DEPARTMENT OF HEALTH& HUMAN SERVICES

Office Of Inspector General

Memorandum

Date NOV 1 1996

From for June Gibbs Brown
Inspector General

Subject Medicare Hospital Patient Transfers Incorrectly Paid As Discharges - January 1992 Through December 1994 (A-06-95-OO083)

To

Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of our final audit report entitled, "Medicare Hospital Patient Transfers Incorrectly Paid as Discharges - January 1992 Through December 1994. " This report provides the results of our latest work in determining whether the Health Care Financing Administration's (HCFA) control system detects incorrectly reported transfers in Medicare's Part A prospective payment system (PPS). This work follows up on a prior HCFA and Office of Inspector General (OIG) joint recovery project. In that project the OIG identified incorrectly reported PPS transfers through November 1991, which resulted in approximately $227 million of recoveries and savings. Our new work found that intermediaries continue to make payments for incorrectly reported transfers. The OIG identified another 43,012 incorrectly reported transfers and approximately $127.3 million of potential overpayments for the 3-year period ended December 31, 1994.

Our work indicated that the PPS transfer edit does detect incorrectly reported PPS transfers; however, fiscal intermediaries may not be processing these transfers according to HCFA's instructions. We are continuing our audit work to fully identify the cause(s) for incorrectly reported PPS discharges not being adjusted to transfers.

We are recommending that HCFA: (1) advise all intermediaries that the PPS transfer instructions must be followed when processing future transactions, (2) assist us in identifying the cause(s) of this problem, and (3) cooperate with the Department of Justice (DOJ) efforts to recoup past overpayments. The DOJ has informed us that it will assume responsibility for the recovery of overpayments related to incorrectly reported and paid PPS transfers occurring between January 1, 1992 and December 31, 1995, as part of its fraud investigation under the Civil False Claims Act. (We are in the process of obtaining the data for 1995 and will transmit it to DOJ when available.) Thus, HCFA should not recover incorrectly reported and paid PPS transfers occurring prior to January 1, 1996 under its usual procedures.

The HCFA Administrator responded to our draft report in a memorandum dated September 3, 1996. The HCFA agreed with our recommendations and stated that it will issue instructions to all intermediaries requiring them to use the edit for processing claims involving PPS transfers. The HCFA also agreed to assist the OIG in identifying the causes of this problem and cooperate with the DOJ in its recovery efforts. The HCFA also included technical comments which we considered in finalizing this report.

We would also 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, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104. Copies of this report are being sent to other interested Department officials.

To facilitate identification, please refer to Common Identification Number A-06-95-00083 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE HOSPITAL PATIENT TRANSFERS INCORRECTLY PAID AS DISCHARGES - JANUARY 1992 THROUGH DECEMBER 1994

JUNE GIBBS BROWN
Inspector General

NOVEMBER 1996
A-06-95-00083

Memorandum

Date NOV 1 1996

From for June Gibbs Brown
Inspector General

Subject Medicare Hospital Patient Transfers Incorrectly Paid As Discharges - January 1992 Through December 1994 (A-06-95-00083)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This final report provides the results of our latest work in determining whether the Health Care Financing Administration's (HCFA) control system detects incorrectly reported transfers in Medicare's Part A prospective payment system (PPS). This work follows up on a prior HCFA and Office of Inspector General (OIG) joint recovery project. In that project the OIG identified incorrectly reported PPS transfers through November 1991, which resulted in approximately $227 million of recoveries and savings. Our new work has found that intermediaries continue to make payments for incorrectly reported transfers. The OIG identified another 43,012 incorrectly reported transfers and approximately $127.3 million of potential overpayments for the 3-year period ended December 31, 1994.

Our work to date indicates that the PPS transfer edit does detect incorrectly reported PPS transfers; however, fiscal intermediaries may not be processing these transfers according to HCFA's instructions. We are continuing our audit work to fully identify the cause(s) for incorrectly reported PPS discharges not being adjusted to transfers.

