care admission. This resulted in the entire claim totaling $5,446.48 being denied.

- For one claim, the principal diagnosis was changed to a lesser-valued Diagnostic Related Group (DRG). The new DRG decreased the Medicare payment by $4,762.43.

- One claim had an incorrect discharge status because the claim was billed as a discharge when it was actually a transfer. The wrong discharge status caused an overpayment of $66.13. When this claim was put into the system to be priced, the average length of stay (ALOS) was 6.1, but the pricer did not read the .1 and treated the ALOS as 6. This caused the ALOS to equal the covered days, and pay the claim as a discharge not a transfer.

- Three claims had an incorrect secondary diagnosis. There was no dollar error for these claims.

- For one claim, an incorrect discharge status was billed. The claim was billed as a discharge to the home, when it was actually a discharge to the home under the care of an organized home health service. There was no dollar error for this claim.

The payment adjustments for these 7 claims either have been or will be processed by TrailBlazer's staff.

TrailBlazer Medical Review

The TrailBlazer medical review staff reviewed 901 claims. These claims were comprised of services for SNFs, Part B of A outpatient services, End Stage Renal Disease (ESRD) services, and all Part B services. From this review, 6 SNF inpatient claims, 17 Part B of A claims, 16 ESRD claims, and 322 Part B claims contained errors. The medical review staff identified errors such as insufficient documentation, no documentation for certain services, medically unnecessary service or treatment, and services incorrectly coded.

A net total of $ 83,519.04 for 361 claims was questioned. The medical reviewers allowed some claims that were previously disallowed. The questioned cost of $83,519.04 is the net of these claims and the claims disallowed by the medical reviewers during the audit. The questioned costs consisted of $22,476.95 for 6 SNF inpatient

claims, $4,122.45 for 17 Part B of A outpatient claims, $7,020.33 for 16 ESRD claims, and $49,899.31 for 322 Part B claims.

We provided TrailBlazer's personnel with a detailed listing, by claim, of those claims that needed to be adjusted. TrailBlazer's staff has agreed to take appropriate adjudication action for these claims. Appendix I to our report provides detailed information, by claim type, for the dollar and claim errors identified in the review.

OIG Claims Review

We tested the 920 sampled claims to determine whether they were paid in accordance with Medicare laws and regulations. This testing included audit steps to determine whether: (1) services were furnished by certified Medicare providers to eligible beneficiaries; (2) duplicate payments were made; (3) Medicare appropriately paid the claims as primary or secondary payer; (4) claim adjustments were warranted and properly accounted for in the contractor's records; (5) claim payments were properly priced; and (6) all claims were billed in a timely manner.

We did not identify any errors in five of the six areas reviewed. However, we determined that the Part A pricing system was using the incorrect pricing information. The provider specific information was not updated in a timely manner causing the claims to be priced using out of date information. We identified eight claims where the pricer used the wrong information to price the claims, resulting in a net overpayment of $68.82, which is included in Appendix I. CMS informed the OIG that these types of errors could either be recouped through a mass adjustment or the cost report settlement process. According to CMS, it is left to the discretion of each contractor as to how they will treat the errors. TrailBlazer staff indicated that the corrections to the Part A pricing errors would be recouped through the cost report settlement process.

RECOMMENDATIONS

We recommend that TrailBlazer:

- Perform a monthly reconciliation of the funds expended as reported on the CMS 1522 to the Medicare paid claims history file;

- Maintain an accurate outstanding check listing by removing the cleared checks from the outstanding check list;

- Correct the classification and reporting of debit and credit memos received from the bank;

- Take the steps needed to ensure that adjustments are made to those claims in our sample that contained errors and that the net adjustment amount of $93,862.90 is refunded to Medicare.

OTHER MATTERS

During our review, we identified other issues that are of concern.

- Part of the CFO review requires that a sample of non-claims transactions reported on the CMS 1522 be tested for supporting documentation. For FY 2002 this test was performed by a CPA firm under contract with CMS. The non-claims transaction report that is used to select a sample for non-claims testing by the CPA firm was incorrect the first time it was provided to us. The program that generates this report did not include Transitional Outpatient Payments (TOP) which caused a problem in reconciling the Settlement Payment totals to the monthly reconciliation. TrailBlazer officials were able to correct this problem through a program change and provide the correct report.

