

**Memorandum**

Date FEB 20 1999

From June Gibbs Brown
Inspector General *June G Brown*

Subject Implementation of Medicare's Postacute Care Transfer Policy at Blue Cross and Blue Shield of Georgia (A-04-00-01210)

To Robert Berenson, M.D.
Acting Deputy Administrator
Health Care Financing Administration

Attached are two copies of the U.S. Department of Health and Human Services, Office of Inspector General's final report entitled, "*Implementation of Medicare's Postacute Care Transfer Policy at Blue Cross and Blue Shield of Georgia.*"

Our review examined the implementation of Medicare's postacute care transfer policy which may reduce inpatient payment rates when prospective payment system (PPS) hospitals discharge beneficiaries in 10 specified diagnosis related groups (DRG) to certain postacute care settings; i.e., skilled nursing facilities, PPS-exempt hospitals or units, and home health agencies.

Our review indicated that the payment system at Blue Cross and Blue Shield of Georgia, Inc. (BCBSGA), which is the fiscal intermediary (FI) for the State of Georgia, was appropriately modified to reduce payments to hospitals for claims related to the 10 specified DRGs which were correctly coded as hospital discharges to postacute care settings. However, we did find that erroneous payments resulted when the coding of the hospital claim was incorrect.

Our review indicated that for the period of October 1, 1998 through September 30, 1999, 20 of 100 sampled claims from the 10 specified DRGs coded as a discharge to home were erroneously coded by the hospital because the beneficiary subsequently received postacute care. At the time of our review, the remaining 80 sampled claims were found to be appropriately reimbursed.

The 20 erroneously coded claims in our sample resulted in excessive DRG payments of \$25,529. Based on these results, we estimate that Georgia hospitals serviced by BCBSGA erroneously coded claims resulting in an overpayment for 20 percent of all "discharge to home" claims for the 10 specified DRGs. We estimate that BCBSGA paid approximately \$890,000 in excessive DRG payments to Georgia hospitals as a result of these erroneous codings.

Page 2 - Robert Berenson, M.D.

These overpayments often occurred because controls were not always in place at the hospital to assure that the discharge code on the Medicare claim was correct.

As a long-term remedy, we recommend that the Health Care Financing Administration (HCFA) establish edits in its common working file (CWF) to compare beneficiary inpatient claims potentially subject to the postacute care transfer policy with subsequent postacute claims. This will allow potentially erroneous claims to be reviewed and appropriate adjustments to be made to the discharging hospital's inpatient claim.

Pending implementation of CWF edits, we recommend that HCFA adopt these interim remedies:

- Issue a memorandum alerting FIs to the problems identified in our review and direct the FIs to re-emphasize to hospitals the importance of appropriate discharge status coding, with particular attention given to physician education regarding subsequent home health care.
- Instruct FIs to implement system edits in their systems to identify inappropriately coded discharges when a postacute care claim is received. This would be applicable for claims for which the FI processes both the inpatient and postacute care claims.
- Instruct BCBSGA to recover the \$25,529 in overpayments identified in our sample.
- Conduct a match using CWF for the remainder of claims (totaling 3,389 claims) identified in our sampling universe of claims coded as discharges to home to identify and recover additional overpayments.

In partnership with HCFA, Office of Inspector General audit staff will assist BCBSGA in implementing the last recommendation.

In response to our draft report, HCFA officials concurred with our recommendations. We are expanding our audit work to additional FIs to further quantify the magnitude of inappropriately coded claims. We are looking forward to working with HCFA to ensure claims subject to the postacute care transfer policy are properly identified and reimbursed.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

Page 3 - Robert Berenson, M.D.

