DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date AUG 10 1993

From Bryan B. Mitchell
Principal Deputy Inspector General

Subject Medicare Prospective Payment System Edit for Incorrect Hospital Coding of Patient (Discharge) Status (A-06-91-00061)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled, "Medicare Prospective Payment System Edit for Incorrect Hospital Coding of Patient (Discharge) Status." This report provides the results of our review of the effectiveness of the prepayment edit used to detect incorrect patient status codes in the Medicare prospective payment system (PPS) when patients are transferred to another hospital. The objective of our review was to determine whether this claims processing edit would prevent overpayments for all incorrect usages of the patient status code.

We determined that while the edit detects most overpayment situations, it does not detect transfers that are improperly coded as transfers to hospitals, or distinct parts of hospitals, which are not participating in PPS. We estimate that annual cost savings of $8.1 million are available if the Health Care Financing Administration (HCFA) revises the edit to also detect these incorrectly coded transfers.

Our analysis of a sample of improperly coded transactions showed that in many cases both the transferring and receiving hospitals were, in fact, PPS hospitals. Under the PPS regulations and HCFA policy, the transferring hospitals should have received per diem payments for services rendered while the receiving hospitals would be entitled to the full PPS payment. Instead, we found situations in which they were each paid the full PPS amount.

We estimate that the overpayments for these transactions amount to $30.4 million. These overpayments are included in our current nationwide PPS transfer recovery project, which will be the subject of a separate report. We are currently recommending, however, that HCFA revise the transfer edit to detect incorrect usage of the patient status code that identifies transfers to a non-PPS hospital.

Officials in your office concurred with our recommendation and stated that the process was underway to implement the additional edit in the common working file (CWF). The HCFA further stated that plans are to implement the new edit in the fourth quarter of this fiscal year. We appreciate the cooperation given us in this audit.

We would appreciate your views and the implementation status of the recommended edit to the CWF 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) 966-7104. Copies of this report are being sent to other interested top Department officials.

To facilitate identification, please refer to Common Identification Number A-06-91-00061 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE PROSPECTIVE PAYMENT SYSTEM EDIT FOR INCORRECT HOSPITAL CODING OF PATIENT (DISCHARGE) STATUS

AUGUST 1993 A-06-91-00061

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Date AUG 10 1993

From Bryan B. Mitchell
Principal Deputy Inspector General

Subject Medicare Prospective Payment System Edit for Incorrect Hospital Coding of Patient (Discharge) Status (A-06-91-00061)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This final report provides you with the results of our review of the Health Care Financing Administration's (HCFA) prepayment edit used to detect incorrect hospital usage of patient status codes. The objective of our review was to determine whether HCFA's prepayment edit would prevent overpayments for incorrect hospital coding of patient status. Our review showed that the edit is not capable of identifying transfers that are improperly coded as discharges to providers that are not in the prospective payment system (PPS). We estimate that correction of this problem will result in future annual savings of $8.1 million per year. We are recommending that HCFA revise the edit to detect improperly coded discharges to non-PPS providers in its payment system. The HCFA agreed with our recommendation and plans to implement the new edit in the fourth quarter of this fiscal year (FY).

INTRODUCTION

BACKGROUND

Section 1886(d) of the Social Security Act, enacted by the Social Security Amendments of 1983 (Public Law 98-21) on April 20, 1983, established PPS for Medicare payments for inpatient hospital services. The PPS became effective with hospital cost reporting periods beginning on or after October 1, 1983. Under this system, intermediaries pay PPS hospitals a predetermined, specific rate for each beneficiary discharged. The payment amount varies by the diagnosis related group (DRG) assigned to the patient's treatment. The list of DRGs for Federal FY 1992 contains 492 specific categories.

Under Federal regulations (42 CFR 412.4(d)), a hospital that transfers a Medicare patient to another PPS hospital receives a per diem payment determined by dividing the full DRG payment for the discharge by the average length of stay for that DRG. Payment to a transferring hospital, except for extraordinarily high cost cases that meet the criteria for cost outliers, may not exceed the full DRG payment rate.

