DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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

April 8, 2008

Report Number: A-06-07-00055

Mr. Ernest Lopez
Chief Financial Officer
TrailBlazer Health Enterprises
8330 LBJ Freeway
Dallas, Texas 75243

Dear Mr. Lopez:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Excessive Payments for Inpatient Services Processed by TrailBlazer Health Enterprises for the Period January 1, 2003, through December 31, 2003." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

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

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, within 10 business days after the final report is issued, it will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me at (214) 767-8414, or contact Trish Wheeler, Audit Manager, at (214) 767-6325 or through e-mail at Trish.Wheeler@oig.hhs.gov. Please refer to report number A-06-07-00055 in all correspondence.

Sincerely,

Gordon L. Sato

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Nan Foster Reilly
Acting Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF EXCESSIVE PAYMENTS FOR INPATIENT SERVICES PROCESSED BY TRAILBLAZER HEALTH ENTERPRISES FOR THE PERIOD JANUARY 1, 2003, THROUGH DECEMBER 31, 2003

Daniel R. Levinson
Inspector General

April 2008
A-06-07-00055

Office of Inspector General

http://oig.hhs.gov

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Pursuant to 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 generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) contracts with fiscal intermediaries to administer the Medicare Part A program. The intermediaries' responsibilities include determining costs and reimbursement amounts, maintaining records, establishing controls, safeguarding against fraud and abuse, conducting reviews and audits, and paying providers for services rendered. Federal guidance requires intermediaries to maintain adequate internal controls to prevent increased program costs and erroneous or delayed payments.

Providers generate the claims for inpatient services provided to Medicare beneficiaries. Medicare guidance requires providers to bill accurately for the services and procedures provided. Inpatient hospital services are paid based on the Medicare prospective payment system (the PPS). Under the PPS, claims are paid a predetermined amount based on a patient's placement into a specific diagnosis-related group and an additional amount, known as an outlier, for stays that have extraordinarily high costs.

To process providers' inpatient claims, the intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File. These systems can detect certain improper payments when processing claims for prepayment validation.

TrailBlazer Health Enterprises (TrailBlazer) is a Medicare Part A intermediary serving Medicare providers in Texas, New Mexico, and Colorado. During calendar year (CY) 2003, TrailBlazer processed 679,432 inpatient claims, 147 of which resulted in payments of $200,000 or more (high-dollar payments).

OBJECTIVE

Our objective was to determine whether TrailBlazer's high-dollar Medicare payments to Part A providers for inpatient services were appropriate.

SUMMARY OF FINDINGS

Of the 147 high-dollar payments that TrailBlazer made to providers, 132 were appropriate. However, TrailBlazer overpaid providers for 11 claims. For 8 of the 11 claims, providers submitted revised claims that resulted in net overpayments totaling $50,044. For the remaining three claims, providers agreed that they had submitted incorrect claims and said that they would submit revised claims. We did not review four claims because payments made to the providers were not based on the Medicare PPS rates.

TrailBlazer made these incorrect payments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in CY 2003 to detect the errors in the provider claims.

RECOMMENDATIONS

We recommend that TrailBlazer:

- ensure that identified overpayments have been recovered,
- follow up with the providers about the three claims that have not been revised,
- use the results of this audit in its provider education activities, and
- consider identifying and recovering any additional overpayments made for high-dollar Part A inpatient claims paid after CY 2003.

TRAILBLAZER HEALTH ENTERPRISES COMMENTS

In its written comments on our draft report, TrailBlazer agreed with our findings. TrailBlazer's comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

Fiscal Intermediary Responsibilities

The Centers for Medicare & Medicaid Services (CMS) contracts with fiscal intermediaries to administer the Medicare Part A program. The intermediaries' responsibilities include determining costs and reimbursement amounts, maintaining records, establishing controls, safeguarding against fraud and abuse, conducting reviews and audits, and making payments to providers for services rendered. Federal guidance requires intermediaries to maintain adequate internal controls to prevent increased program costs and erroneous or delayed payments.

