

II. Coding for Compliance

Introduction

This section will discuss a hospital's compliance program as it relates to the area of coding. As you evaluate your compliance program in terms of addressing coding risk areas consider whether you have addressed these areas within all elements of your compliance program. The following outlines aspects of your compliance program and presents questions and guidance on assessing if you have ongoing processes to address coding areas. We have also provided very specific coding risk areas that CMS is currently monitoring through HPMP and that you should be monitoring and consider auditing as well.

Establish Responsibility

It is important to review who truly has ultimate authority for coding compliance at your hospital. This may be assigned to the compliance officer or it may be assigned, perhaps more appropriately, to your director of medical records/health information management, a coding manager, or a similarly qualified individual. Regardless of whom you assign to this function, this individual must be accountable to the compliance officer regarding coding compliance. He or she should also sit on the compliance committee or a subcommittee.

Using unqualified employees or inappropriate or outdated coding resources could pose high risks for your organization; using either may result in erroneous coding and billing. The most current resources include:

- * *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Code Book (Volume 1,2 & 3)*
- * *Current Procedural Terminology (CPT) code book*
- * *Healthcare Common Procedure Coding System Level II Codes (HCPCS book)*
- * *American Hospital Association (AHA)'s Coding Clinic*
- * *American Medical Association (AMA)'s CPT Assistant*
- * Encoder

If you have not already done so, you should determine if your coding staff has adequate qualifications and current resources. Although it would be preferable, not all organizations can support the costs of using Registered Health Information Administrators (RHIA's); Registered Health Information Technicians (RHIT's); Certified Coding Specialists (CCS's); or Certified Professional Coders-Hospital (CPC-H's). You may choose to use employees who simply have a high degree of knowledge in coding. Whatever qualifications you choose, your policies must require that employees meet established qualifications and keep up to date on coding regulations and practice. Positions with responsibility for coding should be filled with individuals who have the appropriate educational background and training. (Bowman, Health Information Management, 2004, 43) However, successful completion of an educational program does not, by itself, establish the advanced-level coding competency necessary for many coding positions in a complex regulatory environment. In the absence of requisite coding

experience, the work of entry-level professionals should be closely monitored until they have demonstrated that they are able to consistently meet the organization's quality standards. (Bowman, Health Information Management, 2004, 45) You should evaluate your job descriptions and training requirements for coding staff to ensure that they are adequate.

You should also evaluate the qualifications of your existing coding staff to determine if they have the technical knowledge to support the complexity of billing for which they are responsible for at your hospital. Some organizations allow coders to specialize in certain settings (e.g., inpatient versus outpatient) or in certain medical areas (e.g., neurology, endocrinology, etc.) You may want to conduct a survey to determine the qualifications other hospitals are requiring, or consult with the American Health Information Management Association (AHIMA).

Ask yourself the following questions:

- Who has ultimate authority for coding compliance in our hospital?
- Has the compliance officer actually met the coders, outside of general training sessions?
- Who is performing inpatient coding?
- Who is performing outpatient coding?
- What are our coder's qualifications, credentials, background, etc.?
- What is included in the job description for our coding staff? When was the last time it was updated?
- What process do we have to verify coders are maintaining their credentials?

Skills and knowledge that are important for the person the coders report to include:

- * Coding expertise and experience (including knowledge of ICD-9-CM and CPT coding systems and coding guidelines)
- * Familiarity with fraud and abuse regulations
- * Chargemaster experience
- * Ability to compare medical record documentation with the bill
- * Understanding of relationship between coding and billing
- * Knowledge of payers' rules (private as well as government programs)
- * Familiarity with fiscal intermediary and the way in which claims are processed
- * Communication skills
- * Human relations skills
- * Management skills
- * Versatility (broad scope of knowledge, including ambulatory and inpatient coding and billing rules)
- * Possession of HIM credential (Prophet, Fraud and abuse, 1998, 68-69).

Your hospital's general compliance committee may have elected to establish a coding compliance subcommittee. Representatives from relevant areas need to be included on the team. In particular, representatives from medical records or health information management, compliance, billing, data management services, chargemaster, utilization management, and quality management should be considered.

The committee should monitor the coding processes and aspects of the compliance program related to coding outcomes to ensure that the program is functioning well. Regular reports on monitoring of coding practices should be discussed at meetings. The coding compliance committee, or task force, should assist with development of and updates/revisions to policies and procedures related to coding. They may assist with development of monitoring tools for evaluation of medical record completion, coding and abstraction, and the general effectiveness of the coding aspects of the compliance program. They may also develop coding training agendas and related materials. The chairperson of the committee should keep the facility compliance committee informed of compliance issues that pertain to the coding/HIM department.

