



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

REGION V
OFFICE OF
INSPECTOR GENERAL

February 2, 2009

Report Number: A-05-07-00081

Mr. Jeff Wells
Director of Medicaid
Family & Social Services Administration
OMPP/Administrative/Executive
402 West Washington Street, W-461
Indianapolis, Indiana 46207

Dear Mr. Wells:

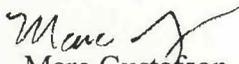
Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Medicaid Inpatient Hospital Transfer Payments in Indiana for October 1, 2003, Through September 30, 2006." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this 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.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, this report will be posted on the Internet at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Jaime Saucedo, Audit Manager, at (312) 353-8693 or through e-mail at Jaime.Saucedo@oig.hhs.gov. Please refer to report number A-05-07-00081 in all correspondence.

Sincerely,


Marc Gustafson
Regional Inspector General
for Audit Services

Enclosure

cc:

Mr. Doug Herrington
Program Integrity Manager
Family & Social Services Administration
OMPP/Administrative/Executive
402 W. Washington Street, Room W382
Indianapolis, Indiana 46204

Direct Reply to HHS Action Official:

Jackie Garner, Consortium Administrator
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Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICAID
INPATIENT HOSPITAL TRANSFER
PAYMENTS IN INDIANA FOR
OCTOBER 1, 2003, THROUGH
SEPTEMBER 30, 2006**



Daniel R. Levinson
Inspector General

February 2009
A-05-07-00081

Office of Inspector General

<http://oig.hhs.gov>

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Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

The Family and Social Services Administration, Office of Medicaid Policy and Planning (State agency) is responsible for inpatient hospital Medicaid reimbursement in Indiana. Attachment 4.19A of the CMS-approved State plan requires, with some exceptions, the State agency to use the Diagnosis Related Groups (DRG) payment methodology to reimburse hospitals for inpatient hospital services. 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.

As part of the State agency's Medicaid DRG system, special payment policies apply to claims involving the transfer of a beneficiary from one hospital to another on the same day. Pursuant to Chapter 7, section 2, of the Indiana Health Coverage Programs Provider Manual (the Manual), the transferring hospital is paid a prorated DRG payment for each day of the beneficiary's stay, not to exceed the full DRG payment.

OBJECTIVE

Our objective was to determine whether the State agency properly paid inpatient hospital claims and claimed Federal reimbursement for beneficiaries transferring from one hospital to another on the same day in accordance with the CMS-approved State plan for the period October 1, 2003, through September 30, 2006.

SUMMARY OF FINDINGS

The State agency did not properly pay inpatient hospital claims and claim Federal reimbursement for beneficiaries transferred from one hospital to another on the same day in accordance with the CMS-approved State plan. Specifically, the State agency made overpayments totaling \$622,351 (\$388,695 Federal share) to 20 hospitals for 83 of 90 inpatient hospital claims reviewed. The overpayments occurred because the hospitals incorrectly coded the claims as discharges. Additionally, the State agency did not notify hospitals of changes to the Manual regarding certain transfers, and the State agency's claim processing system did not identify the claims for beneficiaries that transferred from one hospital to another on the same day. Two other claims, while coded incorrectly, did not result in overpayments. The State agency properly paid the remaining five claims in accordance with the CMS-approved plan.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal government \$388,695 for the overpayments made to the 20 hospitals,
- use the results of this audit in its provider education activities related to proper coding of claims for beneficiaries transferring from one hospital to another, and
- implement controls to detect and review claims for beneficiaries transferred from one hospital to another on the same day.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our recommendations but indicated that it performed a separate calculation of the overpayment amounts and computed an overpayment amount of \$622,351 (\$388,695 Federal share). The State agency indicated that that it will develop provider education materials relating to the appropriate billing of inpatient hospital transfer claims and coordinate with its audit contractor for routine post-payment review of claims to determine that billing guidelines are adhered to and for recoupment of any overpayments.

