DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

October 22, 2008

Report Number: A-05-08-00045

Ms. Janet Olszewski
Director
Michigan Department of Community Health
Capital View Building
201 Townsend Street
Lansing, Michigan 48913

Dear Ms. Olszewski:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Medicaid Inpatient Hospital Transfer Payments in Michigan for October 1, 2003, Through September 30, 2006." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

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

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

If you have any questions or comments about this report, please do not hesitate to call me, or contact Jaime Saucedo, Audit Manager, at (312) 353-8693 or through e-mail at Jaime.Saucedo@oig.hhs.gov. Please refer to report number A-05-08-00045 in all correspondence.

Sincerely,

Marc Gustafson
Regional Inspector General
for Audit Services

Enclosure

cc:
Mr. Paul Reinhart
Senior Deputy Director
Michigan Department of Community Health
Medical Services Administration
Capital Commons Center
400 South Pine
Lansing, Michigan 48933

Ms. Pam Myers
Manager
Michigan Department of Community Health
Office of Audit
Capital Commons Center
400 South Pine
Lansing, Michigan 48933

Direct Reply to HHS Action Official:

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

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID INPATIENT HOSPITAL TRANSFER PAYMENTS IN MICHIGAN FOR OCTOBER 1, 2003, THROUGH SEPTEMBER 30, 2006

Daniel R. Levinson
Inspector General

October 2008
A-05-08-00045

Office of Inspector General

http://oig.hhs.gov

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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 XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

The Department of Community Health (State agency) is responsible for inpatient hospital Medicaid reimbursement in Michigan. Attachment 4.19-A of the CMS-approved State plan requires, with some exceptions, the State agency to use the Diagnosis Related Groups (DRG) payment methodology to reimburse hospitals for inpatient hospital services. A 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.

As part of the State agency's Medicaid DRG system, special payment policies apply to claims involving the transfer of a beneficiary from one hospital to another on the same day. Pursuant to the State agency's Medicaid Provider Manual, section 2.8.F, the transferring hospital is paid a prorated DRG payment for each day of the beneficiary's stay, not to exceed the full DRG payment.

OBJECTIVE

Our objective was to determine whether the State agency properly paid inpatient hospital claims and claimed Federal reimbursement for beneficiaries transferring from one hospital to another on the same day in accordance with the CMS-approved State plan.

SUMMARY OF FINDINGS

The State agency did not properly pay inpatient hospital claims and claim Federal reimbursement for beneficiaries transferring from one hospital to another on the same day in accordance with the CMS-approved State plan. Specifically, the State agency made overpayments totaling $215,137 ($121,209 Federal share) to 28 hospitals for 36 of 57 inpatient hospital claims reviewed. The overpayments were made because hospitals incorrectly coded the claims as discharges and claimed the full DRG payment instead of the transfer, prorated DRG payment. Additionally, the State agency's payment system edits relating to transfers between hospitals on the same day were not functioning properly. The remaining 21 claims were properly paid in accordance with the CMS-approved State plan.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal government $121,209 for the overpayments made to the 28 hospitals,

- use the results of this audit in its provider education activities related to proper coding of claims for beneficiaries transferring from one hospital to another, and

- ensure the system edits designed to detect and monitor inpatient hospital claims for beneficiaries transferred between hospitals on the same day are working as intended.

AUDITEE COMMENTS

In written comments on our draft report, the State agency concurred with our findings and recommendations. The State agency's comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. The Department of Community Health (State agency) administers the Medicaid program in Michigan.

Diagnosis Related Group Payment Methodology

Attachment 4.19-A of the CMS-approved State plan requires, with some exceptions, the State agency to use the Diagnosis Related Groups (DRG) payment methodology similar to the Medicare program[1] to reimburse hospitals for inpatient hospital services. A 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. According to the State agency's Medicaid Provider Manual (the Manual), section 2.1, the Medicaid DRG reimbursement system uses the same Grouper[2] logic as the Medicare Program to assign DRGs to claims.

The State agency developed its own reimbursement methodology based on its historically paid claims and does not use the same version of the Grouper program as Medicare. According to section 2.5 of the Manual, the reimbursement methodology includes statewide relative weights that are calculated using inpatient claims information for admissions in the Michigan Medicaid and Children's Special Care Services programs. The information is derived from four consecutive state fiscal years and hospital-specific cost report data from three consecutive cost report years.