- TrailBlazer medical review staff reviewed all 37 ESRD claims included in our sample. After the first review of these claims, the nurse reviewer determined that a majority of these claims should be denied due to no physician order for the dialysis treatment, and after several requests by the OIG, no orders were received from the facilities. TrailBlazer officials requested that they be allowed to perform additional medical reviews on the ESRD claims that were denied. The TrailBlazer officials contacted the facilities and requested the original standing orders for dialysis treatment and received orders for several claims, thus allowing the claims. Upon our review of the claims, it was noted that the orders were several years old. CMS and TrailBlazer officials informed us that there is no policy covering the timeliness of orders. However, the CMS officials stated that with such old physician orders, there could be a standard of care issue. While the claims were allowed, in our opinion, TrailBlazer should consider establishing a policy as to how old standing orders can be and still be accepted.

- TrailBlazer's medical review staff reviewed 158 claims with 457 line items for ambulance services. Of the 158 claims reviewed, 128 claims (81 percent) were denied due to errors related to insufficient documentation and medically unnecessary services. Of the 457 line items identified, 257 were medically unnecessary and 110 did not have sufficient documentation to support the services rendered. A majority of these claims were related trips to a facility for dialysis treatment multiple times per week. A TrailBlazer official informed us that they currently are not required to perform analysis that would disclose this type of billing pattern. However, TrailBlazer should consider performing an analysis for all ambulance services that are billed multiple times throughout the week. TrailBlazer should also consider providing training/education to providers of ambulance services as to proper billing, specifically what is accepted as medically necessary and proper documentation of the services provided.

Auditee Comments

In their written response to our draft report, TrailBlazer officials stated that they generally agreed with our findings and have taken steps to address our recommendations. TrailBlazer officials included explanations of the corrective actions that they have taken and also included several additional comments as explained below:

- Regarding our recommendation for TrailBlazer to reconcile the funds expended as reported on the CMS 1522 to the Medicare paid claims history file, TrailBlazer officials stated that they perform a monthly reconciliation of funds expended per the Part B CMS 1522 report to MCS system generated financial reports. Various timing differences and inconsistencies between the MCS financial reports and the MCS paid claims tapes exist that currently do not provide MCS users the ability to perform this reconciliation. TrailBlazer expended significant effort over several years in an attempt to achieve this reconciliation, and has come very close to achieving the goal. The remaining issues with this reconciliation now rest with the standard system maintainer (EDS) and CMS. Additionally, in their response the TrailBlazer officials stated that CMS circulated draft Change Request 2795 to provide a standard format for performing the monthly reconciliation. This Change Request requires the standard system maintainer to generate electronic files that include all detail claim records supporting amounts included on system generated financial reports. For contractors using the MCS system, effective implementation of this requirement directly affects their ability to perform this reconciliation.

- Monthly review procedures have been put in place to properly identify cleared checks and outstanding checks over one year old. The large outstanding items identified during the audit have been removed from the outstanding listing and purged from the system.

- A new classification procedure has been put into place for proper reporting of debit and credit memos on the CMS 1522. The incorrect classification of debits and credits identified during the audit was related to bank accounts that are now closed.

- TrailBlazer officials agreed to make the adjustments needed to those claims in our sample that contained errors and to pursue collection of the amounts paid in error. Additionally, in their response TrailBlazer officials agree with the vulnerabilities identified in the accurate payment of certain types of claims. In fact, the vulnerabilities identified in the CFO audit validated TrailBlazer's internal data analysis and medical review results. However, TrailBlazer officials noted that the OIG's sampling approach is designed to achieve a statistically valid and representative sample across all contractors rather than each contractor. Accordingly, TrailBlazer officials do not believe the FY 2002 sample of claims reviewed at TrailBlazer are representative of TrailBlazer's overall paid claims distribution nor an accurate assessment of its overall ability to pay claims accurately.

- TrailBlazer officials addressed two of the items included in the Other Matters section of our report. These officials stated that they will promulgate "documentation guidelines" for dialysis facilities which will specify the expected documentation needed to support the medical necessity for a dialysis service. These officials also stated that they have completed an in-depth analysis of ambulance services and are in the process of implementing several corrective measures to address the problems related to non-emergency ambulance transfers.

The full text of the TrailBlazer officials' written comments is included as Appendix II to our report.

OIG Response

OIG recognizes the problems currently inherent in attempting to perform the reconciliation of the CMS 1522 to the Medicare paid claims tape. We also recognize that CMS has issued a draft Change Request to help resolve the reconciliation problems. However, until the Change Request is implemented, we believe that TrailBlazer should attempt to perform the reconciliation of the CMS 1522 to the paid claims tape. In our opinion, even though this method may not result in a complete reconciliation it should ensure more accurate reporting of the paid claims on the CMS 1522.

