DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of Inspector General

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

January 21, 2005

Report Number: A-06-04-00046

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 Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "*Review of Place of Service Coding for Physician Services – TrailBlazer Health Enterprises, LLC for the Period January 1, 2001 through December 31, 2002.*" A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

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), OIG 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.)

If you have any questions or comments about this report, please do not hesitate to contact me at 214-767-8414 or through e-mail at gordon.sato@oig.hhs.gov, or contact Cheryl Blackmon, Audit Manager, at 214-767-9205 or through e-mail at cheryl.blackmon@oig.hhs.gov.

To facilitate identification, please refer to report number A-06-04-00046 in all correspondence relating to this report.

Sincerely,

Gordon L. Sato

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosures-as stated

Direct Reply to HHS Action Official:

James R. Farris, MD
Regional Administrator
Centers for Medicare and Medicaid Services
1301 Young Street, Room 714
Dallas, Texas 75202-4348

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF PLACE OF SERVICE CODING FOR PHYSICIAN SERVICES – TRAILBLAZER HEALTH ENTERPRISES, LLC FOR THE PERIOD JANUARY 1, 2001 THROUGH DECEMBER 31, 2002

JANUARY 2005
A-06-04-00046

Notices

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OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Medicare Part B pays for services provided by physicians[1] to program beneficiaries. Although physicians routinely perform many of these services in a facility setting, such as an outpatient hospital department or a freestanding ambulatory surgical center, certain of the same services may also be performed in non-facility settings, including a physician's office. To account for the increased practice expense incurred by physicians in their offices, Medicare reimburses a higher amount for services performed in this setting. Physicians are required to identify the place of service on the health insurance claim form submitted to Medicare Part B carriers for payment. The correct place of service code ensures that Medicare is not duplicating payment to the physician and the facility for any part of the practice expense incurred to perform the service.

OBJECTIVE

The objective of the audit was to determine the extent of Medicare Part B overpayments made to physicians by TrailBlazer Health Enterprises, LLC (TrailBlazer) for billings with an incorrect place of service code.

FINDINGS

Medicare overpaid physicians due to incorrect place of service coding. Seventy-six of 100 sampled physician services, selected from a population of services identified as having a high potential for error, were performed in a facility but were billed by the physicians using the "office" or other non-facility place of service codes.[2] As a result of the incorrect coding, Medicare paid the physicians a higher amount for these services. Based on a statistical projection, we estimate that TrailBlazer overpaid physicians $1,051,477 for incorrectly coded services provided during the 2-year period ended December 31, 2002.

We attribute the overpayments primarily to control weaknesses at TrailBlazer, the physician office and the Indian Health Service headquarters levels. Specifically:

- TrailBlazer had not established sufficient controls, due in part to vulnerabilities inherent in Medicare's claims processing system, to detect Medicare Part B place of service billing errors and to prevent, identify, or recover the program overpayments that resulted from these errors. (For example, under the Medicare claims processing system, Medicare Part B carriers do not have access to billing information from outpatient hospitals, whose claims are processed by the Medicare Part A fiscal intermediaries.)

[1] Includes physician assistants and nurse practitioners.

[2] The other non-facility code names billed by the physicians included: (1) home; (2) intermediate care facility/mentally retarded; (3) residential substance abuse treatment facility; and (4) "other place of service".

- Many of the physicians had not implemented controls to prevent, or subsequently identify, billings with incorrect place of service codes.

- The Indian Health Service had not established sufficient controls at the headquarters level to prevent, or subsequently identify, billings with incorrect place of service codes.

RECOMMENDATIONS

We are recommending that TrailBlazer:

- Recover the $2,983 of overpayments for the sampled physician services that were performed in a facility setting but billed as if provided in the physician's office or other non-facility setting.

- Work with the physicians in the developed population of potential errors to reassess their billings and refund any overpayments estimated at $1,051,477.

- Educate physicians about the importance of correctly reporting the place of service and encourage physicians to implement internal control systems to prevent Medicare billings with incorrectly coded place of service.

- Instruct physicians to notify their billing representatives of the importance of using correct place of service codes.