Michigan Payments for Inpatient Hospital Transfers

Section 2.8.F of the Manual states that for beneficiary transfers, the transferring hospital is paid a DRG daily rate for each day of the beneficiary's stay, not to exceed the full DRG payment. The

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[1]Section 1886(d) of the Act, enacted as part of the Social Security Amendments of 1983 (Public Law 98-21), established the Medicare prospective payment system (PPS) for inpatient hospital services. The DRG payment methodology limits PPS payments for patient transfers to other PPS hospitals to per diem payments. Under Federal regulations at 42 CFR § 412.4(f), the per diem rate is determined by dividing the appropriate prospective payment rate by the average length of stay for the specific DRG.

[2]The Grouper is a software program that classifies each case into a DRG based on the beneficiary's diagnosis, procedure codes and demographic information (e.g., sex, age, and discharge status.)

DRG daily rate is calculated by multiplying the DRG price by the relative weight and then dividing by the average length of stay for the DRG. The full payment to the transferring hospital is the DRG daily rate multiplied by the length of stay, plus any outlier payments, if applicable, and must not exceed the full DRG rate.

To ensure appropriate reimbursement for beneficiaries transferred to another hospital on the same day, the transferring hospital must indicate that a transfer occurred by placing code "02" (discharged/transferred to another short-term hospital for inpatient care) in the patient status box on the claim form. Hospital inpatient stays subject to DRG reimbursement are usually paid less than the full DRG amount when the patient is transferred to another inpatient hospital. Therefore, a transfer between hospitals improperly coded as a discharge normally results in an overpayment since both hospitals receive full DRG payments.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency properly paid inpatient hospital claims and claimed Federal reimbursement for beneficiaries transferring from one hospital to another on the same day in accordance with the CMS-approved State plan.

Scope

Of the 57 claims that were identified as potential inpatient hospital transfers paid by the State agency for October 1, 2003, through September 30, 2006, we reviewed 32 claims from 23 hospitals while the State agency reviewed the remaining 25 claims from 20 hospitals.[3] We limited our review of internal controls to obtaining an understanding of the State agency's policies and procedures for reimbursing hospitals for beneficiaries transferred from one hospital to another on the same day.

We conducted fieldwork from January through March 2008 by contacting the State agency, located in Lansing, Michigan, and the 23 hospitals that received Medicaid reimbursement for claims reviewed.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal regulations, the CMS-approved State plan, and the Manual;

- held discussions with State agency officials regarding system processing edits for claims for beneficiaries transferring from one hospital to another on the same day;

[3]The 57 claims were made by 39 hospitals. The State agency and our review of claims overlapped at 4 hospitals.

- used the CMS Medicaid Statistical Information System[4] to identify 7,044 instances of patients discharged from one hospital and admitted to another hospital on the same calendar day and determined that:

    - 4,642 claims were properly coded as transfers and appropriately paid the prorated DRG payment rate;

    - 1,408 claims were appropriately paid the full DRG payment in accordance with the CMS-approved State plan;

    - 923 claims were deemed low risk due to their low-dollar amount;

    - 71 claims at 43 hospitals were potential transfers that may have been improperly coded as discharges resulting in overpayments to transferring hospitals;

- worked with the State agency and determined that for the 71 claims:

    - 10 claims had previously been audited by the State agency's program investigation section;[5]

    - 4 claims were correctly coded based on the referral code; and

    - the 57 remaining claims were potential inpatient hospital transfers and overpayments that required a review of the medical records;

- reviewed discharge summaries[6] contained in hospitals' medical records for 32 of the 57 claims, while the State agency reviewed documentation for the remaining 25 claims[7] to determine whether a beneficiary was discharged or transferred from one hospital to another;

- quantified the number of claims incorrectly coded for beneficiaries that were transferred from one hospital to another and the total overpayments made to the hospitals; and

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[4]The Medicaid Statistical Information System contains Medicaid eligibility and payment information that the States provide to CMS on a quarterly basis.

[5]For hospitals audited by the State's program investigation section, an error rate was determined and extrapolated over the hospitals' claims for the period and the State agency recovered funds from the hospital. Therefore, we did not review these hospitals' claims.

[6]Patient discharge summaries describe the patient's illness, treatment received, and a plan of care, including discharge or transfer information.

[7]The State agency determined that 23 of the 25 claims were inappropriate and included overpayments. We included the State agency results in our audit finding.

- validated our findings with the hospitals and the State agency.