To facilitate identification, please refer to Common Identification Number A-04-00-01210 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**IMPLEMENTATION OF MEDICARE'S
POSTACUTE CARE TRANSFER POLICY
AT BLUE CROSS AND
BLUE SHIELD OF GEORGIA**



JUNE GIBBS BROWN
Inspector General

DECEMBER 2000
A-04-00-01210

**Memorandum**

Date DEC 20 2000

From June Gibbs Brown
Inspector General *June G Brown*

Subject Implementation of Medicare's Postacute Care Transfer Policy at Blue Cross and Blue Shield of Georgia (A-04-00-01210)

To Robert Berenson, M.D.
Acting Deputy Administrator
Health Care Financing Administration

This final report provides you with the results of our review of the implementation of Medicare's postacute care transfer policy at Blue Cross and Blue Shield of Georgia, Inc. (BCBSGA), the fiscal intermediary (FI) for the State of Georgia.

Our review examined the implementation of Medicare's transfer policy which may reduce inpatient payment rates when prospective payment system (PPS) hospitals discharge beneficiaries in 10 specified diagnosis related groups (DRG) to certain postacute care settings; i.e., skilled nursing facilities (SNF), PPS-exempt hospitals or units, and home health agencies (HHA).

EXECUTIVE SUMMARY

The objective of this review was to examine the appropriateness of payments made by BCBSGA under Medicare's postacute care transfer policy for the 10 specified DRGs.

Summary of Findings

Our review indicated that BCBSGA's payment system was appropriately modified to reduce payments to hospitals for claims related to the 10 specified DRGs which were correctly coded as hospital discharges to postacute care settings. However, we did find that erroneous payments resulted when the coding on the hospital claim was incorrect. These erroneous payments resulted when the hospital incorrectly coded their bills as "discharge to home" when, in fact, the Medicare patient received care in a postacute care setting.

Our review indicated that for the period of October 1, 1998 through September 30, 1999, 20 of 100 sampled claims from the 10 specified DRGs coded as a discharge to home were erroneously coded by the hospital because the beneficiary subsequently received postacute care. At the time of our review, the remaining 80 sampled claims were found to be appropriately reimbursed.

The 20 erroneously coded claims in our sample resulted in excessive DRG payments of \$25,529. Based on these results, we estimate that Georgia hospitals serviced by BCBSGA erroneously coded claims resulting in an overpayment for 20 percent of all “discharge to home” claims for the 10 specified DRGs. We estimate that BCBSGA paid approximately \$890,000 in excessive DRG payments to Georgia hospitals as a result of these erroneous codings.

These overpayments often occurred because controls were not always in place at the hospital to assure that the discharge code on the Medicare claim was correct.

As a long-term remedy, we recommend that the Health Care Financing Administration (HCFA) establish edits in its common working file (CWF) to compare beneficiary inpatient claims potentially subject to the postacute care transfer policy with subsequent postacute claims. This will allow potentially erroneous claims to be reviewed and appropriate adjustments to be made to the discharging hospital’s inpatient claim.

Pending implementation of CWF edits, we recommend that HCFA adopt these interim remedies:

- Issue a memorandum alerting FIs to the problems identified in our review and direct the FIs to re-emphasize to hospitals the importance of appropriate discharge status coding, with particular attention given to physician education regarding subsequent home health care.
- Instruct the FIs to implement system edits in their systems to identify inappropriately coded discharges when a postacute care claim is received. This would be applicable for claims for which the FI processes both the inpatient and postacute care claims.
- Instruct BCBSGA to recover the \$25,529 in overpayments identified in our sample.
- Conduct a match using CWF for the remainder of claims (totaling 3,389 claims) identified in our sampling universe of claims coded as discharges to home to identify and recover additional overpayments.

In partnership with HCFA, Office of Inspector General (OIG) audit staff will assist BCBSGA in implementing the last recommendation.

We are expanding our audit work to additional Medicare FIs to further quantify the magnitude of inappropriately coded claims which should have been coded as a transfer. We are looking forward to working with HCFA to ensure claims subject to the postacute care transfer policy are properly identified and reimbursed.

The HCFA concurred with all of our recommendations. The HCFA response is attached to this report as APPENDIX C. The HCFA also made some technical comments, which we have incorporated into this final report.