Since TrailBlazer officials included comments that addressed our sampling approach, we are providing additional comments regarding the sampling plan used in selecting the Medicare claims included in our sample review. Our sampling approach is designed to achieve a statistically valid sample across all contractors. To accomplish our objective, we used a multistage, stratified sample design. In the first stage, our sample frame consisted of 136 contractor quarters. Twelve contractor quarters were selected based on probability-proportional-to-size using Rao, Hartley, Cochran methodology. The second stage of our sample design consisted of a sample of 50 beneficiaries from each of the 12 contractor quarters. The 50 beneficiaries were selected from four strata based on the total payments for services. The sample that was pulled from TrailBlazer was a statistical sample and reflects the paid claims universe.

Our review at TrailBlazer contributes to a nationwide report issued by our headquarters. Information respecting the characteristics of our sample and projections are part of the nationwide reporting. Our review did not involve statistical projections for errors at TrailBlazer; we only recorded the actual amounts of the overpayments identified. Additionally, the OIG has not reviewed any analysis performed by TrailBlazer outside the CFO audit. Also, we did not test TrailBlazer's analysis of the claims that were affected by the deductible being applied incorrectly.

Sincerely,

Gordon L. Sato
Regional Inspector General
for Audit Services

AUDIT OF CMS' FINANCIAL STATEMENTS
AT TRAILBLAZER HEALTH ENTERPRISES
DALLAS, TEXAS
FOR FIRST QUARTER OF FISCAL YEAR 2002
(OCTOBER THROUGH DECEMBER 2001)
Errors in Substantive Testing

LIST BY TYPE OF CLAIM WITH DOLLAR AMOUNTS (Reviewed and Errors)

Listing of the dollar amount of errors by type of claim. The percent of errors was calculated by dividing the specific type of claim dollar errors by the total dollar errors; for example, the dollar amount of errors for Hospital Inpatient PPS was divided by the total dollar errors ($10,343.86 divided by $93,862.90).

TYPE OF CLAIM	TOTAL DOLLARS REVIEWED	DOLLAR ERRORS IDENTIFIED	PERCENT OF ERRORS
Hospital Inpatient - PPS	$ 187,708.22	$ 10,343.86	11.02%
Hospital Inpatient - Non-PPS	$ 284.00	$ 0.00	0.00%
SNF Inpatient	$ 33,793.10	$ 22,476.95	23.95%
End Stage Renal Disease	$ 50,298.36	$ 7,020.33	7.48%
Other Part B of A	$ 13,061.75	$ 4,122.45	4.39%
SUBTOTAL	$ 285,145.43	$ 43,963.59	46.84%
Part B	$ 102,920.01	$ 49,899.31	53.16%
TOTAL	$ 388,065.44	$ 93,862.90	100.00%

AUDIT OF CMS' FINANCIAL STATEMENTS
AT TRAILBLAZER HEALTH ENTERPRISES
DALLAS, TEXAS
FOR FIRST QUARTER OF FISCAL YEAR 2002
(OCTOBER THROUGH DECEMBER 2001)
Errors in Substantive Testing

LIST BY TYPE OF CLAIM WITH DOLLAR AMOUNTS (Reviewed and Errors)

Listing of the number of claims with errors by type of claim. The percent of errors was calculated by type of claim; for example, the number of claims with errors for Hospital Inpatient PPS was divided by the total number of claims with errors (14 divided by 375).

TYPE OF CLAIM	TOTAL CLAIMS REVIEWED	CLAIM ERRORS IDENTIFIED	PERCENT OF ERRORS
Hospital Inpatient - PPS	18	14	3.73%
Hospital Inpatient - Non-PPS	1	0	0.00%
SNF Inpatient	11	6	1.60%
End Stage Renal Disease	37	16	4.27%
Other Part B of A	40	17	4.53%
SUBTOTAL	107	53	14.13%
Part B	813	322	85.87%
TOTAL	920	375	100.00%

AUDIT OF CMS' FINANCIAL STATEMENTS
AT TRAILBLAZER HEALTH ENTERPRISES
DALLAS, TEXAS
FOR FIRST QUARTER OF FISCAL YEAR 2002
(OCTOBER THROUGH DECEMBER 2001)
Errors in Substantive Testing

LIST BY TYPE OF CLAIM WITH DOLLAR AMOUNTS (Reviewed and Errors)

Listing of the number of lines with errors by type of claim. The percent of errors was calculated by type of claim; for example, the number of lines with errors for Hospital Inpatient PPS was divided by the total number of lines with errors (14 divided by 956).