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

The State agency did not properly pay inpatient hospital claims and claim Federal reimbursement for beneficiaries transferring from one hospital to another on the same day in accordance with the CMS-approved State plan. Specifically, the State agency made overpayments totaling $215,137 ($121,209 Federal share) to 28 hospitals for 36 of 57 inpatient hospital claims reviewed. The overpayments were made because hospitals incorrectly coded the claims as discharges and claimed the full DRG payment instead of the transfer, prorated DRG payment. Additionally, the State agency's payment system edits relating to transfers between hospitals on the same day were not functioning properly. The remaining 21 claims were properly paid in accordance with the CMS-approved State plan.

OVERPAYMENTS MADE TO HOSPITALS

The State agency made overpayments, totaling $215,137 ($121,209 Federal share), to 28 hospitals for 36 claims.

State Plan and Provider Manual

Attachment 4.19-A of the CMS-approved State plan requires, with certain exceptions, that the State agency reimburse all hospitals participating in the Medicaid program for inpatient services based on DRGs.

As part of the State agency's Medicaid DRG system, special payment policies apply to claims involving the transfer of a beneficiary from one hospital to another. Pursuant to the Manual, section 2.8.F, the transferring hospital is paid a prorated DRG payment for each day of the beneficiary's stay, not to exceed the full DRG payment.

To ensure appropriate reimbursement for beneficiaries transferred from one hospital to another, the transferring hospital must indicate that a transfer has occurred by placing code 02 (discharged/transferred to another short-term hospital for inpatient care) in the patient status box on the claim form.

Claims Not Coded Correctly

The overpayments were made because hospitals did not use the correct code in the patient status box on the claim form. Specifically, the 28 hospitals improperly coded the patient status on the

claims with a code of "01" signifying that the beneficiaries were "discharged to home or self-care, routine discharge" and claimed the full DRG amount. However, medical records indicated that the hospitals should have coded the patient status with a code of "02" signifying that the beneficiaries were "transferred to another short-term hospital for inpatient care" and claimed the appropriate DRG daily rate.

State Agency System Edits

In addition to the incorrectly coded claims, the State agency's payment system edits relating to transfers between hospitals on the same day were not functioning properly during our audit period. Specifically, the edit was not functioning when a patient was admitted and transferred on the same calendar day.

RECOMMENDATIONS

We recommend that the State agency:

- recover the $215,137 ($121,209 Federal share) in overpayments made to the 28 hospitals,
- use the results of this audit in its provider education activities related to proper coding of claims for beneficiaries transferring from one hospital to another, and
- ensure the system edits designed to detect and monitor inpatient hospital claims for beneficiaries transferred between hospitals on the same day are working as intended.

AUDITEE COMMENTS

In written comments on our draft report, the State agency concurred with our findings and recommendations. The State agency's comments are included in their entirety as the Appendix.

APPENDIX

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

September 19, 2008

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

Re: Report Number (A-05-08-00045)

Dear Ms. Foster Reilly:

Enclosed is the Michigan Department of Community Health's response to the draft report entitled "Review of Medicaid Inpatient Hospital Transfer Payments in Michigan" that covered federal fiscal years 2004 through 2006.

We appreciate the opportunity to review and comment on the report before it is released. If you have any questions regarding this response, please refer them to Pam Myers at (517) 373-1508.

Sincerely,

Janet Olszewski
Director

JO:kk

Enclosure

cc: Paul Reinhart
Susan Kangas
Jim Brandell
Pam Myers

Review of Medicaid Inpatient Hospital Transfer Payments in Michigan
for Federal Fiscal Years 2004 though 2006 (A05-08-00045)

Finding

The State agency did not properly pay inpatient hospital claims and claim Federal Reimbursement for beneficiaries transferring from one hospital to another on the same day in accordance with the CMS-approved State plan. Specifically, the State agency made overpayments totaling$215,137 ($121,209 Federal share) to 28 hospitals for 36 of 57 inpatient hospital claims reviewed.

Recommendations

We recommend that the State agency:

- recover the $215,137 ($121,209 Federal share) in overpayments made to the 28 hospitals,
- use the results of this audit in its provider educations activities related to proper coding of claims for beneficiaries transferring from one hospital to another, and
- ensure the system edits designed to detect and monitor inpatient hospital claims for beneficiaries transferred between hospitals on the same day are working as intended.

DCH Response

The Department concurs with the findings and recommendations and will take the following actions:

- return the Federal share of the overpayments made to the 28 hospitals to the Federal government,
- publish a reminder to providers on the proper billing of transfers from one hospital to another, and
- corrections to the edits for beneficiaries transferring between hospitals on the same day have been made and were tested to ensure that they are working as intended.