BACKGROUND

Generally, discharges and transfers under PPS are defined under 42 CFR 412.4(a) and (b). Under the regulations, a discharge is generally a situation in which a beneficiary is formally released from a PPS hospital after receiving complete acute care treatment. A case is generally considered to be a transfer for purpose of payment when the beneficiary is transferred from one PPS inpatient unit to another PPS unit within the same PPS hospital or to another PPS hospital for related care. Medicare regulations found in 42 CFR 412.4(f) provide that, in a transfer situation, full payment is made to the final discharging hospital and each transferring hospital is paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

In the framing of the Balanced Budget Act of 1997 (BBA), Congress was concerned that Medicare was overpaying hospitals for patients who are discharged to a postacute care setting after a very short acute care hospital stay. Congress believed that Medicare's payment system should continue to provide hospitals with strong incentives to treat patients in the most effective and efficient manner, while at the same time, adjust PPS payments in a manner that accounts for reduced hospital lengths of stay because of a discharge to another setting. To address these concerns, Congress enacted section 4407 of the BBA.

Section 4407 of the BBA expanded the definition of transfer by adding section 1886(d)(5)(J) of the Act. Under this provision, if a beneficiary has a qualified discharge from 1 of 10 DRGs selected by the Secretary to a postacute care provider, the discharge will be treated as a transfer case beginning with discharges on or after October 1, 1998.

Section 1886(d)(5)(J)(ii) defines qualified discharge as a discharge from a PPS hospital of an individual whose hospital stay is classified in 1 of the 10 selected DRGs if, upon discharge, the individual is:

- admitted to a hospital or hospital unit that is not reimbursed under PPS,
- admitted to a SNF, or
- provided home health services if the services relate to the condition or diagnosis for which the individual received inpatient hospital services and if these services are provided within an appropriate period as defined by the Secretary. According to 42 CFR 412.4(c)(3), the transfer policy is applicable

if the individual was discharged to home under a written plan of care for the provision of home health services and the services begin within 3 days after the date of discharge.

Section 1886(d)(5)(J)(iii) gives the Secretary broad authority to select the 10 DRGs based on a high volume of discharges and a disproportionate use of postacute care services. According to 42 CFR 412.4(d), the 10 DRGs selected by the Secretary pursuant to this authority are as follows:

<u>DRG</u>	<u>Title</u>
014	Specific Cerebrovascular Disorders Except Transient Ischemic Attack
113	Amputation for Circulatory System Disorders Excluding Upper Limb and Toe
209	Major Joint and Limb Reattachment Procedures of Lower Extremity
210	Hip and Femur Procedures Except Major Joint Age > 17 with Complications and Comorbidities (CC)
211	Hip and Femur Procedures Except Major Joint Age > 17 without CC
236	Fractures of Hip and Pelvis
263	Skin Graft and/or Debridement for Skin Ulcer or Cellulitis with CC
264	Skin Graft and/or Debridement for Skin Ulcer or Cellulitis without CC
429	Organic Disturbances and Mental Retardation
483	Tracheostomy Except for Face, Mouth, and Neck Diagnoses

Medicare DRGs are sets of diagnoses that are expected to require about the same level of hospital resources to treat beneficiaries. The PPS pays hospitals a predetermined amount based on the DRG for each Medicare patient.

Responsibilities for Postacute Care Transfer Claims

The HCFA contracts with FIs, usually insurance companies, to assist in administering the Medicare program. The principal intermediary for PPS hospitals in the State of Georgia is BCBSGA located in Atlanta, Georgia. The Medicare contractor for HHAs is referred to as a regional home health intermediary (RHHI). In the State of Georgia, the principal RHHI is the Palmetto Government Benefits Administrators located in Columbia, South Carolina. The alternate RHHI for HHAs in Georgia is Wellmark, Inc. located in Des Moines, Iowa. The multiplicity of Medicare claims processors means that contractors may not have complete data on all of the care received by the beneficiary. The lack of complete data by FIs was identified by HCFA as a vulnerability when implementing the postacute care transfer policy.

