To Our Healthcare Clients and Friends:

A major challenge facing hospitals today is developing and implementing the most efficient and effective procedures to ensure that they are getting properly reimbursed for services rendered. This is especially critical when it relates to revenue related to claims impacted by the post-acute transfer rule (PACT). Identifying such underpayments can be a rather convoluted process. To ensure proper payments, a hospital must be able to allocate the resources to audit all claims impacted by the PACT 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 hospitals must realize that there are compliance pitfalls lurking out there and that great care must be taken to avoid such traps.

In this edition of IMA Insights, we will focus on a few compliance risks that exist when completing a transfer DRG review. We will focus on the following areas:

1. Exhausted Skilled Nursing Facility (SNF) Benefits
2. Condition Code Usage
3. Readmission Codes and Utilization
BACKGROUND

Roughly fifteen years ago, PACT was developed and enacted in response to concerns raised by the Centers of Medicare and Medicaid Services (CMS) regarding potential overpayments to hospitals. The intention was to stop what CMS saw as "double payments" for care. The belief was that hospitals were receiving their full payment and then quickly discharging patients (with a specific DRG) to a post-acute setting and thus triggering another full payment to that post-acute provider. To combat this perceived double payment, PACT was enacted and hospitals are now paid a per diem rate versus the full DRG for patients discharged to a post-acute care setting.

Originally, the scope of PACT 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. As of today, CMS has increased that number to 278 DRGs. This means that for any patient admitted to a hospital under one of the relevant 278 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.

CMS has gone to great lengths to establish and implement “edits” to identify instances where a hospital may have been overpaid by Medicare. For example, a hospital will receive a full payment for discharging a patient to home. However, if the edits identify post-acute care activity (i.e. billing from a post-acute care facility) after the hospital discharge, the monies from the “fully paid” claim will be taken back and a new “reduced” per-diem payment will be issued. Unfortunately, hospitals cannot rely on CMS to identify underpayment situations. Currently, a Medicare patient that is discharged from a hospital as a post-acute care transfer will generate a prorated DRG payment to a hospital if that patient has one of the applicable 278 transfer DRGs. Should the patient not actually receive the post-acute care as expected, an underpayment situation may arise for the discharging hospital. This underpayment will go unrecognized unless proactively identified by the hospital.

CHALLENGES

Hospitals need to be diligent in proactively identifying cases where they have indicated that a patient was discharged to a post-acute care facility for care when, in fact, no such care was provided. They must be aware that, in order to conduct a successful transfer DRG audit, there are many pitfalls that can arise which can, in turn, result in compliance risks if not handled properly. Identifying and addressing these issues in advance will help to mitigate any repercussions down the road.

Exhausted SNF Benefits

The first risk scenario that hospitals could fall into is with regard to claims where the patient being discharged has exhausted SNF benefits. Medicare Part A benefit day eligibility is an important consideration when completing a post-acute care audit compliantly because, contrary to the belief of some, claims that indicate exhausted SNF benefit days are not subject for re-billing. A detailed review of the Medicare regulations points out that if a patient’s extended care benefits have been exhausted and the patient still needs to receive a skilled level of care upon discharge, then the status code on the inpatient claim should remain as a 03 (SNF) whether they end up receiving services or not.

Many vendors incorrectly believe the lack of a SNF claim post discharge from the hospital indicates that no skilled care was provided post-discharge and thus the hospital can receive their full reimbursement for that particular stay. Improperly coding claims this way would create a compliance issue. IMA has always taken the stance that patients who have exhausted their Part A SNF benefits do not qualify for re-billing.

Improper Condition Code Usage

One of the primary reasons that overpayments occur is the incorrect utilization of condition codes. The general purpose of condition codes are to describe conditions or events that apply to a specific billing period. Condition Code 42 should be utilized when a patient continues care in a home health setting and the home health treatment plan is unrelated to the patient’s primary diagnosis listed on the hospital bill. Condition Code 43 denotes a discharge with home care services that doesn’t begin until after the third day post-discharge.
We have seen a number of instances where, unbeknownst to the hospital, keypunch errors, system errors, mapping errors and/or bad advice provided by external sources have resulted in improper application of condition codes. Most of the errors revolve specifically around the use of these two condition codes.

Condition code 42 is used to indicate 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 rather than a per-diem payment. Consider an individual who is receiving home health care for mobility issues due to a hip fracture and is admitted to a hospital for the treatment of pneumonia. Once treated, the patient is discharged back to home health for mobility issues related to the hip fracture. In this example, the condition responsible for the hospitalization was pneumonia, while the hospital’s discharge plan called for only home health care related to the treatment for the hip fracture. Since the reasons for the hospital stay and the home health treatment were distinct, the hospital should bill using a condition code 42.

Failure to have an auditing process in place to validate the usage of condition code 42 and 43 could result in significant overpayments without your knowledge. Any review process related 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). This review should look very closely at the relevant hospital medical record information. Be aware that overutilization of either condition code 42 or 43 will send up a red flag to MACs, RACs and anyone else analyzing your claims payment patterns (relative to your peers).

Readmission Codes and Utilization

A third area that could become a compliance risk is related to readmissions. On August 19, 2013, CMS released the Fiscal Year 2014 Final Rule. This Final Rule included changes in the Uniform Billing - 04 code set. Sixteen (16) new discharge status codes were added to the CMS grouper and all apply to MS-DRGs 280, 281, and 282. Of these codes, fifteen (15) were related to a “planned” acute care hospital inpatient readmission.

Traditionally, from a compliance standpoint, reviews are conducted for inpatient discharges to see if proper coding and billing was utilized, but not for readmissions. Managing hospital readmissions is one of the biggest challenges facing healthcare providers today and, while there is no immediate financial impact associated with readmissions, it is critical that they be coded accurately. Providers should be proactive in guaranteeing that their own internal systems have been updated to properly track these changes so that readmissions can be displayed accurately and compliantly.

INSIGHTS

It is critical that hospitals follow the Medicare regulations and guidelines with respect to properly re-billing claims. Compliance is of paramount importance. Clearly understanding how to validate any changes that should be made to a claim is a significant part of the Transfer DRG Review. However, researching claims and performing all of the necessary cross-checks is only part of the process. IMA utilizes a number of additional tools on every claim that it recommends for re-billing to ensure that the recommendations will be compliant with Medicare regulations. Several of these tools can be found below and should be incorporated into your internal process:

- Access to the Direct Data Entry System (DDE)
- Confirmation Calls to the Medicare Administrative Contractor (MAC)
- Post-Acute Care Follow Up Communications
- Medical Records and Clinical Documentation Review
- MedParData (rolling 4 years)
- Medicare Cost Reports
SUMMARY

While quite a bit of time has passed since PACT was enacted, you can see that there are still plenty of hazards that must be avoided. Failure to properly plan and evaluate your procedures could have costly consequences. 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 the information presented above, please do not hesitate to contact me at (267) 626-1192.

Truly yours,

Jim Collins
Jim Collins
Director

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