We are recommending that HCFA: (1) advise all intermediaries that the PPS transfer instructions must be followed when processing future transactions, (2) assist us in identifying the cause(s) of this problem, and (3) cooperate with the Department of Justice (DOJ) efforts to recoup past overpayments. The DOJ has informed us that it will assume responsibility for the recovery of overpayments related to incorrectly reported and paid PPS transfers occurring between January 1, 1992 and December 31, 1995, as part of its fraud investigation under the Civil False Claims Act. (We are in the process of obtaining the data for 1995 and will transmit it to DOJ when available.) Thus, HCFA should not recover incorrectly reported and paid PPS transfers occurring prior to January 1, 1996 under its usual procedures.

The HCFA Administrator responded to our draft report in a memorandum dated September 3, 1996. The HCFA agreed with our recommendations and will issue instructions to all intermediaries requiring them to utilize the edit to correctly process claims involving PPS transfers. The HCFA also agreed that it should assist the

OIG in identifying the causes of this problem and that it should cooperate with the DOJ in its recovery efforts. The HCFA also included technical comments which we considered in finalizing this report. A copy of HCFA's memorandum is included as Attachment D to this report.

INTRODUCTION

BACKGROUND

Section 1886(d) of the Social Security Act, enacted as part of the Social Security Amendments of 1983 (Public Law 98-21) on April 20, 1983, established PPS for Medicare inpatient hospital services. Under this system, the diagnoses for hospital admissions are grouped into diagnosis related groups (DRG) and payment amounts are prospectively determined by DRG. 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.

Medicare regulations (42 CFR 412.4) specify that PPS payments are available at the full prospectively set DRG rate for patients who are discharged from the hospital and that transfers between PPS hospitals do not qualify for the DRG amount. Rather, payments for transfers are determined through the calculation of per diem amounts and the actual length-of-stay at the transferring hospital. These per diem based payments cannot exceed the amount payable had a discharge occurred.

The OIG conducted a computer match of PPS claims processed from January 1986 through November 1991, and identified 123,311 incorrectly reported PPS transfers (same day discharge from a PPS hospital and readmission to a second PPS hospital). The OIG and HCFA determined that a nationwide recovery project was appropriate for recovery of overpayments included in the 123,311 incorrectly reported PPS transfers. We issued the final report for this project in February 1995 reporting recoveries and savings to the Medicare Part A trust fund of about $227 million (A-06-93-00095).

In this and previous reviews, we recommended that HCFA develop and implement a computer edit to detect incorrect reporting of PPS transfers. The HCFA concurred with our recommendation and agreed to develop an edit to detect these types of coding errors and alert the intermediary to take corrective action. The edit was reported in place as early as January 1991. The edit signals the intermediary to change the patient status code of the transferring hospital's claim to reflect a transfer rather than a discharge. Based on this change, the transferring hospital's payment is redetermined on a per diem basis. The intermediary would then recover any identified overpayments as part of its normal claims processing activities.

We conducted a follow-up review to determine the status of HCFA's corrective actions on the PPS transfer issue. The follow-up consisted of a series of computer matches on the 1992 through 1994 Part A hospital payments. This report describes the results of this review.

SCOPE OF REVIEW

We performed our work in accordance with generally accepted government auditing standards. We limited the objective of our review to determining whether HCFA's control system detects and corrects incorrectly reported PPS transfers.

In order to meet our objective, we performed a computer match of Part A hospital payments reported to HCFA for the period January 1, 1992 through December 31, 1994, to identify potential incorrectly reported transfers. Based on the results of the computer match, we conducted a limited analysis of Louisiana hospital payments to determine the validity of the data. The following steps describe our analysis:

- We reviewed Part A hospital payments to Louisiana hospitals for approximately 6 months of 1994.
- We then met with the primary Louisiana intermediary and discussed whether they actually paid full discharge payments to Louisiana hospitals with incorrectly reported transfers.
- We also had teleconference calls with a secondary intermediary for Louisiana hospitals to determine whether the intermediary paid the full discharge rate for incorrectly reported transfers.

