Insights to Coding and Data Quality

OIG reports again on post acute care transfer rule

by Gloryanne Bryant, RHIA, CCS, CDIP, CCDS

What goes around comes around and that is also true of health care. Once again the Office of the Inspector General (OIG) has reported out that there are issues and problems surrounding the post acute care transfer (PACT) rule.

The following is from the report

"Previous Office of Inspector General (OIG) reviews identified Medicare overpayments to hospitals that did not comply with Medicare's post acute care transfer policy. These hospitals transferred inpatients to certain post acute care settings but claimed the higher reimbursement associated with discharges to home. In those reports, we recommended that the Centers for Medicare & Medicaid Services (CMS) provide education to make hospitals aware of the transfer policy and require Medicare contractors to implement system edits to prevent and detect post acute care transfers that are miscoded as discharges. CMS generally concurred with our recommendations. However, more recent OIG reviews found that Medicare contractors made overpayments of approximately $12.2 million to hospitals that did not comply with the policy."

PACT

Medicare's post acute care transfer policy distinguishes between discharges and transfers of beneficiaries from hospitals under the inpatient prospective payment system. Consistent with the policy, Medicare makes full Medicare Severity Diagnosis-Related Group (MS-DRG) payments to hospitals that discharge inpatients to their homes or certain types of health care institutions, such as hospice settings. In contrast, for specified MSDRGs, Medicare pays hospitals that transfer inpatients to certain post acute care settings, such as to homes for the provision of home health services and to skilled nursing facilities, a per diem rate for each day of the stay, not to exceed the full MS-DRG payment for a discharge. Therefore, the full MS-DRG payment is either higher than or equal to the per diem payment dependent on the patient's length-of-stay in the hospital. CMS requires hospitals to include a two-digit patient discharge status code on all inpatient claims to identify a beneficiary's status at the conclusion of an inpatient stay. Whether Medicare pays for a discharge or a transfer depends on the status code.

Medicare inappropriately paid 6,635 Medicare claims subject to the post acute care transfer policy. The hospitals used incorrect patient discharge status codes on their claims, indicating that the patients were discharged to home or certain types of health care institutions rather than transferred to post acute care.

In addition, Medicare overpaid the hospitals because the Common Working File (CWF) edits related to post acute care transfers were not working properly. Specifically, some Medicare contractors did not always receive automatic adjustments, and the CWF edits erroneously calculated the number of days between the dates of service on the inpatient claim and the home health claim.

Medicare could have saved approximately $31.7 million over four years if it had controls in place to ensure that the CWF edits were working properly. It should be noted that when assigning the patient status code 02 (Discharged/transferred to short-term acute hospital) the

calculation for payment applies to all MS-DRGs when the LOS is less than the GLOS. **Note that effective for discharges on or after October 1, 20XX – patients who leave against medical advice (LAMA), but are admitted to another inpatient PPS hospital on the same day they left, will be treated as transfers and the transfer payment policy will apply; this is patient status disposition 07 (LAMA).

What should you do?
Hospitals should review this report and engage their compliance committee or officer and revenue cycle leaders. An internal audit should be conducted on the MS-DRGs that fall within the PACT rule. In the inpatient prospective payment system (IPPS) final rule on Table 5 you will find the list of DRGs that are part of the PACT rule. Of course being proactive and having a continuous internal check and balance process will be ideal. Establishing a monitoring process can be achieved with either internal or external resources. Be sure to discuss compliance with the PACT rule within your health information management (HIM) department, compliance and revenue cycle.

The May 2014 OIG report can be found at *http://oig.hhs.gov/oas/reports/region 9/91302036.pdf*

______

Gloryanne Bryant, RHIA,CCS, CDIP, CCDS, AHIMA Approved ICD-10/PCS Trainer, Supporter of ICD-10, Past President CHIA, is the National Director Coding Quality, Education, Systems and Support, National Revenue Cycle, Kaiser Foundation Health Plan, Inc. & Hospitals, Oakland, California.

Copyright © California Health Information Association, AHIMA Affiliate