Ask yourself the following questions:

- How are we addressing these hospital inpatient coding risk areas at the committee level?
- Do we have a compliance subcommittee that regularly monitors fiscal intermediary (FI) bulletins and newsletters for guidance on coding?
- How do the coders maintain awareness of current coding regulations through other publications such as *Coding Clinic* and *CPT Assistant*?
- How often are coding policies and procedures revised? Who revises them?
- Are we receiving the Program for Evaluating Payment Patterns Electronic Report (PEPPER) from our QIO?
- Do we have a distribution system set up within our hospital once our QIO/Quality Net contact receives the PEPPER reports?
- Which policy addresses review & evaluation of PEPPER data?
- Are we analyzing our data quarterly?

Code of Conduct

In your general Code of Conduct and perhaps also in a separate coding Code of Conduct you should have included conduct expected of all coders in coding diagnoses and procedures. This should include the general conduct expected related to inpatient and outpatient coding and billing areas. You may have incorporated the AHIMA's *Code of Ethics* and *Standards of Ethical Coding* as guides. Copies of these documents are provided in the Appendices of this workbook. **The Code of Conduct should also establish the responsibility to report coding compliance violations; cover in general how to report violations; summarize the disciplinary process; and make clear that compliance is considered in evaluating employee performance.**

Ask yourself the following questions:

- Have we addressed coding compliance risk areas in our Code of Conduct?
- Have we adopted a more specific Code of Conduct related to coding? If not, should we?
- Do we specifically prohibit, in our Code of Conduct, coding for the purpose of maximizing reimbursement, upcoding, DRG creep, although coding to ensure “optimal” code assignment would be reasonable?

Keep in mind “*Optimization* involves selecting the most resource-intensive codes for a particular documented encounter while still following all the rules. *Maximization* involves manipulating the sequence of codes or adding on codes for comorbid conditions that are not substantiated in the records in order to receive higher reimbursement” (Skurka 1994, 106). Your Code of Conduct should explicitly prohibit upcoding and DRG creep. The OIG guidance defines **upcoding** as “the practice of using a billing code that provides a higher payment rate than the billing code that actually reflects the service furnished to the patient.” The OIG guidance defines **DRG creep** as “the practice of billing using a diagnosis related group (DRG) code that provides a higher payment rate than the DRG code that accurately reflects the service furnished to the patient” (OIG 1998, 8).

Coding Policies and Procedures

It is important to confirm that you have updated policies and procedures for coding that derive from and support the Code of Conduct. These should address the HPMP risk areas covered under the Coding Monitoring and Auditing section later in this chapter as well as other risk areas not related to HPMP. Coding areas not related to HPMP include outpatient procedure coding, chargemaster maintenance, Physician at Teaching Hospitals (PATH) requirements, Evaluation & Management (E/M) coding, and laboratory unbundling practices.

You should determine whether your written coding policies and procedures require appropriate medical record documentation to be present prior to coding for claims. Also find out from your coders if there are reoccurring obstacles to obtain medical record documentation prior to coding. This process may be an ongoing struggle that needs monitoring; however, you need to conduct a cause analysis to determine the root cause of any obstacles to prevent them from reoccurring. It is also important to verify that coding policies and procedures are consistent with and supported by medical staff rules and regulations.

Review your documentation requirement procedures, as these impact the timeliness and accuracy of coding. For example, consider whether handwritten operative reports or summaries used for coding are later compared with written reports to ensure consistency. This is an area where a compliance subcommittee made up of compliance, billing, coding, utilization management and medical director representation can help identify the root cause of any concerns in this area and meet to continue to monitor progress.

Although the OIG guidance (1998, 10) states the codes that you bill must be supported by the medical record at the time the claim is submitted, if you bill before dictated reports are transcribed, you would need to correct any discrepancies presented by additional documentation and rebill accordingly. It is strongly advised that you require transcribed reports for purposes of finalizing codes for the claim form. **For the same reasons, laboratory or radiology reports should not be used by coders for coding diagnoses unless there is supporting physician documentation. QIOs have identified many coding errors related to coders using laboratory or radiology results that are not substantiated by the physician's documentation.**

For example, one area CMS is targeting as part of the Hospital Payment Monitoring Program in the 8SOW is the proportion of Medicare inpatient discharges billed to the higher weighted DRG in a CC (Complication or Comorbidity) pair to all Medicare discharges in the CC pair. This target area is expected to be included in the hospital specific PEPPER data in the near future and will clearly show if a hospital's Medicare inpatient discharge data for these DRG pairs appears unusual compared to other hospitals in the state. If your hospital's data appears unusual you will want to audit to determine if upcoding may be occurring at your hospital.