The State agency's comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

We validated the State agency's calculation of the overpayment amounts and revised our report accordingly.

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STATE AGENCY COMMENTS

INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. The Family and Social Services Administration, Office of Medicaid Policy and Planning (State agency) administers the Medicaid program in Indiana. During the audit period, the Federal matching rate for hospital service costs claimed in Indiana ranged between 61.97 and 62.98 percent.

Diagnosis Related Group Payment Methodology

Attachment 4.19A of the CMS-approved State plan requires, with some exceptions, the State agency to use the Diagnosis Related Groups (DRG) payment methodology similar to the Medicare program¹ to reimburse hospitals for inpatient hospital services. 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. According to the State plan, inpatient stays reimbursed according to the DRG methodology are assigned to a DRG using the All Patient DRG Grouper.²

Indiana Payments for Inpatient Hospital Transfers

Chapter 7, section 2, of the Indiana Health Coverage Programs Provider Manual (the Manual), states that in the event of a transfer, the receiving hospital, or transferee hospital, is paid according to the DRG or level-of-care methodology, whichever is applicable.³ Transferring hospitals are reimbursed a prorated DRG daily rate for each day, not to exceed the full DRG amount. The DRG daily rate is calculated by dividing the DRG rate by the average length of stay. The full payment to the transferring hospital is the sum of the DRG daily rate, the capital per diem rate, and the medical education per diem rate.

¹Section 1886(d) of the 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. The DRG payment methodology limits PPS payments for patient transfers to other PPS hospitals 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.

²The Grouper is a software program that classifies each case into a DRG based on the beneficiary's diagnosis, procedure codes and demographic information. The All Patient Grouper is a modified DRG system developed to include non-Medicare patient populations.

³Under the level-of-care system, hospitals are reimbursed for psychiatric, rehabilitation, and certain burn cases on a per diem basis that is not part of the DRG reimbursement system. We did not review any inpatient hospital claims reimbursed using the level-of-care methodology at the transferring hospitals.

Chapter 8, section 2, of the Manual, also requires the transferring hospital to indicate that a transfer has occurred by placing code “02” (discharged/transferred to another short-term hospital for inpatient care) or “05” (discharged/transferred to another type of institution for inpatient care) in the patient status box on the claim form. Hospital inpatient stays subject to the DRG reimbursement methodology are usually paid less than the full DRG amount when the patient is transferred to another inpatient hospital. Therefore, a transfer between hospitals improperly coded as a discharge normally results in an overpayment when both hospitals receive full DRG payments.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency properly paid inpatient hospital claims and claimed Federal reimbursement for beneficiaries transferring from one hospital to another on the same day in accordance with the CMS-approved State plan for the period October 1, 2003, through September 30, 2006.

Scope

We reviewed 90 inpatient hospital claims totaling \$1,866,866 identified as potential inpatient hospital transfers paid by the State agency for the period October 1, 2003, through September 30, 2006. We limited our review of internal controls to obtaining an understanding of the State agency’s policies and procedures for reimbursing hospitals for beneficiaries transferred from one hospital to another on the same day.

We conducted fieldwork from January through April 2008 by contacting the State agency, located in Indianapolis, Indiana, and the 23 hospitals that received Medicaid reimbursement for claims reviewed.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal regulations, the CMS-approved State Plan, and the Manual;
- used the CMS Medicaid Statistical Information System⁴ to identify 4,891 claims for patients discharged from one hospital and admitted to another hospital on the same calendar day;
- determined that of the 4,891 claims, 90 claims at 23 hospitals were potential transfers that may have been improperly coded as “01” discharges resulting in overpayments to the transferring hospitals;

⁴The Medicaid Statistical Information System contains Medicaid eligibility and payment information that the States provide to CMS on a quarterly basis.

- reviewed discharge summaries contained in the hospitals' medical records for the 90 claims to determine whether a beneficiary was discharged or transferred from one hospital to another;
- quantified the number of claims incorrectly coded for beneficiaries that were transferred from one hospital to another and the total overpayments made to the hospitals; and
- validated our findings with the State agency.

