

**Memorandum**

JUN 14 2001

Date

From

Michael Mangano
Michael F. Mangano
Acting Inspector General

Subject

Partnership Review of Hospital Patient Transfers Potentially Paid as Discharges and Claimed Improperly Under the Illinois Medicaid Program (A-05-00-00049)

To

Thomas Scully
Administrator
Health Care Financing Administration

This is to alert you to the issuance on Monday, June 18, 2001, of our final report. A copy is attached. The objective of our review was to determine whether hospitals are paid in accordance with Illinois Medicaid policy when patients are transferred to another hospital. Under its Partnership Plan, the Department of Health and Human Services, Office of Inspector General (OIG), Office of Audit Services entered into this joint project with the Illinois Department of Public Aid's (IDPA) OIG, and the Division of Medical Programs (DMP).

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, hospital admissions are grouped by applicable diagnoses into diagnosis related groups (DRG). The IDPA utilizes this system with modifications deemed appropriate due to the differences in the Medicare and Medicaid patient populations and Illinois Medicaid policy.

Under the State's Medicaid PPS, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to persons receiving coverage under the Medicaid program. The DRG payment amount 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 under the PPS system that admit, stabilize, and transfer patients to other PPS hospitals, generally use fewer resources than hospitals providing the full scope of medical treatment. The PPS payments for patient transfers to other PPS hospitals are limited to per diem payments. Hospital inpatient stays subject to DRG reimbursement are usually paid less than the full DRG amount when the patient is transferred to another inpatient PPS hospital. Therefore, a transfer between PPS hospitals improperly reported as a discharge normally results in an overpayment when both hospitals receive full DRG payments.

To identify the inpatient hospital claims with potential problems in coding transfers as discharges, the IDPA OIG performed an analysis of claims identifying patients being

discharged from one hospital and admitted to another hospital on the same day. The analysis identified 1,410 instances where hospitals discharged patients who were subsequently admitted to a different hospital on the same day. Based on our field work and testing, we concluded that 833 claims in the universe were transfers which might have been improperly coded as discharges. During the period July 1, 1996 through February 28, 2000, we estimated potential overpayments of approximately \$2.3 million (Federal share \$1,150,113) for 753 claims. Although coded incorrectly as discharges, payments for the remaining 80 claims did not result in an overpayment.

To focus on those claims with the greatest potential for recovery, we identified 240 of the 753 claims with estimated overpayments exceeding \$2,500. To determine the estimated overpayment on these 240 discharges, IDPA DMP recomputed the hospital claims as if the patients were transferred. Based on this recalculation, there would have been overpayments of about \$1.7 million on 229 of these claims by 88 hospitals. As previously cited, payment for the remaining 11 claims did not result in an overpayment to the hospital.

We recommended that the IDPA: (i) provide additional guidance to hospitals, emphasizing the importance of coding the correct patient status at the time of discharge/transfer; (ii) review the potential for effective controls in its claims processing system to detect, monitor, and correct inpatient hospital claims improperly coded as discharges; (iii) take the necessary steps to recover the potential overpayments attributable to the 229 claims amounting to \$1,718,951 (Federal share \$859,476); and (iv) use its discretion in the collection of other potential overpayments estimated to be \$581,275 (Federal share \$290,637) for the remaining 524 claims.

The IDPA is developing a plan to recover overpayments to hospitals for transfers that were improperly coded as discharges. The IDPA OIG has begun to prepare letters to the hospitals requesting that they document their claims coded as discharges or make restitution to the State.

Any questions or comments on any aspect of this memorandum are welcome. Please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at 410-786-7104 or Paul Swanson, Regional Inspector General for Audit Services, Region V, at 312-353-2618.

To facilitate identification, please refer to Common Identification Number A-05-00-00049 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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



**JUNE 2001
A-05-00-00049**



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

REGION V
OFFICE OF
INSPECTOR GENERAL

CIN: A-05-00-00049

Ms. Jackie Garner
Director
Illinois Department of Public Aid
201 South Grand Avenue East
Springfield, Illinois 62763

Dear Ms. Garner:

This final report provides you with the results of the partnership review of hospital patient transfers potentially paid as discharges and claimed improperly under the Illinois Medicaid program. Under its Partnership Plan, the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services (OAS), entered into this joint project with the Illinois Department of Public Aid's (IDPA) OIG, and the Division of Medical Programs (DMP). The IDPA administers the Illinois Medicaid program and submits the quarterly claims to the Health Care Financing Administration (HCFA).