Ask yourself the following questions:

- Do our policies cover how coding regulation changes are communicated within the organization and how the organization will respond?
- Do our policies address appropriate resources and instructions for ICD-9-CM diagnosis and procedure coding?
- Do our policies require coders and billers to carefully document any advice received from the FI or carrier upon which we base our decisions?
- Who is reviewing "rejected claims" relative to coding issues? Do they have any concerns? What did we do about those concerns? How do we track our results? How did you arrive at your measurement indicators for coding success with your internal audit procedures after identifying the root cause of any coding problems that you find?
- Do our policies cover general medical record and other documentation and retention requirements?
- Are we addressing all these hospital inpatient coding risk areas in our policies and procedures?
- Do our policies explicitly prohibit coding and billing for services not rendered?
- Do our policies adequately address upcoding/DRG creep and/or inaccurate DRG assignment?
- Do we have a 72 hour rule policy? Have all new billers been trained about this policy?
- Do our policies define how coding consultants may be used? Should they?
- Do our policies and procedures prohibit billing until appropriate codes are established?
- When was the last time we talked to our biller about this?

- Have our billers been told they cannot change codes or add codes? Do they understand why?
- What improvement in the process do our billers feel would be helpful? What rejections and denials are they seeing regularly in relation to coding and documentation issues?
- Do we have a policy regarding the use of discharge status codes? When was the last time it was updated? What system do we have in place to address this? How do we know it works?
- Who is assigning discharge status codes at the hospital? Have they been trained on the policy? Do they understand the importance of using correct discharge status codes? Do they have any questions?

It is very important that you update your coding and related billing policies and procedure with regard to selection of the discharge status codes. We cover this risk area in greater detail under auditing and monitoring below.

Open Lines of Communication

It is important for coders, case reviewers, medical staff, utilization management, admissions clerks, biller and compliance officers to have open lines of communication when concerns arise. Process deficiencies clearly have a direct link to inaccurate claims submission and it is crucial for the compliance officer to assemble the team to resolve concerns. It is not always apparent to those involved that inappropriate procedures and processes can result in submitting false claims, which subject the hospital to liability that could lead to significant fines.

Ask yourself the following questions:

- Do the coders feel comfortable talking to their manager and director about coding concerns? If necessary, are managers and directors encouraging the compliance officer to be part of discussions regarding coders concerns?
- Do our coders have any concerns?
- Have we asked them if there is an area of coding they feel deficient?
- What additional training do they feel they need?
- Where do they believe are areas for improvement in the coding processes?
- How do they communicate with the billers when coding concerns arise?
- What is their process to query physicians when they have questions?
- What is the coders role when they are told an inpatient admission should have been an outpatient observation? What demonstrates that we are addressing this issue?

Develop and Provide Education and Training

When it comes to providing education and training regarding coding this is definitely an ongoing process. Training can be provided in many formal and informal ways. The key element is that the program is developed by a qualified person who understands the coding as well as billing regulations.

As you know you are required by Medicare to use the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes to bill inpatient diagnoses and services. The National Center for Health Statistics is responsible for maintenance of diagnosis classification for ICD-9-CM. CMS is responsible for maintenance of procedure classification for ICD-9-CM. You are required to use the ICD-9-CM, as well as Current Procedural Terminology (CPT) codes and Healthcare Common Procedure Coding System (HCPCS) codes maintained by the AMA and CMS, respectively, to bill outpatient diagnoses and services.

These resources are updated on an ongoing basis and should be referenced for current information on the codes. You are also required to maintain an awareness of current coding regulations through other publications. The *Coding Clinic*, published quarterly by the AHA, provides official information on ICD-9-CM coding changes and the *CPT Assistant*, published monthly by the AMA, provides official information on CPT coding changes. Depending on your state, various FI (and carrier) bulletins and newsletters also provide guidance on coding and should be reviewed regularly. You should evaluate your employees' coding resources to determine if they are up to date. It is also important to determine if they have a mechanism for accessing *Coding Clinic* and *CPT Assistant* guidance.

