



MAY 12 2004

TO: Wynethea Walker
Acting Director, Audit Liaison Staff
Centers for Medicare & Medicaid Services

FROM: Dennis J. Duquette *Duquette*
Deputy Inspector General for Audit Services

SUBJECT: Audit of Hospital Patient Transfers Paid as Discharges and Claimed Under the North Carolina Medicaid Program (A-05-03-00041)

Attached is an advance copy of our final report on hospital patient transfers paid as discharges. We will issue this report to North Carolina Division of Medical Assistance within 5 business days. We suggest you share this report with the Center for Medicaid and State Operations and any other components of the Centers for Medicare & Medicaid Services involved with Medicaid program integrity and provider issues.

The objective of our review was to determine whether inpatient hospital claims for patients transferred from one hospital to another on the same day were properly coded and paid in accordance with North Carolina's Medicaid reimbursement requirements.

We identified 817 claims, submitted by 111 hospitals, that appeared to be transfers incorrectly coded as discharges, which resulted in overpayments to the transferring hospitals. We limited our medical record review to 564 claims from 35 hospitals with total potential overpayments greater than \$20,000 or with neonatal diagnosis related group (DRG) claims with an estimated overpayment per claim greater than \$5,000. Of these, we determined that 512 claims, totaling \$4.7 million at 35 different hospitals, were transfers incorrectly coded as discharges. We considered 18 of these miscoded transfers to be improper because hospital staff was unable to locate the medical records supporting the inpatient stay and discharge status. After recalculating the correct reimbursement for these transfers, we estimated that overpayments to the transferring hospitals amounted to \$2,966,116 (\$1,849,683 Federal share).

We did not evaluate the supporting medical records for the remaining 253 potential transfers within our total universe of 817 claims. We did, however, reprice these claims as if they were transfers. If each claim were confirmed to be a transfer, the additional overpayment would be \$482,968.

We recommend that North Carolina:

- reimburse the Federal Government \$1,849,683 for its share of \$2,966,116 in overpayments

- reassert Medicaid guidance to hospitals, emphasizing the importance of coding the correct patient status and the appropriate DRG with special consideration given to the transfer of newborns
- consider implementing a postpayment edit to detect improperly coded transfers
- ascertain overpayment amounts, estimated to be \$482,968, for the remaining 253 potential transfers identified by our review and refund the Federal share

In a written response dated April 1, 2004, North Carolina officials agreed with our audit findings and took appropriate corrective action. The response is summarized in the body of the report and is included in its entirety as Appendix B to the report.

If you have any questions or comments about this report, please do not hesitate to call me or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at 410-786-7104 or Paul Swanson, Regional Inspector General for Audit Services, at (312) 353-2621. Please refer to report number A-05-03-00041 in all correspondence.

Attachment



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

REGION V
OFFICE OF
INSPECTOR GENERAL

MAY 17 2004

Report Number: A-05-03-00041

Mr. Gary Fuquay
Director
North Carolina Division of Medical Assistance
2501 Mail Service Center
Raleigh, North Carolina 27699-2501

Dear Mr. Fuquay:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General's (OIG) final report entitled "Audit of Hospital Patient Transfers Paid as Discharges and Claimed Under the North Carolina Medicaid Program." A copy of this report will be forwarded to the HHS action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. We request that you respond to the HHS official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-05-03-00041 in all correspondence.

Sincerely,

Paul Swanson
Regional Inspector General
for Audit Services

Enclosures – as stated

Page 2 – Mr. Gary Fuquay

Direct Reply to HHS Action Official:

Associate Regional Administrator
Centers for Medicare & Medicaid Services
Division of Financial Management and Program Initiatives
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**AUDIT OF HOSPITAL PATIENT
TRANSFERS PAID AS DISCHARGES
AND CLAIMED UNDER THE NORTH
CAROLINA MEDICAID PROGRAM**



**MAY 2004
A-05-03-00041**

EXECUTIVE SUMMARY

OBJECTIVE

The objective of our review was to determine whether inpatient hospital claims for patients transferred from one hospital to another on the same day were properly coded and paid in accordance with North Carolina's Medicaid reimbursement requirements.

