Department of Health

Medicaid Program: Improper Medicaid Payments for Misclassified Patient Discharges

Report 2020-S-8 | August 2021

OFFICE OF THE NEW YORK STATE COMPTROLLER
Thomas P. DiNapoli, State Comptroller

Division of State Government Accountability

Audit Highlights

Objective

To determine whether the Medicaid program made inappropriate fee-for-service (FFS) payments to hospitals that failed to properly report correct patient discharge codes on inpatient claims. The audit covered the period from January 1, 2015 to December 31, 2019.

About the Program

The State's Medicaid program is administered by the Department of Health (Department). The Department's eMedNY computer system processes Medicaid claims submitted by providers for services rendered to Medicaid-eligible recipients and generates payments to reimburse the providers for their claims.

The Department uses the All Patient Refined Diagnosis Related Groups methodology to reimburse hospitals for inpatient medical care. When a hospital bills Medicaid for an inpatient stay, the hospital reports certain information on its claims, such as the patient's diagnoses and services received, as well as the time and date of admission and when the services ended. This information is used to calculate the payment made to the hospital.

Hospitals must also use certain patient status codes to indicate whether the patient was transferred or discharged at the end of their stay. These codes are important because payments may vary significantly depending on whether a patient is transferred or discharged. For example, a claim where a patient was transferred to another facility may result in a lower payment than if a patient was simply discharged home from the hospital.

Key Findings

During the audit period, January 1, 2015 through December 31, 2019, we identified 2,048 FFS inpatient claims totaling $28.5 million for Medicaid recipients who were reported as discharged from a hospital but then admitted to a different hospital within 24 hours of the discharge (which often meets the definition of a transfer). These claims are at a high risk of overpayment if the first hospital inappropriately reports an actual transfer as a discharge. We selected a judgmental sample of 31 claims (of the 2,048) from three hospitals totaling Medicaid payments of $457,973 and reviewed the associated patients' medical records. Our review found:

- 15 claims were overpaid $252,107 because they were incorrectly coded as discharges when the patients were actually transferred to another facility.
- The Department does not have a process to identify and recover improper Medicaid payments for inpatient claims with incorrect patient status codes.

Key Recommendations

- Review the $252,107 in overpayments and recover as appropriate.
- Review the remaining 2,017 high-risk claims totaling $28 million identified in this audit and recover overpayments as appropriate. Ensure prompt attention is paid to those providers that received the highest amounts of payments.

- Develop a process to identify and recover Medicaid overpayments for FFS inpatient claims that have a high risk of incorrect patient status codes such as those identified by this audit.

Office of the New York State Comptroller
Division of State Government Accountability

August 17, 2021

Howard A. Zucker, M.D., J.D.
Commissioner
Department of Health
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Albany, NY 12237

Dear Dr. Zucker:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage their resources efficiently and effectively. By so doing, it provides accountability for the tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Medicaid program entitled *Improper Medicaid Payments for Misclassified Patient Discharges*. The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Division of State Government Accountability

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Glossary of Terms

Term	Description	Identifier
ALOS	Average length of stay	*Key Term*
Department	Department of Health	*Auditee*
DRG	All Patient Refined Diagnosis Related Groups	*Key Term*
eMedNY	Department's Medicaid claims processing and payment system	*System*
FFS	Fee-for-service	*Key Term*
LOS	Length of stay	*Key Term*

Background

The New York State Medicaid program is a federal, state, and local government-funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. The Medicaid program is administered by the State's Department of Health (Department). For the State fiscal year ended March 31, 2020, New York's Medicaid program had approximately 7.3 million recipients and Medicaid claim costs totaled about $69.8 billion. The federal government funded about 56.3 percent of New York's Medicaid claim costs, and the State and localities (the City of New York and counties) funded the remaining 43.7 percent.

