MISCODING PATIENT TRANSFERS: EFFECT ON MEDICARE PAYMENT

NATIONAL PROGRAM INSPECTION

OFFICE OF INSPECTOR GENERAL

OFFICE OF ANALYSIS AND INSPECTIONS

JUNE 1988

Office of the Inspector General

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This report entitled "Miscoding Patient Transfers: Effect on Medicare Payment," this inspection was conducted to assess the vulnerabilities within Medicare Prospective Payment System (PPS) rules concerning the transfer of a patient from one hospital to another.

This report was prepared by the Regional Inspector General, Office of Analysis and Inspections, Region VI (Dallas). Assisting the Regional Inspector General (Ralph Tunnell) in this project were the following people.

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MISCODING PATIENT TRANSFERS: EFFECT ON MEDICARE PAYMENT

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INSPECTOR GENERAL

JUNE 1988

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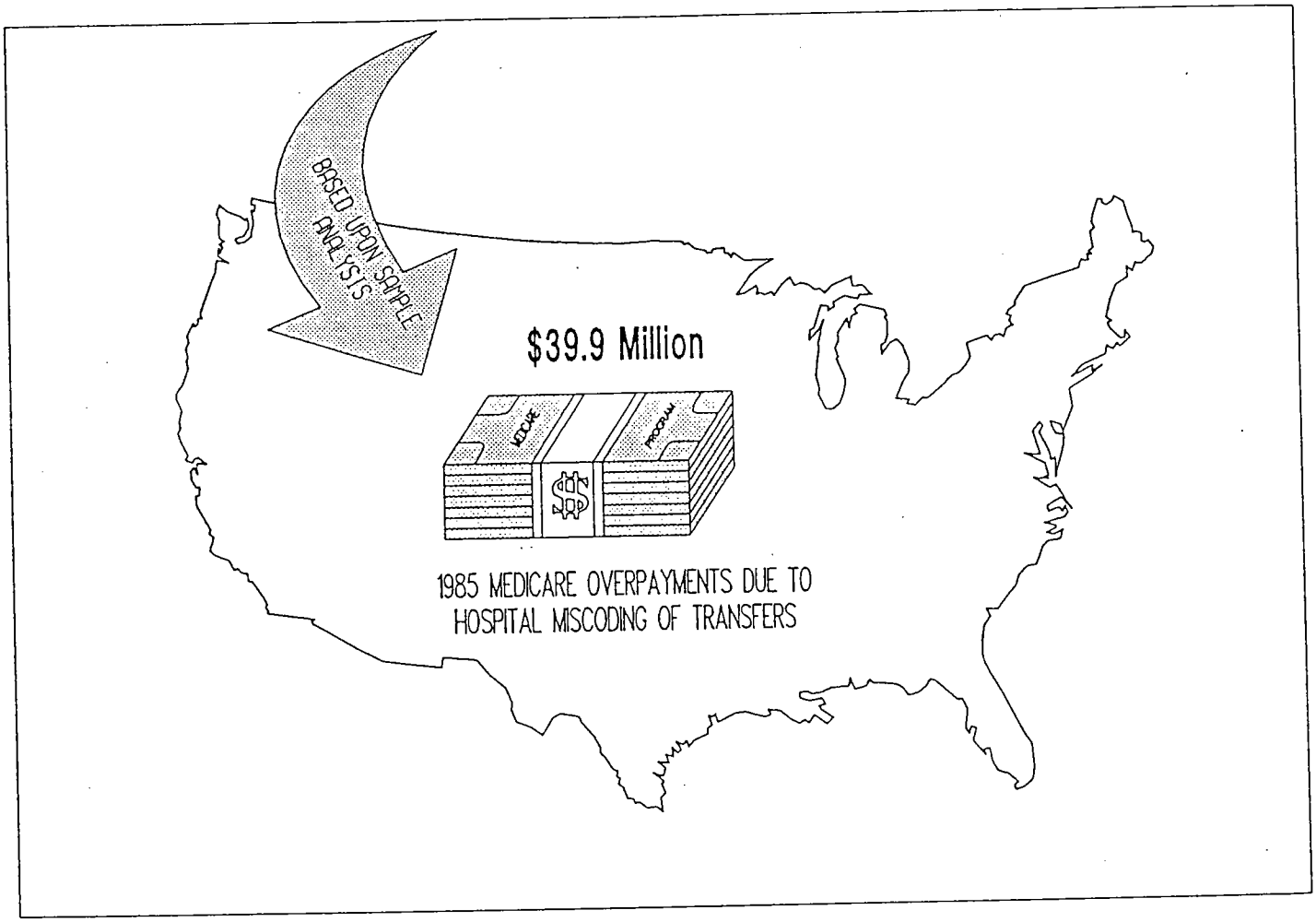

BASED UPON SAMPLE ANALYSIS
$39.9 Million
1985 MEDICARE OVERPAYMENTS DUE TO
HOSPITAL MISCODING OF TRANSFERS

EXECUTIVE SUMMARY

PURPOSE

The purposes of this inspection were: to determine if overpayments were made to hospitals under the prospective payment system (PPS) because of patient transfers not correctly identified during the Medicare claim payment process; to assess the conditions causing the overpayments; and to identify procedures to assure accurate payments in the future.

BACKGROUND

The Medicare prospective payment system was implemented in October 1983 to control inpatient hospital reimbursements, the largest single component of Medicare spending. The PPS is based on fixed per-case payment for diagnosis-related groups (DRGs). While most PPS payments are for the fixed DRG amount, more or less than the DRG rate can be paid.

When a patient is transferred from one short-term acute hospital to another, the first hospital is paid a proportional share up to the full DRG payment based upon the length of the patient's hospital stay. In order for the intermediary to correctly pay for transfers, hospitals must indicate on the billing form when transfers occurred, or the transfer must be detected by peer review organization (PRO) review. The PRO review of transfers must be communicated to the intermediary in order for claims to be correctly paid by the contractor.

FINDINGS

This inspection centered upon a statistically-valid sample of 1985 Medicare hospital discharges where an undetected transfer, material to Medicare payment, may have occurred.

