OFFICE OF THE NEW YORK STATE COMPTROLLER

DIVISION OF STATE GOVERNMENT ACCOUNTABILITY

Department of Health

Improper Medicaid Payments For Misclassified Patient Discharges

Report 2009-S-26

Thomas P. DiNapoli

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State of New York
Office of the State Comptroller

Division of State Government Accountability

December 22, 2009

Richard F. Daines, M.D.
Commissioner
NYS Department of Health
Corning Tower Building
Empire State Plaza
Albany, New York 12237

Dear Commissioner Daines:

The Office of the State Comptroller is committed to helping State agencies, public authorities and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit entitled Improper Medicaid Payments For Misclassified Patient Discharges. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

EXECUTIVE SUMMARY

Audit Objective

Our objective was to determine whether the Department of Health (Department) ensured that Medicaid diagnosis related group claims were billed correctly when a patient was discharged from a hospital or was transferred from one hospital to another hospital.

Audit Results - Summary

The Medicaid program uses a case-based reimbursement methodology known as diagnosis related groups (DRGs) to pay most hospitals for inpatient services. Payments under the DRG system are based on factors such as a patient's medical diagnosis, sex, age, birth weight, length of time in the hospital, procedures performed, and whether the patient was discharged or transferred. Consequently, when a hospital bills Medicaid for services, it must indicate whether the patient was a "transfer" or a "discharge." This is important because a discharge DRG payment typically exceeds a transfer DRG payment for essentially the same services, and the differences in payment amounts are often material. A discharge payment generally pays more than a transfer payment under the presumption that a full range of medical services was provided to a patient, and therefore, the patient was well enough to go home. In contrast, in the case of a transfer, the patient required additional medical services provided by another institution.

Based on our detailed review of 270 high risk claim payments to ten hospitals, we identified 211 claims that were incorrectly coded as a "discharge" (instead of a "transfer") and resulted in Medicaid overpayments totaling about $5.4 million. In addition, we identified about 3,000 other claims for which there was a high risk of significant overpayments because the claims were improperly coded as discharges when they should have been coded as transfers. If the error rates and amounts of overpayments for these 3,000 claims were consistent with the payments we reviewed in detail, the Department could potentially identify and recover an additional $12 million in improper Medicaid payments.

The following is an example of the improper use of discharge codes that we identified. A patient was admitted to a hospital for 18 days for injuries sustained in an accident. After the 18-day period, the patient was transferred to another facility for rehabilitation. Therefore, the first hospital (where the patient was admitted for 18 days) should have coded its claim as a transfer, which would have resulted in a Medicaid payment of about $92,000. However, the hospital incorrectly coded its

claim as a discharge and, consequently, received a payment of nearly $253,000. Because the first hospital miscoded its claim, it received an overpayment from Medicaid of $161,000.

We concluded that providers incorrectly billed Medicaid because they did not adequately understand certain regulations covering DRG discharges and transfers. Specifically, they were unaware of the significance of hospitals which use DRGs for billing purposes versus those which do not. For reimbursement purposes a "transfer" occurs when a patient is sent from one DRG hospital to another DRG hospital. However, when a patient is sent from a DRG hospital to a non-DRG hospital, the originating DRG hospital is allowed to code the claim as a discharge. In several instances, we determined that billing staff at a DRG hospital thought they were sending a patient to a non-DRG hospital, which would normally justify coding the claim as a discharge. However, the patient in question was actually moved to a DRG hospital, and consequently, the claim should have been coded as a transfer which would have resulted in a lower payment.

The providers also misinterpreted the Department's policy on the discharge and transfer of a neonatal patient (newborn). Sometimes, community hospitals send newborns with serious health problems to other hospitals for additional (specialty) services. If a newborn is subsequently returned to the community hospital after receiving services from the specialty hospital, the specialty hospital would be entitled to a discharge DRG payment. However, in many instances, children were born at specialty hospitals, and subsequently, they were transferred to a community hospital for standard care. In this instance, the claim from the specialty hospital should have been coded as a transfer, which would again result in a lower payment.

We also noted that the Department uses a contractor to review a sample of claims to ensure that hospitals properly billed the correct discharge and transfer codes. However, the Department directed the contractor to review only two of ten commonly used discharge codes that we included in our review. Consequently, this significantly limited the contractor's ability to identify overpayments due to misuse of discharge codes on claims. Most of the overpayments we identified corresponded to discharge codes that the contractor did not include in its reviews.