The Department's eMedNY computer system processes Medicaid claims submitted by providers for services rendered to Medicaid-eligible recipients and generates payments to reimburse the providers for their claims. When eMedNY processes claims, the claims are subject to various automated controls (edits), which determine whether the claims are eligible for reimbursement and if the amounts claimed for reimbursement are appropriate.

The Department uses the All Patient Refined Diagnosis Related Groups (DRG) methodology to reimburse hospitals for inpatient medical care. The DRG methodology classifies patients according to their diagnosis and severity of illness, which provides the basis for calculating the reimbursement. To make DRG payment determinations, the Department uses a third-party software (called Grouper).

When a hospital bills Medicaid for an inpatient stay, the hospital reports certain information on its claims, such as the patient's diagnoses and services received, as well as the time and date of the admission and when the services ended. The Grouper software uses this information to assign the appropriate DRG and severity of illness for the inpatient stay, and, based on this information, eMedNY then assigns a service intensity weight to the claim. The service intensity weight, established base payment amounts, and other factors are used to calculate the hospital's full payment. Generally, more acute or severe medical conditions receive a higher weight, which increases the hospital's payment.

Hospitals also report patient status codes to indicate whether the patient was transferred or discharged because DRG reimbursement methodologies for transfers and discharges are different. For a transfer patient, the Medicaid payment is calculated by dividing the DRG payment by the average length of hospital stay (ALOS) and then multiplying by the actual length of stay (LOS), not to exceed the full DRG payment for a discharge. This calculation results in a transfer payment that is lower than the discharge payment when the LOS is lower than the ALOS.

According to New York Codes, Rules and Regulations Title 10, Section 86-1.15, a DRG transfer occurs when a patient is (1) not discharged, not transferred among two or more divisions of merged or consolidated facilities, not assigned to a DRG specifically identified as a DRG for transferred patients only; and (2) meets one of the following conditions:

- Transferred from an acute care facility reimbursed under the DRG payment system to another acute care facility reimbursed under this system;
- Transferred to an out-of-state acute care facility; or
- A neonate (newborn) who is transferred to a DRG-exempt facility for neonatal services.

The regulation states a DRG discharge occurs when a patient whose admission to the facility occurred on or after December 1, 2009:

- Is released from an acute care facility to a non-acute care setting (e.g., nursing home, patient's home);
- Is moved to a facility or unit that is exempt from the DRG payment system except when the patient is a newborn transferred to an exempt hospital for neonatal services and thus classified as a transfer patient pursuant to this section;
- Is a newborn who is released from a hospital providing neonatal specialty services back to the community hospital of birth for weight gain; or
- Dies in the facility.

Audit Findings and Recommendations

For the period January 1, 2015 through December 31, 2019, the audit identified 2,048 fee-for-service (FFS) inpatient claims totaling $28.5 million for Medicaid recipients who were reported as discharged from a hospital but then admitted to a different hospital within 24 hours of the reported discharge (which often meets the definition of a transfer). These claims are at a high risk of overpayment if the first hospital inappropriately reports a transfer as a discharge. We selected a judgmental sample of 31 claims totaling $457,973 from three hospitals and reviewed the associated patients' medical records. For the sampled 31 claims, we identified $252,107 in overpayments from 15 claims that were incorrectly coded as a discharge. As a result, the Department should review the remaining 2,017 high-risk claims (totaling $28 million) to determine if the patient's status was miscoded as a discharge instead of a transfer.

FFS Inpatient Claims at Risk for Incorrect Discharge Coding

We identified 2,048 FFS inpatient claims totaling $28.5 million for Medicaid recipients who had more than one hospital admission between January 1, 2015 and December 31, 2019. These claims were selected because the second admission was within 24 hours of the initial discharge from a different hospital. This time frame is based on the risk that miscoding exists when patients are reported as being discharged (rather than transferred) from a hospital but admitted to another hospital within a short period of time. We reviewed a sample of 31 claims totaling $457,973; the results are summarized in the table on page 9.