We then worked with another intermediary who assisted us in determining the correct payment and overpayment amount for each of the incorrectly reported transfers identified through the series of computer data matches. Lastly, we met with HCFA officials at the central office and regional office level and discussed our preliminary findings.

We performed our field work and evaluation at Mississippi Blue Cross and Blue Shield in Jackson, Mississippi, in our Dallas Regional Office and in our Baton Rouge field office from April to November 1995. As previously indicated, we are continuing our work in order to determine 1995 overpayments and will report these results to DOJ when available.

RESULTS OF REVIEW

Through the computer match of Part A inpatient hospital claims, we identified incorrectly reported PPS transfers in Medicare hospital payments received at HCFA from January 1, 1992 through December 31, 1994. For this period, we found 43,012

incorrectly reported PPS transfers at 4,701 PPS hospitals. The incorrectly reported transfers contain as much as $127,299,507 of overpayments, that could be reduced based on the examination of individual claims.

For the 43,012 incorrectly reported PPS transfers with potential for overpayment, calculations applying Medicare payment methodology were made to determine the correct payment amount and the resulting potential overpayment. Complete details regarding the computer match and calculation of potential overpayment amounts appear in ATTACHMENT A. The financial significance of the incorrectly reported PPS transfers is presented in ATTACHMENT B on a state by state basis. ATTACHMENT C presents the overpayment information segregated by dollar ranges.

Through our data match, we identified that the computer edit/adjudication of exceptions for PPS transfers is not completely effective in preventing overpayments. Through a review of selected periods of PPS payment data for Louisiana hospitals, we found that overpayments continue to be made.

Our work to date indicates that fiscal intermediaries may not be processing all transfers according to HCFA's instructions and thus may not be identifying all incorrect payments. We are continuing our audit work to identify other cause(s) for these incorrect payments.

Subsequent to our work detailed in this report, the DOJ advised that it would assume responsibility for any recovery related to the incorrectly reported and paid PPS transfers reflected in ATTACHMENTS B and C, as part of its False Claims Act case against the hospitals. Additionally, the DOJ requested that we update our information to include incorrectly reported and paid PPS transfers in 1995. We are in the process of identifying incorrectly reported and paid PPS transfers from 1995 Medicare Part A payment data.

LOUISIANA HOSPITAL TRANSFERS

From limited 1994 payments (approximately the first 6 months of payment data), we identified 76 incorrectly reported transfers for further work at Louisiana's primary intermediary. The intermediary received a copy of this list to aid it in researching each transfer. We reviewed the transfers with intermediary officials and jointly determined that 45 of the incorrectly reported transfers contained overpayments. The transferring hospitals received $93,520 of overpayments for these 45 transfers. The remaining 31 incorrectly reported transfers contained no overpayments because the per diem amount (had the transferring hospital been paid correctly) would have equaled or exceeded the DRG amount they received.

In our meeting with intermediary officials, we examined the Intermediary Manual instructions for corrective action following a Common Working File alert to an incorrectly reported transfer. According to Intermediary Manual §3808, the intermediary is to change the patient status code to reflect a transfer to another PPS hospital and reprocess the transferring hospital's claim. Reprocessing the claim leads to determination of an overpayment amount and initiation of recovery action.

Intermediary officials stated that when alerted to an incorrectly reported PPS transfer, they contact the hospital to discuss the transfer. If the hospital agrees a PPS transfer occurred, the intermediary changes the reported patient status code and corrects the payment. If the hospital does not agree, the intermediary ignores the alert and allows the full PPS payment.

We referred an additional 14 incorrectly reported transfers to a secondary intermediary for research. Of the 14 incorrectly reported transfers, the lengths-of-stay for 8 transfers indicated the presence of overpayments. We discussed these eight with intermediary officials who agreed that each involved an overpayment because of incorrect reporting of the transfer. The remaining 6 incorrectly reported transfers did not contain overpayments because the per diem amount (had the transferring hospital been paid correctly) would have equaled or exceeded the DRG amount they received.