Our March 18, 1991 report on improperly paid PPS hospital transfers (A-06-89-00021) identified 163,599 transfers (paid through November 1987) between PPS hospitals with incorrect hospital coding of the patient status. Because of the incorrect coding on the claim form, both hospitals involved in the patient transfer received full DRG payments. Based on our report, HCFA developed an edit to (1) alert intermediaries that hospitals were incorrectly coding patient status and (2) prevent similar overpayments in the future.

SCOPE OF REVIEW

Our work was performed in accordance with generally accepted government auditing standards. We limited the objective of our review to determining whether HCFA's edit would prevent overpayments for incorrect hospital coding of patient status.

In meeting our objective, we reviewed:

- the November 1990 program memorandum informing intermediaries of the transfer edit;
- the PPS regulations, policy, and methodology for establishing DRG payment amounts for hospitals; and
- the PPS transfer matches with incorrect hospital coding of patient status.

We used our data base of PPS transfer matches to perform this review. The data base included Medicare PPS hospital payments made between January 1, 1986 and September 30, 1989. We used statistical sampling techniques to determine the amount of overpayment. The details of our statistical sampling and projection methodology are discussed in Appendix A. In addition, we discussed issues related to the objective with officials of HCFA's Divisions of Medicare and Health Standards and Quality in Region VI.

Our field work and evaluation was performed in our Baton Rouge field office.

RESULTS OF REVIEW

The HCFA needs to revise the prepayment transfer edit in order to prevent future overpayments to PPS hospitals. Our analysis showed that, while significant overpayments will be prevented, the edit will not detect transfers incorrectly coded as transferred to non-PPS providers. The HCFA staff purposefully excluded claims coded as transferred to non-PPS providers from the edit because they did not anticipate that transferring hospitals would incorrectly use this code. (See Appendix B for details of HCFA's edit and the Office of Inspector General's (OIG) analysis of the edit.)

We reviewed a sample of 100 out of 31,445 transfer transactions which were incorrectly coded as transferred to non-PPS providers. (See Appendix A for details of our sampling and projection methodology.) These PPS transactions (claims) were paid by Medicare intermediaries between January 1, 1986 and September 30, 1989. The patient status of each transaction was incorrectly coded by the transferring hospital which resulted in both hospitals receiving full DRG payments. Of these errors, our analysis showed that both the transferring and receiving hospitals were, in fact, PPS hospitals. The transferring hospitals should have received per diem payments rather than full DRG payments.

Using the sample results, we projected an estimated overpayment of $30.4 million for the 45-month period. Based on this projection, we estimate that annual cost savings of $8.1 million are available if HCFA revises the prepayment edit to detect incorrect usage of the patient status transferred to non-PPS providers.

We are not recommending the recovery of the $30.4 million of incorrect payments made from January 1, 1986 to September 30, 1989 since our nationwide PPS transfer recovery project and subsequent report will include these overpayments.

RECOMMENDATION

We recommend that HCFA revise the transfer edit to detect incorrect use of patient status codes, discharged/transferred to a non-PPS provider.

The HCFA responded to our draft report in a memorandum dated June 16, 1993. In that memorandum, HCFA agreed with our recommendation and stated that the process was underway to implement the additional edit in the common working file. The HCFA further stated that plans are to implement the new edit in the fourth quarter of this FY.

OTHER MATTERS

The HCFA officials took immediate positive action to develop a transfer edit as a result of our initial audit work. We reviewed the basic logic of HCFA's transfer edit for consistency in detecting transfers between PPS hospitals incorrectly coded and paid as discharges. With the exception of the problem discussed in this report, we believe that implementation of the transfer edit, as developed, will prevent a significant number of overpayments. We plan detailed testing of the edit in a follow-up audit of claims paid after January 1, 1991.

APPENDICES

STATISTICAL SAMPLING METHODOLOGY AND PROJECTION OF RESULTS

We reviewed the effectiveness of HCFA's edit for incorrect hospital coding of the patient status on hospital claims as it relates to PPS claims coded with an "05" (discharged/transferred to another type of institution) patient status. We used our data base of PPS transfer matches to perform this review. This data base covers Medicare PPS hospital payments made between January 1, 1986 and September 30, 1989. A match consists of hospital claim information for Medicare beneficiaries discharged and admitted by different PPS hospitals on the same day. In addition, the patient status on the transferring PPS hospital's claim is other than code "02" (discharged/transferred to another short term general PPS hospital).