- Coordinate with the Indian Health Service billing program representatives to make certain that (1) in the interim, appropriate action is taken to ensure that place of service coding is performed at the local level and (2) safeguards in the new nationwide billings system under development guarantees facilities enter the correct place of service codes.

- Educate TrailBlazer customer service personnel regarding their instructions to physicians' representatives related to correct place of service codes.

TRAILBLAZER'S COMMENTS

TrailBlazer officials generally agreed with many of our findings. However, they expressed a concern with our conclusion that TrailBlazer had not established sufficient controls to detect Medicare Part B place of service billing errors. They noted that many factors should be considered when evaluating controls designed to detect billing errors, including the cost effectiveness of viable measures and the availability of sufficient resources. For the remaining findings, TrailBlazer officials indicated corrective actions they have taken to address the findings.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We appreciate the actions TrailBlazer has initiated to address our recommendations.

However, TrailBlazer officials expressed concern regarding our conclusion that they had not established sufficient controls to detect Medicare Part B billing errors. We would like to offer the following comments.

We acknowledge that many factors should be considered when evaluating controls designed to detect billing errors, including the cost effectiveness of viable measures and the availability of sufficient resources. We also acknowledge the existence of an inherently vulnerable, complex Medicare program with limited resources to detect and prevent every potential payment error. However, while these may be mitigating circumstances, we believe they do not negate our conclusion that TrailBlazer had not established sufficient controls to detect Medicare Part B place of service billing errors.

Recognizing that TrailBlazer does not have the ability to directly affect the vulnerabilities, we believe that it should emphasize the significance of this control weakness to CMS. CMS could consider implementing some of TrailBlazer ideas in the annual budgeting process.

TrailBlazer's comments are included in their entirety as an appendix to this report.

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INTRODUCTION

BACKGROUND

Medicare Part B Procedures and Services

Medicare Part B pays for services provided by physicians[3] to program beneficiaries. These services include medical and surgical procedures and other services such as office visits and medical consultations. Although physicians routinely perform many of these services in a facility setting, including an outpatient hospital department or a freestanding ambulatory surgical center, certain of the same services may also be performed in non-facility settings, including a physician's office. To account for the increased practice expense incurred by physicians in their offices, Medicare reimburses a higher amount for services performed in this setting.

Medicare Payment Regulations

Physicians are paid for services based on the Medicare physician fee schedule. The Centers for Medicare & Medicaid Services (CMS) established relative value units (RVUs) for physician work, practice expense, and malpractice insurance. Each RVU has a corresponding geographic practice cost index based on the location where the service was performed. To calculate the physician payment, each of the RVUs is multiplied by the appropriate geographic practice cost index. The sum of these products is then multiplied by the nationally uniform conversion factor to determine the payment.

To compensate physicians for the practice expense differences for certain services, Medicare has established two different RVUs for services performed in a facility versus a non-facility setting. Physicians are required to identify the place of service on the health insurance claim form submitted to Medicare Part B carriers for payment. The correct place of service code ensures that Medicare is not duplicating payment to the physician and the facility for any part of the practice expense incurred to perform a Medicare service.

Carrier Responsibility

The Medicare Part B carriers, under contract with CMS, process and pay claims submitted by physicians, clinical laboratories, suppliers, and ambulatory surgical centers. TrailBlazer is the Medicare Part B carrier that processes and pays claims submitted by providers in Delaware, Maryland, Texas, Virginia, and the Metropolitan D.C. area. In addition, TrailBlazer is also the Part B carrier for the Indian Health Service.

[3] Includes physician assistants and nurse practitioners.

OBJECTIVE, SCOPE AND METHODOLOGY

Objective

The objective of the audit was to determine the extent of Medicare Part B overpayments made to physicians by TrailBlazer for billings with an incorrect place of service code.

Scope and Methodology

Our audit covered physician services provided during the period from January 1, 2001 through December 31, 2002. For this 2-year period, we analyzed a stratified random sample of 100 services selected from a population of 42,932 physician services paid by TrailBlazer that had been identified through a computer match as having a high potential for error. The services, although coded by the physicians or their representatives as being performed in non-facility settings, were matched with data that indicated the services may have been performed in a facility setting (outpatient hospital department or ambulatory surgical center).