You should also closely monitor the use of computerized encoders by your staff; experts advise that they should not be relied upon without periodic checks (Russo and Russo 1998, 30). Encoders must be kept updated and evaluated periodically to ensure accuracy. Coders who use encoders should also have code books available, as encoders often use a decision tree approach based on limited input from the user. Compare some claims to associated medical records to determine the accuracy of coding. Don't just focus on the highly publicized areas such as the DRG creep targets as the intense publicity may have resulted in correction. You should look at the general process for coding to ensure that it supports coding using current rules. The OIG Supplemental Guidance (2005, 17-28) also states that "information technology presents new opportunities to advance healthcare efficiency, but also new challenges to ensuring the accuracy of claims and the information used to generate claims. It may be difficult for purchasers of computer systems and software to know exactly how the system operates and generates information. Prudent hospitals will take steps to ensure that they thoroughly assess all new computer systems and software that impact coding, billing, or the generation or transmission of information related to the Federal healthcare programs or their beneficiaries."

Even though our focus is on ensuring accurate ICD-9-CM diagnosis and procedure coding for accurate DRG assignment for reimbursement under the inpatient PPS, please

keep in mind the OIG Supplemental Guidance specifically discusses the fact that with the outpatient prospective payment system (OPPS), procedure codes effectively became the basis for Medicare reimbursement. Under the OPPS, each reported procedure code is assigned to a corresponding Ambulatory Payment Classification (APC) code. In implementing the OPPS, CMS developed new rules governing the use of procedure code modifiers for outpatient coding (OIG Supplement, 9).

As emphasized above under policies and procedure, it is important for coders to clearly understand the importance of coding from the appropriate medical record documentation and query physicians when such documentation is unclear.

One effective method to achieve a greater level of training is to use clinicians from your facility to present classes on new surgical or diagnostic procedures, various clinical disease processes (Bowman, *Health Information Management*, 2004, 47), and/or how certain surgical instruments are utilized. This type of training can serve to educate both the coders and the clinicians. Prior to the training you should ask the coders to list their clinical questions that impact coding on the topic to be presented. This helps the presenter know what to cover and increases his or her understanding of the relationship of clinical documentation to coding. The questions can also point out areas where improved physician documentation is needed.

Another way that training can be accomplished is to assign coders to research issues and discuss their findings in a roundtable format. This serves to educate the researcher as well as the attendees. Many states' Health Information Management Associations sponsor coding roundtables which present a great opportunity to network with peers and discuss questions and continuing education. Vendor or government agency representatives (state health department, FI, QIOs, etc.) can be asked to provide focused training information. Employees can also attend seminars or external trainers can be brought in to provide special or annual update training. Minor coding changes can be covered through periodic telephone conferences or informal meetings.

It is essential that you establish medical staff training regarding medical record documentation and its relationship to coding as well. Physicians, physician extenders, nurses, and other medical professionals should be educated. The lack of medical record documentation is a common problem that contributes to inaccurate coding and billing. You may use nurses, physicians, or other medical professionals to provide the training, as it is often better accepted if provided by a peer.

The OIG Compliance Program Guidance for Hospitals (1998, 9) and Sue Bowman (*Health Information Management*, 2004, 46) suggest that it's a good idea to establish a minimum number of hours of training that coders must have. This may include coding as well as compliance training. Most credentialed coders (RHIA, RHIT, CPC, CPC-H, CCS, CCS-P) are required to maintain a certain number of hours of continuing education to maintain their credentials, so you should consider this in your decision.

Ask yourself the following questions:

- How are our coders trained? How often?
- Do we establish minimum education requirements for our coders?
- What specific ongoing training are our coders receiving?
- Are the coders tested? How often?
- Do we monitor their individual error rates? Should we?
- What resources do they use to code?
- Do our coders feel they need additional training in any of the following areas?
 - * Anatomy and physiology
 - * Medical terminology
 - * Pathology and disease processes
 - * Pharmacology
 - * Health record format and content
 - * Reimbursement methodologies
- Are our coders getting training in coding regulations related to the areas in which they are working?
- Are the coders receiving annual training related to ICD-9-CM and CPT/HCPCS updates?
- How do our coders learn about significant program changes or when periodic coding clarifications are provided?
- Is there a process to train the coders when the organization begins to treat new diseases or acquires technology that involve new codes?
- What training occurs when coding problems are identified?
- Are the coders trained on the CMS coding target areas identified in PEPPER?
- Are the coders receiving general compliance program training?
- Do we have records of training content and attendance?
- How do we measure what they have learned in training?
- Do we use pre- and post-surveys or audits to determine knowledge gained?
- Does our monitoring and auditing efforts guide future training?