Our report includes five recommendations to the Department. These recommendations include recovery of the $5.4 million in overpayments we identified, investigation of 3,000 claims at high risk of overpayment, and actions to preclude overpayments from being made in the future.

In their response to our draft report, Department officials noted that the Office of the Medicaid Inspector General (OMIG) was reviewing the overpayments we identified, and based on the OMIG's review, the Department will seek recovery in those instances where the provider did not provide a level of medical services warranting full (discharge level) DRG payments.

This report, dated December 22, 2009, is available on our website at: http://www.osc.state.ny.us.
Add or update your mailing list address by contacting us at: (518) 474-3271 or
Office of the State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, NY 12236

Introduction

Background

The New York State Medicaid (Medicaid) program uses a case-based reimbursement methodology known as diagnosis related groups (DRGs) to pay most hospitals for inpatient services. Payments under the DRG system are based on such factors as the patient's medical diagnosis, sex, age, birth weight, length of time in the hospital, procedures performed, and whether the patient was discharged or transferred. Medicaid pays approximately $3.5 billion annually in DRG claims.

To clarify the rules over the differences between discharges and transfers, the Department of Health (Department) has established regulations and issued guidance and instructions to providers. In addition, the Department routinely informs hospitals and other medical professionals of guidelines and changes to the Medicaid program through the monthly Medicaid Update.

According to the Department's regulations (NYCRR Title 10, Section 86-1.50) a DRG transfer occurs when a patient is:

- transferred from one DRG hospital to another DRG hospital;
- transferred to an out-of-state acute care facility; or
- a neonate (newborn) who is transferred to a non-DRG hospital for neonatal services.

A DRG discharge occurs when a patient is:

- released from the hospital to a non-acute care setting (i.e., a nursing home);
- transferred to a non-DRG hospital or unit; or
- a newborn who is released from a hospital providing neonatal specialty services back to the community hospital of birth for weight gain.

When a hospital bills Medicaid, it must use certain numeric codes to indicate whether the patient was transferred or discharged. The codes are important because the DRG reimbursement methodology for transfers and discharges are different. Only one code (02) will cause a claim to be paid as a transfer DRG, with the remaining codes corresponding to claims for discharge DRGs. Furthermore, a transfer DRG claim typically pays less than a discharge DRG claim for the same set of medical services, and a transfer DRG claim never pays more than a discharge claim for those services. Often, the difference

between a discharge claim and transfer claim, for ostensibly the same types of services, is significant. A discharge payment generally pays more than a transfer payment under the presumption that a full range of medical services was provided to a patient, and therefore, the patient was well enough to go home. In contrast, in the case of a transfer, the patient required additional medical services provided by another institution which also used a DRG-based claiming methodology.

The following is an example of the difference. If a patient was admitted to a hospital for pneumonia, stayed 5 days and was then released home, Medicaid would pay about $21,000 for the claim, as a discharge DRG. However, if the patient stayed 5 days at the first hospital and was transferred to another DRG hospital for additional care, the first hospital would receive approximately $12,000, for a transfer DRG. Therefore, a claim which should be coded as a transfer, but is incorrectly coded as a discharge, could result in Medicaid overpaying the hospital (in this example, by $9,000).

The Department contracts with the Island Peer Review Organization (IPRO) to review hospital Medicaid claims for appropriateness. As a result of a federal audit of the Department, which was issued in 2003, the Department instructed IPRO to include a sample of hospital claims using the federal criteria (limited to discharge codes 01 and 07) in their future reviews.

Audit Scope and Methodology

We audited to determine whether the Department ensured that Medicaid diagnosis related group (DRG) claims were billed correctly when a patient was discharged from a hospital or was transferred from one hospital to another hospital. Our audit covered the period January 1, 2004 to March 31, 2009.

To accomplish our objective, we reviewed the Department's regulations and provider instructions regarding billing for patients discharged and transferred from a DRG hospital. We used computer assisted audit techniques to review all DRG claims during our audit period to identify claims with the highest risk of being incorrectly billed. We identified all cases where a patient had left one hospital and was admitted to another hospital on the same day. We met with Department and IPRO officials to understand the reimbursement rules, and the extent of IPRO's review activities.