We conducted this 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 objective.

FINDINGS AND RECOMMENDATIONS

The State agency did not properly pay inpatient hospital claims and claim Federal reimbursement for beneficiaries transferred from one hospital to another on the same day in accordance with its CMS-approved State plan. Specifically, the State agency made overpayments totaling \$622,351 (\$388,695 Federal share) to 20 hospitals for 83 of 90 inpatient hospital claims reviewed. The overpayments occurred because the hospitals incorrectly coded the claims as discharges. Additionally, the State agency did not notify hospitals of changes to the Manual regarding certain transfers, and the State agency's claim processing system did not identify the claims for beneficiaries that transferred from one hospital to another on the same day. Two other claims, while coded incorrectly, did not result in overpayments. The State agency properly paid the remaining five claims in accordance with the CMS-approved plan.

STATE REQUIREMENTS

Attachment 4.19A of the CMS-approved State plan and chapter 7, section 2, of the Manual require the State agency to reimburse hospitals for inpatient services based on a DRG or a level-of-care reimbursement methodology. The transferring hospital is reimbursed a prorated DRG payment for each day of the beneficiary's stay, not to exceed the full DRG payment. To ensure appropriate reimbursement, chapter 8, section 2 of the Manual, instructs hospitals to use patient status code "02" (discharge or transfer to another short-term hospital for inpatient care) or "05" (discharge or transfer to another type of institution for inpatient care) on the claim form.

Section 6 of the Indiana Health Coverage Programs' Pricing Manual states that for transfers from a DRG hospital to a non-DRG hospital, the transferring hospital obtains the DRG per diem for the number of days the patient remained in that hospital prior to the transfer, not to exceed the full DRG payment amount.

OVERPAYMENTS MADE TO HOSPITALS

The State agency made overpayments totaling \$622,351 (\$388,695 Federal share) to 20 hospitals for 83 of the 90 claims reviewed.

Transfers to a Rehabilitation or Long-Term Care Facility

For 29 claims, the hospitals transferred beneficiaries to rehabilitation or long-term care facilities but coded these claims with patient status code “01” (discharged home) instead of the proper codes “62” (transferred to a rehabilitation facility) for 21 claims and “63” (transferred to a long-term care facility) for 8 claims. As a result, the State agency made overpayments totaling \$306,975 (\$191,577 Federal share) to 12 hospitals.

Transfers to Another Short-Term Hospital

For 20 claims, the hospitals transferred beneficiaries to another short-term hospital but coded these claims with a patient status code “01” instead of the proper code “02” (discharge or transfer to another short-term hospital for inpatient care). As a result, the State agency made overpayments totaling \$228,851 (\$142,779 Federal share) to 9 hospitals.

Transfers to a Psychiatric Hospital

For 34 claims, the hospitals transferred beneficiaries to psychiatric hospitals or psychiatric units of a hospital but coded these claims with a patient status code “01” instead of the proper code “05” (discharge or transfer to another type of institution for inpatient care). For 25 claims, hospitals used a newly introduced Medicare patient status code “65” (transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) that was not recognized by the State agency’s Medicaid processing system.⁵ When the State agency’s claims processing system rejected the claims, the hospitals changed the patient status code to “01” instead of code “05.” As a result, the State agency made overpayments totaling \$86,525 (\$54,339 Federal Share) to 10 hospitals.

CAUSES OF OVERPAYMENTS

The overpayments occurred because the hospitals incorrectly coded the claims as discharges. Additionally, the State agency did not provide hospitals with proper instructions for certain transfers, and the State agency’s claim processing system did not identify the claims for beneficiaries that transferred from one hospital to another on the same day.

