DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

March 19, 2012

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

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

SUBJECT: Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Wisconsin Physicians Service Insurance Corporation but Transitioned to TrailBlazer Health Enterprises, LLC, in Jurisdiction 4 for the Period January 1, 2006, Through June 30, 2009 (A-07-11-04183)

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

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov or Patrick J. Cogley, Regional Inspector General for Audit Services, Region VII, at (816) 426-3591 or through email at Patrick.Cogley@oig.hhs.gov. Please refer to report number A-07-11-04183.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES, REGION VII
601 EAST 12TH STREET, ROOM 0429
KANSAS CITY, MO 64106

March 22, 2012

Report Number: A-07-11-04183

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

Dear Ms. Rhoades:

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

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

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

If you have any questions or comments about this report, please do not hesitate to call me at (816) 426-3591, or contact Debra Keasling, Audit Manager, at (816) 426-3213 or through email at Debra.Keasling@oig.hhs.gov. Please refer to report number A-07-11-04183 in all correspondence.

Sincerely,

/Patrick J. Cogley/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, MO 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PAYMENTS EXCEEDING CHARGES FOR OUTPATIENT SERVICES PROCESSED BY WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION BUT TRANSITIONED TO TRAILBLAZER HEALTH ENTERPRISES, LLC, IN JURISDICTION 4 FOR THE PERIOD JANUARY 1, 2006, THROUGH JUNE 30, 2009

Daniel R. Levinson
Inspector General

March 2012
A-07-11-04183

Office of Inspector General

http://oig.hhs.gov

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

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at http://oig.hhs.gov

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XVIII of the Social Security Act, the Medicare program provides health insurance for people aged 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS), which administers the program, contracts with Medicare contractors to process and pay Medicare claims submitted for outpatient services. The Medicare contractors use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF) to process claims. The CWF can detect certain improper payments during prepayment validation.

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

During our audit period (January 2006 through June 2009), Wisconsin Physicians Service Insurance Corporation (WPS) processed approximately 55.6 million line items for outpatient services in Jurisdiction 4, of which 408 line items had (1) a Medicare line payment amount that exceeded the line billed charge amount by at least $1,000 and (2) 3 or more units of service. Effective October 2010, the claims that were originally processed by WPS in Jurisdiction 4 were transitioned to TrailBlazer Health Enterprises, LLC (TrailBlazer). Thus, the 408 line items will be adjudicated by TrailBlazer, and we are issuing our report to TrailBlazer. (A single Medicare claim from a provider typically includes more than one line item. In this audit, we did not review entire claims; rather, we reviewed specific line items within the claims that met these two criteria. Because the terms "payments" and "charges" are generally applied to claims, we will use "line payment amounts" and "line billed charges.")

OBJECTIVE

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

SUMMARY OF FINDINGS

Of the 408 selected line items for which WPS made Medicare payments to providers for outpatient services during our audit period, 128 were correct. Providers refunded overpayments

on 13 line items totaling $459,380 before our fieldwork. The remaining 267 line items were incorrect and included overpayments totaling $1,648,224, which the providers had not refunded by the beginning of our audit.

Of the 267 incorrect line items:

- Providers reported incorrect units of service on 190 line items, resulting in overpayments totaling $1,399,404.

- Providers used HCPCS codes that did not reflect the procedures performed on 15 line items, resulting in overpayments totaling $115,151.

- Providers reported a combination of incorrect number of units of service claimed and incorrect HCPCS codes on 49 line items, resulting in overpayments totaling $87,142.

- Providers billed for unallowable services on eight line items, resulting in overpayments totaling $35,613.

- Providers did not provide the supporting documentation for five line items, resulting in overpayments totaling $10,914.

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

RECOMMENDATIONS

We recommend that TrailBlazer:

- recover the $1,648,224 in identified overpayments,

- work with CMS to implement system edits that identify line item payments that exceed billed charges by a prescribed amount, and

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

TRAILBLAZER HEALTH ENTERPRISES, LLC, COMMENTS

In written comments on our draft report, TrailBlazer described actions that it had taken or planned to take to address our recommendations. TrailBlazer agreed with the recommendation to recover the $1,648,224 in overpayments. After furnishing its written comments, TrailBlazer notified us that providers had adjusted additional line items that we had not selected as part of our audit. TrailBlazer added that it had accepted these adjustments

and said that it would recover $1,749,440, which represents $101,216 more than the amount of our recommended recovery.