We extracted all matches with incorrect hospital coding of the "05" patient status from the data base. We extracted a total of 31,445 matches that constitute the universe for reviewing, sampling, and projecting the results of our review.

The second phase of our review was determining overpayments caused by incorrect hospital coding of the "05" patient status. We numbered each of the 31,445 matches on the printout to identify and locate sample items within the universe. The OIG/Office of Audit Services Advanced Techniques Staff generated the 100 random numbers from approved statistical software. We identified each of the 100 random numbers in the printouts and scheduled the information necessary for determining the overpayment amounts.

Under Medicare regulations, a PPS hospital transferring a patient to another PPS hospital receives a per diem payment not to exceed the full DRG amount. Calculation of the per diem amount involves dividing the hospital's DRG payment amount by the DRG's average (geometric mean) length of stay. A transfer with a stay that is less than the average length of stay will receive a total payment that is less than the DRG amount. A transfer with a length of stay that is equal to, or exceeds, the average length of stay will receive a payment that is equal to the DRG amount.

In determining overpayment amounts, we compared the actual length of stay at the transferring hospital with the average length of stay for the assigned DRG. When the length of stay in the transferring hospital was less than the DRG average length of stay, we determined the correct per diem payment. We subtracted this payment from the actual payment to establish the overpayment amount.

We determined that overpayments totaling $96,532.22 occurred in 53 of the 100 sample items. The remaining 47 items had an incorrect patient status but did not have an overpayment because the length of stay exceeded the average for the DRG.

We projected the sampling results at the 90 percent confidence level and obtained the following information:

Point estimate ($ error in the universe)	$30,354,557
Precision Amount ±	$ 7,320,192
Precision Percent ±	24.12

Based on the calculations below, we estimate that $8,094,548.52 will be saved annually if the transfer edit is revised to detect incorrect use of the "05" patient status by PPS hospitals.

$30,354,557	potential overpayments in the universe
45	months reviewed
= $674,545.71	average monthly overpayment
x 12	months in a year
= $8,094,548.52	annual cost savings from revising the transfer edit to detect incorrect use of an "05" patient status

DETAILS OF HCFA'S EDIT AND OIG'S ANALYSIS OF THE EDIT

Hospitals under PPS incorrectly coded beneficiary transfers to other PPS hospitals as discharges/transfers to other types of institutions (patient status code "05"). As a result, approximately $30.4 million of overpayments occurred between January 1, 1986 and September 30, 1989. The HCFA's prepayment edit excludes claims with an "05" patient status. Therefore, the edit will not detect these types of overpayments. We estimate that correction of the transfer edit's deficiency will result in annual savings of $8.1 million.

The following example illustrates the problem and consequences of hospitals incorrectly using the "05" patient status code.

> A Medicare patient stays at hospital A (PPS hospital) for 2 days and is subsequently transferred to hospital B (another PPS hospital). The PPS rate is $10,000 at each hospital, with an average length of stay of 10 days for the DRG. Hospital A would be paid $2,000 (2/10 x $10,000) and hospital B would be paid $10,000, the full PPS payment, upon the patient's discharge. The total payment on behalf of the patient is $12,000. However, if hospital A improperly reported the transfer as a discharge/transfer to another type of institution (patient status code "05"), it would receive a $10,000 payment. As a result of this error, the total payment would be $20,000, or an $8,000 overpayment.

Our March 18, 1991 report on improperly paid PPS hospital transfers (A-06-89-00021), identified 163,599 transfers (paid through November 1987) between PPS hospitals with incorrect coding of the patient status. Because of the incorrect coding, both hospitals involved in the transfer received full DRG payments. Under Medicare regulations, the payment to the transferring hospital should have been a per diem based payment not to exceed the DRG amount.

As a result of our report, HCFA developed a prepayment edit to alert intermediaries that hospitals were incorrectly coding patient status. In a November 1990 program memorandum (Transmittal No. A-90-16), HCFA informed the intermediaries of the edit and its expected implementation date of January 1, 1991.