Claims for Inpatient Services

Providers generate the claims for inpatient services provided to Medicare beneficiaries. Medicare guidance requires providers to bill accurately for the services and procedures provided. Inpatient hospital services are paid based on the Medicare prospective payment system (the PPS). In accordance with the PPS, fiscal intermediaries reimburse hospitals a predetermined amount depending on the illness and its classification under a diagnosis-related group (DRG). Inpatient stays that have extraordinarily high costs are eligible for an additional amount called an outlier payment.

The Medicare fiscal intermediary identifies outlier cases by comparing the estimated costs of a case to a DRG-specific dollar amount. When costs exceed the DRG-specific dollar amount, an outlier payment is made. Because hospitals cannot calculate the costs of cases individually, the fiscal intermediary uses the Medicare charges the hospital reports on its claim to estimate the cost of a case. Inaccurately reporting charges could lead to excessive outlier payments.

To process providers' inpatient claims, the intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File. These systems can detect certain improper payments when processing claims for prepayment validation.

In calendar year (CY) 2003, providers submitted approximately 13.5 million inpatient claims nationwide. Of these 13.5 million claims, only 3,128 resulted in payments of $200,000 or more (high-dollar payments). We considered such claims to be at high risk for overpayment.

TrailBlazer

TrailBlazer Health Enterprises (TrailBlazer) is a Medicare Part A fiscal intermediary serving Medicare providers in Texas, New Mexico, and Colorado. In CY 2003, TrailBlazer processed 679,432 inpatient claims that had payments of approximately $4.9 billion. Of these claims, TrailBlazer processed 147 claims with payments of $200,000 or more.

The Social Security Act's definition of "provider of services" encompasses hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, renal dialysis facilities, and hospice programs. However, all of the providers with high-dollar claims

that were processed by TrailBlazer were hospitals; thus, the term "provider," as used in the remainder of this report, refers to hospitals.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether TrailBlazer's high-dollar Medicare payments to Part A providers for inpatient services were appropriate.

Scope

Of the 147 high-dollar payments, totaling $40.8 million, that TrailBlazer processed during CY 2003, we reviewed 143. We did not review four claims because payments to the providers were not based on Medicare PPS rates.

We limited our review of TrailBlazer's internal controls to those applicable to the 143 claims because our objective did not require an understanding of all internal controls over the submission and processing of claims. Because we were reasonably sure of the authenticity and accuracy of the data obtained from the National Claims History file, we did not assess the completeness of the file.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;
- used CMS's National Claims History file to identify Medicare Part A inpatient claims with high-dollar payments;
- reviewed available Common Working File claims histories for claims with high-dollar payments to determine whether the claims had been canceled and superseded by revised claims or whether the payments remained outstanding at the time of our fieldwork;
- contacted providers to determine whether high-dollar claims were billed correctly and, if not, why the claims were billed incorrectly;
- reviewed itemized bills to determine whether the charges were appropriate; and
- coordinated our claim review with TrailBlazer.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions

based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

Of the 147 high-dollar payments that TrailBlazer made to providers, 132 were appropriate. However, TrailBlazer overpaid providers for 11 claims. For 8 of the 11 claims, providers submitted revised claims that resulted in net overpayments totaling $50,044. For the remaining three claims, providers agreed that they had submitted incorrect claims and said that they would submit revised claims. We did not review four claims because payments made to the providers were not based on the Medicare PPS rates.

TrailBlazer made these incorrect payments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in CY 2003 to detect the errors in the provider claims.

FEDERAL REQUIREMENTS

The Social Security Amendments of 1983 (Public Law 98-21) provided for the establishment of a PPS for Medicare payment of inpatient hospital services. Under Medicare's PPS for inpatient acute care hospitals, CMS reimburses hospitals a predetermined amount, known as a DRG payment, for inpatient services furnished to beneficiaries. Medicare pays a fixed DRG amount per discharge for each type of inpatient case.

Section 1886(d)(5)(A)of the Social Security Act requires that Medicare pay hospitals an outlier payment in addition to the basic DRG amount to protect hospitals from incurring large financial losses due to unusually expensive cases. Furthermore, the "Hospital Manual," section 462, states: "To be paid correctly and promptly, a bill must be completed accurately."