Based on our work at the Louisiana intermediary, we refined the universe of incorrectly reported transfers to exclude those cases that contain no overpayments because the per diem amount (had the transferring hospital been paid correctly) would have equaled or exceeded the DRG amount they received.

CONCLUSIONS AND RECOMMENDATIONS

Incorrect reporting of PPS transfers continues to be a problem. Intermediaries made approximately $127.3 million of overpayments during the 3-year period covered by our review. Precise determination of the cause for these potential overpayments requires additional work. The causes could include anything from clerical errors at the intermediary to systems problems involving claims processing edits. We plan additional work to determine the cause of these potential overpayments as well as to conduct data matches in subsequent periods.

RECOMMENDED ACTIONS

We recommend that HCFA:

(1) advise all intermediaries that the PPS transfer instructions must be followed when processing future transactions,

(2) assist us in identifying the cause(s) of this problem, and

(3) cooperate with DOJ efforts to recoup past overpayments.

HCFA'S COMMENTS AND OIG'S RESPONSE

The HCFA Administrator responded to our draft report in a memorandum dated September 3, 1996. The HCFA agreed with our recommendations and will issue instructions to all intermediaries requiring them to use the edit for processing claims involving PPS transfers. The HCFA also agreed to assist the OIG in identifying the causes of this problem and cooperate with the DOJ in its recovery efforts. The HCFA also included technical comments which we considered in finalizing the report. We revised Attachment A to address these technical comments.

DETERMINATION OF POTENTIAL OVERPAYMENT AMOUNTS

The objective of this project was to determine whether HCFA's control system detects and corrects incorrectly reported PPS transfers. Work conducted to meet this objective involved identifying incorrectly reported PPS transfers in the database of Part A paid claims received at HCFA from January 1, 1992 through December 31, 1994. According to a HCFA official, Medicare policy generally defines a transfer as a situation where a beneficiary is discharged from one hospital and admitted to a second hospital on the same day. For PPS hospitals, Medicare policy requires the intermediary to adjust an incorrectly reported discharge to a transfer and reprocess the transferring hospital's claim.

For this project, the OIG accessed the Inpatient SNF Standard Analytical Variable Length File. This database contains all Medicare Part A inpatient hospital claims. The OIG extracted the inpatient hospital claim record for claims received by HCFA from January 1, 1992 through December 31, 1994 The OIG identified the PPS inpatient hospital claims, and performed computer matching to link PPS inpatient hospital stays with a subsequent admission on the same day as discharge. The OIG reviewed the resulting file and purged the file of:

- correctly identified PPS transfers--transferring hospital used the correct patient/discharge status code,
- transfers involving Maryland hospitals as the transferring or receiving hospital--Maryland hospitals are currently excluded from PPS,
- transfers with lengths-of-stay equal to or exceeding the mean length of stay--per diem payment would equal the DRG payment already made and no overpayment is present, and
- transfers involving emergency access hospital--these hospitals are not under PPS.

As in all of our PPS transfer work, DRGs 385 (Neonates, Died or Transferred to Another Acute Care Facility) and 456 (Burns, Transferred to Another Acute Care Facility) were excluded in the original data extraction. Since the inception of PPS, the regulations have excluded these two DRGs from the transfer payment policy.

While there are reportedly situations where a patient could legitimately be discharged and readmitted on the same day without a transfer occurring, neither the PPS transfer regulations or instructions issued to intermediaries take this into consideration. Therefore, all same day discharges and admissions to PPS hospitals are included in the

DETERMINATION OF POTENTIAL OVERPAYMENT AMOUNTS

extraction and matching of PPS claims to identify incorrectly reported and paid PPS transfers.

There were 43,012 incorrectly reported PPS transfers remaining in the database following removal of the transfers listed above.