TYPE OF CLAIM	TOTAL LINES REVIEWED	LINE ERRORS IDENTIFIED	PERCENT OF ERRORS
Hospital Inpatient - PPS	18	14	1.47%
Hospital Inpatient - Non-PPS	5	0	0.00%
SNF Inpatient	86	26	2.72%
End Stage Renal Disease	170	31	3.24%
Other Part B of A	307	96	10.04%
SUBTOTAL	586	167	17.47%
Part B	1740	789	82.53%
TOTAL	2326	956	100.00%

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June 13, 2003

Mr. Sam Patterson
Audit Manager
DHHS/OIG/Office of Audit Services
3625 NW 56th Street, Suite 101
Oklahoma City, OK 73112

Subject: Response to May 8, 2003 Draft Report "Results of Audit Work Performed At TrailBlazer Health Enterprises, LLC As Part of the Office of Inspector General's Nationwide Determination of the Fiscal Year 2002 Medicare Error Rate" (CIN# A-06-03-00021)

Dear Mr. Patterson:

Thank you for the recommendations resulting from your review and the opportunity to provide comments on this draft report. TrailBlazer Health Enterprises, LLC ("TrailBlazer") places a high priority on financial management and minimizing Medicare payment errors and is committed to continually improving our processes.

We generally agree with the findings contained in the draft report and have taken steps to address the recommendations. Attached is a listing of specific comments to the draft report, arranged by each report section. Again, we appreciate this opportunity to comment. Please let me know if you have any questions or need additional information.

Sincerely,

James A. Kernen, CPA
Chief Financial Officer

Cc: Marti Mahaffey
Kevin Bidwell

ATTACHMENT – TrailBlazer Comments on OIG Draft Report (CIN# A-06-03-0021)

RECOMMENDATIONS

Perform a monthly reconciliation of the funds expended as reported on the CMS 1522 to the Medicare paid claims history file.

TrailBlazer Comments – On a monthly basis, TrailBlazer reconciles funds expended per the Part B CMS 1522 report to MCS system generated financial reports. Various timing differences and inconsistencies between the MCS financial reports and the MCS paid claims tapes exist that currently do not provide MCS users the ability to perform this reconciliation. TrailBlazer expended significant effort over several years in an attempt to achieve this reconciliation, and has come very close to achieving the goal. The remaining issues with this reconciliation now rest with the MCS System Maintainer (EDS) and CMS.

Recognizing current system limitations, on June 12, 2003, CMS circulated draft Change Request (CR) 2795 titled *Procedures for the Reconciliation of Total Funds Expended for Multi-Carrier System (MCS) Medicare Contractors Used in the Preparation of Form CMS-1522, Monthly Contractor Financial Report* to provide a standard format for performing the monthly reconciliation. Importantly, draft CR 2795 requires the MCS Systems Maintainer to generate electronic files that include all detail claim records supporting amounts included on system generated financial reports. For contractors using the MCS system, effective implementation of this requirement directly affects their ability to perform this reconciliation.

Without assistance from CMS and the System Maintainer, our ability to perform the required reconciliation is limited since we do not have the program source code for the MCS Part B system nor do we fully understand the technical design aspects behind its applications. As a result, attempting to reconcile the paid claims portion of net funds expended per the CMS 1522 to system provided paid claims financial reports represents the only option available to contractors using the Part B MCS claims processing system.

Maintain an accurate outstanding check listing by removing the cleared checks from the outstanding checklist.

TrailBlazer Comments - This problem stemmed from a system issue with the shared system maintainer. However, the ending balances reported on the CMS 1522 were not misstated due to adjustments made prior to their submission. Due to the date of these items, they are no longer listed on the outstanding listing and have been purged from the system. However, a process will be developed to identify these for correct cleared status, and an ongoing process will be put into place to ensure that all cleared transactions are removed from the outstanding check listing and updated in the system accurately. The target date for completion is September 30, 2003.

Correct the classification and reporting of debit and credit memos received from the bank

TrailBlazer Comments - This issue related to old bank accounts that were in the process of being phased out due to a bank merger, and again resulted in no net dollar impact or misstatement of funds expended or cash balances reported on the 1522. Upon notification from the OIG in February 2002, a new procedure was put in place for future reports. These accounts were subsequently closed in June of that same year.

