

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF HOSPITAL PATIENT
TRANSFERS PAID AS DISCHARGES
AND CLAIMED IMPROPERLY UNDER
THE INDIANA MEDICAID PROGRAM**



JANET REHNQUIST
Inspector General

JANUARY 2003
A-05-02-00041



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

REGION V
OFFICE OF
INSPECTOR GENERAL

January 22, 2003

Common Identification Number: A-05-02-00041

Ms. Melanie Bella, Assistant Secretary
Indiana Family and Social Services Administration
Office of Medicaid Policy and Planning
Indiana Government Center
402 W. Washington Street, Room W-382
Indianapolis, Indiana 46204-2739

Dear Ms. Bella:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) final report entitled, "Review of Hospital Patient Transfers Paid as Discharges and Claimed Improperly Under the Indiana Medicaid Program." A copy of this report will be forwarded to the HHS action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. We request that you respond to the HHS 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.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, OIG OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification, please refer to Common Identification Number A-05-02-00041 in all correspondence relating to this report.

Sincerely yours,

A handwritten signature in cursive script that reads "Paul Swanson".

Paul Swanson
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Cheryl Harris, Associate Regional Administrator
Centers for Medicare & Medicaid Services – Division of Medicaid, Region V
233 North Michigan Avenue
Chicago, Illinois 60601

EXECUTIVE SUMMARY

OBJECTIVE

The objective of our review was to determine whether inpatient hospital claims for patients transferred from one hospital and admitted to another hospital on the same day were properly coded and paid in accordance with Indiana's Medicaid reimbursement methodology.

FINDINGS

The medical records confirmed that 97 of the 127 claims reviewed were transfers improperly coded as discharges. Transferring hospitals are reimbursed a diagnosis related group (DRG) pro-rated daily rate for each day, not to exceed the full DRG amount. The Office of Medicaid Policy and Planning (OMPP) claims processing system does not have edits to identify transfers between hospitals, which are erroneously coded as discharges and claimed for the full DRG payment. Based on pricing data provided by OMPP, there were overpayments of \$758,681 attributable to 92 of the hospital claims. Although coded incorrectly as discharges, the payment methodology for the remaining 5 claims did not result in an overpayment. Subsequent analysis performed by OMPP resulted in lowering the overpayment amount to \$730,061. We concur with the refinement of the overpayment amount.

RECOMMENDATIONS

We recommend that the OMPP:

- make a financial adjustment of \$730,061 (Federal share - \$441,614);
- provide additional guidance to hospitals, emphasizing the importance of coding the correct patient status at the time of discharge/transfer; and
- consider implementing prepayment controls in its claims processing system to detect, monitor, and correct the transfer/discharge coding of inpatient hospital claims.

In their written response to our draft report, OMPP officials generally agreed with the findings and recommendations presented in the report. The full text of OMPP's comments is included as an Appendix to this report.

TABLE OF CONTENTS

	Page
INTRODUCTION	1
BACKGROUND	1
Prospective Payment System	1
Indiana Reimbursement Methodology	1
Treatment of Transfers	1
OBJECTIVES, SCOPE AND METHODOLOGY	2
Objectives	2
Scope	2
Methodology	2
Identification of Patient Transfers	3
Selection of Hospitals to Visit	3
FINDINGS AND RECOMMENDATIONS	3
INDIANA DRG PAYMENT METHODOLOGY	3
TRANSFERS INCORRECTLY CODED AS DISCHARGES	4
ADDITIONAL GUIDANCE AND CONTROLS NEEDED	4
OVERPAYMENTS TO HOSPITALS	5
RECOMMENDATIONS	5
AUDITEE RESPONSE	5
OAS COMMENTS	6
AUDITEE COMMENTS	Appendix

INTRODUCTION

BACKGROUND

The Medicaid program is jointly administered by the Federal government, through the Centers for Medicare and Medicaid Services (CMS), and by the states, through their designated state agency. The designated state agency in Indiana is the Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning (OMPP). During the audit period, the Federal matching rate for hospital service costs claimed in Indiana ranged between 57.12 and 62.04 percent.