To accomplish the objective of the audit, we:

- reviewed paid claims data to determine the place of service for which the sampled services were paid;

- discussed the billings with physicians, physician office personnel, and physician billing representatives, reviewed medical and billing records to determine whether the place of service was incorrectly coded, and identified the underlying causes contributing to incorrect coding;

- calculated the amounts of any Medicare overpayments; and

- discussed the results of the review with TrailBlazer officials and provided additional data needed to implement our recommendations.

Our review of internal controls was limited to discussions with TrailBlazer officials, physicians, physician employees and representatives. The discussions were intended to establish whether internal controls had been developed to prevent program overpayments resulting from place of service billing errors. The adequacy of any existing controls was not evaluated.

Fieldwork was completed during the period April 2004 through July 2004.

The audit was conducted in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

PAYMENTS BASED ON INCORRECT PLACE OF SERVICE CODING

Medicare overpaid physicians due to incorrect place of service coding. Seventy-six of 100 sampled physician services, selected from a population of services identified as having a high potential for error, were performed by physicians in a facility but were billed by the physicians using the "office" or other non-facility place of service codes.[4] As a result of the incorrect coding, Medicare paid the physicians a higher amount for these services. We attribute the overpayments primarily to control weaknesses at the carrier, physician office, and Indian Health Service headquarters levels. In addition, according to physician billing representatives, TrailBlazer customer service personnel gave them improper instructions, causing the representatives to use incorrect place of service codes. Based on a statistical projection, we estimate that TrailBlazer overpaid physicians about $1,051,477 for incorrectly coded services provided during the 2-year period ended December 31, 2002.

Medicare Requirements

The Medicare physician fee schedule includes two payment amounts depending on whether a service is performed in a facility setting, such as an outpatient hospital department or ambulatory surgical center, or in a non-facility setting, such as a physician's office. The payments to physicians are higher when the services are performed in non-facility settings. The higher payments are designed to compensate physicians for the additional costs incurred to provide the service at an office location as opposed to a facility location.

In order for the physician to receive the higher non-facility practice expense payment, the service must meet the requirements of 42 CFR 414.22(b)(5)(i)(B), as follows:

> . . . The higher non-facility practice expense RVUs apply to services performed in a physician's office, a patient's home, an ASC [ambulatory surgical center] if the physician is performing a procedure not on the ASC approved procedure list, a nursing facility, or a facility or institution other than a hospital or skilled nursing facility, community mental health center, or ASC performing an ASC approved procedure . . . .

Services Billed with Incorrect Place of Service Codes

The place of service for 76 of 100 sampled services had been incorrectly coded on the physicians' billings. Although each of the 76 services was coded as if it was performed in a physician's office or other non-facility place of service[4], 44 of the services were actually performed in outpatient hospital settings; 1 was performed in an emergency room (facility setting); and 30 were performed in an ambulatory surgical center setting. We could not determine the setting for 1 of the services because medical records for the beneficiary were

[4] The other non-facility code names billed by the physicians included: (1) home; (2) intermediate care facility/mentally retarded; (3) residential substance abuse treatment facility; and (4) "other place of service". A physician billed the home place of service for one outpatient claim. For three individual ambulatory surgical center claims, physicians billed the remaining non-facility place of services.

misplaced by provider or copying personnel for a physician that had taken over custody of such records from a physician that had relocated his practice out-of-state.

By re-pricing the claims using the correct place of service code, we determined that claims for 72 of the 76 services were overpaid by TrailBlazer in the amount of $2,983. Even though the place of service had been miscoded, overpayments did not result for 4 of the 76 services because the physicians' billings did not otherwise exceed the Medicare fee schedule amount for the correct facility setting.

Estimate of Overpayments

We estimate that TrailBlazer overpaid physicians about $1,051,477 for services that were billed using incorrect "non-facility" place of service codes for services provided during the period from January 1, 2001 through December 31, 2002. Our estimate is based on the point estimate of a statistical projection as described in the appendix.