FINDINGS

We identified 817 claims, submitted by 111 hospitals, that appeared to be transfers incorrectly coded as discharges and resulted in overpayments to the transferring hospitals. We limited our medical record review of the 817 claims to 564 claims with potential for significant overpayments. Of these, we determined that 512 claims, totaling \$4.7 million at 35 different hospitals, were transfers incorrectly coded as discharges. We considered 18 of these miscoded transfers to be improper because hospital staff was unable to locate the medical records supporting the inpatient stay and discharge status. After recalculating the correct reimbursement for these transfers, we estimated that overpayments to the transferring hospitals amounted to \$2,966,116 (\$1,849,683 Federal share) for the period October 1, 1998 through September 30, 2002.

Our review of medical records was limited to hospitals with total potential overpayments greater than \$20,000 or to neonatal diagnosis related group (DRG) claims with an estimated overpayment per claim greater than \$5,000. We did not evaluate the supporting medical records for the remaining 253 potential transfers within our total universe of 817 claims submitted by 82 hospitals. We did, however, reprice these claims as if they were transfers. If each claim were confirmed to be a transfer, the additional overpayment would be \$482,968.

RECOMMENDATIONS

We recommend that North Carolina:

- reimburse the Federal Government \$1,849,683 for its share of \$2,966,116 in overpayments
- reassert Medicaid guidance to hospitals, emphasizing the importance of coding the correct patient status and the appropriate DRG with special consideration given to the transfer of newborns
- consider implementing a postpayment edit to detect improperly coded transfers
- ascertain overpayment amounts, estimated to be \$482,968, for the remaining 253 potential transfers identified by our review and refund the Federal share

In a written response dated April 1, 2004, North Carolina officials agreed with our audit findings and took appropriate corrective action. The response is summarized in the body of this report and is included in its entirety as Appendix B to this report.

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INTRODUCTION

BACKGROUND

The Medicaid program is jointly administered by the Federal Government, through the Centers for Medicare & Medicaid Services (CMS), and by the States, through their designated State agency. The designated State agency in North Carolina is the North Carolina Division of Medical Assistance (Division of Medical Assistance). During the audit period, the Federal matching rate for Medicaid hospital service costs claimed in North Carolina ranged between 58.99 percent and 63.07 percent.

Prospective Payment System

Section 1886(d) of the Social Security Act, enacted as part of the Social Security Amendments of 1983 (Public Law 98-21), established the Medicare prospective payment system (PPS) for inpatient hospital services. Under this system, the diagnoses for hospital admissions are grouped into DRGs. Payment amounts are prospectively determined by the DRG. A DRG payment is designed to cover an average hospital's operating costs necessary to treat a patient to the point that a discharge is medically appropriate. PPS payments for patient transfers to other PPS hospitals are limited to per diem payments. Under Federal regulations at 42 CFR § 412.4(f), the per diem rate is determined by dividing the appropriate prospective payment rate by the average length of stay for the specific DRG.

North Carolina Reimbursement Methodology

Effective for discharges occurring on or after January 1, 1995, acute care general inpatient services are reimbursed using the DRG system. For each hospital admission, a single DRG category is assigned based on the patient's diagnosis, age, procedures performed, length of stay, and discharge status. The Division of Medical Assistance uses the DRG assignment logic of the Medicare Grouper (a software program that matches a patient's medical diagnosis with the types of services included within a DRG) to assign individual claims to a DRG category. Effective October 1 of each year, the Division of Medical Assistance updates its system by using the most recent revisions of the Medicare Grouper.

Treatment of Transfers

In order to be eligible for inpatient hospital reimbursement, a patient must be admitted as an inpatient and stay past midnight in an inpatient bed. The only exceptions to this requirement are admitted inpatients who die or are transferred to another acute care hospital on the day of admission. When patients are transferred to another acute care facility, both the transferring hospital and the receiving hospital will be paid. The transferring hospital is entitled to a prorated DRG amount, equal to the normal DRG payment multiplied by the patient's actual length of stay and divided by the average length of stay for the DRG. The discharging hospital receives the full DRG payment. If the patient's actual length of stay equals or exceeds the average length of stay for the DRG, the transferring hospital also receives the full DRG payment.