- *In the sample of possible overpaid claims, we found 87.5 percent were miscoded transfers.*
- *An estimated $39.9 million was overpaid in Fiscal Year 1985 because of incorrect coding of transfers to other short-term acute hospitals.*
- *The PRO review resulted in only 1 claim from the 48 possible overpayments being correctly paid through intermediary adjustment.*
- *Sixty-nine percent of the overpaid claims were reviewed by a PRO. Eighty-three percent of the PRO reviews identified a transfer but only 13 percent were communicated to the intermediary responsible for correcting payment. Because of the small sample size, these percentages are not projectable to the universe.*

- *The PRO/intermediary communication failures were due to a lack of clear instructions and procedures concerning PRO identified transfers.*
- *The PRO review is the only current review process available to identify unreported transfers. Thirty-one percent of the unreported 1985 transfers were not subject to PRO review.*
- *Most of the transfers were made to obtain medical care not available in the transferring hospital. Cardiac care accounted for 55 percent of the transfers.*

RECOMMENDATIONS

Instructions concerning transfer cases should provide for clear responsibility on the part of the hospital, the intermediary and the PRO for identification and correct payment of the transfer. Specifically, the Health Care Financing Administration (HCFA) should:

- Periodically review (or provide the PRO access to national data) the posted PPS claims to identify those where interstate movement of an inpatient occurred and where the stay in the first hospital is less than the national mean. Claims identified should be referred to the PRO servicing the first hospital for a determination on the transfer question.

The HCFA responded that the operational problems and cost associated with implementation of this recommendation would far exceed the return in benefits. Also, it stated that insufficient data was given to warrant such review.

The HCFA has acknowledged that a vulnerability exists within the present reimbursement system but is unable to correct the problem because of a lack of required computer system sophistication. Based on our results, an estimated $5 million in 1985 was overpaid because of undetected interstate transfers. As HCFA develops the systems capability to identify these claims, data concerning them should be provided to the PROs to determine whether a transfer had taken place, and if so, to adjust the payment as needed.

- Modify the Medicare Hospital Manual to clearly define which situations should be reported as a transfer.

The HCFA concurred with this recommendation and is in the process of preparing instructions to provide additional clarification to hospitals.

- Strengthen PRO review procedures to include all admissions within 1 day of discharge from another PPS hospital.

The new PRO contract requirements for 1988 require the review of 25 percent of all readmissions to another or the same PPS hospital within 30 days of discharge. The HCFA believes that this will address this problem, because hospitals found to have a pattern of improperly coding discharge destinations will be placed on intensified review.

We continue to believe that requiring the PRO to review 100 percent of readmissions within 1 day will not only identify undetected transfers, but would be a valuable source of information concerning premature discharge and other potential mistreatment.

- Alter the magnetic tape specifications for communication of PRO adjustments to the intermediary to include all transfer status changes as an adjustment code.

The HCFA concurred with the recommendation and is in the process of making computer tape specification changes.

TABLE OF CONTENTS

INTRODUCTION

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and the Social Security Amendments of 1983 made fundamental changes in the Medicare payment system for inpatient hospital services.

Cost Reimbursement System

Prior to 1983, the Medicare program paid a hospital based upon the reasonable cost of the hospital's Medicare services. This retrospective cost reimbursement system had serious drawbacks. Inadequate controls over both the volume of services provided and the cost of hospital operations produced double digit annual percentage increases in program expenditures and predictions of Medicare insolvency in the 1990s. Legislative changes in 1982 and 1983 responded to the escalating cost of inpatient care by setting upper limits on payments and providing hospitals with incentives to control Medicare patient expenses.

Prospective Payment System

Beginning in October 1983, Medicare patient care in short-term general hospitals was covered by a prospective payment system (PPS). This system pays for most of the hospital's inpatient service through a predetermined amount, based upon the patient's medical condition, for each discharge. The actual amount of PPS payment is determined by classification of the patient's medical condition into one of 471 diagnosis related groups (DRGs) and a blend of national and hospital specific information about past and current hospital costs. A unique payment rate is thus established by DRG for each hospital. Since the rate is paid irrespective of actual costs, each Medicare admission provides the opportunity to make or lose money.

While PPS pays most claims at the DRG rate, more or less than the DRG amount can be paid. Additional monies are paid if an unusually high cost or long length of stay is involved. The PPS amount may also be reduced or denied in total.

Payment Distinction

The PPS regulations make a payment distinction between the hospital transferring a patient and other discharges. A full DRG payment is made for a discharge based upon the assumption that the discharging hospital provides the major part of the care needed. On the other hand, the transferring hospital is paid either the full DRG rate, or a reduced amount, depending upon the circumstances of each transfer. (See exhibit A.)

METHODS OF CALCULATING HOSPITAL PAYMENTS WHEN TRANSFERS OCCUR

The following examples, from the preamble to the interim final regulations in the Federal Register at 48 F.R. 39759 (Sept. 1, 1983), illustrate payment for transfers to another short term acute hospital:

Example 1: A patient stays at Hospital A for 2 days and is subsequently transferred to Hospital B. The prospective payment rate is $10,000 at each hospital, with an average length of stay of 10 days for the DRG. Hospital A would be paid $2,000 (2/10 x $10,000) and Hospital B would be paid $10,000, the full PPS payment rate. Total payment is $12,000.

Example 2: A patient stays at Hospital A for 8 days and is subsequently transferred to Hospital B. The prospective payment rate is $10,000 at Hospital A and $12,000 at Hospital B. The average length of stay for the DRG is 5 days. The payment to Hospital A would be limited to $10,000, the full prospective payment rate, since the length of stay exceeds the average length of stay for the DRG. Hospital B would be paid the full prospective payment rate of $12,000. Total payment is $22,000.

Example 3: A patient stays at Hospital A for 2 days under DRG X, which has an average length of stay of 10 days. The prospective payment rate is $10,000 for the hospital for X. He is subsequently transferred to Hospital B under DRG Y. The prospective payment rate at Hospital B is $16,000 for DRG Y. Hospital A would be paid $2,000 (2/10 x $10,000). Hospital B would be paid $16,000, the full prospective payment rate for DRG Y at Hospital B. Total payment is $18,000.