The OIG's objective was to identify the potential recovery amount in the 43,012 incorrectly reported PPS transfers without requiring reprocessing of these claims by the intermediaries.

The OIG reviewed the record layout for the extracted claims and determined that the records contained the following data elements which would allow determination of potential overpayments:

- Element 15: Claim From Date. The first day of the institutional provider's or physician/supplier's billing statement for services rendered to the beneficiary.

- Element 16: Claim Through Date. The last day of the institutional provider's or physician/supplier's billing statement for services rendered to the beneficiary.

- Element 37: Claim Payment Amount. Amount of payment made to provider and/or beneficiary from the Trust Fund (after deductible and coinsurance amounts have been paid) for the services covered by an institutional claim. ..... This payment amount does not include any automatic adjustments. For institutional claims, this payment amount also does not include any pass-through per diem amounts or organ acquisition costs.

- Element 54: Beneficiary Inpatient Deductible Amount. The amount of the deductible the beneficiary paid for inpatient services.

- Element 64: Beneficiary Part A Coinsurance Liability Amount. The amount of money for which the intermediary has determined that the beneficiary is liable for Part A coinsurance on the institutional claim.

DETERMINATION OF POTENTIAL OVERPAYMENT AMOUNTS

- Element 69: Claim Diagnosis Related Group Code. The diagnostic related group to which a hospital claim belongs for prospective payment purposes.

After examination of the data elements, the OIG believed that calculation of the potential amount of overpayment for each incorrectly reported PPS transfer involved:

- determining the DRG amount authorized for the hospitalization by adding elements 37, 54 and 64 (Claim Payment Amount + Beneficiary Inpatient Deductible Amount + Beneficiary Part A Coinsurance Liability Amount = DRG Amount);

- determining the applicable per diem amount for the hospitalization by dividing the calculated DRG Amount by the mean length of stay (OIG built a mean length of stay table from the HCFA published mean length of stays for each fiscal year) for the DRG and discharge date;

- determining the total amount authorized for the transfer by applying the PPS transfer payment regulation according to the date of discharge;[1]

- determining the amount that the intermediary would pay the hospital for the transfer by subtracting applicable deductible and coinsurance from the calculated transfer payment amount (amount authorized for the transfer minus (beneficiary inpatient deductible amount + beneficiary Part A coinsurance liability amount = amount intermediary would pay))

- determining the amount of overpayment by subtracting the amount calculated as the correct transfer payment from the amount previously paid the hospital by the intermediary.

For transfers occurring prior to October 1, 1995, the amount authorized the transferring hospital is the per diem amount times the actual length-of-stay prior to the transfer, limited to no more than the DRG amount. The amount authorized the transferring hospital for transfers occurring on or after October 1, 1995 is an amount equal to twice the per diem for the first day plus a per diem payment for each day prior to the transfer with the total transfer payment limited to no more than the DRG amount. When the database of incorrectly reported PPS transfers is updated, overpayments will be determined based on the PPS transfer payment policy effective for the date of the transfer.

DETERMINATION OF POTENTIAL OVERPAYMENT AMOUNTS

The OIG discussed the logic and applicability of these calculations with HCFA officials and determined that application of these calculations would permit determination of the overpayments without the need to reprocess each individual claim. The OIG calculated $127,299,507.24 of potential overpayments for the 43,012 incorrectly reported PPS transfers in the database.