Prospective Payment System

Section 1886(d) of the Social Security 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. Under this system, the diagnoses for hospital admissions are grouped into diagnosis related groups (DRGs). Payment amounts are prospectively determined by the 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. PPS payments for patient transfers to other PPS hospitals are limited to per diem payments. Under Federal Regulation (42 CFR 412.4(d)), the per diem rate is determined by dividing the appropriate prospective payment rate by the average length of stay for the specific DRG.

Indiana Reimbursement Methodology

The Indiana Medicaid Program reimbursement for inpatient hospital services is based on a prospective cost-based payment rate for each hospital stay established according to a DRG or a level-of-care (LOC) reimbursement methodology. Inpatient stays reimbursed according to the DRG methodology are assigned to a DRG using the All-Patient (A-P) DRG grouper. The (A-P) Grouper was selected as the Grouper for the DRG system in Indiana because the A-P DRG Group more appropriately addresses the resource consumption of the Indiana Health Coverage Program. The DRG rate is equal to the relative weight multiplied by the base amount. Under the LOC system, hospitals are reimbursed on a per diem basis that is not part of the DRG reimbursement system for psychiatric, rehabilitation, and certain burn cases.

Treatment of Transfers

As part of the Indiana Medicaid DRG system, special payment policies apply to transfer cases. The receiving hospital, or transferee hospital, is paid according to the DRG or LOC methodology, whichever is applicable. Transferring hospitals are reimbursed a DRG pro-rated daily rate for each day, not to exceed the full DRG amount. The DRG daily rate is calculated by dividing the DRG rate by the average length of stay. The full payment to the transferring hospital is the sum of the DRG daily rate, the capital per diem rate, and the medical education per diem rate.

To ensure appropriate reimbursement for transfers, the transferring hospital must indicate that a transfer has occurred in the patient status box using codes of 02 (discharged/transferred to another short-term hospital for inpatient care) or 05 (discharge/transfer to another type of institution for inpatient care). 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 when both hospitals receive full DRG payments.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The primary objectives of the review were to:

- identify inpatient claims for patients who were discharged and admitted to a different hospital on the same calendar day;
- determine whether the discharging hospitals properly coded the submitted claims; and
- identify the overpayments to hospitals for claims that were improperly coded as a discharge rather than a transfer.

Scope

Our audit was made in accordance with generally accepted government auditing standards. Fieldwork was performed at OMPP's administrative office in Indianapolis and at 45 hospitals located throughout Indiana. We reviewed the medical records relating to 127 claims totaling \$1,277,150 at these hospitals to determine if the patients were discharged or transferred to another hospital. The medical records to support three claims could not be located by hospital staff at the time of our visit. We referred these three claims to OMPP staff for further review to determine the propriety of the payments to the hospitals. Our review of management controls was limited to obtaining an understanding of OMPP's hospital payment methodology to ensure that hospitals were properly paid when patients were transferred to another hospital. Fieldwork was completed in May 2002.

Methodology

To accomplish our audit objectives, we:

- obtained an understanding of the methods and standards for establishing inpatient rates for hospital reimbursement;
- developed a detection routine to identify potential transfers paid as a discharge; and

- performed an analysis and tests on the results of the computer program to ensure its accuracy and completeness.

Identification of Patient Transfers. The hospital transfer routine was designed to identify patient transfers from one hospital to another that are incorrectly coded as a discharge and resulted in an overpayment. To implement the routine, we used inpatient hospital claims submitted to the CMS through the Medicaid Statistical Information System (MSIS) during the period October 1, 1998 through September 30, 2001. The routine identified 1,860 instances of patients receiving patient care that were discharged by one hospital and admitted by another hospital on the same calendar day. Our analysis of the claim detail disclosed that the hospitals properly coded the patient status as a transfer (02 and 05) for 1,546 of the 1,860 claims. As a result, the transferring hospitals were paid a pro rata share of the DRG depending on the length of stay, in accordance with Indiana's Medicaid DRG system. Further analysis of the detail for an additional 169 claims disclosed that the coding of the potential transfer by the hospital would not result in an overpayment. For the majority of these claims, if coded correctly as a transfer, the per diem payment to the transferring hospital would equal or closely approximate the full DRG payment. As a result, these 169 claims were removed from the potential transfer universe.