Coding Monitoring and Auditing

As stated previously, one main focus area continues to be “upcoding”/“DRG creep” and/or inaccurate DRG assignment. As you know, under the prospective payment system, the DRGs for inpatient acute care depend on accurate coding of ICD-9-CM diagnoses and procedures.

Upcoding and DRG creep have been and continue to be areas under considerable scrutiny by CMS and by QIOs under HPMP. You may want to review specific DRGs that have been determined by the OIG or QIOs to be problematic. The OIG established DRGs as targets in their Work Plans for 1999 and 2000 which included DRG 079 in 1999 and DRG 014 in 2000. These two target areas **are still** target areas by CMS in 2005 and should be monitored by hospitals.

In the 8SOW for QIOs, CMS is focusing on the following coding target areas for every hospital in the nation. Your hospital specific data is collected in the PEPPER reports comparing your hospital to all other short-term acute care PPS hospitals in your state for the following target areas:

CMS Target Area:	Description	Coding Audit Tool Provided in Appendix
DRG 014	Intracranial hemorrhage and stroke with infarct	No
DRG 015	Nonspecific CVA and precerebral occlusion <i>without</i> infarct	No
DRG 524	Transient ischemia	No
DRG 416	Septicemia age > 17	No
DRG 320	Kidney and urinary tract infections age >17 with complication or comorbidity	No
DRG 321	Kidney and urinary tract infections > 17 <i>without</i> complication or comorbidity	No
DRG 079	Respiratory infections and inflammations age > 17 with complications or comorbidity	Yes
DRG 080	Respiratory infections and inflammations age > 17 <i>without</i> complication or comorbidity	Yes
DRG 089	Simple pneumonia and pleurisy age > 17 with complication or comorbidity	No
DRG 090	Simple pneumonia and pleurisy age > 17 <i>without</i> complications or comorbidity	No
DRG 296	Nutritional and miscellaneous metabolic disorders age > 17 with complication or comorbidity	No
DRG 297	Nutritional and miscellaneous metabolic disorders age > 17 <i>without</i> complication or comorbidity	No
DRG 182	Esophagitis, gastroenteritis and miscellaneous digestive disorders age > 17 with complication or comorbidity	No
DRG 183	Esophagitis, gastroenteritis and miscellaneous digestive disorders age > 17 <i>without</i> complication or comorbidity	No

Remember, as stated above, CMS is also adding Medicare inpatient discharges billed to other higher weighted DRG in a Complication or Comorbidity (CC) pair to all Medicare discharges in the CC pair. Some of these DRGs are reflected above but it is expected that there will be a separate target area with all CC pairs in aggregate in the near future and will be included in the PEPPER reports.

This is consistent with OIG Workplan for 2005, which states under Diagnosis Related Group Coding, “We will examine DRGs that have a history of aberrant coding to determine whether some acute care hospitals exhibit aberrant coding patterns. Under the prospective payment system, the DRGs for inpatient acute care depend on accurate coding of diagnosis and procedures. Inaccurate coding by hospitals can lead to Medicare overpayments. We will determine coding payment error rates and incorporate the results of a recent review by quality improvement organizations.”

In terms of auditing and monitoring for coding, the HPMP is focusing on those target areas identified in the PEPPER reports and therefore these should initially be your focus as well.

If your QIO does not distribute PEPPER reports, the first step is for the compliance officer to request the hospital’s PEPPER report from your state’s QIO. The very act of reviewing your data quarterly on the PEPPER report, even if your data does not appear unusual and warrant an audit, is a compliance monitoring activity and should be incorporated into your compliance program auditing and monitoring program. You need to monitor this data.

If your data does appear unusual in a target area, meaning it is above the 75th percentile or below the 10th percentile for the state, that does not necessarily mean you are overcoding/undercoding; however, you should conduct an audit to verify that the cases are being coded and billed correctly.

For example, your PEPPER report data, for the quarter, may indicate the following for DRG 014:

	Count	Sum	St-wide Percent	Outlier Value	Outlier Value Times Count	Avg Mdc. Payment	Sum of Mdc. Payments
DRG 014	61	89	91.3%	3.4	207.4	\$5,814	\$354,656

For this quarter, your hospital had a total of 89 Medicare discharges that were either DRG 014, 015 or 524 (the denominator). Out of all of these discharges, 61 of them were for DRG 014, or 68.5%. The state median was 50.00%

When CMS or QIOs, compares the 68.5% of DRG 014 and puts it on a scale with all the other hospital’s percentages in the state, they come up with your statewide percentile of 91.3%, meaning your hospital’s percentage is greater than 91.3 percent of all other hospitals in the state.

