

Insights to Coding and Data Quality

How much revenue are you losing due to incorrect patient status codes?

by Stacey Leisch and
Barbara Rodenbaugh, RHIT, CCS

This article is intended to educate the reader about:

- Split payment methodology used by Medicare to pay claims in which a patient is transferred to a post acute care provider,
- Why hospitals should conduct frequent audits of their post acute care transfers to ensure they receive all revenue to which they are entitled,
- The significant amount of additional revenue the provider can reasonably expect to capture by conducting internal or external transfer MS-DRG audits, and
- What steps to take to begin an audit

What is PACT?

PACT is the acronym used to denote the Medicare Post Acute Care Transfer policy, which was enacted in the Balanced Budget Act of 1997. It relates to acute inpatient discharges assigned to one of the 273 transfer MS-DRGs in which the patient is transferred from an acute care setting to a post-acute care setting or provider, such as a skilled nursing facility (SNF) or home health (HH) agency for continued care. When PACT was first implemented on October 1, 1998, there were only 10 MS-DRGs affected and they consisted of high-cost DRGs. The number of affected MS-DRGs increased year-by-year so that by 2008 there were 273 PACT MS-DRGs.

In cases subject to the Medicare PACT policy, Medicare uses a split payment methodology, meaning that the acute care provider will receive a per diem or part of the MS-DRG payment, while the post acute care provider will receive the full MS-DRG payment, when applicable. Medicare reasons that they should not pay the acute care provider the full MS-DRG payment when it is providing less than the full course of treatment and the patient is discharged before meeting the geometric mean length-of-stay (GMLOS) for the encounter.

What is Medicare's payment methodology for PACT?

For MS-DRGs designated as PAC MS-DRGs, the hospital receives twice the per diem rate the first day of the stay and the per diem rate for the remaining days up to the full MS-DRG payment. For special PAC MS-DRGs, the hospital receives 50% of the MS-DRG payment the first day plus the per diem rate x 1 followed by 50% of the per diem rate for each additional day of the stay up to the full MS-DRG payment.

Why should facilities conduct PACT audits?

An incorrect patient status code, often referred to the discharge disposition, is a compliance issue. If the patient status code is different than originally assigned during the coding process, the facility may be at risk for overpayment, underpayment, total recoupment of the original payment, or complete rejection of the claim. It is not terribly uncommon for the discharge disposition of a

patient to change after s/he is discharged from the hospital. When this occurs, the reimbursement amount due to the hospital will be different. For instance, assume a patient is discharged to home health, assigned the disposition code to reflect home health, and the facility submits the claim and is reimbursed a per diem of the MS-DRG payment. When a patient fails to follow through with the physician's order for home health care or the home health does not start within three days following discharge, the facility should update the discharge disposition and resubmit the claim. If the home health was never initiated, the disposition should be changed to reflect home health. If the home health started greater than three days following discharge, a condition code is appended to the claim to alert the MAC the facility is entitled to the full MS-DRG payment because the home health services were not initiated within the three-day window.

Auditing is the only way you can determine what transpired once the patient has been discharged. It is the responsibility of the provider to conduct audits to validate the most accurate discharge disposition.

CMS has implemented an audit to identify those claims in which the patient was discharged with post-acute care regardless of what disposition code the facility assigns. When the two do not match and a post acute provider is involved, the MAC either retracts the facility payment until the provider updates their disposition or denies the claim due to involvement of the encounter with a post acute care provider.

It is also important to note the three-day home health window rule. In this rule, if the patient does not initiate home health within three days of being discharged from acute care, but initiates shortly thereafter, the correct patient status is 06, home health, with condition code 43 or 42, depending on the circumstances. Condition code 43 is for claims in which the home health services are initiated greater than three days from discharge, or condition code 42 which alerts the MAC the home health services are not related to the discharge. In both scenarios, the provider would be entitled to the full MS-DRG payment.

Which discharge dispositions are affected?