The objective of our review was to determine whether hospitals are paid in accordance with Illinois Medicaid policy when patients are transferred to another hospital. To identify the inpatient hospital claims with potential problems in coding transfers as discharges, the IDPA OIG performed an analysis of claims identifying patients being discharged from one hospital and admitted to another hospital on the same day. The analysis identified 1,410 instances where hospitals discharged patients who were subsequently admitted to a different hospital on the same day. Based on our field work and testing, we concluded that 833 claims in the universe were transfers which might have been improperly coded as discharges. During the period July 1, 1996 through February 28, 2000, we estimated overpayments to the hospitals of approximately \$2.3 million (Federal share \$1,150,113) for 753 claims. Although coded incorrectly as discharges, the payment methodology for the remaining 80 claims did not result in an overpayment.

To focus on those claims with the greatest potential for recovery, we identified 240 of the 833 claims with estimated overpayments exceeding \$2,500. To determine the estimated overpayment on these 240 discharges, IDPA DMP recomputed the hospital claims as if the patients were transferred. Based on this recalculation, there would have been overpayments of \$1,718,951 on 229 of these claims by 88 hospitals. As previously cited, payments for the remaining 11 claims did not result in an overpayment to the hospital. Although the overpayments of \$1,718,951, relating to the 229 potential transfers incorrectly coded as discharges, could be reduced if the patients' hospital records support valid discharges, the universe refinement and field work results concluded that the majority of these claims were transfers.

We recommend that the IDPA: (i) provide additional guidance to hospitals, emphasizing the importance of coding the correct patient status at the time of discharge/transfer; (ii) review the potential for effective controls in its claims processing system to detect, monitor, and correct inpatient hospital claims improperly coded as discharges; (iii) take the necessary steps to recover the potential overpayments attributable to the 229 claims amounting to \$1,718,951 (Federal share \$859,476) and make the necessary financial adjustments when the funds are received from the hospitals; and (iv) use its discretion in the collection of other potential overpayments estimated to be \$581,275 (Federal share \$290,637) for the remaining 524 claims.

BACKGROUND

PARTNERSHIP PLAN

In order to provide broader audit coverage of State Medicaid programs in Region V States, we proposed to jointly review Medicaid payments, using previously successful approaches presented in the existing publication, *Partnerships Work and Deliver Results, A Summary of Federal/State Joint Audit Initiatives*. That document suggests that State and Federal oversight groups working together is the most effective and efficient use of scarce Federal and State resources. In implementing the partnership approach, the following offices with their compatible missions participated in this joint project.

HHS, OIG OAS: The mission of the HHS OIG is to improve programs and operations of HHS and to protect against fraud, waste, and abuse. By conducting independent and objective audits, evaluations, and investigations, the HHS OIG provides timely, useful, and reliable information and advice to HHS officials, the Administration, the Congress, and the public.

The OAS, one component of the HHS OIG, provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs, in general, and of its grantees and contractors, in regard to carrying out their respective responsibilities. These audits are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency in HHS programs.

IDPA OIG: The IDPA OIG employs 311 staff to fulfill the Illinois General Assembly's mandate to "prevent, detect, and eliminate fraud, waste, abuse, mismanagement, and misconduct" in programs administered by the Department of Public Aid. The IDPA OIG has a multi-disciplinary staff of professionals who initiate enforcement actions and develop prevention strategies to safeguard the Illinois Medical Assistance, Food Stamp, and Temporary Assistance for Needy Families programs.

The IDPA OIG conducts numerous research projects and studies issues affecting the fiscal integrity of the programs it monitors. The IDPA OIG conducted the nation's first statistically valid study of the accuracy of Medicaid payments in Illinois. The project's findings have

provided significant guidance to continuing fraud prevention work, and its methodology has served as a blueprint for other States and other payers who are undertaking medical payment accuracy studies. The IDPA OIG has also produced numerous reports on key program integrity issues.