This is an area of concern because this could be an indication of overcoding because DRG 014 is the highest paying DRG to the universe of existing possibilities of intracranial hemorrhage and stroke, which includes DRG 015 or DRG 524.

You would want to conduct an audit to determine if coding errors exist and correct those claims. Remember, if you find errors you need to correct them, don't keep the money you know you were not entitled to. If problems are identified, seek to determine the root cause, implement corrective action, and monitor for improvement. Coding problems may be due to the following causes:

- * Lack of coder knowledge
- * Lack of appropriate coding resources
- * Unclear policies and procedures
- * Failure of coder to follow policies and procedures
- * Failure of coder to review the medical record completely
- * Inadequate or unclear medical record documentation
- * Misinterpretation of coding rules or guidelines (Bowman, Health Information Management, 2004, 60)

Corrective action may involve such measures as providing training to coders or physicians, purchasing updated resources, revising coding or medical record documentation policies, or counseling of staff. All monitoring and corrective action should be well-documented and maintained.

Don't forget to use your QIO as a resource in the areas of evaluation and improvement. They have a broad range of experience in peer review and can assist you with initiating special projects to reduce coding/DRG errors.

In addition to those specific DRGs and discharges identified by CMS as at high risk for payment errors within PEPPER, also consider running reports within your hospital to perhaps monitor your trends in particular high-volume or high-cost DRGs. You will be able to more easily identify significant increases or decreases in particular DRGs and DRGs that appear questionable in relation to the length of stay.

Patient (Discharge) Status Codes

Another area of focus, which has been a focus for some time and is also again mentioned in the OIG Workplan for 2005 and the OIG Supplemental Compliance Program Guidance in January 2005 is "Postacute Care Transfers."

As the OIG Supplemental Guidance explains the postacute care transfer policy provides that, for certain Diagnosis Related Groups (DRGs), a hospital will receive a per diem transfer payment, rather than the full DRG payment, if the patient is discharged to certain postacute care settings. CMS may periodically revise the list of designated DRGs that are subject to its postacute care transfer policy. The initial 10 designated DRGs were selected by the Secretary pursuant to section 1886(d)(5)(J) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(J)). They were DRGs 014, 113, 209, 210, 211, 236, 263, 264, 429, and 483.

With the 2004 fiscal year PPS rule, CMS revised the list of DRGs paid under CMS's postacute care transfer policy, bring the total number of designated DRGs to 29. *See* 68

FR 45346 (August 1, 2003). Then, with the 2005 fiscal year PPS rule, CMS revised the list again, bringing the current total number of designated DRGs to 30.⁴ *See* 69 FR 48916 (August 11, 2004). *See also* chapter 3, section 40.2.4 of the Medicare Claims Processing Manual.

And now, with the 2006 fiscal year Medicare inpatient prospective payment system (IPPS) regulations, which takes effect October 1, 2005, CMS expanded the postacute care transfer payment policy to **a total of 182 DRGs**. *See* 70 FR 47411-47420, Table 5 47617-47632 (August 12, 2005) included in Appendix H.

CMS has expanded the application of the postacute care transfer policy by applying the policy to any DRG that meets the following criteria:

- * The DRG has at least 2,050 postacute care transfer cases;
- * At least 5.5% percent of the cases in the DRG are discharged to postacute care prior to the geometric mean length of stay for the DRG;
- * The DRG has a geometric mean length of stay of at least 3.0 days;
- * If the DRG is one of a paired set of DRGs based on the presence or absence of a comorbidity or complication, both paired DRGs are included if either one meets the three criteria above.⁵

CMS expanded the application of the postacute care transfer policy to 182 DRGs that have both a relatively high volume and a relatively high proportion of postacute care utilization. This change also avoids applying the postacute care transfer policy to DRGs with only a small number or proportion of cases transferred to postacute care. *See* 70 FR 23416 (May 4, 2005). Originally, CMS had proposed expanding to 223 DRGs in the proposed rule but then examined 231 DRGs for the final rule which ultimately, after consideration of the comments received, in the final rule, revised the criteria and the final list to 182 DRG, listed in Table 5 of the Federal Register pages 47627-47676 (see Appendix H).

