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-06-03-00020

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 June 30, 2002. 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 Recommendation 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.

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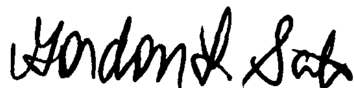
To facilitate identification, please refer to CIN: A-06-03-00020 in all correspondence relating to this report.

Sincerely yours,



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-06-03-00020

Office of Inspector General

http://oig.hhs.gov/

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DEPARTMENT OF HEALTH & HUMAN SERVICES

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Common Identification Number: A-06-03-00020

July 21, 2003

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. 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 third quarter of FY 2002 (April 1, 2002 through June 30, 2002).

Our audit work at TrailBlazer was limited to: (1) identifying all of the Medicare claims paid during the FY 2002 third 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 Quality Improvement Organization, a statistical sample of Medicare beneficiary expenditures paid during the third 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 and any large outstanding checks over one year old from the outstanding check list in preparing the CMS 1522; and
- Recording debit and credit memos properly on the CMS 1522.

In addition, the medical review and OIG review of the 920 claims selected in our statistical sample identified 256 claims that did not comply with Medicare requirements, resulting in net

questioned costs totaling $35,473.70 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.

One of the areas identified in the OIG review involved claims for calendar year (CY) 2002 for which the deductible was inappropriately applied. According to a TrailBlazer official, this problem involved claims processed during the first 3 days of April 2002. TrailBlazer is currently in the process of identifying the claims that were affected.

Prior to the completion of our audit work, TrailBlazer had taken the necessary steps to remove the large outstanding check from the outstanding check register. 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;
- Remove the cleared checks and any large outstanding check that is over one year old from the outstanding check list;
- Correct the classification and reporting of debit and credit memos on the CMS 1522;
- 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 $35,473.70 is refunded to Medicare; and
- Identify and correct all of the claims for CY 2002 that were processed in the Common Working File (CWF) where the deductible was inappropriately applied.

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 $35,473.70 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

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. 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 third quarter of FY 2002 (April 1, 2002 through June 30, 2002).

Our audit work at TrailBlazer was limited to: (1) identifying all of the Medicare claims paid during the FY 2002 third 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 third quarter for compliance with Medicare requirements. 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 third 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 Quality Improvement Organization (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 third 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 Palmetto Government Benefits Administrators in Columbia, South Carolina, as well as, the OIG field offices in Ft. Worth, Texas; Little Rock, Arkansas; Oklahoma City, Oklahoma; and Baton Rouge, Louisiana during the period of April 2002 through November 2002.

FINDINGS AND RECOMMENDATIONS

Our audit work disclosed several areas where TrailBlazer was not in compliance with Medicare requirements that could have an impact on the CMS financial statements. 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 256 claims that did not comply with Medicare requirements, resulting in net questioned costs totaling $35,473.70 that needs to be refunded to Medicare. We are recommending that TrailBlazer 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 Trailblazers during each month. The 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 April through June 2002 for all three systems. Our attempt to reconcile the paid claims data between the CMS 1522 and the paid claims tape disclosed that the computerized Part B claims data 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 tapes and the CMS 1522 for each month in our quarter were:

- $25,306.97 for April
- $114,345.11 for May
- $35,262.16 for June

In January 2002, TrailBlazer implemented a new adjustment process for the MCS system. This new process is referred to as Full Claim Adjustments (FCA). We believe that a majority of the differences between the paid claims tape and the CMS 1522 is attributed to the FCA process. The FCA method for correcting a claim paid in error is to reverse the original claim payment and re-send a corrected claim payment. This payment is determined by taking the amount of the adjusted claim and subtracting the original payment. A FCA results in the review, re-processing, and possible re-pricing of only the service(s) in question. However, the adjusted claim will be reported on the remittance notices, as a corrected claim (including all original services adjusted or not adjusted) with a new Internal Control Number. For example, if the original claim contains five services, and an adjustment is made to only two of those services, the original claim will be shown with negative amount and the fully adjusted corrected claim will show all five original services. Additional payment will only be made on the adjusted services.