In the proposed rule published in the Federal Register on July 31, 1998, HCFA indicated that hospitals need to maintain their responsibility to code the discharge bill based on the

discharge plan for the patient, and if the hospital subsequently learns that postacute care was provided, the hospital should submit an adjustment bill. The HCFA acknowledged that hospitals will not always know if postacute care was rendered. However, the proposed rule states that HCFA will monitor activity in this area to determine if hospitals are acting in good faith.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of this review was to examine the appropriateness of payments by BCBSGA under Medicare's postacute care transfer policy for the 10 specified DRGs.

Scope

Our audit focused on Medicare inpatient claims with the 10 specified DRGs from PPS hospitals in the State of Georgia for which BCBSGA was the FI for the period of October 1, 1998 through September 30, 1999. During this period, BCBSGA processed 320,534 discharges at hospitals in Georgia. Of these, 25,070 inpatient claims were paid by BCBSGA for the 10 DRGs. Of that number, 6,077 Medicare claims were coded by hospitals as if the beneficiary had been sent home with no postacute treatment. We further determined that of these 6,077 claims 3,489 claims could potentially result in lower reimbursement to the discharging hospital if postacute care had been provided. These 3,489 claims constituted our audit universe.

We tested the claims payment system at BCBSGA to determine if payments to hospitals were accurately paid for claims coded as qualified transfers.

We also tested the claims payment system at BCBSGA to determine if payments to hospitals were accurately paid for claims erroneously coded as discharges. Using a statistically valid random sample (see APPENDIX A for details), we projected the percent of claims that were coded in error and the amount of excessive payments made to the hospitals. (See APPENDIX B for details.)

Methodology

We conducted an audit risk assessment of all payments made by BCBSGA relating to the 10 specified DRGs, and concluded that audit risk fell into 2 distinct areas, both of which were addressed during the review:

- ▶ The first area of risk was that the FI's payment system had not been adequately modified to reduce reimbursements for claims which were submitted by hospitals as qualified transfers.
- ▶ The second area of risk was that hospitals were not coding discharges appropriately as qualified transfers and the FI's payment system was not preventing such claims from being paid at a full DRG rate.

Tests of BCBSGA's payment system for claims coded as transfers

For claims which were coded as a qualified transfer, we tested whether:

- appropriate modifications to the FI's payment system were made in accordance with legislation and subsequent HCFA guidance;
- the modifications were implemented timely;
- the modifications included all 10 specified DRGs and no inappropriate DRGs; and
- payments were appropriately calculated.

Discussions with BCBSGA personnel indicated that they were aware of the 10 DRG transfer provision of the BBA and had made appropriate system modifications. The changes had been made to the Fiscal Intermediaries Shared System (FISS). The BCBSGA relies on the FISS software at the Florida Data Center for editing and processing of its claims. We reviewed payment system documentation concerning the transfer provisions, and selected a judgmental probe sample of claims which were coded as transfers for detailed review. The judgmental probe included claims from all 10 DRGs, which varied by discharge date, length of stay, provider number, and patient discharge status. We concluded, based on these tests, that BCBSGA's payment system had been appropriately and timely modified to correctly pay qualified transfer claims submitted by hospitals. No further audit work was conducted in this area.

Tests of BCBSGA's payment system for claims erroneously coded as discharges

Once we were satisfied that BCBSGA's payment system was correctly paying claims which had been coded by hospitals as a qualified transfer, we tested the system's ability to detect claims which were erroneously coded as a discharge to home, not as a qualified transfer. Based on discussions with BCBSGA personnel, published HCFA guidance, and educational material given to the hospitals by BCBSGA, we determined that substantial reliance was being placed on the hospitals' diligence, willingness, and capability to appropriately code discharges.

To test this risk area, we selected a judgmental probe sample of claims with patient discharge status code 01. Discharge status code 01 is designated for use when a beneficiary is discharged to home with no postacute treatment. (This status code is listed in data field 22 of the HCFA form UB-92.) Claims which are correctly coded as 01 should be paid as a discharge at the full DRG rate. The claims in our judgmental sample varied by DRG, discharge date, length of stay, and provider number. The results of our judgmental sample indicated a high degree of audit risk in this area and we determined that additional review was necessary.

We, therefore, selected a statistically valid random sample of 100 claims from a universe of 3,489 claims with discharge status code 01 for detailed review.