Control Weaknesses at the Carrier, Physician Office, and the Indian Health Service Headquarters Levels

We attribute the overpayments primarily to control weaknesses at the Medicare Part B carrier, physician office, and the Indian Health Service headquarters levels.

Control Weaknesses at the Carrier Level

At the carrier level, TrailBlazer had not established sufficient controls, due in part to vulnerabilities in Medicare's claims processing system, to detect place of service billing errors and to prevent, identify, or recover the program overpayments that resulted from these errors. Under the Medicare claims processing system, Medicare Part B carriers do not have access to billing information from outpatient hospitals because hospital claims are processed by the Medicare Part A fiscal intermediaries. In addition, although carriers have access to claims data for freestanding ambulatory surgical centers, the centers have up to 27 months to submit their claims for processing. Therefore, a physician could submit a bill and receive payment well before the ambulatory surgical center submits its claim, making the identification of these cases more difficult.

Control Weaknesses at the Physician Office Level

At the physician office level, we found that many physicians had not implemented controls to prevent, or subsequently identify, billings with incorrect place of service codes. Specifically, we found that incorrect place of service coding often occurred for one or more of the following reasons:

- Billing personnel were inadequately trained regarding the correct place of service codes to use.

- Confusion among billing personnel that appeared to be related to the fact that a billing system was installed prior to the provider having a separate physical location for an ambulatory surgical center.[5]

- Physicians, supervisory billing personnel, facility personnel and others gave improper coding instructions to billing personnel.

- Physician office or billing personnel misunderstood, were unaware, or were unsure about the precise definition of a physician's office, or had not adequately considered whether the "office" place of service code for a particular location was appropriate.

- Misunderstanding by billing personnel of the correct place of service code to use for a provider who furnished services in an outpatient facility that consisted of three separate units - the first, owned by a hospital; the second, owned by a university; and the third, which had the hospital and university as tenants in common.

- Undetected flaws in the design or implementation of some billing systems allowed the systems to assign incorrect place of service codes to specific physical locations or groups of services.

- Default settings were set within some billing systems for the place of service code for physician offices; however, physician office or billing personnel did not manually override the default settings, as required, for the services performed in facility locations.

- Inadvertent data entry errors occurred when apparently well-trained billing personnel made isolated mistakes.

In addition, in some instances, physician office or billing personnel could not identify the reasons for the coding errors.

Control Weaknesses at the Indian Health Service Headquarters Level

The Indian Health Service had not established sufficient controls at the headquarters level to prevent, or subsequently identify, billings with incorrect place of service codes. The lack of sufficient controls resulted in place of service coding errors at two Indian Health

[5] According to counsel for the facility, the corporate compliance officer and billing personnel from the facility identified this issue prior to the conduct of this audit. The counsel also noted that they (1) immediately corrected the place of service in their billing system to assure that all future claims were billed with the appropriate place of service and (2) subsequently initiated an internal audit to determine the extent of the past payment practice.

Service facilities. An Indian Health Service official stated that its procedures relating to default settings and authorizations for the place of service coding may be a nationwide problem for the Indian Health Service. Because it uses the billing system on a nationwide basis, the potential for additional overpayments exists.

TrailBlazer is the Part B contractor for the Indian Health Service. In our sample of 100 claims, provider billing representatives billed 12 claims for Indian Health Service physicians. Of the 12, 2 claims were in error. One of the claims filed in error was for a hospital outpatient clinic and the remaining claim was for a provider-based[6] clinic. Indian Health Service billing representatives incorrectly coded these claims, using a non-facility, rather than the required facility, place of service code.

According to a CMS official, CMS guidelines that prescribe the use of a facility place of service code for services performed in an outpatient hospital setting pertain to both outpatient hospital and provider-based clinics.