TrailBlazer's comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

Pursuant to Title XVIII of the Social Security Act, the Medicare program provides health insurance for people aged 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the program. Part B of the Medicare program helps cover medically necessary services such as doctors' services, outpatient care, home health services, and other medical services. Part B also covers some preventive services.

Medicare Contractors

CMS contracts with Medicare contractors to, among other things, process and pay Medicare Part B claims submitted for outpatient services.[1] The Medicare contractors' responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Federal guidance provides that Medicare contractors must maintain adequate internal controls over automatic data processing systems to prevent increased program costs and erroneous or delayed payments. To process providers' outpatient claims, the Medicare contractors use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF). The CWF can detect certain improper payments during prepayment validation.

Claims for Outpatient Services

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

[1] Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC) between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. In this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever is applicable.

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

Wisconsin Physicians Service Insurance Corporation

As part of its Legacy Workload, Wisconsin Physicians Service Insurance Corporation (WPS) processed some outpatient claims for Jurisdiction 4 during our audit period (January 2006 through June 2009).[3] Effective October 2010, the Legacy Jurisdiction 4 (Legacy J4) Workload transitioned to TrailBlazer Health Enterprises, LLC (TrailBlazer), the Medicare contractor for all States in Jurisdiction 4—Texas, New Mexico, Colorado, and Oklahoma.[4] Thus, the Legacy J4 claims that were originally processed by WPS will be adjudicated by TrailBlazer, and we are issuing our report to TrailBlazer. During our audit period, WPS processed 55.6 million line items for outpatient services that were transitioned to TrailBlazer.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

Of the approximately 55.6 million line items for outpatient services that WPS processed during the period January 2006 through June 2009, 408 line items had (1) a Medicare line payment amount that exceeded the line billed charge amount by at least $1,000 and (2) 3 or more units of service.[5]

We limited our review of WPS's and TrailBlazer's internal controls to those that were applicable to the selected payments because our objective did not require an understanding of all internal controls over the submission and processing of claims. Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

Our fieldwork included contacting WPS in Omaha, Nebraska, as well as TrailBlazer in Dallas, Texas, and the 68 providers in Jurisdiction 4 that received the selected Medicare payments.

[3] The WPS Legacy Workload had previously been processed by Mutual of Omaha. The Legacy Workload includes claims submitted by providers who fall under the geographic jurisdiction of all 15 MACs.

[4] The Legacy Workload transition includes a significant number of providers that are Qualified Chain Providers, a designation for providers located over a large geographic area that belong to multiple MAC jurisdictions. A Qualified Chain Provider has the option to move all of its providers, regardless of geographic location, to the MAC that covers the State in which the Qualified Chain Provider's home office is located.

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

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- used CMS's National Claims History file to identify outpatient line items processed by WPS for providers that billed line items with (1) a Medicare line payment amount that exceeded the line billed charge amount by at least $1,000 and (2) 3 or more units of service;[6]
- coordinated with WPS and TrailBlazer in determining the providers and line items associated with the Legacy J4 Workload;
- identified 408 line items totaling approximately $2.4 million that Medicare paid to 68 providers;
- contacted the 68 providers that received Medicare payments associated with the selected line items to determine whether the information conveyed in the selected line items was correct and, if not, why the information was incorrect;
- reviewed documentation that the providers furnished to verify whether each selected line item was billed correctly;
- coordinated the calculation of overpayments with TrailBlazer; and
- provided the results of our review to TrailBlazer officials on November 15, 2011.

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

FINDINGS AND RECOMMENDATIONS

Of the 408 selected line items for which WPS made Medicare payments to providers for outpatient services during our audit period, 128 were correct. Providers refunded overpayments on 13 line items totaling $459,380 prior to our fieldwork. The 267 remaining line items were incorrect and included overpayments totaling $1,648,224, which the providers had not refunded by the beginning of our audit.

[6] For this audit, we reviewed those line items that met the stated parameters. We applied those parameters to unadjusted line items. In some cases, subsequent payment adjustments reduced the difference between payment and charges to less than $1,000.

