OIG Announces The PPS Transfer Initiative and a New Fraud-Fighting Partner...The PRO!

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Practice Area: Health Law & Healthcare Billing and Collection

Just when you thought it was safe to bill Medicare. The Office of the Inspector General ("OIG") has announced yet another national initiative – this time focusing on the correctness of coding for patient discharges/transfers. The OIG contends that some prospective payment system ("PPS") hospitals improperly coded Medicare patients as "discharge" rather than "transfer" to receive higher reimbursement. Already, the government has collected approximately $175 million in overpayments, and the OIG estimates that an additional $185 million has been improperly paid.

The Transfer Initiative

In the OIG's fraud-microscope are PPS hospitals that allegedly improperly coded and billed Medicare for patients as if the patients had been discharged when the patients had been transferred to another facility. A transferring hospital is reimbursed based on a graduated per diem amount (not to exceed the full DRG amount), while a discharging hospital receives the full prospective payment. The difference in payment for the transferring hospital can be substantial. Indications are that the scope of the OIG's investigation of Part A inpatient hospital claims covers discharges between January 1, 1992, and September 30, 1997.

According to the Medicare regulations in effect for the period in question, a hospital inpatient was considered "discharged" from a hospital paid under the PPS when: 1) the patient was formally released from the hospital; 2) the patient died in the hospital; or 3) the patient was transferred to hospitals or units that were excluded from the PPS system, such as psychiatric or rehabilitation hospitals. A "transfer" occurred if a transfer was made: 1) from one inpatient area or unit of the PPS hospital to another; 2) from a PPS hospital to the care of another PPS hospital; or 3) from a PPS hospital to the care of another hospital that was excluded from the PPS system because of participation in a statewide cost control program or whose first cost reporting period under PPS had not yet begun. Note that as a result of the Balanced Budget Act, these definitions changed for discharges occurring after October 1, 1998.

There is some good news. According to June Gibbs Brown, Inspector General for Health and Human Services, the OIG expects that a majority of the cases will be referred to HCFA and treated as overpayment cases. However, a small percentage of cases will be referred to the Department of Justice ("DOJ") and pursued as part of the national investigation. These latter hospitals will receive letters from the DOJ questioning the propriety of these discharge/transfers. A copy of the DOJ letter obtained by von Briesen & Roper, s.c., indicates the DOJ is requesting cooperation by hospitals in the form of waiver of the statute of limitations as well as submission of copies of specified hospital records.

The Wisconsin Fiscal Intermediary, United Government Services, confirmed the above information but at present has no further information available. There is no indica tion when to expect the PPS Transfer Project to start in Wisconsin. Preparing for the transfer project may be difficult for hospitals. Because the OIG is matching data by beneficiary, it is able to identify a discharge from one facility and admission to another facility that occur on the same day. An individual hospital, when doing an internal analysis, will not have access to other hospitals' data and will not be able to identify an admission to another facility. Hospitals can, however, do the following:

1. Review their discharge coding to verify that it has discharges to various locations;
2. Review their system to verify that the system does not default to "discharge to home," for example;
3. If the hospital is part of a system or has multiple facilities, review that transfers within the system are properly coded; and
4. Review a sample of medical records to verify that the discharge designation in the medical record agrees with the discharge designation on the claim – a nurse, social worker, or case manager should document in a patient's medical record exactly where the patient went following discharge.

The PRO as P.I. (Private Eye)

HCFA also plans to utilize Peer Review Organizations ("PROs") to assist it in identifying fraud. A draft of the PROs' Sixth Scope of Work includes a Payment Error Prevention Program ("PEPP"). Under PEPP, the PRO will be expected to ferret out and correct inappropriate billing and coding. These duties will be in addition to the PROs' current DRG validation responsibilities and are expected to start in August 1999.

The PROs' tasks under the PEPP include analyzing billing data and identifying trends of inappropriate billing and coding. Kinds of inappropriate billing and coding include: 1) patterns of poor documentation; 2) incorrect DRG assignment; 3) inappropriate transfers; 4) premature discharges; and 5) inappropriate or medically unnecessary care. The PRO is then charged with developing interventions to reduce errors.

A bounty system will reward successful PROs. If a PRO meets certain evaluation criteria – for example, a reduction in the payment error rate – it will receive an incentive payment. For every one percent relative decrease in the payment error rate in the PRO's state, the PRO will be awarded an incentive payment equal to .05 per-cent of its base contract.

What this will mean for hospitals is unclear. At the very least, it is expected to mean more intensive PRO medical record reviews.

Conclusion

Expect the OIG's fraud-fighting efforts to continue along these lines. As with any national initiative, preparation is important. Thus, hospitals should consider reviewing data relating to transfers and discharges now. Finally, a good working relationship with the PRO will be essential in dealing with the increased scrutiny that will be experienced under PEPP.