This new FCA process also caused problems in reconciling the paid claim tape to the system reports. The tapes provided had both original paid amount and adjusted paid amounts. The tapes contain three fields, Provider Check amount, Beneficiary Check amount and the Claim Total Paid amount. The Provider Check amount added to the Beneficiary Check amount should equal the Claim Total Paid amount. When the tapes were run after the FCA was implemented, the Claim Total Paid amount was the difference between the original and the adjusted claim. If the amount in the Claim Total Paid amount was negative, then the tape showed a $0 in this field. By converting all negative amounts to zero, the Claim Total Paid amount on the tapes is less than what is on the system reports.

We attempted to reconcile the tapes to the CMS 1522 by determining the FCA's and changing the $0 to the correct amount. We determined that this was not the only issue related to the FCA. Due to time constraints, we decided to accept the tapes, even though they did not reconcile to the CMS 1522.

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. We are recommending that TrailBlazer 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 SYSTEM REPORTS

The Contractor Draws on Letter of Credit (CMS 1521) and Monthly Contractor Financial Report (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 April through June 2002. TrailBlazer also provided computerized Part A and Part B paid claims data for the same period. Our analysis of CMS 1521, CMS 1522 and the related supporting data disclosed that TrailBlazer did not:

- Remove cleared checks and a large outstanding check within one year of issuance from the outstanding checklist; and
- Record debit and credit memos properly on the CMS 1522.

Outstanding Check

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. We selected a sample of outstanding checks to determine if the outstanding check list was accurate and to determine if any large outstanding checks were voided after one year.

Our review of the sample outstanding checks did not disclose any problems. However, in the CFO audit for the first quarter of FY 2002, we determined that TrailBlazer's system had duplicate checks listed as outstanding while the bank's records showed these checks as cleared. These same checks were still showing as outstanding on the system during this audit. According to TrailBlazer officials, there was a system error in August 2001 where the issue file did not match the 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.

We reviewed the June 2002 check register to identify any outstanding checks over $100,000 and over 1 year old. One check was identified that met this criteria. This check, dated May 3, 2001, was improperly written on a closed account. A manual check with the same number was issued on the proper account and cleared the bank on May 7, 2001. However, because both checks had the same number, the bank considered the check written on the closed account to be outstanding.

TrailBlazer voided this check sometime in August 2002. Since this check was not voided until after our audit period, the check represented a reconciling item at the time of our review. We are recommending that TrailBlazer maintain an accurate outstanding check list by removing cleared checks and any large outstanding checks over 1 year old from the list in preparing the CMS 1522.

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 third quarter. The 920 transactions included 94 Part A claim transactions comprised of 27 inpatient transactions and 67 outpatient transactions. The remaining 826 transactions were Part B. The total amount paid for all of the sampled claims was $490,158.36, and was comprised of $313,388.29 of Part A inpatient claims, $57,602.40 of Part B of A outpatient claims, and $119,167.67 of Part B outpatient claims. The sample claims were selected from a universe of approximately $3.6 billion in paid claims.

The medical review and OIG review of the 920 claims selected in our statistical sample identified 256 claims that did not comply with Medicare requirements, resulting in net questioned costs totaling $35,473.70 that needs to be refunded to Medicare. We are recommending that TrailBlazer make the appropriate adjustments resulting from both the medical review and OIG 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. QIO involved in the review was the Texas Medical Foundation. 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. The review of providers' medical records by 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

QIO reviewed 23 inpatient claims consisting of 21 PPS and 2 Non-PPS claims, and identified seven inpatient claims with errors. The effect of these seven errors resulted in a net overpayment to the providers of $17,522.16. The circumstances surrounding these claims were as follows:

- Two claims were denied due to invalid inpatient admission. For the first claim, the medical reviewer concluded that the patient could have been admitted to day surgery (outpatient). This resulted in the entire claim of $8,165.25 being denied. For the second claim, the medical reviewer determined that the patient could have received treatment in another medical setting without having been admitted as an inpatient. As a result, the entire claim of $13,749.96 was denied.