This audit evaluated claims which had a high risk of being billed incorrectly. We selected a judgmental sample of 270 claims from ten DRG hospitals which had among the largest differences between payments for transfer DRGs and discharge DRGs for similar types of services. The ten hospitals included Beth Israel Medical Center, Brooklyn Hospital Center, Crouse Hospital, Lincoln Medical Center, Montefiore Medical Center, New York Hospital, Presbyterian Hospital, St. Vincent's Hospital Medical Center,

Strong Memorial Hospital, and Westchester Medical Center. We compared patient discharge documentation from the hospitals with the billing codes that were used for the sample population. In addition, we spoke with hospital officials to gain an understanding of their billing procedures.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members (some of whom have minority voting rights) to certain boards, commissions, and public authorities. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of it. Department officials indicated that there could have been extenuating circumstances with respect to some of the claim payments in question, and consequently, the providers might have been entitled to more than the amounts of the base DRG payments for patient transfers. Department officials further noted that the Office of the Medicaid Inspector General (OMIG) was reviewing the overpayments we identified, and based on the OMIG's review, the Department will seek recovery in those instances where the provider did not provide a level of medical services warranting full (discharge level) DRG payments.

Auditor Comment's: It should be noted that the Department's response is referenced to our preliminary analysis of 350 transfer pairs whereas our audit report is based on a sample of 270 transfer pairs. Therefore we question

the relevance of the Department's specific observations to the findings in the actual audit report. Moreover, regarding the 270 transfer pairs included in the audit report, the Department states it is difficult for them to confirm appropriateness until a complete review is undertaken.

We acknowledge that there could be extenuating circumstances which justify additional payment amounts, in certain instances, for services provided to patients who are transferred by [as opposed to discharged from] a provider. However, the Department should require sufficient documentation and formal approval of such additional amounts prior to payment. The additional payment amounts identified in our report were not supported by documentation provided to the Department and were not formally approved prior to payment. Consequently, we maintain that the amounts in question represent overpayments, which the Department should recover. Moreover, during the course of our fieldwork, we shared the payments in question with Department officials - who agreed that the claims should have been treated as transfers.

Contributors to the Report

Major contributors to this report include Paul Alois, Daniel Towle, Emily Wood, and Brian Mason.

Audit Findings and Recommendations

Transfers Incorrectly Claimed as Discharges

For the period January 1, 2004 through March 31, 2009, we identified about 3,300 DRG claims from the Department's Medicaid claims payment system wherein a patient left one DRG hospital and was then admitted to another DRG hospital on the same day. These claims totaled about $57 million and had a high risk of overpayment because they probably were transfers, but were instead coded as discharges.

To assess the propriety of the claims, we requested pertinent documentation for a judgmental sample of 270 of them (representing about $16 million in Medicaid payments). The payments selected for review were among the larger claims from the ten providers (hospitals) that received among the higher amounts of payments. Based on our review, we found that 211 of these claims were incorrectly coded as discharges, when they should have been coded as transfers. We calculated the appropriate transfer DRG payment amount for each of the 211 claims and found that Medicaid overpaid the hospitals more than $5.4 million for them. In addition, certain hospitals were unable to provide supporting documentation for four of the remaining claims. The four claims totaled about $50,000. Because there was no documentation of these claims, the Department should also seek repayment for them.

The following is an example of the improper use of discharge codes that we identified in the course of our audit. A patient was admitted to a hospital for injuries that occurred in an accident and was on a respirator for 18 days. After that period, the patient was transferred to another DRG facility for rehabilitation. Therefore, the first hospital (where the patient was admitted for 18 days) should have coded its claim as a transfer, which would have corresponded to a Medicaid payment of about $92,000. However, this hospital incorrectly coded its claim as a discharge and, consequently, received a payment of nearly $253,000. Because the first hospital miscoded its claim, it received an overpayment from Medicaid of $161,000 ($253,000-$92,000).

Further, if the Department formally reviewed the remaining 3,000 high risk claim payments (totaling about $41 million), we believe the Department would find material amounts of additional overpayments that should be recovered. If the error rates and amounts of overpayments for the remaining 3,000 claims were consistent with the payments we reviewed, the Department could potentially identify and recover an additional $12 million in improper payments. We provided the Department with computerized files of all the

high risk claim payments identified in our audit to help officials identify and recover additional overpayments.