For each of the 100 claims:

- we examined CWF to determine if the beneficiary received postacute care as defined in legislation and regulation;
- for claims erroneously coded as “discharged to home” when postacute care had indeed been provided, we calculated the variance in payment between what was actually paid and what should have been paid; and
- we discussed the errors with hospital medical coding and financial staff to the extent possible within time constraints.

We did not review the overall internal control structure of the intermediaries or of the Medicare program. We did not test the internal controls because the objective of our review was accomplished through substantive testing.

Our review was limited to the period of October 1, 1998 through September 30, 1999, which is the first full year that the 10 DRG postacute care transfer provision was in effect. Our audit was performed at the offices of BCBSGA, at various hospitals, and at the OIG Atlanta regional office between November 1999 and March 2000.

We conducted our audit in accordance with generally accepted government auditing standards.

**DETAILED RESULTS OF
REVIEW**

Our review indicated that BCBSGA's payment system was appropriately modified to reduce payments to providers for claims related to the 10 specified DRGs which were correctly coded as qualified transfers by the hospitals. However, we did find that erroneous payments resulted when the coding on the hospital claim was incorrect.

Our review indicated that for the year audited, 20 of 100 sampled claims from the 10 specified DRGs coded as a discharge to home were erroneously coded because the beneficiary subsequently received postacute care. At the time of our review, the remaining 80 sampled claims were found to be appropriately reimbursed.

The 20 erroneously coded claims in our sample resulted in excessive DRG payments of \$25,529. Based on these results, we estimate that Georgia hospitals serviced by BCBSGA erroneously coded claims resulting in an overpayment for 20 percent of all "discharge to home" claims for the 10 specified DRGs. We estimate that BCBSGA paid approximately \$890,000 in excessive DRG payments to Georgia hospitals as a result of these erroneous codings.

These overpayments often occurred because controls were not always in place to assure that the discharge code on the Medicare claim was correct.

Criteria

Effective with discharges on or after October 1, 1998, a discharge from a PPS hospital with 1 of the 10 specified DRGs to a postacute care setting will be treated as a postacute care transfer case. The applicable postacute care settings are a hospital or hospital unit that is not reimbursed under PPS, a SNF, or home under a written plan of care for the provision of home health services and the services begin within 3 days of the discharge.

Reimbursement for qualified discharges is made under one of two payment methods, each of which is designed to more closely match the reimbursement to the hospital's cost of providing care to the patient. In the event that the cost of providing care to a patient meets the criteria to be deemed an outlier, additional payment is allowed for the qualified discharges.

For DRGs 014, 113, 236, 263, 264, 429, and 483, hospitals are reimbursed at a graduated per diem rate for each day of the beneficiary's stay. Under this calculation method, the full DRG payment amount is divided by the geometric mean length of stay for the specific DRG

to which the case is assigned. Twice the per diem amount is paid for the first day, and the per diem rate is paid for each of the remaining days, not to exceed the full DRG payment.

For DRGs 209, 210 and 211, the reimbursement is calculated as follows: on day one of a postacute care transfer, hospitals would receive one-half the DRG payment amount plus the per diem payment for the DRG. For each subsequent day prior to transfer, hospitals receive one-half the per diem up to the full DRG payment.

In the proposed rule published in the Federal Register on July 31, 1998, HCFA indicated that hospitals need to maintain their responsibility to code the discharge bill based on the discharge plan for the patient, and if the hospital subsequently learns that postacute care was provided, the hospital should submit an adjustment bill. The HCFA acknowledged that hospitals will not always know if postacute care was rendered. However, the proposed rule states that HCFA will monitor activity in this area to determine if hospitals are acting in good faith.

Medicare Bulletin Number 1817 advised providers that the use of Patient Status Code 01 is only appropriate for these 10 DRGs in instances where a patient is discharged from an inpatient facility and (1) is not admitted on the same day to another inpatient facility or SNF, or (2) does not receive any home health services within a 3-day period from the date of discharge.