1992 - 1994 POTENTIAL OVERPAYMENTS INCORRECTLY REPORTED PPS TRANSFERS BY DOLLAR AMOUNT

STATE	HOSPITALS	ESTIMATED OVERPAYMENT	TRANSFERS
CA	422	$ 16,592,147.49	4,421
FL	210	13,027,647.65	4,162
NY	204	9,009,305.48	2,390
MI	162	6,581,503.30	2,274
PA	212	6,540,559.96	2,298
TX	322	6,333,144.75	1,920
NJ	87	4,558,487.26	1,627
IL	196	4,426,026.16	1,520
IN	114	4,276,089.00	1,543
MA	96	3,934,275.50	1,130
NC	108	3,200,973.02	971
OH	168	3,163,176.94	968
LA	127	3,121,603.71	1,052
AZ	62	3,034,670.44	1,048
MO	126	2,996,321.85	1,101
GA	136	2,711,170.10	1,021
WA	85	2,396,880.42	803
VA	95	2,371,731.33	1,001
MS	102	2,348,518.69	1,239
KY	97	2,222,489.38	1,004
TN	121	2,208,192.90	808
AL	108	2,153,040.82	839
OK	109	2,065,942.85	810
WI	114	1,687,980.52	588
MN	112	1,337,608.73	490
KS	97	1,312,580.42	522
WV	53	1,306,524.55	600
CT	34	1,057,615.52	374
SC	60	1,029,705.91	426
AR	68	783,740.05	384
IA	95	776,941.66	376
OR	55	753,296.18	286
NV	19	703,229.69	147
ME	37	687,656.68	234
DC	9	613,704.86	173

1992 - 1994 POTENTIAL OVERPAYMENTS INCORRECTLY REPORTED PPS TRANSFERS BY DOLLAR AMOUNT

STATE	HOSPITALS	ESTIMATED OVERPAYMENT	TRANSFERS
NE	67	$ 543,513.83	258
NM	31	532,674.39	180
UT	34	527,714.53	185
NH	22	524,098.15	194
RI	12	483,982.01	172
AK	18	428,967.13	97
SD	39	361,368.08	172
PR	50	350,463.39	306
WY	23	347,007.96	140
DE	7	343,792.94	137
CO	44	330,907.46	123
ID	28	289,007.81	118
MT	40	261,784.33	132
ND	35	238,098.44	110
HI	13	216,625.45	40
VT	14	184,243.68	81
VI	2	10,773.89	17
	4,701	$127,299,507.24	43,012

INCORRECTLY REPORTED PPS TRANSFERS
POTENTIAL RECOVERIES BY RANGE
1992 - 1994

HOSPITALS	ESTIMATED OVERPAYMENT	TOTAL TRANSFERS	RECOVERY RANGE IN DOLLARS
3	$ 1,713,099.66	325	$500,000 and greater
3	1,349,248.10	324	400,000 - 499,999
11	3,898,517.80	1,030	300,000 - 399,999
37	8,450,460.93	1,760	200,000 - 299,999
188	25,790,432.69	6,520	100,000 - 199,999
153	13,211,519.66	3,958	75,000 - 99,999
307	18,592,790.72	5,883	50,000 - 74,999
724	25,553,447.39	9,339	25,000 - 49,999
271	6,071,073.71	2,509	20,000 - 24,999
395	6,835,941.96	2,861	15,000 - 19,999
541	6,616,580.86	3,105	10,000 - 14,999
138	1,312,967.00	633	9,000 - 9,999
165	1,401,558.61	711	8,000 - 8,999
168	1,255,881.90	678	7,000 - 7,999
179	1,158,541.51	639	6,000 - 6,999
174	957,821.84	533	5,000 - 5,999
215	970,673.71	568	4,000 - 4,999
255	891,997.68	535	3,000 - 3,999
283	713,408.75	473	2,000 - 2,999
283	427,948.13	396	1,000 - 1,999
30	28,552.57	32	900 - 999
32	27,149.17	38	800 - 899
33	24,654.21	39	700 - 799
18	11,568.95	21	600 - 699
22	12,305.50	25	500 - 599
18	8,229.48	19	400 - 499
19	6,773.87	20	300 - 399
13	3,207.25	14	200 - 299
23	3,153.63	24	55 - 199
4,701	$127,299,507.24	43,012	

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administratic

The Administrator
Washington, D.C. 20201

DATE: SEP 3 1996

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General Draft Report: "Medicare Hospital Patient Transfers Incorrectly Paid As Discharges - January 1992 Through December 1994" (A-06-95-00083)

We reviewed the subject draft report which looks at whether HCFA's control system detects incorrectly reported transfers in Medicare's Part A Prospective Payment System. Our detailed comments are attached for your consideration.