According to an Indian Health Service official, the Indian Health Service has medical facilities nationwide, including 49 hospitals, numerous provider-based clinics, and free-standing centers/clinics. The official explained that most of its medical facilities use a standard nationwide billing system for filing both Medicare and non-Medicare claims. However, the Indian Health Service's procedures allow for the place of service default codes to be changed by local facility information technology managers during or subsequent to implementation of the system at the local facility level. Further, the Indian Health Service headquarters establishes authorization levels that restrict access to the managers for changing the place of service default codes. However, upon implementation of the billing system at the local levels, the managers are able to further delegate such access to their lower-level employees.

For the outpatient hospital clinic, the Indian Health Service official stated that the incorrect place of service coding occurred for one or both of the following reasons: (1) the place of service code default setting was incorrectly set in the nationwide billing system, at the local level by the facility information technology manager or (2) a lower-level employee that had been given access to make such a change set the default incorrectly.

For the provider-based clinic, another Indian Health Service official attributed the place of service error to an incorrect place of service code being set during implementation of the billing system at the local level.

As a result of these inadequate controls, Indian Health Service billing representatives incorrectly coded 2 of 12 Indian Health Service claims, using a non-facility, rather than the required facility, place of service code, resulting in Medicare overpayments to the Indian Health Service.

[6] Provider-based status means the relationship between a main provider and a provider-based entity. A provider-based entity means a provider of health care services that is either created or acquired by a main provider for the purpose of furnishing health care services of a different type from those of the main provider, under the name, ownership, administrative and financial control of the main provider.

An Indian Health Service official stated that its procedures relating to default settings and authorization levels for the place of service coding may be a nationwide problem for the Indian Health Service.

Because the Indian Health Service uses the billing system on a nationwide basis, the potential for additional overpayments exists. The Indian Health Service official stated that they are currently developing a new nationwide billing system that will tie place of service codes to specific medical services.

Improper Coding Instructions from Carrier

According to physician billing representatives, TrailBlazer (the carrier) customer service personnel gave them improper instructions, causing the billing representatives to use incorrect place of service codes. These improper instructions were contrary to Medicare guidelines, and resulted in 3 of the 70 sampled outpatient hospital claims being in error, causing Medicare to make overpayments for these claims.

According to a CMS official, CMS guidelines that prescribe the use of a facility place of service code for services performed in an outpatient hospital setting pertain to outpatient hospital clinics.

The following is an example of the improper instructions provided by customer service representatives from TrailBlazer. A billing representative filed two claims for a physician, using a place of service code for services performed in a non-facility setting. The representative informed the OIG that TrailBlazer customer service personnel had told them to bill using a non-facility place of service code for services provided by the physician at a wound healing center (Center).

However, an official from the hospital that billed for the Center stated that the Center is an outpatient hospital clinic, and therefore the billing representative should have used an outpatient facility place of service code.

A TrailBlazer official attributed the improper instructions issued by its customer service representatives to lack of training regarding place of service coding.

As a result of the improper instructions, Medicare overpaid 3 of these 70 claims.

RECOMMENDATIONS

We recommend that TrailBlazer:

- Recover the $2,983 of overpayments for the sampled physician services that were performed in a facility setting but billed as if provided in the physician's office or other non-facility setting.

- Work with the physicians in the developed population of potential errors to reassess their billings and refund any overpayments estimated at $1,051,477.

- Educate physicians about the importance of correctly reporting the place of service and encourage physicians to implement internal control systems to prevent Medicare billings with incorrectly coded place of service.

- Instruct physicians to notify their billing representatives of the importance of using correct place of service codes.

- Coordinate with the Indian Health Service billing program representatives to make certain that (1) in the interim, appropriate action is taken to ensure that place of service coding is performed at the local level and (2) safeguards in the new nationwide billings system under development guarantees facilities enter the correct place of service codes.

- Educate TrailBlazer customer service personnel regarding their instructions to physicians' representatives related to correct place of service codes.

TRAILBLAZER COMMENTS

TrailBlazer officials generally agreed with many of our findings. However, they expressed a concern with our conclusion that TrailBlazer had not established sufficient controls to detect Medicare Part B place of service billing errors. They noted that many factors should be considered when evaluating controls designed to detect billing errors, including the cost effectiveness of viable measures and the availability of sufficient resources. They further noted, as our draft report had stated, that Medicare Part A and Part B claims are processed in separate systems, resulting in a vulnerability that these errors could occur without easily being detected. TrailBlazer stated that combining Part A and Part B claims processing systems would help address this vulnerability, but this represents a challenge beyond TrailBlazer's control.