We also sought to determine why hospitals incorrectly coded claims as discharges when their own documentation indicated that they were, in fact, transfers. We interviewed billing office personnel at several of the hospitals we selected for review. At certain providers, we found that billing personnel lacked an understanding of the regulations covering DRG discharges and transfers, and consequently, they coded claims improperly (as discharges when they actually were transfers).

In addition, billing staff were sometimes confused about the DRG (or non-DRG) status of the facility that a patient was subsequently admitted to. For reimbursement purposes a "transfer" occurs when a patient is sent from one DRG hospital to another DRG hospital. However, when a patient is sent from a DRG hospital to a non-DRG hospital, the Department allows the originating DRG hospital to code the claim as a discharge. In several instances, we determined that billing staff at a DRG hospital thought they were sending a patient to a non-DRG hospital, which would normally justify coding the claim as a discharge. However, the patient in question was actually moved to a DRG hospital, and consequently, the claim should have been coded as a transfer. In certain instances, billing staff from the originating hospital were unaware that the receiving hospital changed from a non-DRG-based reimbursement system to a DRG-based system. As a result, staff at the originating hospital coded claims incorrectly (as discharges) and overpayments resulted.

Further, in several instances, hospital staff misinterpreted the Department's policy for billing services for neonatal patients (newborns). Sometimes, community hospitals send newborns with serious health problems to other hospitals for additional (specialty) services. If a newborn is subsequently returned to the community hospital (where it was born) to gain weight after receiving services from the specialty hospital, the specialty hospital would be entitled to a discharge DRG payment. However, in many instances, children were born at specialty hospitals, and subsequently, the specialty hospitals transferred them to a community hospital for more standard neonatal care. In this instance, the claim from the specialty hospital should have been coded as a transfer, which would result in a lower payment. However, specialty hospitals often coded such claims as discharges, and consequently, they received excessive reimbursements.

As noted previously, the Department contracts with IPRO to review Medicaid claims and payments to help ensure their propriety. In conjunction with this effort, IPRO staff review samples of claims to determine if discharge and transfer codes were used properly. During the course of our review, we

contacted IPRO officials to determine the extent of IPRO's discharge and transfer review. According to IPRO officials, IPRO's reviews were limited to claims with discharge codes (01) and (07), pursuant to direction from the Department. This represented only two of the ten commonly used codes we included in our review. Consequently, IPRO did not review many other high risk claims which used discharge codes other than (01) and (07). Moreover, most of the claims we found to be in error had discharge codes other than the codes on claims IPRO generally reviewed. As such, we concluded that the Department should formally review its guidance to IPRO on this matter and consider expanding the discharge codes that IPRO reviews. This could help ensure that the benefits of IPRO's efforts are maximized - and overpayments from the improper use of discharge codes are further reduced.

Recommendations

1. Recover the overpayments of $5.4 million corresponding to the 211 claims, as identified in this report, in which hospitals improperly used discharge (instead of transfer) codes.

2. Follow-up with the hospitals on the four claims (totaling about $50,000) for which there was no supporting documentation. Recover payments, as appropriate, if the hospitals cannot adequately document the claims.

3. Investigate the additional 3,000 discharge DRG claim payments (totaling about $41 million) that we identified as high risk. Determine if these claims were billed properly, and if not, recover overpayments, as appropriate.

4. Issue formal guidance and reminders to providers on the appropriate uses of discharge and transfer codes for DRG claims. Such guidance and reminders should include, but not be limited to, coding for patients sent to DRG versus non-DRG facilities and coding for newborns admitted to specialty as well as community hospitals.

5. Formally review the Department's guidance to IPRO regarding its reviews of payments to hospitals for DRG claims which use discharge codes. As appropriate, expand the range of discharge codes that IPRO includes in its claims reviews.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

December 18, 2009

Brian E. Mason, Audit Manager
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 12236

Dear Mr. Mason:

Enclosed are the New York State Department of Health's comments on the Office of the State Comptroller's draft audit report 2009-S-26 on "Improper Medicaid Payments For Misclassified Patient Discharges."

Thank you for the opportunity to comment.

Sincerely,

James W. Clyne, Jr.
Executive Deputy Commissioner

Enclosure

cc: James Sheehan
Robert W. Reed
Donna Frescatore
Richard Cook
Diane Christensen
Nicholas Meister
Gerald Stenson
Stephen Abbott
Ron Farrell
Mary Elwell
Irene Myron
Lynn Oliver

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2009-S-26 on
"Improper Medicaid Payments for Misclassified Patient Discharges"

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2009-S-26 on "Improper Medicaid Payments for Misclassified Patient Discharges", including general discussion followed by responses to the specific recommendations contained in the report.