The IDPA OIG Fraud Science Team (FST) also has an active effort to develop innovative fraud and overpayment detection routines of which this project is a component.

The IDPA OIG also has a Fraud and Abuse Executive who coordinates actions with State and Federal law enforcement agencies. The Fraud and Abuse Executive also leads and coordinates other State-Federal initiatives for the IDPA OIG, including the HHS OIG Partnership Plan.

The IDPA OIG FST staff developed and implemented the detection routine used in this review and identified an initial result set for desk and field validation. They also contributed to the desk validation, development of the field validation procedures, interpretation of the field validation results, edit and policy recommendations, and the preparation of this report.

IDPA DMP: The IDPA DMP is responsible for administering the Illinois Medical Assistance Program, which includes the Medicaid program and several State-only programs. The DMP is an active and committed partner with IDPA OIG on a wide range of initiatives to address health care fraud and abuse and develop effective program safeguards.

On this project, DMP staff performed several crucial roles in the formulation and review of the routine. They supplied policy rules and exclusions, contributed to the desk validation of the results, led the development of the field review procedures, performed the repricing of the audited claims, and contributed to the formulation of editing and policy recommendations.

HOSPITAL REIMBURSEMENT METHODOLOGY

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, hospital admissions are grouped by applicable diagnoses into diagnosis related groups (DRG). Payment amounts for the DRGs are prospectively determined. The IDPA utilizes this system with modifications deemed appropriate due to the differences in the Medicare and Medicaid patient populations and Illinois Medicaid policy.

Under the State's Medicaid PPS, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to persons receiving coverage under the Medicaid program. The DRG payment amount 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. The patient status code recorded by the hospital at

the time of discharge or transfer is the determining factor whether the inpatient claim will be paid as a discharge or a transfer by IDPA.

The PPS payments for patient transfers to other PPS hospitals are limited to per diem payments. The receiving hospital is normally paid the full amount of the DRG payment. If the patient is transferred to a hospital excluded from PPS, the transferring hospital receives the full DRG payment, as if the patient was discharged. The types of hospitals excluded from PPS reimbursement include children's hospitals, psychiatric hospitals, rehabilitation hospitals, and long term stay hospitals.

Under Illinois Medical Assistance Program payment rules, the transferring hospitals are paid a per diem rate for each day of the patient's stay in that hospital. Dividing the appropriate prospective payment rate by the average length of a stay determines the per diem rate for the specific DRG. Applying this rate to the actual length of the stay determines the amount paid for this DRG. The payment to the transferring hospital may not exceed the full DRG payment rate, unless the case meets the criteria for cost outliers. 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 PPS hospitals improperly reported as a discharge normally results in an overpayment when both hospitals receive full DRG payments.

OBJECTIVES, SCOPE, AND METHODOLOGY

The Federal and State government audit groups coordinated this review throughout. Below is a discussion of what, particularly, each group performed within the overall audit effort.

Methodology Used by OAS. The OAS conducted the audit in accordance with generally accepted government auditing standards. 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.

To accomplish its audit objective, OAS:

- < 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.

The OAS conducted its field work at IDPA administrative offices in Springfield, Illinois and at four hospitals in the Chicago area. Field work was completed in October 2000.

Methodology Used by IDPA OIG to Identify Hospital Transfers. The hospital transfer routine is designed to identify patient transfers from one hospital to another that are incorrectly coded as a discharge and resulted in an overpayment. The routine identifies instances where a hospital discharged a patient who received inpatient care and the patient was admitted to a different hospital for inpatient care on the same calendar day.

To implement the routine, FST (as noted, a component of IDPA) used all inpatient hospital discharge data available on IDPA's data warehouse. These data included hospital discharge claims that IDPA adjudicated for payment between July 1, 1996 and February 28, 2000. Because the focus of this review was on instances of a potential transfer, our unit of analysis was a pair of inpatient hospital claims rather than a single claim. The FST was interested in identifying pairs of inpatient hospital claims where the patient's discharge date on the first claim is the same as the admission date on the second claim. Throughout this document, these pairs are referred to as "instances."