To avoid improperly billing for discharges, hospitals should pay particular attention to the CMS postacute care transfer policy and keep an accurate list of all designated DRGs subject to that policy. (OIG Supplemental, 13-14)

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. Based on an analysis that showed that the first day of hospitalization is the most expensive (60 FR 45804), the CMS policy provides for payment that is double the per diem amount of the first day (Section 412.4(f)(1)). Transfer cases are also eligible for outlier payments. The outlier threshold for transfer cases is equal to the fixed-loss outlier threshold for nontransfer

⁴ Effective October 1, 2003, DRGs 263 and 264 were deleted from the postacute care transfer policy. Effective for discharges on or after October 1, 2003, the following DRGs were added to the policy: 012, 024, 025, 088, 089, 090, 121, 122, 127, 130, 131, 239, 277, 278, 294, 296, 297, 320, 321, 395, and 468. DRG 483 was replaced with DRG 541 and 542.

⁵ *See* 70 FR 47419 (August 12, 2005)

cases, divided by the geometric mean length of stay for the case, plus one day. The purpose of the IPPS transfer payment policy is to avoid providing an incentive for a hospital to transfer patients to another hospital early in the patients' stay in order to minimize costs while still receiving the full DRG payment. The transfer policy adjusts the payment to approximate the reduced costs of transfer cases. *See* 70 FR 23411 (May 4, 2005).

The 182 DRGs that are subject to the transfer policy, effective October 1, 2005, are listed below.

DRG 1	DRG 79	DRG 146	DRG 211	DRG 265	DRG 321	DRG 482
DRG 2	DRG 80	DRG 147	DRG 213	DRG 266	DRG 331	DRG 485
DRG 7	DRG 82	DRG 148	DRG 216	DRG 269	DRG 332	DRG 487
DRG 8	DRG 83	DRG 149	DRG 217	DRG 270	DRG 395	DRG 497
DRG 10	DRG 84	DRG 150	DRG 218	DRG 271	DRG 401	DRG 498
DRG 11	DRG 85	DRG 151	DRG 219	DRG 272	DRG 402	DRG 501
DRG 12	DRG 86	DRG 154	DRG 225	DRG 273	DRG 403	DRG 502
DRG 13	DRG 89	DRG 155	DRG 226	DRG 277	DRG 404	DRG 521
DRG 14	DRG 90	DRG 157	DRG 227	DRG 278	DRG 415	DRG 522
DRG 15	DRG 92	DRG 158	DRG 233	DRG 280	DRG 416	DRG 529
DRG 16	DRG 93	DRG 170	DRG 234	DRG 281	DRG 418	DRG 530
DRG 17	DRG 101	DRG 171	DRG 235	DRG 283	DRG 423	DRG 531
DRG 18	DRG 102	DRG 172	DRG 236	DRG 284	DRG 429	DRG 532
DRG 19	DRG 104	DRG 173	DRG 238	DRG 285	DRG 430	DRG 537
DRG 20	DRG 105	DRG 176	DRG 239	DRG 287	DRG 440	DRG 538
DRG 24	DRG 108	DRG 180	DRG 240	DRG 292	DRG 442	DRG 541
DRG 25	DRG 113	DRG 181	DRG 241	DRG 293	DRG 443	DRG 542
DRG 28	DRG 114	DRG 188	DRG 244	DRG 294	DRG 444	DRG 543
DRG 29	DRG 120	DRG 189	DRG 245	DRG 296	DRG 445	DRG 544
DRG 34	DRG 121	DRG 191	DRG 250	DRG 297	DRG 462	DRG 545
DRG 35	DRG 126	DRG 192	DRG 251	DRG 300	DRG 463	DRG 547
DRG 73	DRG 127	DRG 197	DRG 253	DRG 301	DRG 464	DRG 548
DRG 75	DRG 130	DRG 198	DRG 254	DRG 304	DRG 468	DRG 549
DRG 76	DRG 131	DRG 205	DRG 256	DRG 305	DRG 471	DRG 550
DRG 77	DRG 144	DRG 206	DRG 263	DRG 316	DRG 475	DRG 553
DRG 78	DRG 145	DRG 210	DRG 264	DRG 320	DRG 477	DRG 554

If the discharge status codes are not properly assigned as transfers instead of discharges for these DRGs, it will result in the hospital billing inappropriately and possibly receiving excessive DRG payments due to the erroneous coding of transfers as discharges, perhaps erroneously using Patient Status Code "01- Discharge to Home" by the hospital when the patient's discharge (transfer) is made under any of the following circumstances:

- * To a hospital or distinct part hospital unit excluded from the inpatient prospective payment system (under Subpart B at 42 CFR 412). Some facilities excluded from IPPS are inpatient rehabilitation facilities and units, long term care hospitals, psychiatric hospitals and units, children's hospitals, and cancer hospitals
- * To a skilled nursing facility