- For two claims, the medical reviewer determined that the assigned DRG was incorrect. For the first claim, the medical reviewer determined that the principal diagnosis was incorrect. The medical reviewer determined that the records supported a different diagnosis and as a result $624.22 was denied. For the second claim, the medical reviewer determined that the medical records supported a different procedure than what was billed. The change in the procedure code resulted in a DRG change. As a result, the provider should be paid an additional $5,017.27.

- Two claims had an incorrect discharge status. Once the discharge status code was changed, there was no dollar effect.

- One claim had an incorrect secondary diagnosis. Once the secondary diagnosis was changed there was no dollar effect for this claim.

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

TrailBlazer Medical Review

The TrailBlazer medical review staff reviewed 897 claims. These claims were comprised of claim services for SNFs, Part B of A outpatient services, ESRD services, and all Part B services. From this review, 1 SNF inpatient claim, 2 Part B of A claims, and 246 Part B claims were found to contain 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 $17,849.05 for 237 claims was questioned. The medical reviewers allowed some claims that were previously disallowed. The questioned cost of $17,849.05 is the net of these claims and the claims disallowed by the medical reviewers during the audit.

The questioned costs consisted of $2,076.80 for 1 SNF inpatient claims, $144.26 for 2 Part B of A outpatient claims, and $15,627.99 for 234 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 requirements. 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, our testing disclosed two concerns in the pricing area:

- There were 14 claims included in our sample that contained drug code pricing errors. This resulted in a total overpayment of $22.49. The errors resulted from TrailBlazer not using the Red Book as the source for pricing these 14 claims. Until April 2001, TrailBlazer contracted with a company that provided TrailBlazer with a customized quarterly report that included drug code pricing information. According to TrailBlazer, this company used the Blue Book as a source for the drug code prices. Because of discrepancies in the information provided by the company, TrailBlazer terminated the contract and in April 2001 began pricing the drugs in-house using the Red Book. However, the documentation provided to us by TrailBlazer to support the 14 claims in our sample was a spreadsheet of drug prices dated June 1, 2000, that was provided by the company whose contract had been terminated. The prices on the spreadsheet did not match the Red Book prices. Although at the time of our review TrailBlazer could use discretion in determining the source for pricing drug claims, we believe that TrailBlazer should have used the Red Book prices that it had established in April 2001. According to TrailBlazer officials, CMS now requires that a single drug pricer be used by Medicare contractors to price drug claims. As a result, we do not have any procedural recommendations regarding drug code pricing.

- We identified one Part B claim where the deductible was applied inappropriately. CWF shows that there was no deductible for this claim. MCS system shows that the deductible was applied to the claim. Further research showed that the deductible was actually applied to a B of A claim for this beneficiary. Therefore, the deductible was inappropriately applied to the Part B claim in the MCS system resulting in an underpayment of $80. A TrailBlazer official stated that there was a problem with the

deductible application for the first 3 days in the month of April 2002. This claim was put in the CWF system on April 2, 2002. TrailBlazer is now in the process of identifying the claims that were affected.

The claims errors identified by the OIG are included in the $35,473.70 of dollar errors shown in Appendix I.

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;
- Remove the cleared checks and any large outstanding check that is over one year old from the outstanding check list;
- Correct the classification and reporting of debit and credit memos on the CMS 1522;
- 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 $35,473.70 is refunded to Medicare; and
- Identify and correct all of the claims for CY 2002 that were processed in the CWF where the deductible was inappropriately applied.

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.

- All claims having deductibles applied during April and May 2002 were identified and checked for accuracy. Any that were processed incorrectly have been submitted to the overpayment unit for appropriate recovery.

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.

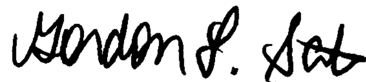
Since TrailBlazer officials included comments that addressed our sampling approach, we are providing additional comments regarding the sampling plan used in selecting the Medicare claims included in our sample review. Our sampling approach is designed to achieve a statistically valid sample across all 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.

TrailBlazer officials identified a technical correction that needed to be made to the report. We agreed and made the correction.