To correctly identify instances that are highly likely to be incorrectly coded transfers, FST needed to exclude several types of instances. While most of these exclusions were applied to the initial result set, several were either identified or modified during the desk validation effort. The excluded instances were those where:

- < The first hospital coded the claim as a transfer.
- < The first or second hospital billed for a Medicare crossover service. While of potential interest to the Medicare program, the Medicaid-only services are those that are actionable and of interest to the IDPA.
- < The first hospital was paid on a per diem basis.
- < The second hospital was considered another type of facility. Examples include children's hospitals and long term care hospitals. In this case, the first hospital's transfer is reimbursed at the full DRG amount.

- < The specific DRG code billed by the first hospital allowed for transfers to another facility. The DRGs 385, 456, and 985 specifically permit transfers since the geometric length of a stay (GLOS) for that DRG is based on both transferred and non-transferred stays.
- < The length of a stay for the first hospital was equal to or greater than the GLOS on which the DRG reimbursement amount is calculated. In those cases, the per diem payment to the first hospital for a transferred patient would be comparable to the DRG payment for a discharged patient. As a result, the incorrectly coded first hospital claim is merely a technical error since no overpayment has resulted.

Universe Refinement. By applying previously discussed matching routines to inpatient hospital claims, the IDPA OIG identified 1,410 instances of hospital patients who were discharged and subsequently admitted to a different hospital on the same day. Further analysis identified 327 claims for patients transferred to hospitals excluded from PPS reimbursement. The transferring hospital would be entitled to the full DRG payment as if the patient was discharged. As a result, the 327 claims were eliminated from the universe of potential erroneously coded discharges. A revised universe of 1,083 claims was established.

The OAS selected a judgmental sample of 40 claims at 4 hospitals to validate the accuracy of the data matching logic for the hospital transfer analysis and the patient status code. Using the medical record documentation such as transfer forms, doctors' orders, and attestation forms, OAS confirmed that the hospitals had transferred 37 of the 40 patients to another PPS hospital. Three claims were correctly coded as discharges, entitling the releasing hospital to appropriately receive a full DRG payment. Two of the patients were discharged home and the other patient left against medical advice. In all three situations, the patients later sought medical attention in another hospital on the same day. The OAS reviewed the universe for similar situations and eliminated an additional 250 claims from the universe of 1,083. Based on its field work and testing, the remaining 833 claims were apparent transfers which may have been improperly coded as discharges.

RESULTS OF AUDIT

Hospitals receive the full DRG payment when the patient status code indicates that the patient was discharged. When a patient is transferred to another hospital, only a portion of the DRG payment amount should be paid to the first hospital. The PPS payments for patient transfers to other PPS hospitals are limited to per diem payments. The IDPA claims processing system does not have edits to identify transfers between PPS hospitals, which are erroneously coded as discharges and claimed for the full DRG payment. As a result, the inappropriate payment of the full DRG amount to both the releasing and receiving hospitals goes undetected. Based on the results of this partnership effort, we concluded that 833 claims, attributable to 158 hospitals,

were for transfers which might have been improperly coded as discharges. The estimated overpayments to the hospitals for 753 of the 833 claims amounted to approximately \$2.3 million (Federal share \$1,150,113).

Further analysis showed that 102 of the 753 potential transfers were for 1-day stays relating to newborns with complications such as extreme immaturity, prematurity, and neonates with problems. The HCFA average length of a stay for these newborn DRGs ranged from 2.4 days to 10.2 days. Since the transferring hospitals would only be entitled to a per diem payment for the 1 day, the transfers of these newborns incorrectly reported as discharges results in substantial overpayments to the hospitals. The estimated overpayments to the hospitals for these 102 1-day stays accounted for \$923,472 of the total estimated overpayment of \$2.3 million. As part of IDPA's prepayment review of inpatient hospital claims, its professional review organization examines 1-day stays to determine the appropriateness and medical necessity of the inpatient stay. However, it excluded 1-day stays applicable to newborns from the scope of the prepayment review. As a result, they did not detect the above mentioned overpayments to hospitals attributable to newborn 1-day stays. The OAS understands the complexity of systematically editing for these transfers because the claims submitted by the two hospitals are not simultaneously transmitted to the Department for payment.