Of the 267 incorrect line items:

- Providers reported incorrect units of service on 190 line items, resulting in overpayments totaling $1,399,404.

- Providers used HCPCS codes that did not reflect the procedures performed on 15 line items, resulting in overpayments totaling $115,151.

- Providers reported a combination of incorrect number of units of service claimed and incorrect HCPCS codes on 49 line items, resulting in overpayments totaling $87,142.

- Providers billed for unallowable services on eight line items, resulting in overpayments totaling $35,613.

- Providers did not provide the supporting documentation for five line items, resulting in overpayments totaling $10,914.

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

FEDERAL REQUIREMENTS

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

CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04 (the Manual), chapter 23, section 20.3, states: "providers must use HCPCS codes … for most outpatient services." Chapter 25, section 75.5, of the Manual states: "… when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was performed." [7] If the provider is billing for a drug, according to chapter 17, section 70, of the Manual, "[w]here HCPCS is required, units are entered in multiples of the units shown in the HCPCS narrative description. For example, if the description for the code is 50 mg, and 200 mg are provided, units are shown as 4 …."

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

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

OVERPAYMENTS FOR SELECTED LINE ITEMS

Incorrect Number of Units of Service

Providers reported an incorrect number of units of service on 190 line items, resulting in overpayments totaling $1,399,404. The following examples illustrate the incorrect units of service:

- One provider billed Medicare for an incorrect number of units of service on four line items. Rather than billing 3 service units, the provider billed 90 service units. These errors occurred because of an incorrect multiplier in the provider's billing system. As a result of these errors, WPS paid the provider $191,364 when it should have paid $5,187, an overpayment of $186,177.

- Another provider billed Medicare for an incorrect number of units of service on four line items. Rather than billing 40 service units, the provider billed 400 service units. These errors occurred because the provider's chargemaster[8] was incorrect. As a result of these errors, WPS paid the provider $127,106 when it should have paid $10,563, an overpayment of $116,543.

Incorrect Healthcare Common Procedure Coding System Codes

Providers used HCPCS codes that did not reflect the procedures performed on 15 line items, resulting in overpayments totaling $115,151. For example, because of an error in the chargemaster, 1 provider billed Medicare for 12 line items with an HCPCS code (P9035) involving plateletpheresis,[9] rather than using the correct HCPCS code (P9011) involving platelet leukocyte reduction. As a result of this error, WPS paid the provider $39,180 when it should have paid $6,912, an overpayment of $32,268.

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

Providers reported a combination of incorrect number of units of service and incorrect HCPCS codes on 49 line items. These errors resulted in overpayments totaling $87,142. For example, 1 provider billed Medicare for both an incorrect number of units of service and incorrect HCPCS codes on 10 line items. Rather than billing between 1 and 2 service units of an injection of doxorubicin hydrochloride (HCPCS code J9000), the provider billed between 10 and 20 service units of an injection of doxorubicin hydrochloride for all lipid formulations (HCPCS code J9001). As a result of these errors, WPS paid the provider $38,361 when it should have paid $0. The provider refunded the entire incorrect payment of $38,361.

[8] A provider's chargemaster contains data on every chargeable item or procedure that the provider offers.

[9] Plateletpheresis is the process of removing whole blood from a donor, separating the blood into its components, keeping the platelets, and then returning the remaining blood components to the donor.

Services Not Allowable for Medicare Reimbursement

Providers incorrectly billed Medicare for eight line items for which the services rendered were not allowable for Medicare reimbursement, resulting in overpayments totaling $35,613.

For example, one provider posted a filed claim to the wrong patient account because of a clerical error, and for that reason the provider was paid twice for the same service. As a result of this error, WPS paid the provider $16,591 when it should have paid $0, an overpayment of $16,591.

Unsupported Services

Five providers billed Medicare for five line items for which they did not provide supporting documentation. The providers agreed to cancel the claims associated with the five line items and refund the combined $10,914 overpayments received.

CAUSES OF INCORRECT MEDICARE PAYMENTS

The providers attributed the incorrect payments to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors. WPS made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place to prevent or detect the overpayments. In effect, CMS relied on providers to notify the Medicare contractors of incorrect payments and on beneficiaries to review their *Medicare Summary Notice* and disclose any overpayments.[10]

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

RECOMMENDATIONS

We recommend that TrailBlazer:

- recover the $1,648,224 in identified overpayments,
- work with CMS to implement system edits that identify line item payments that exceed billed charges by a prescribed amount, and
- use the results of this audit in its provider education activities.