While the State agency added patient status codes “62” (transferred to rehabilitation facility) and “63” (transferred to long-term care facility) to the Manual in July 2004, it did not notify hospitals of the changes. Consequently, hospitals did not use the codes when beneficiaries transferred from a hospital to rehabilitation and long-term care facilities. The State agency’s claims processing system was programmed to pay the claims with these codes as if the claims were

⁵The State agency did not enter patient status code “65” into its Medicaid claims processing system until January 2007.

coded as “05” and thus, the hospitals should have received the prorated DRG rate for each day, not to exceed the full DRG amount.

The State agency’s claim processing system did not identify the claims for beneficiaries that transferred from one hospital to another on the same day because controls did not exist to detect and review such claims.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal government \$388,695 for the overpayments made to the 20 hospitals,
- use the results of this audit in its provider education activities related to proper coding of claims for beneficiaries transferring from one hospital to another, and
- implement controls to detect and review claims for beneficiaries transferred from one hospital to another on the same day.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our recommendations but indicated that it performed a separate calculation of the overpayment amounts and computed an overpayment amount of \$622,351 (\$388,695 Federal share). The State agency indicated that that it will develop provider education materials relating to the appropriate billing of inpatient hospital transfer claims and coordinate with its audit contractor for routine post-payment review of claims to determine that billing guidelines are adhered to and for recoupment of any overpayments.

The State agency’s comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

We validated the State agency’s calculation of the overpayment amounts and revised our report accordingly.

APPENDIX



"People
helping people
help
themselves"

Mitchell E. Daniels, Jr., Governor
State of Indiana

Office of Medicaid Policy and Planning
MS07, 402 W. WASHINGTON STREET, ROOM W382
INDIANAPOLIS, IN 46204-2739

January 15, 2009

Marc Gustafson
Regional Inspector General for Audit Services
Office of Inspector General, Region V
Office of Audit Services
233 North Michigan Avenue
Chicago, IL 60601

RE: Indiana Medicaid Inpatient Hospital Transfer Payment Review (report number A-05-07-00081)

Dear Mr. Gustafson:

The Indiana Office of Medicaid Policy and Planning (OMPP) appreciates the opportunity to comment on the Office of Inspector General's (OIG) draft report titled "Review of Medicaid Inpatient Hospital Transfer Payments in Indiana for October 1, 2003, Through September 31, 2006". We have listed OIG's three audit recommendations below followed by our responses.

Recommendation #1: Refund to the Federal government \$391,298 for the overpayments made to the 20 hospitals.

The OMPP has reviewed the above referenced OIG report and the supporting detail of the OIG findings that are contained in a spreadsheet titled "overpayments for Indiana.xls". A separate calculation of the overpayment amounts was conducted to compare to the overpayment amounts identified by the OIG. This review identified a total overpayment of \$622,351.02 compared to a total overpayment amount identified by OIG of \$626,491.90 (difference of \$4,140.88). This reduces the amount to be refunded to the Federal government from \$391,298.04 to \$388,694.64 (difference of \$2,603.40). Enclosed with this letter is an attachment containing a comparison of the OIG and OMPP calculations. This attachment can be provided electronically upon request.

Recommendation #2: Use the results of this audit in its [OMPP] provider education activities related to proper coding of claims for beneficiaries transferring from one hospital to another.

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The OMPP will develop provider education materials relating to the appropriate billing of inpatient hospital transfer claims.

Recommendation #3: Implement controls to detect and review claims for beneficiaries transferred from one hospital to another on the same day.

Because the detection of improper billing of transfer claims is difficult to identify until the second (transferee) claim has been billed, real-time monitoring is likely not feasible. The OMPP will coordinate with its audit contractor for routine post-payment review/audit of claims to determine that billing guidelines are adhered to and for recoupment of any overpayments.

Please do not hesitate to contact Robin Kirby by telephone at 317-233-1195 or by email at robin.kirby@fssa.in.gov if you have any questions regarding the above responses or the enclosure.



Jeffrey M. Wells
Director of Medicaid

Enclosure