Estimated Hospital Overpayments. By using a formula proposed by IDPA, the partnership estimated the per diem payment to the hospital for these transfers coded as discharges. The difference between the DRG amount paid to the hospital and the estimated per diem amount is the overpayment. Since this would only give us an estimate, OAS and IDPA jointly agreed that DMP would compute the actual per diem payments to the hospitals based on historical pricing data for claims. The OAS initially focused on claims with the greatest potential overpayment, or those claims with an estimated overpayment of over \$2,500. The results of our revised computation of the 833 claims were as follows:

No Overpayment. Of the 833 claims identified as transfers incorrectly coded as discharges, 80 claims did not result in overpayments. Because of the payment methodology for certain newborn DRG codes, the transfers were reassigned to and reimbursed under a different DRG when the patient was transferred to another hospital. The appropriate payments under this new DRG were greater than the amount previously paid to the hospital. As a result, there were no overpayments to the hospital for these DRG codes for these 80 claims. These 80 claims were eliminated from our universe.

DMP Computation of Overpayment. The OAS provided DMP with 229 claims with potential overpayments in excess of \$2,500. Using its historical pricing data, DMP recomputed the claims as transfers rather than discharges. Based on their recomputations of these claims, overpayments to 88 hospitals amounted to \$1,718,951. The overpayment amounts ranged from \$1,759 to \$20,874 with an average overpayment of \$7,506.

OAS Estimate of Overpayment. Based on the formula proposed by IDPA, OAS estimated the overpayments on the remaining 524 claims. The overpayments, totaling \$581,275, varied from \$70 to \$2,490 with an average overpayment of \$1,109.

These overpayments to 156 hospitals, totaling \$2.3 million (\$1,718,951 + \$581,275), could be reduced if the hospital medical records substantiate a transfer or if IDPA's recomputation of the overpayment for the additional 524 claims results in a reduced amount.

Based on our universe analysis and field tests, we believe that these 753 claims should have been coded as transfers. Initially, the 88 hospitals with overpaid claims, estimated to be in excess of \$2,500, will be given the opportunity to support their discharge codes during the audit resolution process. At IDPA's discretion, the additional 524 overpaid claims to 138 hospitals will be considered for collection.

Recommendations. We jointly recommend that IDPA:

- < provide additional guidance to hospitals emphasizing the importance of the correct coding of the patient status at the time of discharge or transfer;
- < review the potential for more effective controls in its claims processing system to detect, monitor, and correct inpatient hospital claims improperly coded as discharges;
- < take the necessary steps to recover the potential overpayments attributable to the 229 claims amounting to \$1,718,951 (Federal share \$859,476) and make the necessary financial adjustments when the funds are received from the hospitals; and;
- < use its discretion in the collection of other potential overpayments estimated to be \$581,275 (Federal share \$290,637) for the remaining 524 claims.

Recovery in Progress. The IDPA agreed with the recommendations and is developing a plan to recover overpayments to hospitals for transfers that were improperly coded as discharges. The IDPA OIG has begun to prepare letters to the hospitals requesting that they document their claims coded as discharges or make restitution to the State. The OAS has agreed to conduct follow-up examinations of records that may be submitted in response to these recovery letters.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action 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 (Public Law 90-23), HHS, OIG, OAS reports issued to the Department's grantees and contractors are made available, if requested, 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). As such, within 10 business days after the report is issued, it will be posted on the world wide web of HHS/OAS at <http://www.dhhs.gov/progorg/oig> and IDPA/OIG at <http://www.state.il.us/agency/oig>.

To facilitate identification, please refer to Common Identification Number A-05-00-00049 in all correspondence relating to this report.



Paul Swanson
Regional Inspector General
for Audit Services



Robb Miller
Inspector General
Illinois Department of
Public Aid

Direct Reply to HHS Action Official:
Cheryl Harris, Associate Regional Administrator
HCFA - Division of Medicaid, Region V
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