Selection of Hospitals to Visit. The remaining 145 claims, submitted by 62 different hospitals, were apparent transfers that may have been improperly coded as discharges. The total payment to the hospitals for these 145 claims was \$1,335,278. Based on our estimate of the potential overpayment for each claim, the number of claims at each hospital, and the proximity to other hospitals, we judgmentally selected 45 hospitals to determine whether the claims were hospital transfers incorrectly coded as discharges. These 45 hospitals encompassed 127 of the 145 claims and 97 percent of the estimated potential overpayments for all 145 claims.

FINDINGS AND RECOMMENDATIONS

Our review of the medical records at the 45 hospitals disclosed that 97 of the 127 patients were transferred to another hospital for continued care. The patient status was incorrectly coded as a discharge on the claim submitted to OMPP. According to Indiana's Medicaid DRG system, transferring hospitals should be reimbursed a DRG pro-rated daily rate for each day, not to exceed the full DRG amount. The OMPP claims processing system does not have edits to identify transfers between hospitals, which are erroneously coded as discharges and claimed for the full DRG payment. As a result, overpayments were made to the hospitals in the amount of \$730,061 (Federal share - \$441,614).

INDIANA DRG PAYMENT METHODOLOGY

The Indiana Medicaid Program reimbursement for inpatient hospital services is based on a prospective cost-based payment rate for each hospital stay, established according to a DRG or a level-of-care (LOC) reimbursement methodology. As part of the Indiana Medicaid DRG system, special payment policies apply to transfer cases. The receiving hospital, or transferee hospital, is paid according to the DRG or LOC methodology, whichever is applicable. Transferring hospitals are reimbursed a DRG pro-rated daily rate for each day, not to exceed the full DRG

amount. The DRG daily rate is calculated by dividing the DRG rate by the average length of stay. The full payment to the transferring hospital is the sum of the DRG daily rate, the capital per diem rate, and the medical education per diem rate.

TRANSFERS INCORRECTLY CODED AS DISCHARGES

To determine the propriety of the hospitals' claims, we requested the medical records at the 45 hospitals for the 127 patients. The medical records contained a discharge summary describing the patient's illness, treatment received, and plan of care, which included discharge and/or transfer information. In addition, physician orders, progress notes, nurse notes, and other documentation were available, if needed, to determine if the patient was discharged or transferred. The results of our review of the medical records were, as follows:

- 97 patients were transfers incorrectly reported as a discharge on the claims submitted to OMPP. Since the patient status code indicated that the patient was discharged, the hospital received the full DRG payment.
- 18 patients were properly coded, thus, entitling the releasing hospital to appropriately receive the full DRG payment. The patients were either discharged home or left against medical advice and later sought medical attention in another hospital on the same day.
- 9 patients transferred to other hospitals, that were originally miscoded as discharges, were adjusted during a medical record review performed by the Health Care Excel Surveillance and Utilization Review team. Health Care Excel is contracted with the Indiana Family and Social Services Administration to identify and recoup overpayments based on Federal and State laws and regulations.
- 3 patients' medical records could not be located by hospital staff at the time of our visit. The OMPP should follow-up on these 3 claims to determine the propriety of the payments to the hospitals.

In summary, our analysis of documentation contained in the medical records concluded that 97 of the 127 patients were transfers to another hospital. We discussed the results of our review with OMPP staff, who agreed that the 97 claims were transfers incorrectly coded as discharges.

ADDITIONAL GUIDANCE AND CONTROLS NEEDED

The transferring hospitals erroneously reported the patient status code on the 97 claims as a discharge even though the patient was actually transferred to another hospital. The code for the majority of the transfers was incorrectly reported as a discharge to home or self-care, routine discharge. The OMPP's claims processing system does not have edits to identify transfers between hospitals, which are erroneously coded as discharges and claimed for the full DRG payment.