To ensure appropriate reimbursement for transfers, the transferring hospital must indicate that a transfer has occurred by entering a code of “02” in the patient status box (transferred to another short-term general hospital). When the patient is transferred to another hospital, inpatient stays subject to DRG reimbursement are usually paid less than the full DRG amount. Therefore, a transfer improperly coded as a discharge normally results in an overpayment when both hospitals receive the full DRG payments.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The objectives of the review were to:

- identify inpatient claims for patients who were discharged and admitted to a different hospital on the same calendar day
- determine whether the discharging hospitals properly coded the submitted claims
- identify the overpayments to hospitals for transfer claims improperly coded as discharges

Scope

The total payments for the 817 claims, identified as potential miscoded transfers from 111 hospitals, amounted to approximately \$6.4 million. Based on available pricing information, we estimated that the potential overpayment was \$3,734,327. We limited our medical records review to hospitals with total potential overpayments greater than \$20,000 (554 claims) or neonatal DRGs with an overpayment per claim greater than \$5,000 (10 claims). For these 564 claims totaling \$5,441,833 at 35 hospitals, we ascertained whether the patients were discharged or transferred to another hospital. We did not evaluate the medical records for the remaining 253 potential transfer claims submitted by 82 hospitals totaling \$944,157. We did, however, reprice these claims as if they were transfers, and determined that hospitals could have been overpaid an additional \$482,968 for improperly coded transfers.

Our review of management controls was limited to obtaining an understanding of North Carolina’s hospital payment methodology to ensure that hospitals were properly paid when patients were transferred to another hospital.

Methodology

To accomplish our audit objectives, we:

- obtained an understanding of the methods and standards for establishing inpatient rates for hospital reimbursement
- developed a detection routine to identify potential transfers paid as a discharge

- performed an analysis on the results of the computer program to isolate potential claims improperly coded as discharges resulting in an overpayment
- reviewed medical records to substantiate the transfer to another hospital

Identification of Potential Transfers. To identify potential patient transfers from one hospital to another that might be incorrectly coded as a discharge, we matched inpatient hospital claims submitted to CMS through the Medicaid Statistical Information System during the period October 1, 1998 through September 30, 2002. We identified 23,699 instances of patients discharged from one hospital and admitted to another hospital on the same calendar day. We excluded 14,555 claim records that were properly coded as transfers and 5,104 claims that were appropriately paid the full DRG payment in accordance with North Carolina reimbursement requirements. We also excluded 2,901 claims of which the majority was for PPS-exempt DRG codes and for inpatient hospital services provided by specialty hospitals excluded from the PPS reimbursement system. In addition, we excluded 279 claims that had been previously reviewed and adjusted during North Carolina’s monthly utilization review process and 43 claims reviewed and adjusted by North Carolina’s Medicaid Fraud Control Unit. The remaining 817 claims, submitted by 111 different hospitals, were apparent transfers that may have been improperly coded as discharges resulting in overpayments to the transferring hospitals.

Selection of Claims to Review Medical Records. From the universe of 817 claims, we selected 554 claims from 27 hospitals with total potential overpayments greater than \$20,000 and 10 neonatal DRG claims (from 8 hospitals) with an estimated overpayment per claim greater than \$5,000. Six of these eight hospitals had other potential transfer claims that were not reviewed. We reviewed the medical records for the 564 claims submitted by these 35 hospitals, which accounted for \$3,251,359 or 87 percent of the estimated total overpayments of \$3,734,327 for all 817 claims.

We reviewed medical records during site visits to three hospitals in the Raleigh/Durham area and seven additional hospitals located throughout North Carolina. We requested copies of the discharge summaries, doctor’s orders, and progress notes for the remaining 25 hospitals.