Condition

In our sample of 100 claims coded as discharge to home, our audit revealed that 20 claims were improperly coded as discharges to home rather than to other postacute care. These 20 erroneously coded claims resulted in the discharging hospitals receiving excessive payments relating to the 10 qualified discharge DRGs. The erroneous claims included:

- Six claims which were followed by an admission to an inpatient facility (non-PPS hospital or SNF) on the same day as the discharge date on the sample claim. These erroneously coded claims resulted in \$5,952 in excess payments to the discharging provider.
- Fourteen claims which were followed by a claim for home health services within 3 days of the discharge date on the sample claim. These erroneously coded claims resulted in \$19,577 in excess payments to the discharging provider.

By examining the CWF payment records for the beneficiaries in our sample, we found that six claims were erroneously coded as discharge to home but were actually transferred to other Medicare inpatient facilities, resulting in excessive payments to the discharging hospitals totaling \$5,952.

The six erroneously coded inpatient claims that resulted in excessive payments involved discharges to one SNF and five non-PPS rehabilitation units of hospitals' facilities. Only two of these five rehabilitation units were related to the hospitals. We noted that five of the six erroneously coded claims occurred where the hospital and the postacute care provider were serviced by the same FI.

When we examined the CWF for 14 of our sample items, we found that Medicare home health services were provided to the beneficiaries within 3 days of discharge from the hospitals, resulting in excessive payments to the discharging hospitals totaling \$19,577.

Cause

We were able to interview hospital staff relating to 13 of the 20 sample errors. The hospital staff offered explanations as to how the errors occurred. Their responses indicated that the claims were erroneously coded due to:

- clerical error during the discharge process at the hospital;
- lack of clear communication between hospitals and patient physicians regarding use of subsequent home health services; and
- lack of knowledge at the hospitals regarding delivery of postacute care.

These overpayments often occurred because controls at the hospitals were not always in place to assure that the discharge code on the Medicare claim was correct.

We found that 8 of the 13 erroneous claims discussed with hospital staff were erroneously coded due to a clerical error during the discharge process at the hospital. Original medical coding was performed by staff from the review of medical records. Such coding is subject to human error. We were informed that many of the providers in our sample have initiated some form of monitoring of the medical coding and Medicare reimbursement relating to the qualified discharges. However, these eight erroneously coded claims indicate that these monitoring activities are inadequate to assure correct coding.

We found that 3 of the 13 erroneous claims discussed with hospital staff were erroneously coded due to a lack of clear communication between providers and patient's physicians regarding use of subsequent therapy services. Physicians authorized postacute care in the medical records, but did not indicate postacute care on the discharge documents.

We found that 2 of the 13 erroneous claims discussed with hospital staff were erroneously coded by the hospitals because they had no knowledge of postacute care that was delivered to the Medicare beneficiaries subsequent to discharge. Hospital personnel could find no evidence in the medical records which indicated the patient would receive postacute care.

Effect

Our review found that 20 of the 100 claims were inappropriately coded and resulted in an overpayment. Based on our sample, we estimate that 20 percent of all claims submitted under the discharge to home status code were improperly coded and resulted in excessive reimbursement to the discharging hospital.

Projecting our results to the universe of claims for the period of October 1, 1998 through September 30, 1999, we estimate that BCBSGA paid approximately \$890,000 in excess payments to hospitals in the State of Georgia. See APPENDIX B for the methodology used in projecting our sampling results.

RECOMMENDATIONS

As a long-term remedy, we recommend that HCFA establish edits in CWF to compare beneficiary inpatient claims potentially subject to the postacute care transfer policy with subsequent postacute care claims. This will allow potentially erroneous claims to be reviewed and appropriate adjustments to be made to the discharging hospital's inpatient claim.

Pending implementation of CWF edits, we recommend that HCFA adopt these interim remedies:

- Issue a memorandum alerting FIs to the problems identified in our review and direct the FIs to re-emphasize to hospitals the importance of appropriate discharge status coding, with particular attention given to physician education regarding subsequent home health care.
- Instruct the FIs to implement system edits in their system to identify inappropriately coded discharges when a postacute care claim is received. This would be applicable for claims for which the FI processes both the inpatient and postacute care claims.
- Instruct BCBSGA to recover the \$25,529 in overpayments identified in our sample.
- Conduct a match using CWF for the remainder of claims (totaling 3,389 claims) identified in our sampling universe of claims coded as discharges to home to identify and recover additional overpayments.