General Discussion:

In reviewing the results of this audit, it is important to recognize that the intent of the regulations related to DRG transfers and discharges is to appropriately reimburse providers based on the medical services provided. To that end, there are a number of issues raised by the audit that require further investigation before making a definitive determination as to whether an overpayment occurred.

OSC's findings are based on an analysis of 270 transfer pairs, of which the auditors identified 211 claims as overpaid because hospitals improperly used discharge (instead of transfer) codes. Until a complete review of the 211 claims is undertaken, it is difficult for the Department to confirm the appropriateness of the OSC findings. However, based on preliminary analyses of OSC's original (350 pairs) sample, the Department believes that a significant number of the claims associated with the OSC findings can be categorized into one of the following groups:

1. Discharge/Transfer of Neonatal (Newborn) Patients.
2. Discharge/Transfer to Blythedale Children's Hospital.
3. Discharge/Transfer to Sub-Acute Care Facilities.

Discharge/Transfer of Neonatal (Newborn) Patients

Approximately 25 percent of the cases in the original OSC sample are associated with the discharge/transfer of neonatal (newborn) patients. As stated in the OSC report, there are a number of findings where the OSC concluded that hospital staff misinterpreted the Department's policy for billing services for neonatal patients (newborns). According to NYCRR Title 10, Section 86-1.50, a **DRG Transfer** would be billed when a neonatal patient (newborn) is (1) transferred to a non-DRG hospital for "specialty" neonatal services, (2) transferred from one DRG hospital to another DRG hospital, or (3) transferred to an out-of-state acute care facility; while a **DRG Discharge** would be billed when a newborn is (1) released from a hospital providing neonatal "specialty" services back to the community hospital of birth for weight gain, (2) transferred to a non-DRG hospital or unit, or (3) released from the hospital to a non-acute care setting. OSC chose to apply a strict interpretation of the aforementioned regulation to newborn admissions to neonatal "specialty" providers which does not reflect the clinical realities of the situation.

For some claims identified by the OSC as incorrectly billed, it appears the mother was admitted to a community hospital (or emergency room), and was quickly transferred to the neonatal "specialty" hospital (prior to delivery) given the assessed risk to the newborn and/or mother. Analysis of the original OSC sample shows the average length of stay (ALOS) of neonatal DRG claims (billed by the neonatal "specialty" providers) to be 27.6 days, with the majority of those claims having a length-of-stay between 10 and 79 days. This high ALOS is consistent with the expected ALOS for the higher-weighted neonate DRGs, which consists of newborns with low birth-weights and/or complicating diagnoses. Given the high ALOS of these newborn admissions, it is expected that there will be justifiable higher costs associated with the additional medical services provided by these neonatal "specialty" providers.

OSC concluded that these neonatal "specialty" providers should receive a reduced "transfer" DRG payment, since the newborns (born at the specialty hospital) were being transferred from one DRG hospital to another DRG hospital. When the neonatal "specialty" provider discharged/transferred the newborn, the intent was to release the newborn to a community hospital (for weight-gain) even though the newborn was not originally delivered at the community hospital. Based on the ALOS and the designation of these hospitals as neonatal "specialty" providers, it appears that the most costly specialized neonatal care was provided by these facilities and they are appropriately discharging the newborns to the community hospital to free-up the specialty services.

The Department believes that applying the OSC interpretation of this regulation is not consistent with the intent of Department policy. Prior to recovering any overpayments, the Department will further review the "neonate transfer" denials identified by OSC, to determine in which cases the neonatal "specialty" provider was providing the additional medical services. Additionally, the Department will be reviewing this regulation and will consider any potential changes to better reflect Department policy as it pertains to the appropriate reimbursement based on the medical services provided in these types of neonatal "specialty" provider transfers.

Discharge/Transfer To Blythedale Children's Hospital

Approximately 30 percent of the cases in the original OSC sample are associated with a discharge/transfer to Blythedale Children's Hospital. Historically, Blythedale has been defined as a non-DRG specialty hospital providing care to children with complex medical and rehabilitative needs. According to regulation, an acute care hospital transferring a patient to a non-DRG specialty hospital for on-going, specialty services would bill the claim as a discharge, under the guidelines of it being "a transfer to a non-DRG hospital or unit".