Our audit was made in accordance with generally accepted government auditing standards. Fieldwork was performed at the Division of Medical Assistance’s administrative office in Raleigh and at selected hospitals located throughout North Carolina.

FINDINGS AND RECOMMENDATIONS

We determined that 494 out of 564 potential transfers, totaling \$5.4 million at 35 different hospitals, were actual transfers incorrectly coded as discharges. Furthermore, hospital staff was unable to locate the medical records supporting the inpatient stay and the discharge status for 18 additional claims. By recalculating the proper reimbursement for these 512 claims, we determined that overpayments to the transferring hospitals amounted to \$2,966,116 (\$1,849,683 Federal share). North Carolina should recover these overpayments from the hospitals and refund the Federal share.

Although we did not evaluate the medical records for 253 claims submitted by 82 hospitals, we did reprice these claims as if they were transfers. If each claim were confirmed to be a transfer, improperly coded as a discharge, the additional overpayment would be \$482,968. The overpayment amounts for these 253 claims ranged from \$135 to \$9,097.

CRITERIA USED IN REIMBURSING PATIENT TRANSFERS

Federal regulations and North Carolina reimbursement requirements allow payment to both the transferring hospital and the receiving hospital; the transferring hospital is entitled to a prorated DRG amount, while the discharging hospital received the full DRG payment. A transfer improperly coded as a discharge normally results in an overpayment when both the transferring and receiving hospitals receive the full DRG payments.

Transfers Coded as Discharges

To determine if the patients were transferred or discharged, we requested the patients' medical records for the 564 claims at 35 hospitals. The medical records contained a discharge summary describing the patient's illness, treatment received, and plan of care, which included discharge or transfer information. In addition, physician orders, progress notes, nurse notes, and other documentation were available, if needed, to determine if the patient was discharged or transferred. Our review of the medical records determined that:

- 494 patients were transferred to another short-term general hospital, but reported as discharges on the claims submitted to the Division of Medical Assistance. Since the patient status code did not indicate a transfer, the hospital erroneously received the full DRG payment.
- 28 patients were transferred to non-PPS specialty hospitals, Medicare recognized distinct part units, or other beds in general acute care hospitals for psychiatric and rehabilitation services. As a result, the transferring hospital was entitled to the full DRG payment.
- 12 patients left against medical advice, or discontinued care and later sought medical attention in another hospital on the same day. This entitled the releasing hospital to receive the full DRG payment.
- 7 patients were discharged home, but later sought medical attention in another hospital on the same day. Since the patient was discharged home, the hospital was entitled to the full DRG payment.
- 3 patients were transferred to other hospitals and miscoded as discharges, but the hospitals were correctly paid a prorated DRG amount.
- 2 patients, who were transferred to other hospitals and miscoded as discharges, were previously reviewed and adjusted by North Carolina's medical utilization review.

- 18 patients' medical records could not be located by hospital staff at the time of our request.

From medical record documentation, 494 or 88 percent of 564 potential transfers were incorrectly coded as discharges. The medical records were not available to substantiate the discharge for 18 additional claims.

ADDITIONAL GUIDANCE AND CONTROLS NEEDED

We attribute the miscoding of transfers as discharges to data entry errors by the hospital coders, which were not detected by North Carolina's monthly utilization review process. The transferring hospitals erroneously reported the patient status code on the 494 claims as a discharge even though the patient was actually transferred to another hospital. To ensure appropriate reimbursement when a patient is transferred to another acute care facility, the hospital must indicate that a transfer has occurred. The transfer code for the majority of the claims was incorrectly reported as either a routine discharge to home or self-care, or as a discharge/transfer to another type of facility.

According to hospital staff interviewed during our visits, the incorrect coding of the patient status was often attributable to data entry errors by coders and system problems within the hospital. North Carolina's claims processing system generally did not have prepayment or postpayment edits to identify transfers between hospitals, which were erroneously coded as discharges and paid the full DRG payment. While North Carolina's medical record utilization review was effective in identifying incorrectly coded transfers in its monthly sampled claims, other incorrectly coded claims went undetected and hospitals were overpaid.