Example 4: A patient stays at Hospital A for 4 days under DRG X, which has an average length of stay of 8 days. The prospective payment rate at Hospital A is $16,000 for DRG X. He is subsequently transferred to Hospital B for 4 days under DRG Y which has an average length of stay of 10 days. The prospective payment rate is $10,000 for DRG Y. He is finally transferred to Hospital C. The prospective payment rate for DRG Y in this hospital is $15,000. Hospital A would be paid $8,000 (4/8 x $16,000). Hospital B would be paid $4,000 (4/10 x $10,000). Hospital C would be paid $15,000, the full prospective payment rate for DRG Y at Hospital C. Total payment is $27,000.

Exhibit A

Reduced Payment to Transferring Hospital

A full DRG rate is paid whenever a length of stay is equal to or greater than the national mean for the DRG. A portion of the full DRG is paid when the transfer occurs earlier. The reduced payment is calculated by dividing the hospital DRG payment by the national mean length of stay, and then multiplying this per diem amount by the patient's length of stay.

What is a Transfer?

Guidance on distinguishing transfers from other discharges is found in 42 CFR 412.4. For the purpose of this report, a transfer exists when:

1) the patient is transferred from one short-term PPS hospital to another short-term PPS hospital, or

2) the patient is transferred from a PPS hospital to a hospital that is excluded from PPS because of a statewide cost control program or demonstration project, or to a hospital whose first PPS cost reporting period has not yet begun.

The circumstances of the patient's departure from a hospital are coded by the hospital on the Medicare claim form. Exhibit B shows the possible status codes that can be entered on the hospital claim form. The particular code used depends upon individual circumstances.

Requirement for Correct Transfer Payment

Correct payment of claims involving a transfer depends upon (1) accurate identification by the transferring hospital or peer review organization (PRO) review and (2) proper application of the regulations regarding the claim payment by the intermediary.

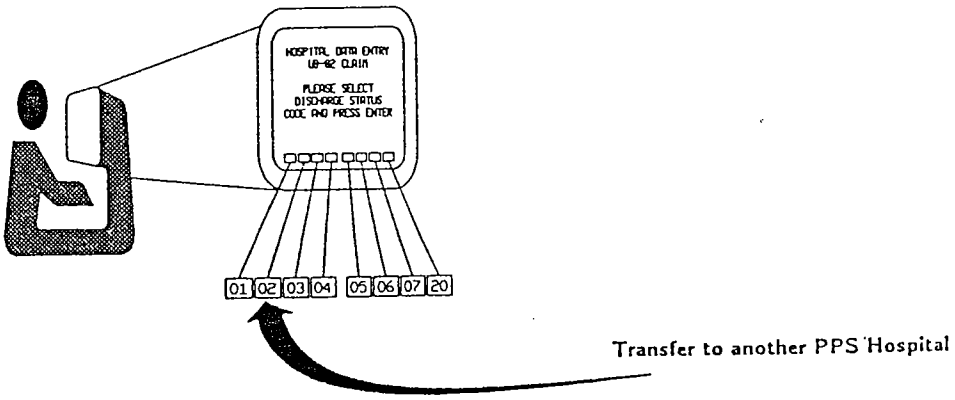
Early in the planning process for PPS, the OIG recognized, as did others, the vulnerability of transfers to incorrect payment. The HCFA's requirement that PROs review all transfers and all related readmissions was seen as a safeguard to prevent overpayments.

Detection of a Miscoded Transfer

Hospital failure to identify the transfer may be detected during the adjudication of the Medicare claim. At the time of this inspection, the PRO was required to review hospital admissions occurring within 7 days of a previous discharge, if the discharge appeared related. This PRO review permits identification of the transfer when a related admission exists. When the intermediary is notified, payments are adjusted (lowered) in applicable cases.

UB-82 (HCFA Form 1450) and Discharge Status Codes

The following is a copy of the hospital billing form submitted to intermediaries in order to receive payment for hospital services provided to Medicare patients. Field 21 refers to discharge status code (STAT). Below are a list of the possible entries which can be entered by the hospital depending on the circumstances of the patients discharge/transfer.



Discharge Status Codes:

Code	Description (Source: Hospital Manual, Sec. 425)
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short-term general hospital
03	Discharged/transferred to skilled nursing facility (SNF)
04	Discharged/transferred to an intermediate care facility (ICF)
05	Discharged/transferred to another type of institution (including distinct parts)
06	Discharged/transferred to home under care of home health service
07	Left against medical advice
20	Patient expired (or did not recover - Christian Science Patient)