OVERPAYMENTS TO HOSPITALS

Special payment policies apply to transfer cases. Transferring hospitals are reimbursed a DRG pro-rated daily rate for each day, not to exceed the full DRG amount. Using its historical pricing data, OMPP recomputed the 97 claims as transfers rather than discharges. Based on the recomputations, there would have been overpayments to the hospitals for 92 claims amounting to \$758,681. Subsequent to the issuance of our draft report, OMPP performed additional analysis and determined that the overpayment amounts should be lowered to \$730,061. We concur. The overpayment amounts ranged from \$746 to \$120,839. Although incorrectly coded as discharges, the payment methodology for the remaining five claims did not result in an overpayment.

RECOMMENDATIONS

We recommend that the OMPP:

- make a financial adjustment of \$730,061 (Federal share - \$441, 614);
- provide additional guidance to hospitals, emphasizing the importance of coding the correct patient status at the time of discharge/transfer; and
- consider implementing prepayment controls in its claims processing system to detect, monitor, and correct the transfer/discharge coding of inpatient hospital claims.

AUDITEE RESPONSE

In a letter dated November 18, 2002, OMPP generally concurred with the findings and recommendations presented in the report. In a follow-up letter dated December 6, 2002, OMPP reaffirmed the overpayment amount of \$730,061 recommended for financial adjustment. The difference between the amount reported in the draft report is attributable to (i) overpayments for two claims have been rescinded on appeal; (ii) three claims for which medical records could not be located are considered overpayments by OMPP; and (iii) the overpayment amount was recomputed on several claims. The OMPP has already recovered several of the overpayments, and the Federal share has been refunded. The OMPP is in the process of recovering the remaining overpayments and will make the adjustments associated with these claims.

OMPP recognizes the importance of providing guidance to hospitals emphasizing the necessity of correct coding at the time of discharge/transfer and intends to reinforce this issue with providers in the future through periodic provider notices and educational opportunities. In regard to prepayment controls, the nature of overpayments associated with incorrect discharge status coding does not facilitate prepayment review. There is no systematic way to conduct a prepayment review to monitor the discharge/transfer coding of inpatient claims from the transferring hospital unless the receiving hospital has already received payment for the services. However, OMPP will explore establishing a post payment review process to identify possible inappropriate discharge status coding. The full text of OMPP's response is included as an Appendix to this report.

OAS COMMENTS

The OMPP continues to work with the results of our review of the medical records for the 127 claims at the 45 hospitals. Based on their follow-up on these claims, we agree that the total overpayment amount is \$730,061 (Federal share - \$441,614). The continued emphasis by OMPP through educational opportunities and provider notices should adequately reinforce the importance of correct coding at the time of discharge/transfer. We agree that rather than implementing prepayment controls, the establishment of a post payment review process would be an alternative to identify possible inappropriate discharge status coding of inpatient hospital claims.

APPENDIX



"People
helping people
help
themselves"

Frank O'Barinon, Governor
State of Indiana

Office of Medicaid Policy and Planning
402 W. WASHINGTON STREET, ROOM W382
INDIANAPOLIS, IN 46204-2739

John Hamilton, Secretary

November 18, 2002

Mr. Paul Swanson
Regional Inspector General for Audit Services
Department of Health and Human Services
233 N Michigan Ave
Chicago, IL 60601

Dear Mr. Swanson:

Thank you for providing our office with a draft copy of Audit Report A-05-02-00041, entitled "Review of Hospital Patient Transfers Paid as Discharges and Claimed Improperly Under the Indiana Medicaid Program." Our office appreciates the time and effort dedicated to this audit by the OIG staff. The draft report was received in our office on October 10, 2002. The purpose of this letter is to provide your office with our comments in response to the recommendations set out in the audit report.

Recommendation 1 – Make a financial adjustment (to CMS) of \$758,681.

Health Care Excel (HCE), who is under contract with OMPP to perform Surveillance and Utilization Review services for the Indiana Medicaid program, worked with the OIG audit team to initially identify the overpayments outlined in Attachment A. Hospitals identified as having been overpaid (due to their use of incorrect discharge status codes) have been informed of the overpayment amount that must be refunded to the Medicaid Program.

