DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JUN 29 2005

TO: Dennis Smith, Director
Center for Medicaid and State Operations
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Hospital Patient Transfers Paid as Discharges Under State Medicaid Programs (A-05-03-00014)

Attached are two copies of the U.S. Department of Health and Human Services, Office of Inspector General's final report entitled "Hospital Patient Transfers Paid as Discharges Under State Medicaid Programs."

The objectives of our audit were to (1) consolidate the results of four prior State Medicaid agency reports on hospital patient transfers billed as discharges and (2) review Medicaid reimbursement policies for the unaudited States and the District of Columbia to determine whether overpayments could occur if transfers were incorrectly coded as discharges.

We evaluated four States with Medicaid payment provisions similar to the Medicare prospective payment system (PPS). Our audits in North Carolina, Illinois, New York, and Indiana identified overpayments of approximately $6.4 million ($3.6 million Federal share) for hospital patient transfers incorrectly reported as discharges and additional potential overpayments of $3.7 million ($1.9 million Federal share). We referred the potential overpayments to the States for further evaluation and appropriate recovery.

We also evaluated other Medicaid State plans to identify States that prospectively pay for inpatient services and limit payments for transfers. We examined Medicaid hospital payment methodology and transfer payment policy and found that significant overpayments for transfers inappropriately billed as discharges could exist in an additional 25 States and the District of Columbia.

We recommend that the Centers for Medicare & Medicaid Services (CMS):

- monitor the recovery of identified and potential overpayments described in our 4 State-specific reports and

- encourage the 25 States and the District of Columbia to consider performing focused postpayment assessments of hospital discharges and to recover overpayments for transfers inappropriately billed as discharges.

In response to our draft report, CMS agreed with our recommendations.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at 410-786-7104 or through e-mail at george.reeb@oig.hhs.gov. Please refer to report number A-05-03-00014 in all correspondence.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

HOSPITAL PATIENT TRANSFERS PAID AS DISCHARGES UNDER STATE MEDICAID PROGRAMS

Daniel R. Levinson
Inspector General

June 2005
A-05-03-00014

Office of Inspector General

http://oig.hhs.gov

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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

OBJECTIVES

Our objectives were to (1) consolidate the results of four prior State Medicaid agency reports on hospital patient transfers billed as discharges and (2) review Medicaid reimbursement policies for the unaudited States and the District of Columbia to determine whether overpayments could occur if transfers were incorrectly coded as discharges.

SUMMARY OF RESULTS

We evaluated four States with Medicaid payment provisions similar to the Medicare prospective payment system (PPS). Our audits in North Carolina, Illinois, New York, and Indiana identified overpayments of approximately $6.4 million ($3.6 million Federal share) for hospital patient transfers incorrectly reported as discharges and additional potential overpayments of $3.7 million ($1.9 million Federal share). We referred the potential overpayments to the States for further evaluation and appropriate recovery.

We also evaluated other Medicaid State plans to identify States that prospectively pay for inpatient services and limit payments for transfers. We examined Medicaid hospital payment methodology and transfer payment policy and found that significant overpayments for transfers inappropriately billed as discharges could exist in an additional 25 States and the District of Columbia.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services (CMS):

- monitor the recovery of identified and potential overpayments described in our 4 State-specific reports and

- encourage the 25 States and the District of Columbia to consider performing focused postpayment assessments of hospital discharges and to recover overpayments for transfers inappropriately billed as discharges.

AUDITEE COMMENTS

In a written response dated June 1, 2005, CMS concurred with our recommendations. The response is included in its entirety as Appendix B to this report.

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INTRODUCTION

BACKGROUND

Medicaid Program

Title XIX of the Social Security Act (the act) authorizes Federal grants to States for Medicaid programs that provide medical assistance to needy people. The States' Medicaid programs are jointly administered by the Federal Government, through CMS, and by States, through their designated State agencies in accordance with approved State plans. The Federal Government and States share the States' costs for medical assistance payments to medical providers who furnish care and services to Medicaid beneficiaries.

The Federal Government pays its share of a State's medical assistance expenditures according to a formula that compares the State's average per capita income with the national average. States with a higher per capita income are reimbursed a smaller share of their costs. By law, the Federal share of medical cost, referred to as Federal financial participation, cannot be lower than 50 percent. Although the States have flexibility in designing their State plans and operating their Medicaid programs, they must comply with broad Federal requirements.