HCFA's Transfer Edit

The HCFA's transfer edit identifies hospital claims where there is a same day discharge and admission for the same beneficiary at two different hospitals. Further, the claims have the following characteristics:

- o bill type 11X (inpatient hospital);
- o condition code 65 (non-PPS) not present;
- o patient status not equal to:
  - -- "02" (discharged/transferred to another short term general hospital), or
  - -- "05" (discharged/transferred to another type of institution), or
  - -- "07" (left against medical advice);
- o condition code 61 (cost outlier) not present; and
- o DRG not equal to 385 or 456 (any treatments for these two DRGs receive full PPS payment amounts).

For the intermediaries to be alerted, all characteristics of the edit must be present. Under the edit's logic, if the transferring hospital codes an "05" as the patient status, no alert occurs, even when both the transferring and receiving hospitals are PPS hospitals.

OIG Analysis of HCFA's Edit

Our selection criteria for identifying hospital claims with incorrectly coded PPS transfers did not exclude transfers with an "05" patient status. (See Appendix C for the PPS transfer selection criteria.) To test the effectiveness of HCFA's edit, we extracted from our PPS transfer data base all transfers with an "05" patient status. For the period January 1, 1986 through September 30, 1989, we identified 31,445 transfers with an "05" patient status code.

In discussions with HCFA officials, we determined that non-PPS providers or a "distinct part" (e.g., physical therapy wing) of a PPS provider would be assigned provider numbers that would fall outside the series reserved for PPS providers. These officials agreed that if the provider numbers for the hospitals included in our transfer matches were within the PPS series, these hospitals were classified as PPS hospitals.

We determined for each of these matches (62,890 total transactions), that the provider identification number for both the transferring and receiving hospitals fell within the number series assigned to PPS hospitals. Further, using our random sample of 100 match transactions, we verified with HCFA's Division of Health Standards and Quality that the provider number and code for facility type identified each of these facilities as a PPS hospital. Because both hospitals are PPS hospitals, the transferring hospitals incorrectly used the "05" code. The edit's treatment of claims with an "05" patient status would not have prevented overpayments for these 31,445 PPS transfer matches.

SELECTION CRITERIA USED FOR COMPUTER MATCHING

We designed our computer matching program to identify patients that were discharged from one PPS hospital and admitted to a second PPS hospital on the same day. We extracted PPS transactions from HCFA's Part A Medicare Payment Files using the following criteria:

- Record Identification Code: equal to V (Medicare Part A);
- Query Code: equal to 3 (final bill--patient left hospital);
- Transaction Code: equal to 3 (general care hospital facility);
- Primary Payer Code: equal to Z (Medicare primary payer);
- Data Indicators: equal to 2 or 3 (PPS claim);
- DRG Code: other than 385 or 456 (any treatment for these two DRGs receives full PPS payment amounts); and
- DRG Discharge Status Code: other than "02" (code "02" identifies a transfer to another PPS hospital).

We sorted the extracted data by Medicare beneficiary number and date of service. We arranged the potential errors by (1) the Department of Health and Human Services, OIG Region; (2) intermediary; and (3) provider serviced by the intermediary.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE JUN 16 [illegible]

FROM Bruce C. Vladeck
Administrator

SUBJECT Office of Inspector General (OIG) Draft Report: "Medicare Prospective Payment System (PPS) Edit for Incorrect Hospital Coding of Patient (Discharge) Status" (A-06-91-00061)

TO Bryan B. Mitchell
Principal Deputy Inspector General

We have reviewed the above-referenced draft report which assessed the Health Care Financing Administration's (HCFA) prepayment edit for detecting incorrect hospital usage of patient discharge status codes.

OIG recommends that HCFA revise the transfer edit to detect incorrect use of patient status code that identifies transfers to a non-PPS provider. Specifically, all Medicare beneficiary claims that are coded as a transfer to a non-PPS hospital should be reviewed to determine the accuracy of the coding. We concur with the recommendation, and have already begun the process necessary to implement the additional edit in the Common Working File. We plan to implement the new edit in the fourth quarter of this fiscal year.

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