Section 3700 of the "Medicare Intermediary Manual" states: "It is essential that you [the fiscal intermediary] maintain adequate internal controls over Title XVIII [Medicare] automatic data processing systems to preclude increased program costs and erroneous and/or delayed payments."

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

Eleven claims (three of these have not been revised) for $200,000 or more, totaling $50,044 in net overpayments, resulted in the following inappropriate payments:

- On two claims totaling $10,713 in overpayments, one provider charged an incorrect code for services provided. The provider billed first-day ventilator charges rather than subsequent-day ventilator charges, which resulted in daily overcharges.

- On two claims totaling $63,431 in overpayments, two providers overstated their charges by incorrectly accounting for the number of units provided. One provider overstated pharmacy charges because the number of milliliters ordered was inadvertently entered as

the number of billable units. The other provider overstated pharmacy, lab work, radiology, and supplies/implant units supplied.

- On three claims totaling $4,760 in overpayments, three providers identified billing errors but did not provide an explanation.

- On one claim totaling $28,860 in underpayments, one provider identified billing errors that were caused by human error but did not elaborate.

- On three claims, three providers identified billing errors but did not provide an explanation.

Eight of the 11 inpatient claims for CY 2003 contained net overpayments totaling $50,044. The providers agreed that they had submitted incorrect claims and plan to submit refunds or have already done so. Providers have not submitted revisions for the remaining three claims.

CAUSES OF INCORRECT PAYMENTS

The providers attributed the incorrect claims to clerical errors or to billing systems that could not detect and prevent billing for incorrect units of service. The incorrect charges affected outlier payments. In addition, during CY 2003, TrailBlazer did not have prepayment or postpayment controls to identify inappropriate claims or payments, and the Common Working File prepayment editing process lacked edits to detect inappropriate claims and prevent inappropriate high-dollar payments to providers. In effect, Medicare relied on providers to notify the intermediaries of excessive payments.

RECOMMENDATIONS

We recommend that TrailBlazer:

- ensure that identified overpayments have been recovered,

- follow up with the providers about the three claims that have not been revised,

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

- consider identifying and recovering any additional overpayments made for high-dollar Part A inpatient claims paid after CY 2003.

TRAILBLAZER HEALTH ENTERPRISES COMMENTS

In its written comments on our draft report, TrailBlazer agreed with our findings. TrailBlazer stated that the providers have corrected and resubmitted 10 of the 11 claims. One provider has not submitted a revised claim. Additionally, TrailBlazer offers training to Medicare providers to help them submit accurate care claims for proper reimbursement and maintains a Web site

dedicated to inpatient acute care services. TrailBlazer's comments are included in their entirety as the Appendix.

APPENDIX

TrailBlazer Health Enterprises, LLC
Response to OIG Audit Report A-06-07-00055

INAPPROPORIATE HIGH-DOLLAR PAYMENTS

Eleven claims (three of these have not been revised) for $200,000 or more, totaling $50,044 in net overpayments, resulted in the following inappropriate payments:

- On two claims totaling $10,713 in overpayments, one provider charged an incorrect code for services provided. The provider billed first-day ventilator charges rather than subsequent-day ventilator charges, which resulted in daily overcharges.

  TrailBlazer response: TrailBlazer agrees that the identified amount has been collected. The corrected claim was initiated by the provider.

- On two claims totaling $63,431 in overpayments, two providers overstated their charges by incorrectly accounting for the number of units provided. One provider overstated pharmacy charges because the number of milliliters ordered was inadvertently entered as the number of billable units. The other provider overstated pharmacy, lab work, radiology, and supplies/implant units supplied.

  TrailBlazer response: TrailBlazer agrees that the identified amount has been collected. The corrected claim was initiated by the provider.

- On three claims totaling $4,760 in overpayments, three providers identified billing errors but did not provide an explanation.

  TrailBlazer response: TrailBlazer agrees that the identified amount has been collected. The corrected claim was initiated by the provider.