It is considered to be a post acute care transfer when the patient is transferred to one of the following settings and is a PACT MS-DRG:

- 03 Skilled Nursing Facility (SNF)
- 05 Transferred to a designated children's hospital or cancer center
- 06 Home health (HH) within three days of discharge
- 62 Inpatient Rehabilitation Facility (IRF)
- 63 Long term care hospital (LTCH)
- 65 Psychiatric hospital

What is an example of a PACT claim that results in a reimbursement change?

The following is a scenario that would result in an additional reimbursement:

A 76-year old male patient is admitted for total resection of colon for colon cancer. Patient received antibiotics for pneumonia. The LOS is nine days, at which point the patient is discharged to a SNF. HIM assigned the discharge disposition to 03, skilled nursing facility, and case grouped to MS-DRG 329.

MS-DRG 329 (Major small & large bowel procedures w/ MCC)

Relative Weight: 5.2807; Geometric Mean Length of Stay: 12.9 days

RW 5.2807 x Hospital Base Rate (\$8,000) = Full MS-DRG Payment of \$42,246

PACT Rule Applies because the patient grouped to one of the 273 transfer MS-DRGs and was transferred to a SNF, so the split payment methodology applies:

- GMLOS = Per diem \$3,275
- Per diem rate x 2 the first day = \$6,550
- Per diem rate x 1 subsequent days (8 days) = \$26,200
- Total MS-DRG Reimbursement: \$32,750

If during a PACT audit it is determined that the care rendered by the post acute care provider was not at a “skilled” level of care, the correct patient status would be 04, Intermediate-care facility or nursing facility with Medicare certification. Therefore, the facility is entitled to the full MS-DRG payment of \$42,246, meaning they are entitled to additional reimbursement of \$9,496.

How many claims will result in lost reimbursement?

Although the number of claims that will result in a change in patient status is small (often less than one percent), the dollar impact is quite significant. The revenue that results from a PACT audit is revenue that would otherwise be lost or left on the table.

What are the initial steps for beginning PACT audits and who are the key stakeholders?

Whether or not the audit is performed internally or by a vendor, the key stakeholders include HIM directors, coders, billers, the CFO, IT staff, and post acute care providers. Generally it is the IT or Decision Support staff (although HIM often can also run these reports) that generates the list of discharges assigned to one of the post-acute care disposition codes of 03, 05, 06, 62, 63, 64, and for a specific timeframe. The auditor will access the Medicare Common Working File (CWF) to determine whether or not the patient received post acute care following discharge from your facility. If they did not, further investigation needs to be done to determine what the true discharge disposition should be. Billers will need to resubmit the claim with the proper discharge disposition in order to receive the correct reimbursement. The CFO and HIM director will need to be informed about the reimbursements that are being collected as a result of the audit.

Last year, Medicare changed the timely filing period such that claims must be submitted or changed within one year from the date of service to be considered timely. While changes to claims that are more than one year old can still result in successful reimbursements, they are much more difficult to obtain. As such, it is recommended that audits be completed at least once a quarter for claims from the previous quarter.

In summary, providers are encouraged to implement a process to audit all patient discharges that group to one of the 273 transfer MS-DRGs. In today's health care economy a provider cannot afford to leave revenue on the table they are rightfully entitled. It is strongly recommended a provider either implement an internal process to audit their disposition codes or hire a vendor to assist them in recouping revenue that would otherwise be lost.

References/Resources

"Clarification of Patient Discharge Status Codes," MLN Matters SE0801 Revised, 14 Sept. 2010

Medicare Claims Processing Manual, Chapter 25, Section 75.1

United States, Office of Inspector General, Hospital Compliance with Medicare's Post Acute Care Transfer Policy During Fiscal Years 2003 Through 2005, Feb. 2009.

_____ Stacey Leisch, Post Acute Care Transfer Manager, Healthcare Cost Solutions, Santa Clara, California.

Barbara Rodenbaugh, RHIT, CCS, HIM Revenue Integrity Manager, Corporate HIM Operations, Dignity Health, Pasadena, California.

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