HI215 Unit 7 Case Study Script

Case 7: Transfer Cases

BACKGROUND

The objectives of our audit were to determine whether (1) Prospective Payment System (PPS) hospitals were paid in accordance with New York State (NYS) Medicaid policy when beneficiaries were transferred to other PPS hospitals, and (2) Medicaid overpayments resulted from the incorrect coding of the patient (discharge) status on claims for the transferred beneficiaries.

FINDINGS

For the most part, PPS hospitals in NYS were paid in accordance with Medicaid policy when beneficiaries were transferred to other PPS hospitals. However, we noted a relatively small number of exceptions that resulted from the incorrect coding of the patient (discharge) status on claims for transferred beneficiaries.

Under the NYS Medicaid PPS, hospitals were supposed to be paid an amount per discharge for inpatient hospital services rendered to beneficiaries that have been assigned to the appropriate diagnosis related group (DRG) based on such factors as each beneficiary's medical diagnosis, sex, age, birth weight, and procedures performed. Discharges of beneficiaries to their homes and those instances where they left against medical advice (LAMA) were eligible for the full DRG payment. Conversely, NYS Medicaid PPS regulations indicated that generally, reimbursement for claims involving the transfer of a beneficiary to another PPS hospital would be paid less than the full DRG amount. Also, according to NYS Department of Health (DOH) instructions, providers were to enter a patient status code indicating "Transferred to DRG hospital" on the claim form to properly

identify when a patient was transferred to another acute care hospital. A transfer incorrectly reported by the transferring hospital as a discharge would usually result in an overpayment because both hospitals would receive the full DRG amount.

We have concluded based on substantive testing that, in general, the NYS DOH had sufficient controls in place to ensure proper patient (discharge) status codes were utilized by PPS hospitals in claiming Medicaid reimbursement for transferred beneficiaries. Our conclusion was based primarily on the fact that there were a very small number of potential improperly coded LAMA and “discharged to home” claims identified by our computer analyses.

For the 1-year period ending March 31, 2001, we identified a total maximum sample universe of 895 potential improperly coded Medicaid LAMA and “discharged to home” claims for which the DRG Medicaid paid amount would, based on a preliminary “pricing” analysis, have been greater than the per diem transfer payment amount. From this universe, we judgmentally selected claims submitted by the top seven hospitals, each with potential overpayments exceeding $100,000, for detailed review. In addition, we augmented this judgmental sample with a detailed review of claims submitted by four providers in the Albany, New York, area. In total, we selected 185 claims from 11 hospitals having a total potential Medicaid overpayment amount of $1,428,171.

The NYS DOH had overpaid hospitals a total of $986,316 ($493,158 Federal share) for 74 of the 185 claims reviewed. Specifically, overpayments for which hospitals incorrectly coded the patient (discharge) status included:

- $904,525 ($452,263 Federal share) for 62 claims coded to indicate the beneficiaries were discharged to home, but the medical records indicated they were transferred to other PPS hospitals;
- $62,772 ($31,386 Federal share) for nine claims coded to indicate the beneficiaries left against medical advice, but the medical records indicated they were transferred to other PPS hospitals, and;
- $6,151 ($3,075 Federal share) for one claim where the beneficiary was actually "transferred" between units within the same PPS hospital.

In addition, one hospital lacked supporting medical documentation for two claims with a total Medicaid paid of $12,868 ($6,434 Federal share).

According to hospital officials, the incorrect coding of the patient (discharge) status occurred, for the most part, because of internal control and system problems, including data entry errors. In addition, some hospital officials and personnel were not fully aware of or had misinterpreted NYS Medicaid regulations.

Source: United States Department of Health and Human Services. (2003). Compliance with New York State Medicaid inpatient prospective payment system transfer regulations. Retrieved from http://oig.hhs.gov/oas/reports/region2/20201004.pdf

QUESTIONS:

1. What would you recommend that the New York State Department of Health do to address this issue with transfer cases? List at least three items along with your rational. Review the OIG website link above for additional information and background.

2. Review the “Calculation of Transfer Cases” in Exhibit 7-3 and 7-4 in your text. What do you see as the main difference in the calculations?