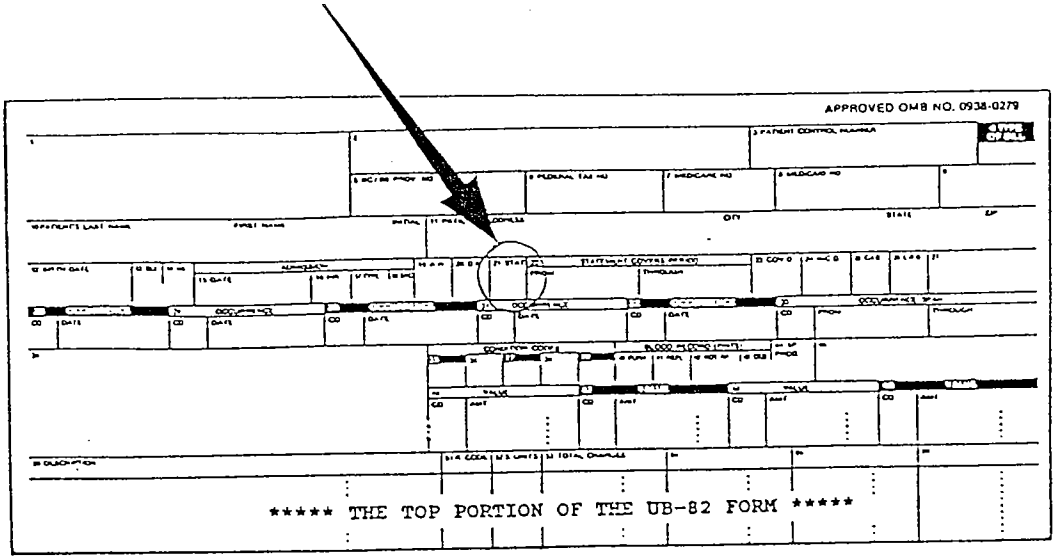


Exhibit B

OBJECTIVES

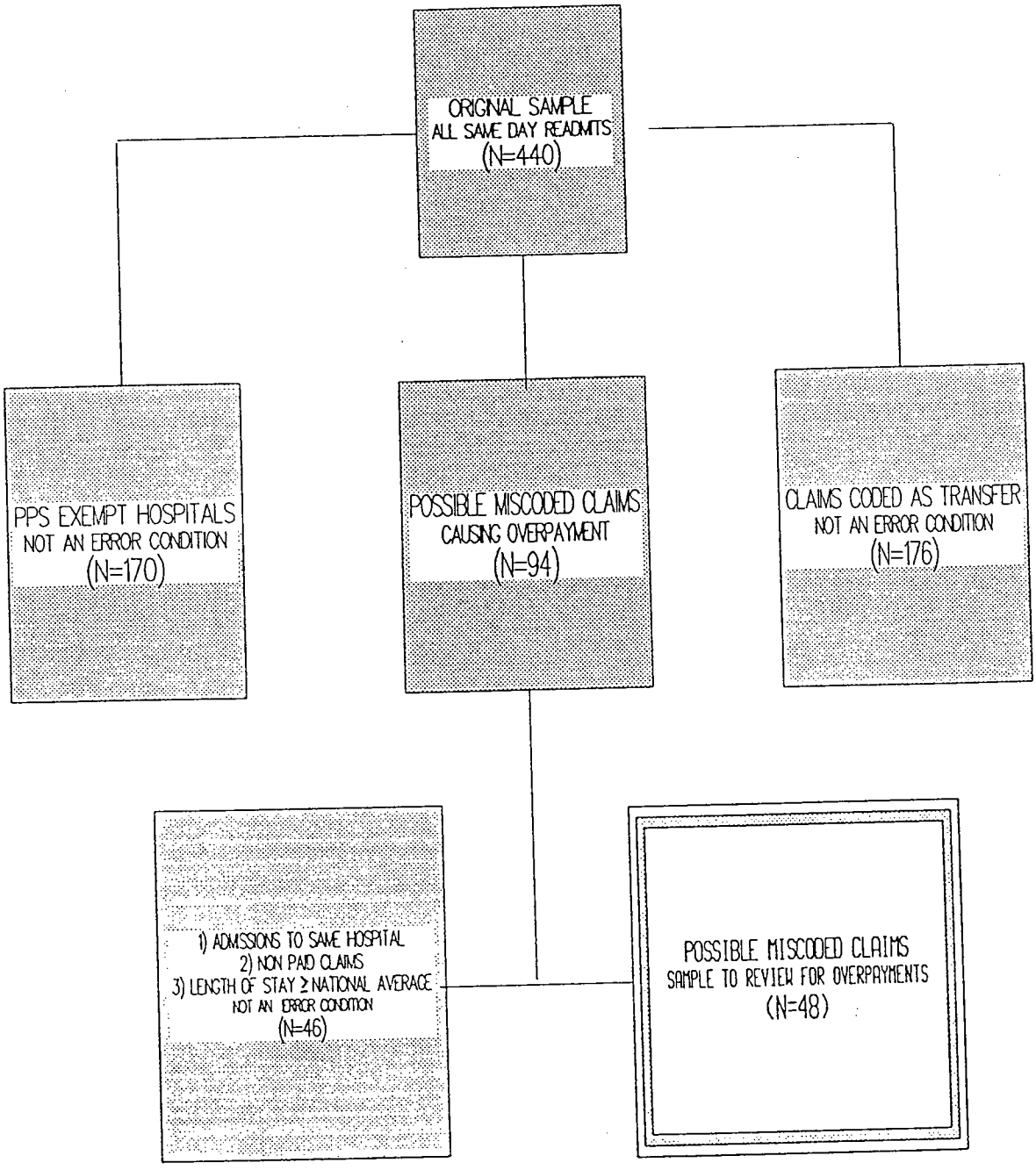
This inspection centered upon identifying overpayments due to full DRG payments being made for transferred patients when only a pro rata payment was due.

Specifically:

Issues

- *Were Medicare PPS transfer claims accurately coded by the hospital?*
- *Were the transfer claims accurately paid by the Medicare contractors?*
- *What procedures were in place to detect and correctly pay transfer claims when the hospital failed to code the transfer?*
- *If overpayments were made, how many claims were involved and what was the amount of misspent dollars?*
- *Were there any distinguishing features of either the patients or providers involved in cases where a Medicare overpayment was made?*
- *What steps can be taken to strengthen the transfer-related administrative processes and procedures and reduce vulnerabilities?*

DEVELOPMENT OF SAMPLE FOR REVIEW OF POSSIBLE OVERPAYMENTS DUE TO MISCODING OF TRANSFER



THESE 48 CLAIMS REPRESENT POSSIBLE OVERPAYMENTS TO BE INVESTIGATED TO DETERMINE IF THE READMISSION WAS THE RESULT OF A TRANSFER OR NOT.

Exhibit C

METHODOLOGY

National Sample of Same Day Readmissions

The ideal framework to evaluate the transfer issues was a review of all possible transfers during a time period. Since thousands of these situations exist each year, we identified a national sample of Medicare discharges for analysis. The file used for the sample selection was the master record of Medicare experience maintained by the Health Care Financing Administration (HCFA), the Federal agency responsible for the day-to-day operations of the Medicare and Medicaid programs. The sample period was Fiscal Year 1985, which was the most recent year with data sufficiently complete for analysis.

The sampling technique selected all discharges with Medicare beneficiary numbers ending with terminal digits 095 and 595. The size of the sample was two-tenths of 1 percent of the national total.

Since the objective included a review of all possible transfers, no regard was given to patient discharge status in selecting the sample. All claims were identified and listed where two or more inpatient claims included the same day. (See exhibit C.)

Four hundred and forty paired claims were identified, representing a variety of situations. Some were readmissions to the same hospital. Other claims were coded to show a transfer from one hospital to another or showed discharges from a short-term acute hospital to a hospital or hospital unit excluded from the PPS system.

Sample with 48 Possible Overpayments

Forty-eight of the paired claims met the requirements for analysis:

1) the discharge claim was not coded as a transfer,
2) the receiving hospital was a PPS hospital,
3) the claim was paid, and
4) the hospital length of stay in the first hospital was less than the national mean for the DRG.

The next step was to determine facts surrounding the 48 paired claims and to establish the criteria to use in defining a transfer.

