IMA Insights

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How Hospitals Can Arm Themselves to Recover Lost Transfer DRG Revenue

To Our Healthcare Clients and Friends:

There are millions of dollars in Post Acute Care Transfer (PACT) recoveries that Hospitals have both the information and the tools to capture without any outside intervention. In this edition of *Insights* we will look at this issue and discuss the proper ways to document and capture this revenue. We will also look at some of the potential pitfalls and how the Centers for Medicare and Medicaid Services (CMS) edits for PACT impacts these claims.

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BACKGROUND

Roughly fifteen years ago, PACT was developed and enacted in response to concerns raised by the 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 specific DRGs) 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 (under certain circumstances).

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 payment adjustment through DRG proration. As of today, CMS has increased that number to 280 DRGs. This means that for any patient admitted to a hospital under one of the relevant 280 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 setting.

CMS has two exceptions for patients discharged to Home Care. For Home Care patients that do not receive their care within three days post discharge, the Hospital can use Condition Code 43 in connection with Discharge Status Code 6 and receive their full payment. Additionally, for patients discharged to Home Care where the home care is unrelated to the Hospital stay, the Hospital can use Condition Code 42 in connection with Discharge Status Code 6 and receive the full DRG payment.

CHALLENGES

While these two exceptions appear on the surface to be clear cut, both areas have their benefits and pitfalls that the Hospital must consider when utilizing these codes.

Home Health Care Not Provided Within Three Days of Discharge

The more clear cut of the two exceptions relates to care not provided by the Home Care Agency within three days of discharge. For these claims, if the Hospital uses a Condition Code 43 in connection with Discharge Status Code 6 the hospital will receive its' full DRG payment as opposed to the per diem payment.

The challenge lies in tracking the thousands of claims discharged to home care to find those nuggets. Hospitals that own their own Home Care Agency have had some success in this area by setting up a tickler system where the Home Care Agency alerts the Hospital when the instances occur. The problem is that the Home Care Agency is sometimes reluctant to do this for fear that this will be perceived as a quality of care issue.

Additionally, compliance concerns have been raised by Hospitals and Agencies that the utilization of this code may be seen as gaming the system and as such there is a reluctance to work together to find these claims.

Home Health Care Not Related to the Hospital Stay

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.

Typically, the Hospitals have all the information they need to determine if this code can be utilized upon discharge. From the intake of the patient through the discharge process there are typically notes indicating all the information needed to make the determination to use this code. The problem lies in that the coders and the discharge planners are not working together to identify these claims and make sure they are coded correctly.

Indeed a Hospital must be due diligent in this area, as this code is not subject to the CMS edit and could result in audit if there is over utilization of the code. There should be clear documentation in the medical record to support the use of the code.

INSIGHTS

It is essential that Hospitals perform their due diligence and ensure proper documentation to utilize these codes as the financial impact could be considerable. Consider a recent experience where the review of a Hospitals claims for a four year period resulted in approximately $750,000 in recoveries related to the utilization of these two codes. By following the principles identified below any Hospital can be sure to capture these recoveries:

- Set up communication protocols between Hospital owned agencies to ensure the Hospital is aware of cases where the care is refused or does not start with three days of discharge.

- Document clearly upon admission if a patient is being seen by a Home Care Agency and why.

- Document in the Medical Record that the resumption of Home Care is not related to the Hospital stay when the conditions exist.

- Be sure coding and billing are brought into the loop so that the Hospital can be properly reimbursed for these cases.

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SUMMARY

Proper documentation and communication are key to ensure the compliant recovery of these claims. This may require new policies and procedures be implemented and followed to accomplish this but as the above example shows the dollar impact is well worth the time investment by the Hospital.

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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

MEET THE AUTHOR - Jim Collins

Jim has over 30 years of progressive experience in the healthcare industry. His experience comes from both the provider side as well as the consulting side and includes finance, regulatory compliance, and third-party reimbursement for a number of provider settings including hospitals and health systems, home health agencies, continuing care retirement communities, and skilled nursing facilities. Areas of concentration include compliance plan development and re-design, compliance auditing, IRO services, revenue recovery, acquisition due diligence, financial modeling, and third-party reimbursement.

In his current role as a Director for the Revenue Recovery Practice for IMA Consulting, Jim is responsible for overseeing the Transfer DRG Revenue Recovery Team. This responsibility entails overseeing the revenue recovery efforts for IMA Consulting's 1,000 plus Hospital clients for which IMA Consulting has recovered over $400 million to-date.

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