The Department has not developed controls to identify miscoded discharges. According to Department officials, a medical record review is necessary to make a determination whether a claim should be reported as a discharge or a transfer. However, claims data can be used to identify questionable claims. For example, Medicaid paid $30,129 on one claim for a patient who was discharged from a hospital on October 10, 2019 at 6 a.m. and the hospital used a patient status code indicating the patient had passed away. However, the same patient was admitted to a different hospital two hours later (where the patient ultimately passed away 10 days later). If the first claim was coded appropriately as a transfer, Medicaid would have paid $7,128. As a result, we calculated an overpayment of $23,001 for this miscoded claim.

We recommend the Department review the 2,017 remaining claims to assess whether the discharge code is accurate. It is also worth noting that the top 10 hospitals received 35 percent of the $28 million ($9.8 million) in claims that are at high risk of overpayment.

Review of Medical Records to Validate Risk of Incorrect Discharge Coding

In order to validate and confirm our analysis, we selected a judgmental sample of 31 inpatient claims totaling $457,973 submitted by three hospitals that billed Medicaid for patients who were later admitted to another hospital within 24 hours of their discharge. We reviewed patient medical records to assess the patients' status on leaving the hospitals and identified 15 claims that should have been billed as transfers (instead of discharges). Using the DRG formula, we recalculated the payment for the 15 claims as if they were correctly billed as transfers and identified $252,107 in overpayments, as detailed in the following table.

Summary of Sample Results

	Number of Sampled Claims	Sample Payment Amount	Number of Miscoded Claims	Miscoded Claims Payment Amount	Correct Payment Amount	Overpayment Amount
United Health Services	14	$170,796	10	$137,298	$46,076	$91,222
Albany Medical Center	10	85,816	3	28,296	12,483	15,813
Vassar Brothers Medical Center	7	201,361	2	170,659	25,587	145,072
Totals	**31**	**$457,973**	**15**	**$336,253**	**$84,146**	**$252,107**

For one sampled claim, Medicaid paid $11,515 for a patient who was admitted to a hospital and stayed one day, and the hospital indicated the patient was discharged. However, the same patient was admitted to another hospital for additional care within an hour of the discharge from the first hospital. We contacted officials from the discharging hospital, and they agreed the patient was not discharged but was transferred to the second hospital. We recalculated the claim as if the discharging hospital had correctly coded this patient as a transfer, and determined Medicaid would have only paid $2,301. As a result of the incorrect discharge coding, Medicaid overpaid $9,214 for this claim.

For each of the 15 findings, we concluded the claim was incorrectly coded as a discharge as the patient's medical record indicated that the patient was transferred to another facility for continued care. If all of the 15 claims were correctly coded as a transfer, Medicaid would have only paid $84,146, resulting in overpayments of $252,107.

Incorrect reporting generally occurred because the hospitals made clerical errors coding the claims. When we provided the three hospitals with our findings, officials from all three confirmed the claims were inappropriately coded and indicated they would take actions to prevent future billing errors. The Department routinely reminds

providers about appropriate billing practices and applicable regulations; however, the last formal reminder to hospitals on the importance of accurately reporting patient status codes was in May 2013.

Recommendations

1. Review the $252,107 in overpayments and recover as appropriate.
2. Review the remaining 2,017 high-risk claims totaling $28 million identified in this audit and recover overpayments as appropriate. Ensure prompt attention is paid to those providers that received the largest dollar amounts of payments.
3. Formally remind hospitals to use correct billing codes based on information documented in the medical records.
4. Develop a process to identify and recover Medicaid overpayments for FFS inpatient claims that have a high risk of miscoded patient status codes such as those identified by this audit.

Audit Scope, Objective, and Methodology

The objective of this audit was to determine whether the Medicaid program made inappropriate FFS payments to hospitals that failed to properly report correct patient discharge codes on DRG inpatient claims. This audit examined inpatient FFS claims from January 1, 2015 through December 31, 2019 for patients who were discharged from a hospital and had a second admission to a different hospital within 24 hours. We excluded Medicare crossover claims and claims where the LOS was equal to or greater than the ALOS.