Medicare Prospective Payment System and Hospital Reimbursement for Transfers

In prior Medicare audits of hospital patient transfers, we cited section 1886(d) of the act, enacted as part of the Social Security Amendments of 1983 (Public Law 98-21), which established the PPS for inpatient hospital services. Under this system, diagnoses for hospital admissions are grouped into diagnosis-related groups (DRGs), and payments are based on prospectively determined amounts for each grouping. The DRG payment is designed to cover an average hospital's operating costs necessary to treat a patient to the point that a discharge is medically appropriate. Hospitals that admit, stabilize, and transfer patients to other hospitals generally use fewer resources than hospitals providing the full scope of medical treatment. Therefore, Medicare PPS payments for patient transfers to other PPS hospitals are generally limited to per diem payments up to the full DRG. The receiving hospital is normally paid the full DRG payment.

A discharge of a hospital inpatient is considered an "acute care" transfer for purposes of payment if the discharge is from one hospital to another hospital that is paid under the inpatient PPS system. Medicare regulations at 42 CFR § 412.4(f) provide that in a transfer situation, each transferring hospital is paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

Medicaid Payment Methodology and Hospital Reimbursement for Transfers

Under the inpatient hospital payment methodology prescribed in Medicaid State plans, States reimburse hospitals for inpatient services by using a variety of payment methods, including methods similar to the Medicare PPS system. As with Medicare, the Medicaid patient status code that the hospital records at the time of transfer determines whether the inpatient claim will be paid as a discharge or a transfer. To ensure appropriate reimbursement for transfers, the

transferring hospital must use the proper code to indicate that a transfer has occurred. A transfer incorrectly reported as a discharge normally results in an overpayment because both hospitals receive the full payment.

Prior Medicare audits identified substantial overpayments for PPS patient transfers incorrectly reported as discharges. States with Medicaid payment requirements that establish a set payment for inpatient services and reduce the payment for transfer situations are susceptible to such overpayments. This report presents the results of Medicaid audits replicating the Medicare audit approach and our assessment of further potential State and Federal recoveries associated with incorrectly coded patient transfers.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to (1) consolidate the results of four prior State Medicaid agency reports on hospital patient transfers billed as discharges and (2) review Medicaid reimbursement policies for the unaudited States and the District of Columbia to determine whether overpayments could occur if transfers were incorrectly coded as discharges.

Scope

We performed audits in North Carolina, Illinois, New York, and Indiana. Each State had a payment methodology for inpatient services that was similar to Medicare PPS. We also evaluated Medicaid State plan provisions to determine whether the 46 other States and the District of Columbia could be overpaying for transfers inappropriately billed as discharges.

Our reviews did not require an evaluation of internal controls, and we did not review State computerized system edits or medical review procedures designed to detect discharges or transfers to another hospital on the same day. We performed our fieldwork at the State Medicaid agencies and at selected hospitals in Illinois, North Carolina, New York, and Indiana. We began our fieldwork for the initial audit in May 2000 and completed the final audit in July 2003.

Methodology

We identified four States that used a form of Medicaid prospective payment and applied the approach used in prior Medicare PPS audits of hospital patient transfers.

In the initial Medicaid audit, we formed a partnership with the Illinois Department of Public Aid's Office of Inspector General to perform data analysis of the State's paid claims files and to identify beneficiaries discharged from one hospital and admitted to another hospital on the same day. The State agency eliminated properly coded transfers, previously adjusted claims, miscoded transfers with no overpayment, and transfers not subject to reduction. The remaining matches were considered potential transfers incorrectly coded as discharges. Using historical pricing data, the State agency computed potential overpayments by reducing the transferring hospital's acceptable payment to per diem for the length of stay. From the universe of potential

transfers incorrectly billed as discharges, we selected a nonstatistical sample of hospitals and their related claims and reviewed medical record information to substantiate the inappropriate billing and the overpayment. Because this review substantiated the incorrect billing of discharges, we jointly recommended that the State Medicaid agency recover the potential overpayments and make the necessary financial adjustment. We provided the identified universe of potential overpayments to the hospitals for evaluation and appropriate refund. We conducted similar reviews in North Carolina, New York, and Indiana.

To identify other States that were potentially overpaying for incorrectly coded transfers, we reviewed the CMS Web site and State Medicaid agency Web sites to ascertain the States' methods and standards for establishing payment rates for inpatient hospital care and the transfer payment policy specified in their respective State plans. If necessary, we also reviewed the States' Medicaid agency Web sites to obtain additional information from hospital handbooks and manuals relating to the payment of inpatient hospital claims. We initially focused our survey on States that used prospective payment methodologies and patient transfer policies that reduced payments to the transferring hospital. We subsequently focused on States that established set payment levels that were reduced when patients were transferred.

We performed our audits in accordance with generally accepted government auditing standards.