Thank you for the opportunity to review and comment on this report. Please contact us if you would like to further discuss our comments.

Attachment

Health Care Financing Administration (HCFA) Comments
On Office of Inspector General (OIG) Draft Report:
"Medicare Hospital Patient Transfers Incorrectly Paid As Discharges
January 1992 Through December 1994" (A-06-95-00083)

OIG Recommendation

HCFA should advise all intermediaries that the Prospective Payment System (PPS) transfer instructions must be followed when processing future transactions.

HCFA Response

We concur. HCFA will advise all intermediaries, prior to December 1, 1996, of the proper instructions to follow when processing PPS transfers.

OIG Recommendation

HCFA should assist the OIG in identifying the cause(s) of this problem.

HCFA Response

We concur. HCFA will work with the OIG to better identify the causes of the problem. As stated in the report, HCFA does have an edit in place which alerts contractors to incorrect reporting of PPS transfers. HCFA will issue instructions to intermediaries, prior to December 1, 1996, requiring them to utilize the edit to correctly process claims involving PPS transfers. These instructions will not interfere with the current efforts of the Department of Justice (DOJ) to recover overpayments for incorrectly reported and paid PPS transfers occurring prior to January 1, 1996.

OIG Recommendation

HCFA should cooperate with DOJ efforts to recoup past overpayments.

HCFA Response

We concur. HCFA will issue a memorandum to all Associate Regional Administrators for Medicare advising them to instruct intermediaries to comply with the OIG's recommendations and to take immediate steps to identify and record the overpayments incurred by the providers. We will also inform the regional offices and the intermediaries that DOJ will assume responsibility for the recovery of the overpayments related to the incorrectly reported and paid PPS transfers occurring prior to January 1, 1996.

Technical/ General Comments

Attachment A describes the method used to determine the potential overpayment amounts. The attachment indicates that transfer cases were identified by matching two PPS hospital claims where the discharge date of the first claim matches the admission date on the second claim. Of this subset, the following categories were removed from the analysis: claims coded as transfers; one or both of the hospitals involved was located in Maryland (due to its waiver from PPS); the length of stay prior to transfer was equal to or exceeded the mean length of stay for the Diagnostic Related Group (DRG); and transfers involving emergency access hospitals not paid under PPS. There were 43,012 cases remaining in the subset after removing these categories.

Our concern is that some of these cases may not actually be transfer cases. For example, the attachment makes no mention of whether claims assigned to DRGs 385 (Neonates, Died or Transferred to Another Acute Care Facility) or 456 (Burns, Transferred to Another Acute Care Facility) were removed from the subset. Transfers assigned to either of these DRGs are paid the full DRG amount, irrespective of whether they are transferred prior to the mean length of stay, under 42 CFR 412.4(d)(2).

In addition, there are situations where a patient could legitimately be discharged and readmitted on the same day, without a transfer having occurred. In such a situation, the full DRG amount should be paid to the discharging hospital even though the patient was subsequently readmitted the same day. We would note, however, that we would expect such occurrences to be infrequent. Nevertheless, we would add this as a caveat to the report's overpayment estimates.

Finally, in the cover note to the Administrator, the Inspector General indicates that the DOJ will assume responsibility for the recovery of overpayments occurring during the period January 1, 1992 and December 31, 1995. However, effective October 1, 1995, our per diem payment methodology was revised so that we now pay double the per diem amount for the first day of a transfer case and cases transferred 1 day before the mean length of stay will now actually be receiving the full DRG amount. Since the report only examined cases through December 1, 1994, it did not address this policy change. This change should be incorporated into the analysis identifying transfer cases after October 1, 1995.