In 2004, Blythedale opted to receive Medicaid acute care reimbursement under the DRG case payment system, thereby changing its status from a non-DRG hospital to a DRG hospital. Since Blythedale was historically known as a non-DRG specialty facility, transferring acute care providers may not have been aware of this change, and continued to bill these claims as a discharge rather than as a transfer. However, these cases are still "specialty" in nature and strict interpretation of the regulation may not reflect the appropriate reimbursement to the transferring hospital, based on the medical services provided during the initial admission.

Analysis of the original OSC sample identified 95 out of 101 claims associated with a discharge/transfer to Blythedale, excluding neonatal claims. The ALOS for the non-neonatal

admissions resulting in a discharge/transfer to Blythedale was 9.6 days, which is twice the ALOS for the non-neonatal admissions resulting in a discharge/transfer to another provider, which averaged 4.8 days.

Given that these cases are associated with a specialized population, an ALOS of 9.6 days is not insignificant, and a reduction in reimbursement based solely on the regulation may be unduly penalizing the "transferring" hospitals, depending on the circumstances of the case.

Prior to recovering any overpayments of this type, the Department will further review the "transfer to Blythedale" denials identified by OSC, to determine in which cases the transferring provider may have been providing reasonable medical services warranting full DRG payment.

Discharge/Transfer To Sub-Acute Care Facilities

Approximately 15 percent of the cases in the original OSC sample represent discharges/transfers to sub-acute care facilities such as skilled nursing facilities or intermediate-care facilities. What is questionable about this group is that hospital #1 in the claim pairs specifically coded the claim as a discharge/transfer to a sub-acute care facility; however, within 24 hours the patient was admitted to another acute care provider. There are a couple of possible explanations:

1. Hospital #1 appropriately treated and discharged the patient, and correctly coded the discharge to a sub-acute care facility, but the patient relapsed and was reassessed as requiring acute care level care. Therefore, the admission to hospital #2 was not the result of a transfer and there was no overpayment.
2. Hospital #1 incorrectly coded the discharge disposition. If it is determined that hospital #1 was transferring the patient to another DRG hospital for additional medical care, then identification of the overpayment would be correct.

Review of the original OSC sample determined some of these cases overlap the "transfer to Blythedale" issue; such cases will be addressed with the Blythedale claims above. For the remainder, prior to recovering any overpayments of this type, the Department will further review the "transfer to sub-acute care facility" denials identified by the OSC to determine whether the coding is appropriate for the circumstances.

Recommendation #1:

Recover the overpayments of $5.4 million corresponding to the 211 claims, as identified in this report, in which hospitals improperly used discharge (instead of transfer) codes.

Recommendation #2:

Follow-up with the hospitals on the four claims (totaling about $50,000) for which there was no supporting documentation. Recover payments, as appropriate, if the hospitals cannot adequately document the claims.

Recommendation #3:

Investigate the additional 3,000 discharge DRG claim payments (totaling about $41 million) that we identified as high risk. Determine if these claims were billed properly, and if not, recover overpayments, as appropriate.

Response #1, #2 and #3:

The Department understands that the Office of the Medicaid Inspector General (OMIG) will conduct an independent review of the potential overpayments identified in the OSC report and make a determination if recoveries are warranted. The Department will consult with the OMIG and recommend, consistent with the above discussion, that it only seek recovery in cases where it is determined the transferring provider did not reasonably provide a level of medical services warranting full DRG payment.

Recommendation #4:

Issue formal guidance and reminders to providers on the appropriate uses of discharge and transfer codes for DRG claims. Such guidance and reminders should include, but not be limited to, coding for patients sent to DRG versus non-DRG facilities and coding for newborns admitted to specialty as well as community hospitals.

Response #4:

The Department agrees and will issue formal guidance and reminders to providers following completion of its regulatory review activities noted above.

Recommendation #5:

Formally review the Department's guidance to IPRO regarding its reviews of payments to hospitals for DRG claims which use discharge codes. As appropriate, expand the range of discharge codes that IPRO includes in its claims reviews.

Response #5:

Following completion of the review of the claims in Recommendation #1 above, the Department will assess the results and determine whether expanding the range of discharge codes that IPRO includes in its reviews is warranted.