- On one claim totaling $28,860 in underpayments, one provider identified billing errors that were caused by human error but did not elaborate.

  TrailBlazer response: TrailBlazer agrees that the identified amount has been collected. The corrected claim was initiated by the provider.

- On three claims, three providers identified billing errors, but did not provide an explanation.

  TrailBlazer response: The three remaining claims have the following status.

Claim #1[1]
The provider has initiated an adjustment and an overpayment of $11,993.00 has been collected.

Claim #2[1]
The provider had billed 2 claims.
Dates of service 08-20-03 to 11-1-03 – payment of $251,510.54 (noted by OIG).
Dates of service 11-2-03 to 11-26-03 – payment of $5,479.30 (not noted by OIG).
Upon receipt of the inquiry from OIG, the provider canceled both claims and TrailBlazer collected the amount of $256,989.84. The provider then billed a single claim for dates of service 08-20-03 to 11-26-03 for a payment of $327,057.06. Thus the provider was paid an additional $70,067.22

Claims #3[1]
The provider has not initiated an adjustment. The provider was paid $278,271.47.

Eight of the 11 inpatient claims for CY 2003 contained net overpayments totaling $50,044. The providers agreed that they had submitted incorrect claims and plan to submit refunds or have already done so. Providers have not submitted revisions for the remaining three claims.

TrailBlazer response: The OIG provided the HIC and DCN for the above three pending remaining claims. For claims one and two, TrailBlazer agrees that the identified amount has been collected. In those two cases, the corrected claims were initiated by the respective providers. The status for the three pending claims is outlined above.

CAUSES OF INCORRECT PAYMENTS

The providers attributed the incorrect claims to clerical errors or to billing systems that could not detect and prevent billing for incorrect units of service. The incorrect charges affected outlier payments. In addition, during CY 2003, TrailBlazer did not have prepayment or postpayment controls to identify inappropriate claims or payments, and the Common Working File prepayment editing process lacked edits to detect inappropriate claims and prevent inappropriate high-dollar payments to providers. In effect, Medicare relied on providers to notify the intermediaries of excessive payments.

RECOMMENATIONS

We recommend that TrailBlazer:

- ensure that identified overpayments have been recovered.
- follow up with the providers about the three claims that have not been revised.

[1] Personally identifiable information has been removed.

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

- consider identifying and recovering any additional overpayments made for high-dollar Part A inpatient claims paid after CY 2003**.**

TrailBlazer response: TrailBlazer has ensured that the corrections of amounts for ten of the 11 claims identified as overpayments/underpayments have been finalized. In all instances, the claim adjustments were initiated by the provider, at the request of the OIG. One claim is still pending a provider initiated adjustment that the OIG has previously identified.

In addition, TrailBlazer is dedicated to providing the necessary training and information needed to aid providers in submitting accurate claims and ultimately receiving proper reimbursement. It is imperative that new providers coming into the program are given the tools they need to bill correctly, thus reducing potential inquiries and ensuring the error rate is not adversely affected, therefore, TrailBlazer offers focused new provider training to all new Medicare providers.

TrailBlazer maintains a Web site that is dedicated to providing timely, relevant and accurate information. There are links to popular items such as the Calendar of Events, FAQs, LCDs and Self-Service Options tools, as well as links to the CMS Web pages and other important information to assist providers. The TrailBlazer Web site consists of a specialty specific Web page dedicated to inpatient acute services, providing an Internet-based Inpatient Manual and job aids for provider reference. In addition, TrailBlazer offers numerous training opportunities in the form of seminars, teleconferences, Web-based trainings and computer-based training modules.

TrailBlazer followed the then current instructions for processing inpatient claims in FY2003. Quality Improvement Organizations (QIO) are charged with the review of any discrepancies related to inpatient claims. In contrast with inpatient claims, edits do exist for the validation of excessive outpatient claim payments and beginning in 2007 CMS instructed FISS to create a process for returning claims to the provider that edit for HCPC/unit combinations classified as Medically Unlikely Edits (MUE).