After thoroughly reviewing the OIG's draft report, OMPP's accounting of the total overpayment amount is \$730,061; an explanation for the difference is outlined below and on Attachment A.

- Of the 126 claims the OIG reviewed, 97 claims were identified as overpayments. This number has been reduced to 88 for the following reasons:
 - 2 claims have been rescinded on appeal. (These claims are annotated in red on Attachment A.)

Equal Opportunity / Affirmative Action Employer



- 6 claims that were improperly coded as a discharge (code 01 or 03) should have been coded as status 04 (discharge or transfer to an immediate care facility). Since a "04" status pays a full DRG, the payment to the hospital would have remained the same if the claim had been coded correctly. (These claims are annotated in blue on Attachment A.)
- 1 claim (line 95 on Attachment A) was improperly coded as a discharge. However, if the claim had been coded as a transfer, the claim would have grouped to DRG 639, which is designated as a transfer DRG, and thus would not have resulted in an overpayment.
- The 3 claims for which medical records could not be located are considered overpayments by OMPP and included in the total overpayment amount of \$730,061.

Several of the overpayments identified by the OIG audit have already been recovered by OMPP and the federal share of the overpayments refunded via established procedures. The date of the refund for these claims is annotated on Attachment A and claims history has been adjusted. OMPP is in the process of recovering the remaining overpayments and will make any adjustments associated with these claims.

Recommendation 2 – Provide additional guidance to hospitals, emphasizing the importance of coding the correct patient status at the time of discharge/transfer.

OMPP recognizes the importance of providing guidance to hospitals emphasizing the necessity of correct coding at the time of discharge/transfer. On November 12, 2002 a provider notice was sent to providers reminding them of the importance of using proper discharge status coding. Additionally, during the exit conference held at the conclusion of a SUR audit, HCE routinely educates and reminds facilities of the importance of correct discharge status coding. OMPP intends to reinforce this issue with providers in the future through periodic provider notices and educational opportunities.

Recommendation 3 – Consider implementing prepayment controls in the claims processing system to detect, monitor and correct the transfer/discharge coding of inpatient hospital claims.

While OMPP recognizes the benefits of prepayment controls to help prevent inappropriate claims payment, the nature of overpayments associated with incorrect discharge status coding does not facilitate prepayment review.

A hospital cannot bill the Medicaid program until a member has been discharged from the facility. Hospitals have up to a year from the date of service to file a claim. OMPP cannot determine if a transfer has occurred until the receiving hospital has filed a claim. Since any inappropriate payments related to discharge status would be made to the transferring provider, there is no systematic way to conduct a prepayment review to monitor the discharge/transfer coding of inpatient hospital claims from the transferring hospital unless the receiving hospital has already received payment for the services. However, OMPP will explore establishing a post payment review process to identify possible inappropriate discharge status coding.



"People
helping people
help
themselves"

Frank O'Bannon, Governor
State of Indiana

Office of Medicaid Policy and Planning
402 W. WASHINGTON STREET, ROOM W382
INDIANAPOLIS, IN 46204-2739

John Hamilton, Secretary

December 6, 2002

Mr. Paul Swanson
Regional Inspector General for Audit Services
Department of Health and Human Services
233 N Michigan Ave
Chicago, IL 60601

Dear Mr. Swanson:

This letter is a follow-up to our November 18, 2002 response to draft Audit report A-05-02-00041. Upon review, OMPP discovered an error in calculating the overpayment amount. The amount reported should have read \$730,061 instead of \$658,821. The incorrect information has been updated. Please replace the original pages with the attached corrected pages.

If you have any questions, please contact Angela Jackson at 317-232-4944

Sincerely,

Melanie Bella, Assistant Secretary
Office of Medicaid Policy and Planning

Electronic Copy: Victor Schmitt, OIG/OAS

Equal Opportunity / Affirmative Action Employer



ACKNOWLEDGMENTS

This report was prepared under the direction of Paul Swanson (RIGA). Other principal Office of Audit Services staff who contributed include:

Ross Anderson, *Audit Manager*

Victor Schmitt, *Senior Auditor*

Tom Tucker, *Auditor*

Leslie Foster, *Auditor*

For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.