Page 12 - Robert Berenson, M.D.

In partnership with HCFA, OIG audit staff will assist BCBSGA in implementing the last recommendation.

We are expanding our audit work to additional FIs to further quantify the magnitude of inappropriately coded claims. We are looking forward to working with HCFA to ensure claims subject to the postacute care transfer policy are properly identified and reimbursed.

HCFA Comments

The HCFA concurred with all of our recommendations. The HCFA response is attached to this report as APPENDIX C. The HCFA also made some technical comments, which we have incorporated into this final report.

APPENDICES

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SAMPLING METHODOLOGY

OBJECTIVE:

The objective of this audit was to determine the appropriateness of the payments relating to the 10 qualified discharges by BCBSGA. Effective October 1, 1998, the 10 qualified discharges are DRGs that are treated as transfers, rather than discharges, under section 1886(d)(5)(J) of the Act.

POPULATION:

The population was 3,489 claims for the 10 DRGs specified by the Secretary with the discharge code of "discharged to home." These claims were paid by BCBSGA to Georgia hospitals during the period October 1, 1998 through September 30, 1999. The claims totaled \$24,891,014.56.

SAMPLE UNIT:

The sampling unit was a DRG claim.

SAMPLE DESIGN:

A simple random sample was used.

SAMPLE SIZE:

We selected 100 claims from the universe that we have identified.

ESTIMATION METHODOLOGY:

Using the Department of Health and Human Services, OIG, Office of Audit Services (OAS) RAT-STATS Variable Appraisal Program for unrestricted samples, we projected the excessive payments to discharging hospitals resulting from erroneously coded claims. The erroneous payments were calculated by using the payment methods for these 10 DRGs as adopted under section 1886(d)(5)(J) of the Act.

APPENDIX B

SAMPLE RESULTS AND PROJECTIONS

Sample Results

<u>Sample Size</u>	<u>Value of Sample</u>	<u>Number of Non-Zero Errors</u>	<u>Value of Errors</u>
100	\$818,730.73	20	\$ 25,528.81

Variable Projections

Point estimate	\$ 890,700
90% Confidence Interval	
Lower Limit	\$ 436,324
Upper Limit	\$1,345,076

Attributes Projection

We also used our random sample of 100 claims to project the percentage of claims in error. We used the Department of Health and Human Services, OIG, OAS RAT-STATS Attribute Appraisal Program for unrestricted samples to project the percentage of claims in error. The results of these projections are presented below:

Sample Claims in Error:	20
Point Estimate:	20.000%
90% Confidence Interval	
Lower Limit	13.729%
Upper Limit	27.630%



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Administrator
Washington, D.C. 20201

OCT 18 2000

DATE:

TO: June Gibbs Brown
Inspector GeneralFROM: Michael M. Hash
Acting Administrator

A handwritten signature in black ink that reads "Michael M. Hash".

SUBJECT: Office of the Inspector General (OIG) Draft Report: "Implementation of Medicare's Postacute Care Transfer Policy at Blue Cross and Blue Shield of Georgia," (A-04-00-01210)

Thank you for your letter to Nancy-Ann Min DeParle concerning the Health Care Financing Administration's (HCFA's) implementation of Medicare's postacute care transfer policy which may reduce inpatient payment rates when prospective payment system (PPS) hospitals discharge beneficiaries in 10 specified diagnosis related groups (DRGs) to certain postacute care settings. I am responding on her behalf.