Sincerely,



Gordon L. Sato
Regional Inspector General
for Audit Services

AUDIT OF CMS' FINANCIAL STATEMENTS
AT TRAILBLAZER HEALTH ENTERPRISES
DALLAS, TEXAS
FOR THIRD QUARTER OF FISCAL YEAR 2002
(APRIL THROUGH JUNE 2002)
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 ($17,522.16 divided by $35,473.70).

TYPE OF CLAIM	TOTAL DOLLARS REVIEWED	DOLLAR ERRORS IDENTIFIED	PERCENT OF ERRORS
Hospital Inpatient - PPS	$ 292,365.51	$ 17,522.16	49.40%
Hospital Inpatient - Non-PPS	$ 11,845.32	$ 0.00	0.00%
SNF Inpatient	$ 9,177.46	$ 2,076.80	5 .85%
End Stage Renal Disease	$ 29,259.26	$ 0.00	0 %
Other Part B of A	$ 28,343.14	$ 144.26	.41 %
SUBTOTAL	$ 370,990.69	$ 19,743.22	55.65%
Part B	$ 119,167.67	$ 15,730.48	44.34%
TOTAL	$ 490,158.36	$ 35,473.70	100.00%

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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 (7 divided by 256).

TYPE OF CLAIM	TOTAL CLAIMS REVIEWED	CLAIM ERRORS IDENTIFIED	PERCENT OF ERRORS
Hospital Inpatient - PPS	21	7	2.74%
Hospital Inpatient - Non-PPS	2	0	0.00%
SNF Inpatient	4	1	.39%
End Stage Renal Disease	30	0	0%
Other Part B of A	37	2	.78%
SUBTOTAL	94	10	3.91%
Part B	826	246	96.09%
TOTAL	920	256	100.00%

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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 (7 divided by 412).

TYPE OF CLAIM	TOTAL LINES REVIEWED	LINE ERRORS IDENTIFIED	PERCENT OF ERRORS
Hospital Inpatient - PPS	21	7	1.70%
Hospital Inpatient - Non-PPS	14	0	0.00%
SNF Inpatient	38	6	1.46%
End Stage Renal Disease	218	0	0.00%
Other Part B of A	167	2	.48%
SUBTOTAL	458	15	3.64%
Part B	1734	397	96.36%
TOTAL	2192	412	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-06-03-00020)

Dear Mr. Patterson:

Thank you for the recommendations resulting from your review and the opportunity to provide comments on the 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-06-03-0020)

REVIEW OF EXPENDITURES – QIO Review

Regarding the first claim described in the second bullet, we suggest that the phrase "the medical reviewer changed the diagnosis…" be deleted or modified to state that "the medical reviewer determined that the records supported a different diagnosis …" since only the provider can actually render a medical diagnosis.

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.

Remove the cleared checks and any large outstanding check that is over six months old from the outstanding checklist.

TrailBlazer Comments- Based upon CMS instructions in CR 1364, the staledate criterion is set at one year. The check in question was issued on 5/3/01 and remained on the outstanding listing in error until August 2002. However, the amount reported on the 1522 was accurate due to our process of calculating and reflecting appropriate adjustments to the system

generated outstanding listing. This check was a manual payment requested by CMS that was keyed to an old bank account that was in process of being phased out due to a bank merger. This account was subsequently closed. Due to the monthly review procedure in place for the new accounts, this should not be an issue in the future.

Correct the classification and reporting of debit and credit memos on the CMS 1522.

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 $35,473.70 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 consider the FY 2002 sample of claims reviewed at TrailBlazer and related results 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 15% of the total sample while claims for these services represent approximately 2% of our overall claims universe. Similarly, the percentages of claims and dollars paid for SNF services in the Part A sample exceeded 12% of the total sample while claims for these services again account for approximately 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.

Identify and correct all of the claims for CY 2002 that were processed in the CWF where the deductible was inappropriately applied.

We identified and checked the accuracy of all claims having deductibles applied during April and May 2002. Those that processed incorrectly have been submitted to our overpayments unit for appropriate recovery as necessary.