TrailBlazer also noted that without the efficiency of automated prepayment claims edits, that TrailBlazer and other contractors rely on controls such as pre- and postpayment manual reviews to detect incorrect billings and overpayments. It explained, however, that due to the limited resources available to perform these reviews, that TrailBlazer is required to evaluate the cost effectiveness of reviewing a wide variety of Medicare claims. Each year, it develops a medical review strategy based on extensive data analysis and available information that is designed to maximize the cost effectiveness of its medical review efforts. This strategy is presented to and approved by CMS in connection with their annual budgeting process.

TrailBlazer stated that the results of this review should be evaluated to determine whether its strategy should be modified or if other resources could be made available to focus on issues identified on the report. However, it noted that our conclusion regarding a control weakness on TrailBlazer's part appeared to oversimplify the reality of an inherently vulnerable, complex Medicare program with limited resources to detect and prevent every potential payment error.

TrailBlazer further explained that while it does not have the ability to directly affect many of the vulnerabilities discussed, it agreed that continuing to aggressively pursue opportunities to provide effective instructions on this specific issue [place of service coding] can lead to improved place of service coding accuracy. Finally, TrailBlazer stated that it continues to believe that its education efforts represent the primary means to cost effectively minimize the extent of place of service miscoding.

TrailBlazer comments are attached in its entirety as Appendix B of this report.

OIG'S RESPONSE

We appreciate the actions TrailBlazer has initiated to address our recommendations.

However, TrailBlazer officials expressed concern regarding our conclusion that they had not established sufficient controls to detect Medicare Part B billing errors. We would like to offer the following comments.

We acknowledge that many factors should be considered when evaluating controls designed to detect billing errors, including the cost effectiveness of viable measures and the availability of sufficient resources. We also acknowledge the existence of an inherently vulnerable, complex Medicare program with limited resources to detect and prevent every potential payment error. However, while these may be mitigating circumstances, we believe they do not negate our conclusion that TrailBlazer had not established sufficient controls to detect Medicare Part B place of service billing errors.

We believe that TrailBlazer should emphasize to CMS the significance of this control weakness. TrailBlazer describes in its response several concerns that could be discussed with and considered by CMS in the annual budgeting process. Through these discussions, CMS could possibly consider implementing some of the ideas to improve weaknesses in this area. We also recognize that TrailBlazer does not have the ability to directly affect many of the vulnerabilities. We also agree that continuing to aggressively pursue opportunities to provide effective instructions on this specific issue can lead to improved place of service coding accuracy.

APPENDICES

APPENDIX A

SAMPLING METHODOLOGY

POPULATION

The population included 42,932 services that were provided during the period from January 1, 2001 through December 31, 2002 and were billed to Medicare Part B by physicians who may have used incorrect "non-facility" place of service codes. Claims for the services were processed and paid by TrailBlazer. Through a computer match, we identified the services as having a high potential for error. These services, although coded by the physicians as being performed in non-facility settings, were matched with data that indicated the services may have been performed in an outpatient hospital setting or in an ambulatory surgical center.

SAMPLE DESIGN

We designed a stratified random sample of 100 services selected from two strata. The first stratum consisted of 7,462 services that were billed by physicians under the "non-facility" place of service code, but may have been performed in an ambulatory surgical center location. The second stratum consisted of 35,470 services that were billed by physicians using a "non-facility" place of service code, but may have been performed in an outpatient hospital setting. We selected a random sample of 30 services from the first stratum and 70 services from the second stratum.