The PPS distinguishes between "discharges," situations in which a patient leaves an acute care (prospective payment) hospital after receiving complete acute care treatment, and "transfers," situations in which the patient is transferred to another acute care hospital for related care. In a transfer situation, full payment is made to the final discharging hospital and transferring hospitals are paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

The Balanced Budget Act of 1997 required the Secretary, beginning October 1, 1998, to define and pay as transfers all cases assigned to one of 10 DRGs selected by the Secretary if the individuals are discharged to one of the following settings: a hospital excluded from payment under the PPS (psychiatric hospitals and units, rehabilitation hospitals and units, children's hospitals, long-term care hospitals, and cancer hospitals); a skilled nursing facility; or to home health care provided by a home health agency. Therefore, any discharge from a prospective payment hospital from one of the selected 10 DRGs that is admitted to a hospital excluded from the PPS on the date of discharge from the acute care hospital, on or after October 1, 1998, would be considered a transfer and paid accordingly under the PPS (operating and capital) for inpatient hospital services. Similarly, a discharge from an acute care inpatient hospital paid under the PPS to a skilled nursing facility on the same date would be defined as a transfer and paid as such. We consider situations in which home health services related to the condition or diagnosis of the inpatient admission are received within 3 days after the discharge as a transfer.

Page 2- June Gibbs Brown

There has been evidence that over the years since the beginning of the PPS, hospitals have lowered the costs of care by shortening the period of time patients spend in the hospital and discharging them to postacute sites of care increasingly sooner. Since prospective payment rates are based on a full course of hospital treatment, Medicare was paying twice for some aspects of care: once to the hospital for care no longer provided in the inpatient setting, and again to the postacute provider who received patients sooner and sicker and provided services previously furnished to the patient by the hospital.

The postacute transfer policy benefits Medicare beneficiaries by providing incentives for hospitals to provide care in the most appropriate setting based on clinical rather than payment criteria (including reducing payment incentives for hospitals to discharge patients prematurely). It also aligns payments more appropriately with the services provided, thus benefiting future beneficiaries by preserving the Medicare Trust Fund.

OIG found that 20 of 100 sampled claims were erroneously coded by the hospital as discharges to home when the patient in fact received subsequent postacute care. As a result, OIG recommends that the Health Care Financing Administration (HCFA) adopt a long-term remedy of establishing edits in the common working file (CWF) to compare claims potentially subject to the postacute care transfer policy with subsequent claims. This would allow potentially erroneous claims to be reviewed and appropriate adjustments to be made. We support this recommendation. This approach was discussed within HCFA prior to implementing the postacute care transfer policy, but was not put in place at the time due to the need to focus attention on Y2K readiness. We intend to pursue this approach as soon as possible.

OIG also identifies a number of short term steps to ensure that hospitals accurately code discharge status for these situations. These recommendations and our responses are attached. We have also attached technical comments.

We appreciate the effort that went into this report and the opportunity to review and comment on the issues raised.

Attachment

Comments of the Health Care Financing Administration on the OIG Draft Report:
"Implementation of Medicare's Postacute Care Transfer Policy at Blue Cross and Blue Shield of
Georgia"
(A-04-00-01210)

OIG Recommendation

Issue a memorandum alerting fiscal intermediaries to the problems identified in the report and direct them to reemphasize the importance to hospitals of appropriate discharge status coding, especially with respect to physician education regarding home health care.

HCFA Response

We concur with the recommendation and will issue a program memorandum (PM) by the end of November.

OIG Recommendation

Direct the fiscal intermediaries (FIs) to implement system edits to identify inappropriately coded discharges when a postacute care claim is received. This would be applicable for claims for which the FI processes both the inpatient and postacute care claims.

HCFA Response

We concur. We will develop the business requirements for the CWF edits after the appropriate policy has been developed.

OIG Recommendation

Instruct Blue Cross and Blue Shield of Georgia to recover the \$25,529 in overpayments identified in our sample.

HCFA Response

We concur. We will initiate recovery of the \$25,529 in overpayments as soon as possible.

OIG Recommendation

Conduct a match using the CWF for the remainder of claims (totaling 3,389 claims) identified in our sampling universe of claims coded as discharges to home to identify and recover additional overpayments.

HCFA Response

We agree HCFA needs to aggressively monitor the implementation of this policy. We intend to propose a cooperative monitoring plan to the Program Integrity Group to look for patterns of miscoding across hospitals nationwide.

Technical Comments:

(Redacted)