RESULTS OF REVIEW

STATE-SPECIFIC AUDITS

We identified approximately $6.4 million ($3.6 million Federal share) in Medicaid overpayments for hospital patient transfers in North Carolina, Illinois, New York, and Indiana. We found an additional $3.7 million ($1.9 million Federal share) in potential overpayments for inappropriately billed transfers that we referred to the States for further evaluation and appropriate recovery. Individual audit results were as follows:

		Medical Record Review		No Medical Record Review	
State	Years in Audit Period	Identified Overpayments	Federal Share	Potential Overpayments	Federal Share
North Carolina	4	$2,966,116	$1,849,683	$482,968	$301,372
Illinois	3.67	1,718,951	859,476	581,275	290,637
New York	1	986,316	493,158	2,634,162	1,317,081
Indiana	3	730,061	441,614	0	0
Total	**11.67**	**$6,401,444**	**$3,643,931**	**$3,698,405**	**$1,909,090**

The identified overpayments were based on nonstatistical reviews of medical records confirming the inappropriate billing of transfers as discharges. The potential overpayments, representing the balance of the developed universes, were not subjected to medical record review but warrant State agency evaluation and appropriate recovery. The appendix contains the report numbers and issue dates for the four audits.

Medicaid Hospital Patient Transfer State Audits

During our Illinois partnership audit, a nonstatistical sample and review of medical records confirmed that 37 of 40 claims in our developed universe were transfers inappropriately billed as discharges. Illinois believed that the results of this joint evaluation were sufficient to direct hospitals to evaluate coding of the 713 potential overpayments in the unsampled universe and to recover overpayments. In a jointly issued audit report, the State Medicaid agency questioned claims with estimated overpayments greater than $2,500 (229 claims for $1,718,951, $859,476 Federal share) without reviewing the medical records. We encouraged Illinois to seek recovery of potential overpayments of $581,275 associated with the remaining 524 claims.

Consistent with the approach developed during the Illinois audit, we identified apparent transfers, defined as beneficiaries being discharged from one hospital and admitted to another hospital on the same day, for three additional States. We also evaluated nonstatistical samples of hospitals and their related claims. The medical records often contained a discharge summary describing the illness, treatment received, and plan of care, which included discharge or transfer information. Medical record review of discharge summaries and other notes substantiated the extent of inappropriately coded discharges resulting in an overpayment. As in Illinois, the States believed that the data analysis, along with the confirming sample results, provided a reliable universe of miscoded transfers and potential overpayments, and the States sought to recover the overpayments directly from the hospitals.

Our review of nonstatistical samples of medical records confirmed inappropriate billing and overpayments of $2,966,116 ($1,849,683 Federal share) for 512 of 564 claims in North Carolina, $986,316 ($493,158 Federal share) for 74 of 185 claims in New York, and $730,061 ($441,614 Federal share) for 97 of 127 claims in Indiana.

Expanded State Agency Recovery

Because of the substantial percentage of miscoded transfers that were confirmed by the review of medical records, North Carolina, Illinois, and New York referred the additional potential overpayments to hospitals for further evaluation and appropriate refund. Illinois and North Carolina directed hospitals to review and refund any inappropriately coded transfers within the additional potential overpayments that our analyses identified. Illinois had 524 potential overpayments amounting to $581,275 ($290,637 Federal share), and North Carolina had 253 potential overpayments amounting to $482,968 ($301,372 Federal share).

For New York, the estimated additional overpayments for the 710 claims from 109 hospitals in the unsampled universe amounted to $2,634,162 ($1,317,081 Federal share). Twenty-six of the 109 hospitals had potential overpayments exceeding $50,000. We recommended that New York research the economic feasibility of analyzing the remaining claims and determining the actual overpayments warranting recovery.

We did not recommend that Indiana evaluate the additional 18 potential overpayments that our data analysis identified.

Reasons for the Overpayments

We attribute these overpayments to transferring hospitals' inappropriately reporting the patient status code as a discharge even though the patient was actually transferred to another PPS hospital. The majority of the incorrectly reported transfers were coded as a discharge to home or self-care, a routine discharge, or a discharge or transfer to a non-PPS institution for inpatient care. Because the coded discharges were actually transfers to other PPS hospitals, they should have been classified as transfers, with the transferring hospital receiving a per diem payment for the inpatient stay. Classifying transfers as discharges often results in substantial overpayment because both hospitals receive the full DRG payment.

Lack of Edits

Hospital staff attributed transfer overpayments to errors in the coding of patient status during data entry, computer system problems, a lack of knowledge of the States' Medicaid payment and transfer regulations, and an inability to effectively screen prior to payment. Because States generally did not have prepayment or postpayment edits to systematically identify potential transfers between hospitals, erroneously coded discharges and full prospective payments to both providers went undetected.

Neonatal Services

A large number of incorrectly coded transfers and significant overpayments pertained to newborn stays with complications. Complications with a birth and the need for additional neonatal services may require patients to transfer to another hospital. We found that newborns were often transferred shortly after birth, sometimes on the same day. Because a DRG for a newborn with complications generally involves an extended length of stay and a high payment, a substantial overpayment could occur when a newborn's transfer on the first day is claimed as a discharge.