To accomplish our audit objective and assess related internal controls, we used the Medicaid Data Warehouse to identify DRG inpatient claims. We interviewed officials from the Department and examined the Department's relevant Medicaid policies and procedures as well as applicable federal and State laws, rules, and regulations. We contacted three hospitals with a high number of claims in our audit population and requested medical records to assess the appropriateness of the discharge status code for a judgmental sample of 31 claims. The claims were selected based on the discharge status code and Medicaid payment amount. We spoke to officials from the three hospitals and considered their feedback in finalizing the review of the claims. The results of our sample cannot be projected to the population as a whole.

During the audit, we shared our methodology and our findings, including the calculation of overpayments, with officials from the Department and the Office of the Medicaid Inspector General for their review.

Statutory Requirements

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

We conducted our 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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of it. In their response, Department officials agreed with the audit recommendations and indicated that certain actions have been and will be taken to address them. Our rejoinder to one Department comment is embedded in the Department's response as a State Comptroller's comment.

Within 180 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

LISA J. PINO, M.A., J.D.
Executive Deputy Commissioner

April 15th, 2021

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2020-S-8 entitled, "Medicaid Program: Improper Medicaid Payments for Misclassified Patient Discharges."

Thank you for the opportunity to comment.

Sincerely,

Theresa Egan
Deputy Commissioner for Administration

Enclosure

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Department of Health Comments on the Office of the State Comptroller's Draft Audit Report 2020-S-8 entitled, "Improper Medicaid Payments for Misclassified Patient Discharges"

The following are the responses from the New York State Department of Health (Department) to Draft Audit Report 2020-S-8 entitled, "Improper Medicaid Payments for Misclassified Patient Discharges" by the Office of the State Comptroller (OSC).

Recommendation #1:

Review the $252,107 in overpayments and recover as appropriate.

Response #1:

The Office of the Medicaid Inspector General (OMIG) is developing a methodology to address the OSC-identified issue of discharges and transfers, which will require a medical review of the inpatient files of the discharging and admitting facilities. OMIG will perform its own extraction of data from the Medicaid Data Warehouse (MDW), which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and to confirm the accuracy of the claims detail for use in OMIG audit activities. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

State Comptroller's Comment – The Department states, "OMIG will perform its own extraction of data from the Medicaid Data Warehouse (MDW), which may include those OSC-identified overpayments not already adjusted or recovered." We note that our recommendation pertains to only 15 claims submitted by three hospitals that, as stated on page 9 of our report, already agreed the 15 claims we identified were incorrectly coded as a discharge. As such, OMIG should prioritize the recovery of these 15 claims, totaling $252,107, without delay.

Recommendation #2:

Review the remaining 2,017 high-risk claims totaling $28 million identified in this audit and recover overpayments as appropriate. Ensure prompt attention is paid to those providers that received the largest dollar amounts of payments.

Response #2:

OMIG is developing a methodology to address the OSC-identified issue of discharges and transfers, which will require a medical review of the inpatient files of the discharging and admitting facilities. OMIG will perform its own extraction of data from the MDW, which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and to confirm the accuracy of the claims detail for use in OMIG audit activities. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #3:

Formally remind hospitals to use correct billing codes based on information documented in the medical records.

Response #3:

The Department is reminding hospitals to bill using the appropriate discharge status code based on the information documented in the patient's medical record as part of an upcoming Medicaid Update article, to be released in the summer of 2021.

Recommendation #4:

Develop a process to identify and recover Medicaid overpayments for FFS inpatient claims that have a high risk of miscoded patient status codes such as those identified by this audit.

Response #4:

The Department has begun internal discussions to determine if any internal controls, such as edits to eMedNY or post audit and review procedures, can be implemented to identify Fee-For-Service (FFS) inpatient claims at high risk for inaccurate use of discharge status codes.

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