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September 19, 2012

Nirav R. Shah, M.D., M.P.H.
Commissioner
NYS Department of Health
Corning Tower Building
Empire State Plaza
Albany, New York 12237

Re: Report 2012-F-10

Dear Dr. Shah:

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, we have followed up on the actions taken by officials of the Department of Health (Department) to implement the recommendations contained in our audit report, *Improper Medicaid Payments for Misclassified Patient Discharges* (Report 2009-S-26).

Background, Scope and Objective

The New York State Medicaid (Medicaid) Program used (until December 2009) 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. During the original audit period (January 1, 2004 through March 31, 2009), Medicaid paid approximately $3.5 billion annually in DRG claims.

When a hospital bills Medicaid, it must use certain numeric codes to indicate whether a patient was transferred or discharged. 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. These codes are important because the DRG reimbursement methodology for transfers and discharges are different. A discharge DRG claim generally pays more than a transfer DRG claim 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 and therefore, was not discharged

from the original hospital. To ensure hospitals are appropriately paid for the services rendered, hospitals must correctly indicate whether patients were transferred or discharged. The Department contracts with the Island Peer Review Organization (IPRO) to review the propriety of hospital claims. However, IPRO's review of hospital claims is limited to only certain types of hospital discharges.

Our initial report was issued on December 22, 2009. Our objective was to determine whether the Department ensured 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. During the audit period, January 1, 2004 through March 31, 2009, our audit identified 211 claims that were incorrectly coded as a discharge (instead of a transfer) and resulted in Medicaid overpayments totaling $5.4 million. We also identified 3,000 other high risk claims that required further review. The Office of the Medicaid Inspector General (OMIG) investigates and recovers improper Medicaid payments on behalf of the Department. We provided the detail of the overpayments we identified to OMIG officials during the course of our initial audit. The objective of our follow-up was to assess the extent of implementation, as of June 2012, of the five recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

Department officials made some progress in correcting the problems we identified in the initial report. At the time of our follow-up review, overpayments totaling $2.2 million had been recovered. Additional actions, however, are still warranted. Of the initial report's five recommendations, four were partially implemented, and the remaining recommendation was not implemented.

Follow-up Observations

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.

Status - Partially Implemented

Agency Action - As a result of claim adjustments submitted by hospitals, the Department recovered $2.2 million (of the $5.4 million) in overpayments we identified in the initial audit. In addition, OMIG officials are currently reviewing another $1.3 million in overpayments we identified in the initial review. However, Department and OMIG officials advised us that many of the overpayments could not be investigated and recovered until the Department formally clarified billing guidelines for certain DRG claims. Because the clarifications were not made until August 2012, officials cannot recover $1.9 million in overpayments for claims which exceed the statute of limitation.

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.

Status - Not Implemented

Agency Action - In its formal response to the initial audit, Department officials stated OMIG would investigate these overpayments to determine if recoveries were warranted. However, the claim payments in question were not investigated, and consequently, no recoveries were made.

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.

Status - Partially Implemented

Agency Action - As noted previously, OMIG could not investigate many discharge payments until the Department clarified the billing guidelines for certain DRG claims. With the clarifications issued, Department and OMIG officials are initiating plans to investigate these claims and recover overpayments, as appropriate.

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.

Status - Partially Implemented

Agency Action - In January 2012, the Department formally reminded providers of the importance of accurately reporting patient status codes to reflect patient transfers. However, the Department did not provide specific guidance on the appropriate coding for patients who were transferred to DRG versus non-DRG facilities and for newborns who were initially admitted to specialty hospitals and subsequently transferred to community hospitals.

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.

Status - Partially Implemented

Agency Action - The Department did not issue updated guidance to IPRO pending the aforementioned clarification of billing guidelines for certain DRG claims. Based on the guideline clarifications, Department officials are planning to revise instructions to IPRO regarding its payment reviews, including the possibility of expanding the range of codes included in those reviews.

Major contributors to this report were Paul Alois, Amanda Strait and Rebecca Tuczynski.

We would appreciate your response to this report within 30 days, indicating any actions planned to address the unresolved issues discussed in this report. We also thank the management and staff of the Department of Health for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Dennis Buckley
Audit Manager

cc: Mr. Stephen Abbott, Department of Health
Mr. Stephen LaCasse, Department of Health
Mr. Thomas Lukacs, Division of the Budget