Although we attribute the miscoding of transfers to data entry, we noted 206 claims related to North Carolina's unique neonatal DRGs (800 series). The overpayments for these neonatal DRGs were \$2,009,100 or 68 percent of the total overpayments identified in our review. The average length of stay for these DRGs ranged from 5.9 days to 55.1 days. If a newborn is transferred and the length of stay was less than 3 days, the DRG assigned should be 385 (neonates died or transferred to another acute care facility) and the patient status code should be 02 (transferred to another short-term general hospital). If a newborn is transferred but is not properly coded as a transfer, a substantial overpayment would be made to the transferring hospital. Given the preponderance of the overpayments relating to neonatal DRGs, the Division of Medical Assistance should provide additional guidance to hospitals on the proper coding of newborn transfers and consider implementing a postpayment edit to detect improperly coded neonatal transfers.

INCORRECTLY CODED TRANSFERS

As a result of our review of the medical records for 564 potential transfers, we concluded that 494 of the potential transfers were incorrectly coded as discharges. Hospital staff were unable to locate the medical records supporting the inpatient stay and the discharge status for 18 additional claims. Based on our recomputations using historical hospital rates and DRG weight tables, overpayments to the hospitals for the 512 claims amounted to \$2,966,116, as follows:

	<u>Claims</u>	<u>Amount Paid</u>	<u>Transfer Payment</u>	<u>Overpayment Amount</u>
Transfers Coded as Discharges	494	\$4,554,436	\$1,697,043	\$2,857,393
Missing Medical Records	<u>18</u>	<u>163,086</u>	<u>54,363</u>	<u>108,723</u>
Total	<u>512</u>	<u>\$4,717,522</u>	<u>\$1,751,406</u>	<u>\$2,966,116</u>

The overpayment amounts ranged from \$25 to \$57,643. One hospital accounted for 131 of the claims and \$1,209,768 of the total overpayments. See Appendix A for a schedule of the total overpayments by hospital.

RECOMMENDATIONS

We recommend that North Carolina:

- reimburse the Federal Government \$1,849,683 for its share of \$2,966,116 in overpayments
- reassert Medicaid guidance to hospitals, emphasizing the importance of coding the correct patient status and the appropriate DRG with special consideration given to the transfer of newborns
- consider implementing a postpayment edit to detect improperly coded transfers
- ascertain overpayment amounts, estimated to be \$482,968, for the remaining 253 potential transfers identified by our review and refund the Federal share

AUDITEE COMMENTS

In a letter dated April 1, 2004, the North Carolina Department of Health and Human Services, Division of Medical Assistance, agreed with our audit findings. The State agency has recouped identified overpayments amounting to \$2,966,119, provided additional guidance to hospital administrators, and is in the process of contracting for an enhanced system of editing transfer coding. Although supporting medical records for the reported 253 potential transfers were not evaluated, the State agency requested that the hospitals perform self-audits and refund the inappropriate payments, estimated to be \$482,968. The full text of their response is included as Appendix B to this report.

ADDITIONAL OIG RESPONSE

We agree with the action taken and planned to resolve the audit findings.