The Federal regulations and hospital manual instructions do not provide guidance in all identified situations. For example, the patient left one hospital and was taken by private car to another

VERIFIED OVERPAYMENTS

CASE #	TRANSFERRING HOSPITAL STATE	TYPE	BEDS	ACTUAL Reimb $	CORRECT Reimb $	DRG	HOSP stay	AVER LOS	STAY DIFF	Dest	MEDICARE MISCODING OVERPAYMENT	RECEIVING HOSPITAL STATE	TYPE	BEDS	Reimb $	DRG
1	01	*4	57	$1,343	$76	296	2	7.3	5.3	01	$1,267	25	*10	617	$1,688	018
2	03	12	120	$6,868	$6,541	124	8	8.4	0.4	05	$327	03	12	343	$13,296	108
3	05	18	402	$5,124	$4,117	122	8	9.8	1.8	01	$1,007	05	18	438	$17,046	108
4	05	18	34	$4,502	$1,685	121	5	11.9	6.9	01	$2,817	29	20	538	$17,059	108
5	05	12	171	$7,469	$4,890	121	8	11.9	3.9	05	$2,579	05	12	240	$29,174	104
6	05	12	560	$11,202	$973	112	1	11.2	10.2	01	$10,229	05	12	231	$3,905	452
7	10	11	569	$6,455	$2,582	125	2	5.0	3.0	01	$3,873	10	12	285	$2,779	331
8	10	12	183	$2,296	$546	138	2	5.7	3.7	03	$1,750	10	11	310	$4,791	125
9	10	12	300	$3,107	$951	346	3	6.9	3.9	05	$2,156	10	11	569	$3,685	346
10	10	4	204	$1,718	$1,525	140	5	5.5	0.5	01	$193	10	4	459	$9,193	116
11	11	18	40	$1,854	$290	122	3	9.8	6.8	05	$1,564	11	18	561	$6,097	124
12	11	11	40	$3,697	$932	121	3	11.9	8.9	05	$2,765	11	18	168	$1,633	138
13	14	11	220	$4,889	$3,391	122	7	9.8	2.8	05	$1,498	14	11	426	$4,006	145
14	14	18	163	$4,817	$2,283	122	5	9.8	4.8	01	$2,534	14	11	287	$525	122
15	16	20	49	$976	$888	180	4	6.2	2.2	01	$88	16	11	500	$2,451	207
16	16	20	49	$1,801	$1,580	138	5	5.7	0.7	01	$221	16	11	500	$3,331	135
17	18	12	100	$1,592	$0	207	1	6.6	5.6	05	$1,592	18	14	461	$7,567	195
18	19	12	158	$1,726	$258	132	1	6.7	5.7	01	$1,468	45	11	1181	$3,435	139
19	19	4	61	$1,257	$846	138	3	5.7	2.7	05	$411	19	11	304	$7,614	116
20	19	18	34	$3,603	$1,965	121	6	11.9	5.9	01	$1,638	19	11	757	$2,079	140
21	19	4	70	$3,218	$3,218	416	6	9.2	3.2	05	$2,079	19	11	304	$2,906	308
22	25	20	90	$1,411	$513	140	2	5.5	3.5	01	$898	25	12	409	$1,788	140
23	25	12	<100	$1,566	$431	403	3	7.1	4.1	01	$1,135	25	20	268	$2,323	296
24	26	12	459	$4,776	$3,101	087	5	7.7	2.7	01	$1,675	26	12	198	$3,131	101
25	27	11	225	$5,293	$2,257	211	7	15.9	8.9	01	$3,036	53	18	42	$3,565	236
26	34	12	472	$6,631	$5,329	112	9	11.2	2.2	03	$1,302	34	12	112	$2,750	403
27	34	12	388	$1,923	$874	253	3	6.6	3.6	01	$1,049	34	20	333	$3,314	236
28	36	20	63	$1,441	$715	207	4	6.6	2.6	01	$726	36	12	225	$4,102	197
29	37	18	54	$1,490	$970	096	5	6.9	1.9	05	$520	37	12	294	$5,696	397
30	39	11	205	$1,972	$1,434	140	4	5.5	1.5	05	$538	39	12	687	$8,295	125
31	39	12	260	$5,901	$2,079	121	5	11.9	6.9	03	$3,822	39	12	464	$27,095	106
32	43	10	154	$2,304	$324	130	1	7.1	6.1	03	$1,980	43	10	456	$9,983	110
33	44	20	57	$2,990	$1,879	121	8	11.9	3.9	01	$1,111	44	4	296	$2,565	127
34	45	20	155	$1,511	$439	174	3	6.7	3.7	01	$1,072	45	4	253	$2,784	205
35	45	4	43	$3,430	$501	011	2	8.5	6.5	01	$2,929	45	11	1127	$10,078	400
36	45	4	162	$4,619	$3,406	121	9	11.9	2.9	01	$1,213	45	11	844	$11,899	109
37	45	20	39	$2,477	$762	014	4	9.9	5.9	01	$1,715	45	4	142	$7,175	002
38	45	18	26	$1,465	$306	140	2	5.5	3.5	01	$1,159	45	11	258	$1,832	157
39	49	12	424	$2,167	$289	243	1	7.5	6.5	05	$1,878	49	12	401	$2,557	409
40	50	18	303	$6,755	$852	124	1	8.4	7.4	01	$5,903	50	11	376	$13,058	107
41	53	11	121	$3,191	$1,454	122	5	9.8	4.8	03	$1,737	06	4	465	$13,451	107
42	53	4	64	$2,732	$385	130	1	7.1	6.1	01	$2,347	53	4	107	$8,043	110
	AVERAGE:		185	$3,534	$1,615		4.3	8.3	4.0		$1,900			402	$5,974	

This table represents data gathered on 42 overpayments found in our sample of 48 possible miscoded transfers. The remaining 6 claims are not included as they were found to be correctly coded and paid.

SAMPLE TOTAL OVERPAYMENTS = $79,801.4

*facility type: see addendum
Dest = discharge status

Exhibit D

Classification of a Transfer

hospital to obtain care for a condition diagnosed at the first hospital. Was this situation a transfer? What facts must exist for classification of a transfer? The questions were addressed by classifying a discharge as a transfer when (1) the patient was directly admitted to the second hospital and (2) the patient's medical record established the staff at the first hospital, including the attending physician, had prior knowledge of the second admission.