Stratum Number	Description of Stratum	Number of Services in Population	Number of Services in Sample
1	Provider - Ambulatory Surgical Center Setting	7,462	30
2	Provider - Outpatient Hospital Setting	35,470	70
		42,932	**100**

RESULTS OF SAMPLE

The results of the sample review follow:

Stratum Number	Size of Population	Size of Sample	Number with Incorrect Coding	Number with Overpayments	Value of Overpayments
1	7,462	30	30	29	1,783
2	35,470	70	46	43	$1,200
	42,932	**100**	**76**	**72**	**$2,983**

The point estimate of the projection was $1,051,477, with a precision of plus-or-minus $264,197 at the 90 percent confidence level.

TrailBlazer HEALTH ENTERPRISES, LLC℠

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Dallas, Texas 75243-1213

Marti Mahaffey
Executive Vice President and
Chief Operating Officer

December 16, 2004

Mr. Gordon L. Sato
Regional Inspector General for Audit Services
Office of Inspector General
1100 Commerce Street
Room 632
Dallas, Texas 75242

Re: CIN: A-06-04-00046

Dear Mr. Sato:

In response to your draft audit report *Review of Place of Service Coding for Physician Services – TrailBlazer Health Enterprises, LLC For the Period January 1, 2001 Through December 31, 2002*, we appreciate the opportunity to provide our comments for your consideration. We support your efforts to highlight the need to improve controls related to processing this category of Medicare claims. In our comments, presented below, you will note some efforts we have taken to strengthen our ability to process these claims properly. In addition, our comments provide certain clarifications and other factors we believe should be considered to ensure the accuracy and reasonableness of your findings and recommendations.

General Comments

We generally agree with many of the findings contained in the draft report. However, we are concerned with the OIG's conclusion that TrailBlazer had not established sufficient controls to detect Medicare Part B place of service billing errors. Many factors should be considered when evaluating controls designed to detect billing errors, including the cost effectiveness of viable measures and the availability of sufficient resources. As the draft report states, Medicare Part A and Part B claims are processed in separate systems, resulting in a vulnerability that these errors can occur without being easily detected. This significantly limits our ability to establish automated prepayment claim edits to facilitate an efficient method for detecting errors and preventing related overpayments. Combining Part A and B claims processing systems would help address this vulnerability but represents a challenge beyond TrailBlazer's control. Further, time differences between the submission of Part A and Part B claims would limit our ability to detect billing errors efficiently.

Without the efficiency of automated prepayment claims edits, TrailBlazer and other contractors rely on controls such as pre- and postpayment manual reviews to detect incorrect billings and overpayments. Due to the limited resources available to perform these reviews, however, we are required to evaluate the relative cost effectiveness of reviewing a wide variety of Medicare claims. Each year, we develop a medical review strategy based on extensive data analysis and available information that is designed to maximize the cost effectiveness of our medical review

efforts. This strategy is presented to and approved by CMS in connection with our annual budgeting process.

Certainly, the results of the OIG's review should be evaluated to determine whether our strategy should be modified or if other resources could be made available to focus on the issues identified in the report. However, the OIG's conclusion that this represents a control weakness on our part appears to oversimplify the reality of an inherently vulnerable, complex Medicare program with limited resources to detect and prevent every potential payment error.

While we do not have the ability to directly affect many of the vulnerabilities discussed, we agree that continuing to aggressively pursue opportunities to provide effective instructions on this specific issue can lead to improved place of service coding accuracy. We continue to believe that our provider education efforts represent the primary means to cost effectively minimize the extent of place of service miscoding.

Comments to Recommendations

Recommendation 1: Recover the $2,983 in Medicare overpayments for the sampled physician services that were incorrectly billed.

We are working with the audit team to obtain the claim specific detail information needed to recover the overpayments identified by the OIG. We anticipate initiating the recovery process, including sending demand letters, within approximately two weeks from when the needed information is obtained.

Recommendation 2: Work with physicians in the developed population of potential errors to reassess their billings and refund any overpayments identified estimated at $1,051,477.

As we discussed with the audit team during their fieldwork, identifying each claim that might have been incorrectly coded and billed within the total population of all the claims included in the sampled population would not be cost effective due to the relatively small recovery potential as compared to other types of claims where recovery efforts would likely result in a greater return to the Medicare Trust Funds. Our overall assessments regarding the best use of CMS funding to review claims is articulated in our Medical Review Strategy which is reviewed and approved by CMS through the annual contractor budgeting process.