APPENDICES

Appendix A

SCHEDULE OF TOTAL OVERPAYMENTS BY HOSPITAL

Hospital	Number of Claims	Amount Paid	Recomputed Transfer Payment	Overpayment Amount
1	13	\$ 39,096	\$ 15,380	\$ 23,716
2	10	162,367	69,432	92,935
3	10	42,994	13,564	29,430
4	2	20,523	1,760	18,763
5	11	54,588	16,531	38,057
6	15	109,472	32,278	77,194
7	3	24,314	7,930	16,384
8	9	49,043	7,879	41,164
9	131	2,121,679	911,911	1,209,768
10	5	66,143	6,148	59,995
11	7	78,666	10,808	67,858
12	12	102,512	52,183	50,329
13	1	12,493	951	11,542
14	11	53,028	19,722	33,306
15	1	16,108	7,443	8,665
16	20	96,991	23,283	73,708
17	9	69,234	21,675	47,559
18	27	146,631	54,182	92,449
19	45	247,413	82,761	164,652
20	1	8,054	1,036	7,018
21	4	59,413	23,057	36,356
22	46	168,775	56,909	111,866
23	19	46,902	17,634	29,268
24	1	8,426	1,157	7,269
25	5	46,437	7,978	38,459
26	20	298,926	100,604	198,322
27	1	21,765	1,157	20,608
28	26	108,718	44,221	64,497
29	26	283,905	107,867	176,038
30	14	51,328	17,071	34,257
31	2	16,745	2,100	14,645
32	1	21,276	6,719	14,557
33	1	6,598	951	5,647
34	1	8,426	1,215	7,211
35	<u>2</u>	<u>48,533</u>	<u>5,909</u>	<u>42,624</u>
Total	<u>512</u>	<u>\$4,717,522</u>	<u>\$1,751,406</u>	<u>\$2,966,116</u>



North Carolina Department of Health and Human Services

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Michael F. Easley, Governor

Carmen Hooker Odom, Secretary

April 1, 2004

Report Number: A-05-03-00041

Mr. Paul Swanson
Regional Inspector General for Audit Services
US DHHS Office of Audit Services
233 North Michigan Avenue
Chicago, Illinois 60601

Dear Mr. Swanson:

We have received your March 4, 2004 letter and draft report entitled, *Review of Hospital Patient Transfers Paid as Discharges and Claimed Improperly Under the North Carolina Medicaid Program*.

NC DHHS Response

The report indicated an overpayment to various hospitals across the State resulting from hospital staff incorrectly coding hospital patient transfers on Medicaid billings. The total of these hospital overbillings was \$2,966,116. We have reviewed and agree with the OIG audit report. Four of the hospitals audited could show where they had already detected the error and had refunded the overpayments in the amount of \$127,872.12. The Department has also already recouped the balance, an additional \$2,838,246.88, for a grand total of \$2,966,119. Thus, all of the identified overpayments have been repaid to the State and Federal government.

Medical Review of North Carolina, Inc.'s (MRNC) monthly sample of paid claims will continue to identify any inappropriately billed transfers and improper payments will be recovered. Recurring patterns of incorrect billing of transfers will be reported to DMA Program Integrity and hospitals will be notified by letter.

North Carolina is in the process of re-bidding our MMIS system which will include new software features and capabilities. As part of that process, we will attempt to maximize audits and edits designed to detect coding errors such as those mentioned in this report.

In addition to specific overpayments identified in the OIG audit, there were other hospital transfer situations that needed investigation and follow-up. The Department requested that these other hospitals in question perform self-audits and refund monies improperly billed. To-date, nine hospitals have completed their self-audits, six are in-progress, six have indicated that no



Mr. Paul Swanson
April 1, 2004
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further self-auditing is necessary and fourteen others have not yet responded to the self-audit. We will continue to encourage self-audits and recoupments by the affected hospitals. The self-audit process will also enhance the internal education process of hospital employees and thus serve to minimize future coding errors.

As to the recommendation on additional guidance to the hospitals, the Division's Medical Policy Section on November 25, 2003 sent a letter to Hospital Administrators to educate them on the correct coding procedures for hospital patient transfers. We may follow-up that letter with guidance in a future Medicaid Bulletin.

We trust that the foregoing responses address the various report recommendations. If additional information is needed, please contact Dan Stewart, Director of NCDHHS Office of the Internal Auditor, at (919) 715-4791 or Dan.Stewart@ncmail.net. Lastly, we would like to compliment Victor Schmitt and staff that worked on this project. They were very professional in defining and gathering information, listening to our comments and objective in writing the report.

Sincerely,



Carmen Hooker Odom

CHO:ds

Cc: Lanier Cansler
Gary Fuquay
Dan Stewart
Laketha Miller
Allyn Guffey
Honorable Ralph Campbell