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

TRAILBLAZER HEALTH ENTERPRISES, LLC, COMMENTS

In written comments on our draft report, TrailBlazer described actions that it had taken or planned to take to address our recommendations. TrailBlazer agreed with the recommendation to recover the $1,648,224 in overpayments. After furnishing its written comments, TrailBlazer notified us that providers had adjusted additional line items that we had not selected as part of our audit. TrailBlazer added that it had accepted these adjustments and said that it would recover $1,749,440, which represents $101,216 more than the amount of our recommended recovery.

TrailBlazer's comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: TRAILBLAZER HEALTH ENTERPRISES, LLC, COMMENTS

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

MEDICARE

January 13, 2012

Patrick J. Cogley
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

Report Number: A-07-11-04183

Dear Mr. Cogley:

We received the December 21, 2011, draft report entitled "Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Wisconsin Physicians Service Insurance Corporation but Transitioned to TrailBlazer Health Enterprises, LLC, in Jurisdiction 4 for the Period January 1, 2006, Through June 30, 2009." In the draft report, the OIG recommended that TrailBlazer:

- Recover the $1,648,224 in identified overpayments;
- Work with CMS to implement system edits that identify line item payments that exceed billed charges by a prescribed amount; and
- Use the results of this audit in provider education activities.

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

Recovery of Identified Overpayments: The OIG worked directly with the impacted providers to make claim adjustments prior to the issuance of the draft audit report. TrailBlazer received the listing of 267 claim line adjustments which documented the calculated overpayment per claim line, agreeing in total to the $1,648,224 identified overpayment. Based on our review of this file, we determined:

257 Claim Line Overpayments Fully Collected	$1,649,880
3 Claim Line Overpayments Billed but not Collected	46,971
7 Claim Lines not Adjusted by Provider – To be adjusted by TrailBlazer	52,589
Total Overpayment – TrailBlazer	$1,749,440
Total Overpayment – OIG	1,648,224
Difference	$101,216

TrailBlazer will provide the listing of claims with our analysis so that the difference noted above can be reviewed by the OIG.

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

ISO CERTIFIED

Implement System Edits – Payments Exceed Charges: TrailBlazer will follow the OIG's recommendation and work with CMS to develop system edits to identify line item payments that exceed line item charges by a prescribed amount.

Provider Education Activities: TrailBlazer transitioned the providers from Wisconsin Physicians Service Insurance Corporation (WPS) October 18, 2010. Since the transition, TrailBlazer has made the following educational resources available to the transitioned providers:

TrailBlazer provides a Part A Beginner's Guide to Medicare to assist providers with basic Part A information to help ensure Part A claims are submitted properly.
http://www.trailblazerhealth.com/Publications/Training%20Manual/MedicareBasicsManual.pdf

TrailBlazer also offers the TrailBlazer Outpatient Prospective Payment System (OPPS) manual, which includes policies, billing information, billing examples, requirements, revenue codes, form locators, initiatives and significant changes to the Medicare program.
http://www.trailblazerhealth.com/Publications/Training%20Manual/HosptialOutpatientManual.pdf

Part A Beginner's Guide to Medicare and OPPS training are routinely offered through Web-based training events. The PowerPoint presentations are available for download and, upon completion of these events, the recorded training sessions are posted on the TrailBlazer Web site for reference.
http://www.trailblazerhealth.com/Education/EncoreWBTs.aspx?DomainID=1

TrailBlazer provides an OPPS specialty page on the TrailBlazer Web site, which offers a centralized location for provider resources to assist with proper claim submission.
http://www.trailblazerhealth.com/Facility%20Types/OPPS/default.aspx?DomainID=1

TrailBlazer will develop an article targeting our WPS providers highlighting these OIG findings. This article will be placed on the TrailBlazer Web site, sent in listserv and added to the TrailBlazer e*Bulletin* for further exposure. In addition, these findings will be addressed in future online training sessions and various outreach events when appropriate.

If you have any questions regarding our response, please contact me.

Sincerely,

Melissa Halstead Rhoades

Melissa Halstead Rhoades
Area Director & Medicare CFO

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