In Illinois, the average length of stay for one neonatal DRG was 10.2 days. In one case, an actual length of stay of only 1 day resulted in an overpayment of almost $15,000. In North Carolina, we found two overpayments attributable to newborn transfers that had expected stays of 31 days and 48.5 days but actual stays of 4 days and 1 day, respectively. The overpayments attributed to these miscoded transfers amounted to $21,063 and $53,915.

Hospitals encountering significant numbers of neonatal cases may have a higher incidence of transfer overpayments. At a minimum, State Medicaid agencies should consider concentrating their oversight of transfer coding on hospitals with significant volumes of newborns transferred to other facilities.

POTENTIAL IN OTHER STATES

We reviewed information on the remaining 46 States and the District of Columbia to see if similar errors could occur. Our review of information on Federal and State agency Web sites

indicated that similar problems could occur in 25 States and the District of Columbia. In the remaining 21 States, there appeared to be little or no potential for these types of overpayments.

PPS Payment Methodology

We identified 17 States (Colorado, Iowa, Kansas, Kentucky, Michigan, Montana, Nebraska, New Hampshire, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Utah, Washington, and West Virginia) that followed the Medicare PPS payment methodology for Medicaid reimbursement of hospitals. Their payment methodologies for inpatient hospital care and transfer policy were similar to those applied during our prior audits. These States reimburse hospitals prospectively on the basis of preestablished DRGs, but also reduce the reimbursement to the transferring hospitals to a per diem rate for each day of the stay, not to exceed the full prospective payment for the specific group.

Reduced Payment for Transfers

Eight States and the District of Columbia used established payment levels, which were reduced after considering the transfer versus discharge status. The States included Georgia, Massachusetts, Minnesota, New Jersey, New Mexico, Texas, Virginia, and Wisconsin. Because these States and the District of Columbia have unique policies concerning payment and transfers, discharges incorrectly coded as transfers could result in overpayments to hospitals. Here are the methods that three of the eight States used to reduce payments for transfers:

- In Texas, the receiving hospital of a transferred patient is generally paid the full prospective amount, and the transferring hospital is paid a diagnosis-related amount per day. However, the payment amounts are reversed if the transferring hospital provided a greater amount of care. The transferring hospital is paid the full DRG payment.

- In Massachusetts, discharges are reimbursed at a hospital-specific standard payment, but the hospital receives a per diem capped at the standard payment if the patient is transferred.

- In Virginia, the definition of a transfer is expanded to include a patient who is transferred to another hospital for related care or who is discharged and admitted to another hospital within 5 days with the same or similar diagnosis.

RECOMMENDATIONS

We recommend that CMS:

- monitor the recovery of identified and potential overpayments described in our 4 State-specific reports and

- encourage the 25 States and the District of Columbia to consider performing focused postpayment assessments of hospital discharges and to recover overpayments for transfers inappropriately billed as discharges.

AUDITEE COMMENTS

In a written response dated June 1, 2005, CMS concurred with our recommendations. The response is included in its entirety as Appendix B to this report.

APPENDIXES

APPENDIX A

PREVIOUSLY AUDITED STATES

State	Report Number	Date Issued
Illinois	A-05-00-00049	6/18/2001
Indiana	A-05-02-00041	1/22/2003
New York	A-02-02-01004	5/8/2003
North Carolina	A-05-03-00041	5/17/2004

NOTE: These reports are available at http://oig.hhs.gov/.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

JUN - 1 2005

TO: Joseph E. Vengrin
Deputy Inspector General for Audit Services

FROM: Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: "Hospital Patient Transfers Paid as Discharges under State Medicaid Programs" (A-05-03-00014)

Thank you for the opportunity to review and comment on the above OIG draft report. The purpose of the audit was to consolidate the results of four prior State Medicaid agency (North Carolina, Illinois, New York, and Indiana) reports on hospital patient transfers billed as discharges. In addition, the purpose was to review Medicaid reimbursement policies for the unaudited States and the District of Columbia to determine whether overpayments could occur if transfers were incorrectly coded as discharges.

OIG Recommendation

CMS monitor the recovery of identified and potential overpayments described in our four state-specific reports.

CMS Response

We concur. CMS will work with these States regarding the recovery of overpayments.

OIG Recommendation

Encourage the 25 states and the District of Columbia to consider performing focused postpayment assessments of hospital discharges and to recover overpayments for transfers inappropriately billed as discharges.

CMS Response

We concur. CMS will ensure that all of the Regional Offices receive copies of this report and are aware of this issue. The Regional Offices will work with states, and if necessary, encourage them to perform focused postpayment assessments of hospital discharges and to recover overpayments.