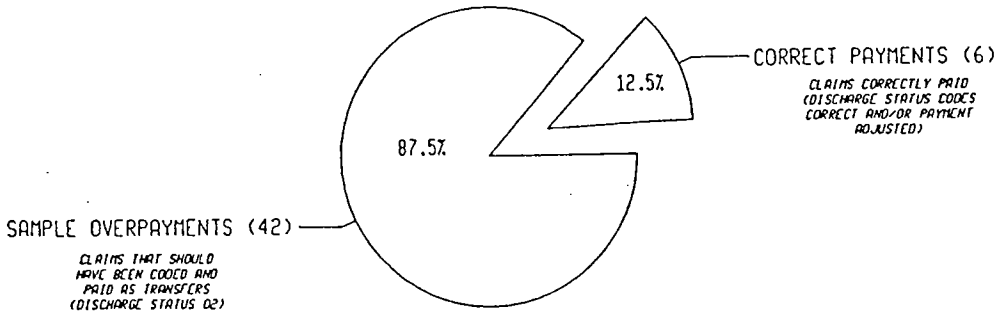
Extensive Review of Patient Records

Fact finding on the sample records was extensive. We requested the medical records from the two hospitals involved with the paired stay. Claim procedures and claim processing facts were obtained from the cognizant intermediaries and peer review organizations. Exhibit D summarizes several of the pertinent facts regarding claims from our sample.

We also discussed the transfer rules with regional and central office HCFA staff when questions arose in our analyses. Patients or the patients' representatives were interviewed to determine transfer facts from the patients' perspectives.

ANALYSIS OF SAME DAY READMISSIONS

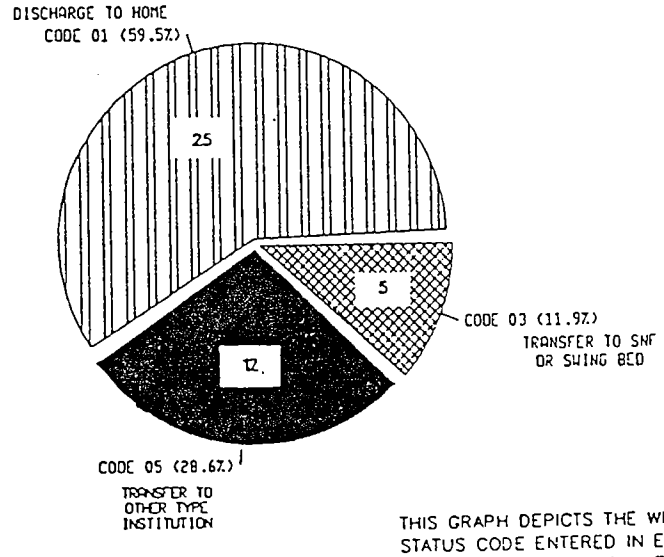
TO ANOTHER ACUTE HOSPITAL
NOT CODED AS A TRANSFER
SAMPLE SIZE IS 48



DATA REPRESENTS AN ANALYSIS OF 1985 CLAIMS FOR TWO TENTHS OF ONE PERCENT OF BENEFICIARIES, THOSE WITH MEDICARE HIC TERMINAL DIGITS 095&595.

SAMPLE OVERPAYMENTS (42)

TRANSFER CODING ERROR
CAUSING OVERPAYMENT



THIS GRAPH DEPICTS THE WRONG DISCHARGE STATUS CODE ENTERED IN ERROR WHICH CAUSED THE 42 OVERPAYMENTS IN THE SAMPLE.

Exhibit E

We estimate that failure to pay hospital transfers accurately resulted in incorrect payments of $39.9 million in 1985.

$39 Million Misspent

Forty-two of the 48 paired hospital claims were not correctly coded. (See exhibit E.) This caused overpayments of $79,801. Sample findings were projected to the universe by multiplying findings by the inverse of the sampling fraction. We estimate, at the 90 percent confidence interval, the total amount misspent was $38 to 41 million.

In the original sample of 48 possible overpayments, only 1 case was referred by the PRO and an adjustment made by the intermediary.

The circumstances of the 42 overpaid claims were analyzed for insight on specific corrective actions. We found:

- 12 percent of the claims involved an interstate transfer;
- 31 percent of the claims from the transferring hospital had not been reviewed by a PRO;
- 50 percent of the claims had been reviewed by the PRO and the transfer was identified; however, the PRO had not notified the intermediary of the transfer status change; and
- 7.7 percent of the claims were referred by the PRO for intermediary adjustments, but no adjustments were made.

