Ten years ago, the Centers for Medicare and Medicaid Services (CMS) deter-
determined that, for certain diagnostic-related groups (DRGs), Medicare was
double paying” for care. In these instances, patients were admitted to acute
care hospitals but transferred to postacute care facilities—typically a skilled
nursing facility (SNF) or home care agency—shortly thereafter (i.e., under
the geometric mean length-of-stay). CMS reasoned that the hospital was
receiving full payment under the DRG for treatment of a condition that was
also being treated by the postacute care provider, which in turn was also
receiving payment.

To address this perceived double payment, Congress authorized the creation
of what are commonly termed transfer DRGs, and the postacute transfer rule
came into effect. In a nutshell, the idea of transfer DRGs was to reduce
the hospital payment to a per diem payment and to pay the postacute facility
their full payment. Unfortunately, the resulting system of checks and bal-
cances put in place by CMS does not fully protect the interests of both CMS
and hospitals.

Proliferation of Transfer DRGs
The initial scope of the postacute transfer payment policy enacted by Congress
and implemented by CMS was relatively narrow. For discharges that occurred
on or after Oct. 1, 1998, CMS identified 10 DRGs likely to result in a transfer to
a postacute care provider. In the absence of a transfer, full payment is made to
the final discharging hospital. However, in the case of a transfer, each trans-
ferring hospital is generally paid a graduated per diem rate for each day of the
patient’s stay, not to exceed the full DRG payment that would have been made
if the patient had been discharged without being transferred.

The per diem rate paid to a transferring hospital is calculated by dividing the
full DRG payment by the geometric mean length of stay for the DRG. For the
first day of the admission, subject to an exception for certain DRGs, the transferring hospital is paid twice the per-diem amount.

In its FY05 final rule, CMS significantly expanded the application of the transfer payment policy, increasing the number of transfer DRGs to 182 (as of federal fiscal year [FFY] 2006, the number of transfer DRGs stands at 190), as described in 42 C.F.R. § 412.4(d). As a result of this expansion, transfer DRG payments have become a priority for many hospitals.

Under current Medicare regulations, a discharge of a hospital inpatient is considered to be a “transfer” for Medicare payment purposes when the patient’s discharge is assigned to one of the 190 DRGs and the patient is discharged to:
- A hospital, or hospital unit, that was excluded from payment under the prospective payment system
- A SNF
- The patient’s home, where there is a written care plan for home health services, the services are related to the condition or diagnosis for which the individual received inpatient hospital care, and the services began within three days after the date of discharge

To facilitate compliance with the prorated payment provision, CMS implemented edits on Jan. 1, 2004, to detect transfers that were improperly coded as discharges to the home, thereby ensuring that hospitals were not overpaid for transfer cases. However, CMS did not implement similar checks and balances to ensure that providers were not underpaid. It therefore is incumbent upon providers to identify cases in which they potentially were underpaid.

And underpayments can easily occur. The problem arises when a hospital discharges a patient with one of the qualifying transfer DRGs, and uses a discharge code that designates that the patient will receive follow-up care from a SNF or home health agency. If the patient was in the acute care setting for less than the geometric mean length of stay, the hospital will receive a per diem DRG payment. But CMS does not perform retrospective reviews to verify that the follow-up level of care was actually received or that it was received within the required time frames. The hospital is paid what it was expecting to receive under transfer DRG payment rules, and because no corresponding outstanding accounts receivable balance exists to alert the hospital’s management if an underpayment issue exists, the hospital is not aware that it has been underpaid. Hospitals must perform their own investigation to identify the underpayment.

**Key Issues for Hospitals**

At the heart of the question of how hospitals should proceed in such circumstances are two key issues: the hospital’s right to receive proper payment and the need for the hospital to fully comply with the rule regarding transfer DRGs.

**Proper payment.** Because CMS has chosen not to identify underpayments, hospitals cannot rely upon their servicing Medicare fiscal intermediary to identify and correct such claims. Instead, hospitals need to identify underpayments and seek to recoup appropriate additional payment through the claims correction and rebilling process.

To identify every instance of possible underpayment and recover all lost revenues, hospitals must complete a retrospective review of all claims billed, on a one-by-one basis. Hospitals should not be concerned that rebilling these claims to recover payment to which they are entitled in any way affects the Medicare payment received by SNF or home health agencies—if these entities did not deliver care to the patient, they would not have reason to file any claim for the care, and if they did provide care and billed for it, then everyone (including the hospital) would have been paid appropriately and no changes would be required.

**Compliance.** Obviously, hospitals should be concerned with compliance issues related to the correct assignment of patient status codes. In fact, when CMS first implemented its edits in January 2004, requiring hospitals to change the patient status code upon receipt of common working file
edit 7272, hospitals were concerned that they would now have bills that were not supported by the medical record. As a direct result of the hospital provider community’s concerns, CMS issued Transmittal 140, dated April 16, 2004. This transmittal states:

Hospitals have expressed concerns to CMS over the changing of patient status codes on the bill when their medical records do not support such changes. They are concerned that they will be considered out of compliance if there is an audit performed by the Office of Inspector General. This CR [change request] seeks to alleviate some of their concerns by instructing them to change their patient status code in order to receive reimbursement while CMS considers what can be done when medical necessity issues arise with transfers from acute care to post-acute care entities.

This transmittal goes on to inform providers that they must change the patient status codes upon receipt of CWF edit 7272 and that fiscal intermediaries must notify hospitals that they will not be penalized by the OIG when the hospitals change the patient status code to indicate a transfer, even if the indication does not correspond with the hospital’s medical records.