Take the steps needed to ensure that adjustments are made to those claims in our sample that contained errors and that the net adjustment amount of $93,862.90 is refunded to Medicare.

TrailBlazer Comments- We agree with the OIG's recommendation and are in the process of adjusting and recouping the amounts due to Medicare. While the adjustment and recovery of Part A related payment errors is largely complete, we expect to begin the Part B related adjustment and recovery efforts in August 2003.

With respect to the claims payment errors identified through the OIG's claims testing, we agree with the vulnerabilities identified in the accurate payment of certain types of claims. In fact, the vulnerabilities identified in the CFO Audit validate our internal data analysis and medical review results. However, it is important to note that the OIG's sampling approach is designed to achieve a statistically valid and representative sample across all contractors rather than each contractor. Accordingly, we do not believe the FY 2002 sample of claims reviewed at TrailBlazer are representative of our overall paid claims distribution nor an accurate assessment of our overall ability to pay claims accurately.

For example, the percentages of claims and dollars paid for ambulance services in the Part B sample exceeded 19% of the total sample while claims for these services represent less than 2% of our overall claims universe. Similarly, the percentages of claims and dollars paid for SNF services in the Part A sample exceeded 33% of the total sample while claims for these services again account for less than 2% of our overall claims universe. These appear to be significant differences which, due to the relatively higher claim payment vulnerabilities associated with these types of services, should be considered in evaluating the FY 2002 audit results.

Further, in our FY 2003 Part A Medical Review (MR) Strategy, we identified the evaluation of payments to dialysis facilities as one of our major MR targets for the year. During the course of the OIG's review, we performed a medical review audit on 100 random ESRD claims. Based on medical review of these claims, TrailBlazer found a 16% payment error rate. The denials resulting from these findings include:

- Claims with no documentation;
- Acute services with no physician's order for the service; and
- Dialysis flow sheets without patient identification.

All of these findings represented various inadequacies of documentation. The findings of the OIG's review confirmed these observations.

OTHER MATTERS

Bullet 2 - Regarding need for policy for accepting old standing orders.

TrailBlazer Comment - In response to the OIG's review and the medical review audit discussed above, TrailBlazer will promulgate "documentation guidelines" for dialysis facilities. These documentation guidelines will specify the expected documentation to support the medical necessity for a dialysis service. For instance, we would expect to see the most recent revisions to the "Patient's Long-Term Program" and the "Patient's Plan of Care" (which includes the dialysis prescription). These guidelines will also include our general advice regarding medical documentation:

- Every document in the patient's medical record should include the patient's identification;
- Documentation supporting the medical necessity of services should be legible, maintained in the patient's medical record and must be made available to Medicare upon request; and
- A physician's order must be in the medical record for medical services provided.

We are genuinely concerned about the apparent infrequency of review and revisions to the dialysis prescription orders but must be sensitive to provider concerns regarding imposition of onerous documentation requirements. Consequently, before issuing these guidelines, we intend to share the draft with physicians, dialysis facilities, and others with knowledge of dialysis facility procedures for their advice.

Bullet 3 – Regarding the need for additional ambulance services data analysis and related training.

TrailBlazer Comment - The appropriate payment of ambulance services has been an area of focus for TrailBlazer since FY 1999. We agree with the OIG's assessment that the problem is related to non-emergency ambulance transfers. Our analysis has identified that outliers for non-emergency ambulance transfers relate primarily to dialysis patients. We have completed an in-depth analysis of ambulance services and are in the process of implementing the following interventions:

- Referral of potential fraud to the PSC;
- Development of an LMRP;
- Establishment of a beneficiary specific edit, and;
- Development of an educational program for ambulance providers based on the new LMRP.

Active outreach is also part of our provider strategy. In addition to articles published in our newsletters and on our website, we have conducted the following outreach for our Texas providers:

- Ambulance Fee Schedule Training was held in 2000 in six major Texas cities.
- Ambulance Fee Schedule Training was held in 2002 in eight major Texas cities.
- Staff attended the National American Ambulance Association Meeting in 2002 and 2003 and provided input during the CMS presentation.

Staff participated in the Texas Ambulance Association (TAA) quarterly meetings in 2002 and 2003. These meetings are open to TAA members and non-members. CMS is invited and has attended the last two meetings.