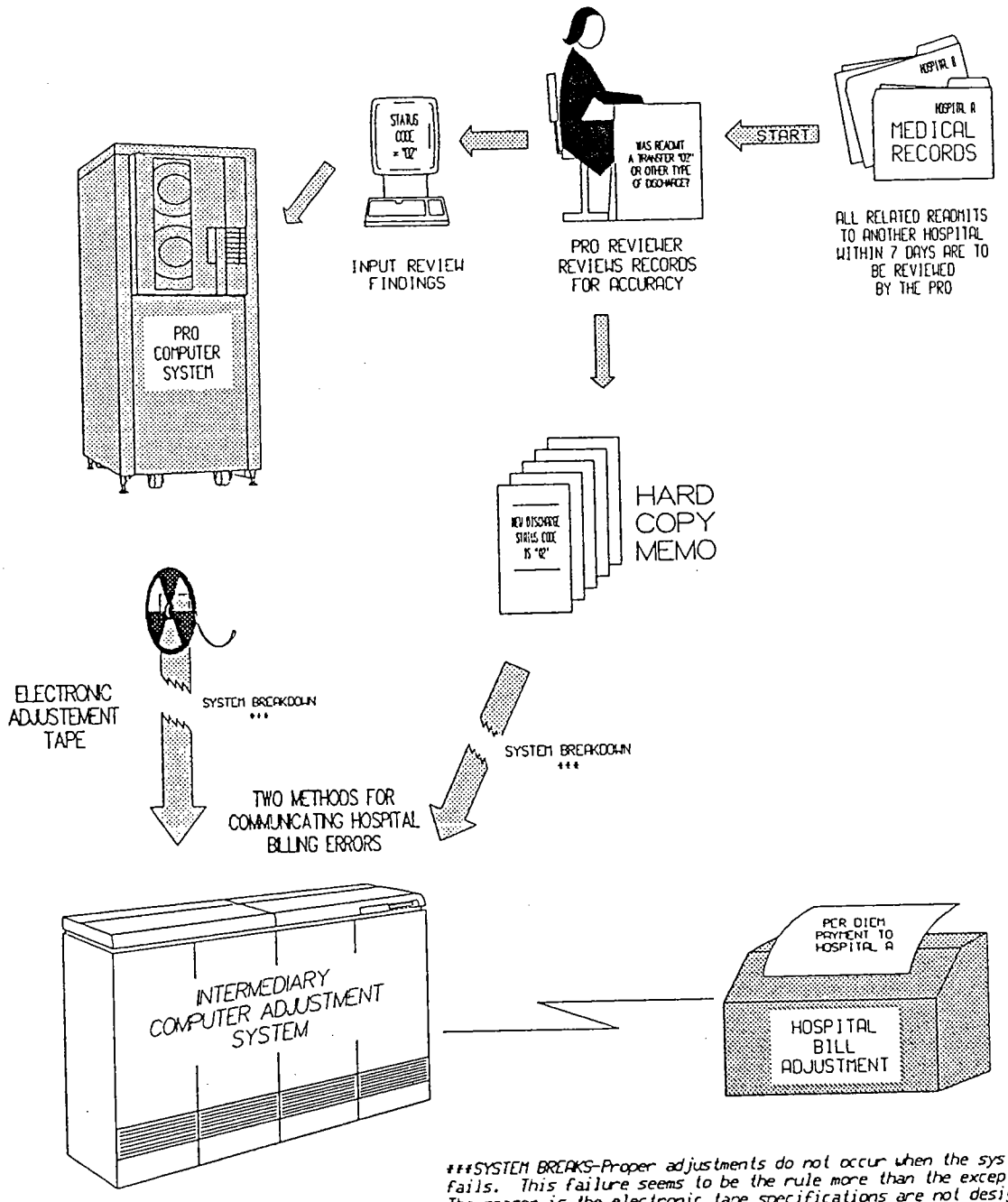
Note: The percentages given above cannot be projected to the universe because of the small sample size.

No Review of Transfers Between States

Since the current PPS system does not advise PROs of admissions in other States and since the current PRO review does not include 100 percent of readmissions, correction of transfer vulnerabilities will require more than improved communication between the PRO and the intermediary.

PRO CLAIM REVIEW AND COMMUNICATIONS WITH THE FI

DETECTING AND RELATING STATUS CODE CHANGES



****SYSTEM BREAKS-Proper adjustments do not occur when the system fails. This failure seems to be the rule more than the exception The reason is the electronic tape specifications are not designed to include an adjustment field for discharge status code changes not affecting the DRG. Hard copy memos fail for one of two reasons. 1) PROs fail to send them because they do not affect a DRG change or 2) If sent the Intermediary does not act.*

Exhibit F

The PRO Manual (section 2050.1 D) charges the PRO with the responsibility "...for identifying all cases involving transfers from a PPS hospital to any other ... acute hospital..."; however, there is no PRO requirement to review all same-day discharges and admissions and thus be able to identify the unreported transfer.

Weaknesses in PRO and Intermediary Instructions

The manual instructions (PRO Manual addendum A) are not clear concerning PRO reporting of claims where the intermediary needs to recover transfer-related overpayments. The record layout describes the specific action needed by the intermediary through a combination of two data fields. Field 8 tells the intermediary an adjustment is needed and the nature of the adjustment (e.g., admission denied, DRG change, etc.). Field 12 provides the specific information needed by the intermediary to act (e.g., the new DRG). While field 12 reports the PRO-identified transfer, field 8 does not provide a code for a transfer adjustment. The end result is no recovery of the overpayment unless ad hoc agreements solve this problem. (See exhibit F.)

Few PROs Transmit Status Code Changes

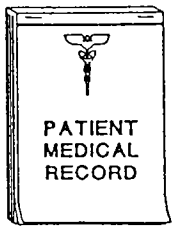
The PRO and the intermediary in some states have made arrangements to overcome the deficiency. Some 16.7 percent of State PROs responding to a survey (3 out of 18 respondents) presently communicate all status code changes to intermediaries through electronic computer tape. In our sample, only one of the intermediaries had acted upon the PRO-identified transfer and recovered the overpayment. Of those not using electronic tape communication for status changes, 27.8 percent (5 respondents) use hard copy letters to inform intermediaries. The PROs not communicating status code changes (56 percent) stated their responsibility was to only inform intermediaries of status code changes which change the DRG.

Hospital Error Causes Miscoding

Vulnerabilities in the intermediary and PRO identification of transfers and the related communication problems in the Medicare PPS system are the most significant findings. However, we also found major problems in the hospitals. (See exhibit G.) A survey of the overpaid hospitals attributed 84 percent of the status code errors to communication problems within the hospital.

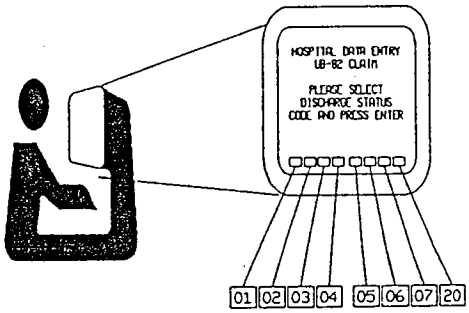
While the survey showed most hospitals recognized the status code error, 16 percent of the hospitals did not recognize the transfer, even after reviewing the circumstances which clearly show a transfer occurred.