Nonetheless, we agree that a reasonable and cost effective approach to recover overpayments to those in the sample population made due to incorrect coding of these claims should be pursued. In this regard, we plan to notify the providers included in the sampled population regarding the results of this review and stress the requirement that all claims be appropriately coded and billed in accordance with Medicare regulations. In addition we will request that these providers perform a self assessment of their billings and refund any and all overpayments identified. We anticipate sending this notification and request during the first quarter of 2005.

Recommendation 3: Educate physicians about the importance of correctly reporting the place of service and encourage them to implement internal control systems to prevent Medicare billings with incorrectly coded place of service.

TrailBlazer devotes significant efforts at delivering a robust, proactive array of provider education and communication services to ensure that the providers we serve are given the information they need to meet Medicare requirements. A variety of education and training methods are being used to educate all providers regarding appropriate billing, including the use of correct place of service codes including:

- Six newsletters have been published since 2002 containing various place of service instructions, complete CMS-1500 claim form instructions, and listings of place of service codes;
- Billing instructions are posted and periodically updated on our website in the "What's New" section;
- Provider Outreach and Education seminars and workshops regularly cover place of service billing requirements in depth;
- An audio computer based training module providing information for each field and item contained on the CMS-1500 is available to assist providers; and
- Presentations made in 12 cities during the most recent Annual Texas Medical Association and TrailBlazer seminar series included sessions on proper claim submissions and specifically addressed the appropriate use of place of service codes.

We will continue to educate the providers we serve regarding the importance of using appropriate place of service codes and associated Medicare requirements. We plan to publish, in our next newsletter and on our website, an article which describes the OIG audit and findings and encourages providers to review their billing practices related to place of service codes. We will reiterate the place of service code requirements in this article.

Recommendation 4: Instruct physicians to notify their billing representatives of the importance of using correct place of service codes.

We plan to include this instruction in the notification described in our comments for Recommendation 2 above.

Recommendation 5: Coordinate with the Indian Health Service billing program representatives to make certain that (1) in the interim, appropriate action is taken to ensure that place of service coding is performed at the local level and (2) safeguards in the new nationwide billings system under development guarantees facilities enter the correct place of service codes.

Based on the OIG review, TrailBlazer initiated several educational methods for Indian Health Service (IHS), including:

- Three listserv messages addressing point of service coding have been sent to IHS since July 2004;
- Frequently asked questions (FAQs) on place of service codes 11 and 22 were included in the July and November 2004 IHS Quarterly Reports;
- Information was provided on how to determine correct the point of service code for claims submission during scheduled training and workshops,
- Information was sent on July 15, 2004 to IHS Business Office Coordinators (BOCs) and IHS Headquarters regarding OIG audit of place of service codes and what they must do to be compliant.

TrailBlazer will continue to educate IHS on proper claims filing instructions, which will include a broader explanation of POS codes.

As indicated in the draft report, IHS utilizes a nationwide billing system that is currently being updated. TrailBlazer will continue to work with IHS Headquarters and area BOCs to ensure that the place of service coding is correct for each billing entity using the updated software. As part of our education effort, we will encourage IHS facilities to self assess the POS codes and submit any overpayments and implement internal controls to prevent Medicare billings with incorrectly coded place of service.

Recommendation 6: Educate customer service personnel regarding their instructions to physicians' representatives related to correct place of service codes.

TrailBlazer created a "Job Aid for Part B Provider Customer Service Call-Center – Place of Service Inquiries (22 versus 11)" document that includes numerous questions and answers to assist customer service representatives in providing instructions for the appropriate use of place of service codes. This aid was provided and discussed with our customer service representatives in August 2004 for use as part of their quick reference desk materials.

Again, we appreciate this opportunity to provide our comments. If you have any questions or need additional information concerning our comments, let me know.

Sincerely,

Marti Mahaffey
Executive Vice President and Chief Operating Officer

Cc: James Randolph Farris, M.D., CMS
John Delaney, CMS