- * To home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge

Note: FY2006 Postacute Care “**Special Pay**”⁶ Transfer DRGs include:⁷

DRG 7	DRG 210	DRG 233	DRG 471	DRG 498	DRG 545	DRG 550
DRG 8	DRG 211	DRG 234	DRG 497	DRG 544	DRG 549	Blank

The following is a list of the current patient/discharge status codes:⁸

Code	Structure
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to short-term general hospital for inpatient care
03	Discharged/transferred to SNF with Medicare certification in anticipation of covered skilled care (effective 2/23/05). See Code 61 below.
04	Discharged/transferred to an Intermediate Care Facility (ICF)
05	Discharged/transferred to another type of institution not defined elsewhere in this code list (effective 2/23/05) Usage Note: Cancer hospitals excluded from Medicare PPS and children’s hospitals are examples of such other types of institutions.
06	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care (effective 2/23/05).
07	Left against medical advice or discontinued care
08	Discharge/transferred to home under care of a home IV drug therapy provider. To be DISCONTINUED effective 10/1/05.
09*	Admitted as an inpatient to this hospital
10-19	Reserved for National Assignment
20	Expired (or did not recover – Religious Non Medical Healthcare Patient)
21-29	Reserved for National Assignment
30	Still patient or expected to return for outpatient services
31-39	Reserved for National Assignment
40	Expired at home (Hospice claims only)
41	Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice (Hospice claims only)
42	Expired – place unknown (Hospice claims only)
43	Discharged/transferred to a Federal hospital (effective for discharges after October 1, 2003) Usage Note: Applies to discharges and transfers to a government operated healthcare facility such as a Department of Defense hospital, a Veteran’s Administration hospital or a Veteran’s Administration nursing facility. To be used whenever the destination at discharge is a federal healthcare facility, whether the patient resides there or not.
44-49	Reserved for National Assignment
50	Discharged/transferred to Hospice – home
51	Discharged/transferred to Hospice – medical facility
52-60	Reserved for National Assignment
61	Discharged/transferred within this institution to a hospital based Medicare approved swing

⁶ See, 70 FR 47419 (August 12, 2005)

⁷ See Table 5, 70 FR 47617-47632 (August 12, 2005)

⁸ Monitor the listing of patient status codes to verify that the patient status codes you are using are current and accurate, as they do change periodically.

Code	Structure
	bed
62	Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital
63	Discharged/transferred to long term care hospitals
64	Discharge/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.
66	Discharges/transfers to a critical access hospital (effective for discharges/to dates on or after January 1, 2006)
67-70	Reserved for National Assignment
71	Discharged/transferred/referred to another institution for outpatient services (discontinued effective October 1, 2003)
72	Discharged/transferred/referred to this institution for outpatient services (discontinued effective October 1, 2003)
73-99	Reserved for National Assignment

*In situations where a patient is admitted before midnight of the third day following the day of an outpatient diagnostic service or service related to the reason for the admission, the outpatient services are considered inpatient. Therefore, code 09 would apply only to services that began longer than 3 days earlier or were unrelated to the reason for admission, such as observation following outpatient surgery, which results in admission.

Although the focus of this workbook is the inpatient setting, coding should be monitored in both the inpatient and outpatient settings. Coding that results from the chargemaster should also be monitored. It is imperative for the charge capture process to be reviewed and the chargemaster updated each year for compliance and for the hospital to get paid for all the services provided. If the charges are not captured so an appropriate APC can be assigned the hospital will be losing revenue as well as not coding and billing correctly.

Ask yourself the following questions:

- How are we performing ongoing monitoring to ensure that coding practices result in accurate code assignment, proper sequencing, and accurate DRG grouping?
- Are we monitoring our PEPPER reports? How are we tracking our actions and results? How are we choosing our measurement indicators to determine our effect and measure our outcomes (success)? How do we tie the PEPPER data into our existing data reports? Do they complement one another? Are they incongruent sources of data?
- Are we auditing the areas in which our data appears unusual in the target areas CMS is focusing upon?
- How are we monitoring completeness and timeliness of medical record documentation?
- How are we monitoring to ensure that billing accurately reflects coding assignments and that billers are not changing codes to get paid?
- What is our monitoring/auditing process to ensure we are properly assigning discharge status codes?
- Who is assigning these codes?
- When was the last time we updated our chargemaster?
- Who is responsible for implementing chargemaster updates?