To Our Healthcare Clients and Friends:

Yes, it really has been almost fifteen years since the inception of the Transfer DRG Rule ("The Rule"). Surely there is nothing new to learn and the risks are minimal, right? WRONG! The fact is there are compliance issues lurking around the corner. If you aren’t keeping an eye out for these potential issues, you could risk paybacks, fines, and penalties. In our experience, we have seen providers with overpayments ranging from $300,000 to $400,000 annually. When you factor in how far back a Government investigation would look, and take into consideration fines and penalties, these issues very quickly reach multi-million dollar levels.

In this edition of IMA Insights, we will focus on Condition Codes and how they may be contributing to Transfer DRG overpayments. We will specifically discuss the following:

1. The use of Condition Codes relating to discharges to Home Care.
2. Why Condition Codes may put Hospitals at risk for overpayments.
3. How to identify if you have overpayment issues and prevent them from recurring.
BACKGROUND

As initially enacted by Congress and implemented by The Centers for Medicare and Medicaid Services (CMS), the scope of the post-acute transfer payment policy was relatively narrow. Effective for discharges that occurred on or after October 1, 1998, CMS originally identified 10 DRGs as those likely to result in a “transfer” to a post-acute care provider that might require a PPS payment adjustment through DRG proration.

Changes effective for Federal Fiscal Year 2012 brought the total number of Transfer DRGs to 275. This means that for any patient admitted to a hospital under one of the 275 DRGs, providers will be paid a per-diem rate as opposed to the full DRG payment if the patient’s stay is less than the geometric mean length of stay and the patient is discharged to a post-acute care setting.

For claims where the patient is discharged to Home Care, the care must begin within three days of discharge to be subject to The Rule, and the Home Care must be related to and as a result of the care received in the Hospital. Where care is not started within three days of discharge or is not related to the Hospital stay, the Hospital applies Condition Code 43 or 42 respectively to the discharge status code to trigger a full payment as opposed to a per-diem payment.

Over time, CMS put edits in place to identify overpayments to hospitals. Of course, when it comes to underpayments relating to Transfer DRGs, the Government doesn’t try to correct the payment (which would only be fair); rather, they ignore the issue altogether. The OIG issued an advisory stating the post-acute transfer edits may not be fool proof. Our experience confirms that there are areas that escape detection from CMS’s edits. This can unfortunately result in overpayments to Providers.

CHALLENGES

The obvious challenge facing Hospitals is how to ensure that they are getting properly reimbursed for the services rendered. To ensure proper payment, a Hospital must be able to allocate the resources to audit claims affected by The Rule to determine if the correct discharge status was utilized based upon the care the patient actually received post discharge. There are a number of methods to determine the “correct discharge status”, but those methods are not the focus of this article as many providers already have processes in place (internal and/or external) to ensure accurate discharge status coding.

The not-so-obvious challenge is making sure Transfer DRG overpayments are not occurring in your Hospital. How are overpayments possible if CMS has edits in place to catch them? The answer is through incorrect utilization of Condition Codes. We have seen a number of instances where overpayments have occurred without the knowledge of the Hospital due to key punch errors, system errors, mapping errors, and/or bad advice provided by external sources. Most of the errors revolve specifically around the use of Condition Codes 42 and 43 for Home Care claims. Utilization of these Condition Codes basically circumvents the edits that CMS has in place.
Condition Code 42 is used to indicate to your Medicare Administrative Contractor (MAC) that the care provided by the Home Care Agency is not related to the Hospital Care and therefore the Hospital should receive the full DRG payment not a per-diem payment. Failure to have an auditing process in place to validate the usage of Condition Code 42 could result in significant overpayments without your knowledge. Any review process relating to Condition Code 42 should be comprehensive and performed by individuals who thoroughly understand the importance of getting it right (and the risks of getting it wrong). Said review should look very closely at the relevant hospital medical record information including, but not limited to: admission notes/diagnosis/orders, physician orders, social service notes, case management notes, discharge planning notes/instructions, home care assessment notes (if available). If necessary, you may need to contact the Home Care Agency directly. Be aware that overutilization of Condition Code 42 will act like a red flag to MACs, RACs and anyone else analyzing your claims payment patterns (relative to your peers).

Condition Code 43 indicates to your MAC that Home Care was started more than three days after discharge from the Hospital, thereby entitling the Hospital to full payment. In order to determine if these codes are being utilized in the correct manner, a detailed review should be performed on a regular basis. The review can be done by Compliance, Internal Audit or an outside auditor depending on the resources available. Again, be aware that overutilization of Condition Code 43 will also act like a red flag to MACs, RACs and others analyzing your claims payment patterns (relative to your peers).

INSIGHTS

So what can a Provider do to ensure that these overpayments don’t occur? Following the guidelines below will help to identify potential issues and ensure compliant billing practices:

• Identify all discharges to Home Care where: 1) the stay is related to one of the 275 MS-DRGs subject to the Rule, and 2) the length of stay was less than the geometric mean length of stay. Identification of these claims should be on a quarterly basis if possible but no less than at least once a year.

• Once the claims have been identified, review the billing to determine if either Condition Code 42 or 43 was utilized.

• If Condition Code 42 was utilized, review the supporting documentation to ensure there is documentation to support that the Home Care provided post-discharge was unrelated to the hospital stay (if necessary, contact the Home Care Agency).

• If Condition Code 43 was utilized, review the CWF or HETS eligibility screens to ensure that home care was not started within the first three days after discharge.

Please note, if you anticipate that you may have a problem relating to the utilization of Condition Codes 42 or 43, we strongly recommend that you notify your Compliance department and legal counsel BEFORE doing any internal reviews. It is important that this review be performed independently from the staff responsible for the initial billing. Internal Audit, Compliance or external resources should be employed to look at this issue.
SUMMARY

While "The Rule" is fifteen years old, you can see there are still a lot of potentially costly pitfalls. Understanding the issues and being able to navigate your way around them will ensure that your Hospital is fairly and accurately reimbursed for services rendered.

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We are pleased to have the opportunity to present this information to you. If you have any questions or need assistance with evaluating your hospital’s exposure to this issue, please do not hesitate to contact me at (267) 626-1192.

Truly yours,

Jim Collins

Jim Collins
Director