POSSIBLE REASONS FOR DISCHARGE CODING ERRORS



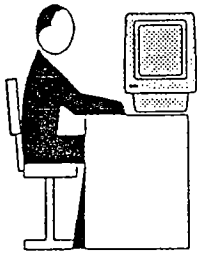
HOSPITAL
NURSE/DOCTOR ERROR

MEDICAL RECORD FAILS TO INDICATE CORRECTLY WHERE THE PATIENT IS GOING OR NURSING STAFF FAIL TO CORRECTLY RELATE STATUS TO THE ADMISSION/BILLING DEPARTMENTS



HOSPITAL
BILLING CLERK ERROR

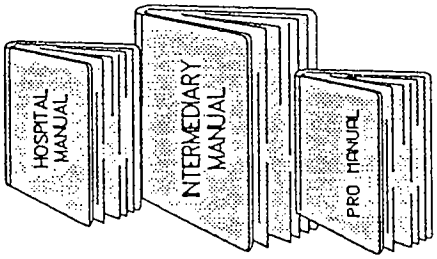
DATA INPUT ERROR OR CLERK MAY NOT UNDERSTAND THE CORRECT USE OF MEDICARE STATUS CODES



INTERMEDIARY DATA CLERK

INTERMEDIARY ERROR

A DATA ENTRY CLERK ERRS WHEN ENTERING FROM A HARD COPY HOSPITAL BILL (THIS PROBLEM CANNOT OCCUR WITH HOSPITALS WHO SUBMIT THEIR CLAIMS ELECTRONICALLY)



HCFA
POLICY ISSUE

SOME READMISSIONS TO OTHER HOSPITALS ARE DIFFICULT TO CLASSIFY (ex. Referrals from transferring hospital physician to specialist at another hospital)

Exhibit G

The hospitals disagreeing to the transfer classification did so reasoning:

- the transfer was not one which directly involved arrangements by the hospital (e.g., the patient went to the second hospital by private transportation with arrangements made between physicians) or

- the medical condition triggering the transfer is a new event, and the hospital views the care "complete" for the problems involved in the first stay.

Hospital Reasoning Differs

Discharge to "Home" Entered in Error Most Often

The majority of hospitals which miscoded the discharge status of the patient reported the reason for such a mistake as an error on the part of billing department staff responsible for recording discharge status. Hospital staff, according to the sample, coded the transfer as a discharge home (code 01) more often than any other code. This may be due in part to the fact that most hospital discharges are discharges home which hospital staff routinely enter. As a consequence, staff may use it without thinking. Another reason was given by one hospital which reported that its computer system defaults to a "home" discharge status code whenever billing clerks fail to enter a code.

Confusion with Transfer to Other Type Institution

The second most commonly misused status code was code 05, "discharge to another type institution." The most probable reason for misuse of this code was lack of understanding of the use of the two codes. This lack of understanding was expressed by a medical records director who emphatically believed (in error) that sending a patient to another type of institution (code 05) was appropriate when its hospital did not have the capabilities to treat the patient. Clearly, his statement represents a lack of understanding as to the distinction between a transfer to another short-term acute hospital and a transfer to another type institution.

Reasons for transferring patients fell into two basic groups:

1) patient request (N = 5) and
2) need for specialized care (N = 37).

Patient requests for transfers were generally to relocate near relatives and friends. As an example, patients may go to a large teaching hospital to have a special heart procedure done, but prefer to return to a hospital close to home for the rehabilitation phase of their treatment.

Most Miscoded Transfers are for Cardiac Procedures

The most common need for special care was in the area of cardiology (55 percent). Twenty-nine percent (12 of 42) of the overpaid claims were for cardiac catheterization.

RECOMMENDATIONS

Instructions concerning transfer cases should provide for clear responsibility on the part of the hospital, the intermediary and the PRO for identification and correct payment of the transfer.

HCFA Identification of Interstate Movement

- The HCFA should periodically review (or provide the PRO access to national data) the posted PPS claims to identify those where interstate movement of an inpatient occurred and where the stay in the first hospital is less than the national mean. Claims identified should be referred to the PRO servicing the first hospital for a determination on the transfer question.

The HCFA responded that the operational problems and cost associated with implementation of this recommendation would far exceed the return in benefits. Also, it stated that insufficient data was given to warrant such review.

The HCFA has acknowledged that a vulnerability exists within the present reimbursement system, but it is unable to correct the problem because of a lack of required computer system sophistication. Based on our results, an estimated $5 million in 1985 was overpaid because of undetected interstate transfers. As HCFA develops the systems capability to identify these claims, data concerning them should be provided to the PROs to determine whether a transfer had taken place, and if so, to adjust payment as needed.

Strengthen PRO Review

- The PRO review should be strengthened to require determination of the status code accuracy of discharges where an admission to another PPS hospital occurred within 1 day of the discharge and was not coded as a transfer to another short-term acute hospital.

The new PRO contract requirements for 1988 require the review of 25 percent of all readmissions to another or the same PPS hospital within 30 days of discharge. The HCFA believes that this will address the problem, because hospitals found to have a pattern of improperly coding discharge destinations will be placed

on intensified review. We continue to believe that requiring the PRO to review 100 percent of readmissions within 1 day would not only identify undetected transfers, but would also be a valuable source of information concerning premature discharge and other potential mistreatment.

Hospital Manual Guidance

- The Medicare Hospital Manual should include a section on the transfer issue and should, through examples, provide additional clarification to the hospital on the definition of a transfer and calculation of correct payments. One situation that should be included in the manual involves transfers arranged by the physicians where other hospital staff may not be involved in the transfer.

The HCFA concurred with this recommendation and is in the process of preparing instructions to provide additional clarification to hospitals.

Computer Tape Specification Change

- The magnetic tape specifications for communication of PRO adjustments to the intermediary should be expanded to include transfer status changes as an adjustment code in field eight.

The HCFA concurred with the recommendation and is in the process of making computer tape specification changes.

Addendum

ADDENDUM

REFERENCE CHART FOR EXHIBIT D: TYPE OF FACILITY OWNERSHIP

TYPE OF OWNERSHIP

CODE	DESCRIPTION
	FOR PROFIT
01	INDIVIDUAL
02	PARTNERSHIP
03	CORPORATION
04	PROPRIETARY
05	OTHER
	NON-PROFIT
07	INDIVIDUAL
08	PARTNERSHIP
09	CORPORATION
10	PRIVATE
11	CHURCH
12	OTHER
	GOVT. (NON-FED)
14	STATE
15	COUNTY
16	CITY
17	CITY/COUNTY
18	HOSP. DIST./AUTH
19	COMB. GOVT. & VOL
20	LOCAL GOVT.
21	OTHER
22	GOVT. (NON OR FED)
	GOVT. (FED)
23	VET. ADM.
24	PHS. HOSP.
25	MILITARY
26	FEDERAL
27	OTHER
	OTHER
00	INVALID/MISSING