Based on this CMS transmittal, hospitals can infer that they must change a patient’s status code whenever they are reasonably able to determine that the original assignment was incorrect. Indeed, the main goal of corporate compliance is to ensure accurate payment, so an incorrect payment requires correction whether the hospital has been overpaid or underpaid. Unfortunately, as noted previously, when it comes to the issue of postacute transfer payments, CMS is concerned only with recovering overpayments.

**Key Questions**

The issue of transfer DRGs and lost revenue raises several questions for hospitals: How many of a hospital’s claims are likely to have been underpaid and how much revenue might have been lost? Which postacute settings are most likely to be involved? Most important, how can a hospital go about identifying instances in which it was underpaid and has legitimate cause to request full payment, and how can it recover these monies? Finally, how can the hospital ensure it is paid accurately and appropriately in the future?

**Number of claims.** The findings of a review of more than 150,000 claims from FFY05 and FFY06 include some interesting statistics that indicate the magnitude of the issue. Out of the claims reviewed, about 35,000 were for FFY05 (when there were only 30 transfer DRGs). Out of these 35,000 claims, which represent about $76 million, roughly 4,300 claims, or 12 percent, were incorrectly billed as transfers and were, as a result, underpaid. For the roughly 115,000 claims that were for FFY06, 14.1 percent needed to be rebilled.

**Postacute care settings most frequently involved.** The review disclosed that 54 percent of the FFY05 claims requiring rebilling were claims originally billed as transfers to a SNF, 36 percent were originally billed as transfers to a home health agency, and the remaining 10 percent were billed as transfers to other postacute care settings. By comparison, the corresponding percentages of FFY06 claims requiring rebilling were 53 percent, 36 percent, and 11 percent, respectively.

**When full payment is appropriately due.** In simple terms, a hospital is entitled to receive full payment if a patient is discharged ostensibly to receive SNF, home health, or other postacute care and the anticipated care is not provided at all, or in the very least within the required regulatory time frames (i.e., within three days of the date of the hospital discharge, in the case of home care transfers).

For example, in a situation where a patient was discharged with a qualifying transfer DRG to home care and was not admitted to the home health agency within the required three-day window, the hospital should have been paid the full DRG. Another example would be if a patient is discharged to a nursing home, but is placed in a
non-Medicare certified bed or does not receive skilled care. This type of care does not constitute a transfer, and a full DRG should have been paid to the hospital.

**Tactics for recovering lost revenue.** As previously indicated, to ensure that transfer DRGs are paid correctly, hospitals should perform a review of all paid acute care inpatient claims for services delivered to patients under the qualifying transfer DRGs to retrospectively verify that postacute care was actually provided. Given that conducting a thorough and accurate analysis of the issue can take time, a hospital should consider taking quick action.

The hospital’s leaders should first educate themselves on the nuances of the Medicare regulations relating to postacute transfers (going back to the creation of postacute transfers in 1998), and on all of the OIG reports, program manuals, Medicare transmittals, and other relevant documentation.

Once key hospital stakeholders—including Finance, Patient Financial Services, Health Information Management, and Compliance—thoroughly understand the issues, the next step is to perform the necessary data mining steps to identify the population of patients (and revenues) at risk. The hospital then should perform a number of rationality tests to determine whether the data gathered are correct.

For example, what was the hospital actually paid for the services? Occasionally, hospitals can identify system mapping issues (from the patient accounting system to the billing system) that can be immediately corrected without having to go through sometimes painful “process” changes.

When the hospital is confident that the data are sound, the next step is to develop an audit approach to evaluate each claim. This step might include reviewing the common working file, contacting nursing homes, and contacting home health companies. Although some providers may choose to review the medical record, limiting the review to just the medical record might be ineffective because the real focus is on what happened to the patient after he or she was discharged from the hospital.

In the event the hospital decides to engage a consultant to perform the retrospective revenue recovery project on a contingency basis, the hospital should keep two points in mind. First, the hospital should control the rebilling. Once an analysis is completed, a listing of those claims that qualify for rebilling should be part of the final deliverable. The hospital should perform the rebilling function only after a thorough review of the findings because consultants performing rebilling services present certain compliance risks and perceptions, especially if a contingency agreement is in place. Second, the hospital should control the documentation. It is critical that documentation supporting qualifying rebillable claims accompany any final deliverable. Such documentation will help the patient accounting department re bill qualifying claims and will be necessary should any of the claims be reviewed in the future.

**Caveats**

As indicated previously, from a compliance perspective, there is no reason that a hospital should be hesitant about seeking to recover lost revenue to which it is legally entitled. There are, however, certain times when a hospital should be careful from a compliance perspective.

One instance is if the hospital is reviewing claims prior to Jan. 1, 2004. Most fiscal intermediaries allow providers to correct claims only within the normal timely filing window. However, some intermediaries do allow providers to go back as far as four years to correct claims. Having the liberty to review a number of previous years might be appealing to a hospital, but the hospital needs to keep in mind that CMS implemented its overpayment edits on Jan. 1, 2004. A review of claims prior to this date, therefore, must look for both underpayments and overpayments. Failure to look for overpayments in claims...
prior to Jan. 1, 2004, would create a significant compliance concern for a hospital.

Finally, one additional area where a hospital should be careful is with respect to expired patients. Providers need to pay close attention to ensure that the status coding of expired patients is accurate, as this is not an area where recoveries can be made, and efforts to recover revenues in such instances can cast the hospital in a negative light.

**Time Is of the Essence**

Hospitals should take the necessary steps to recover payment that they have earned, while at the same time implementing the necessary process improvements to ensure that future payment is accurately received. Most important, hospitals need to act now, as claims are subject to time limits. Dec. 31, 2007, the date when all FFY06 claims move beyond the typical timely filing window, is rapidly approaching. That doesn’t leave much time to complete the review, rebill the claims, and recover the lost allowable payment.

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