REVINT SOLUTIONS INSIGHTS

Volume 16
Issue 6
June 2018

Once Again CMS Digs Deeper Into Hospitals' Pockets - Reduced Payments for "Early Discharge" to Hospice Care is Coming!

To Our Healthcare Clients and Friends:

The Post-Acute Care Transfer Rule (PACT) was enacted in 1998 and has had a major impact on Hospital reimbursement. Unfortunately, recent legislation could negatively impact your System's bottom line by $1,000,000 to $3,500,000 annually or as much as $500,000 for an individual Hospital. Are you ready?

In this edition of *Insights*, we will look at the effect of the revisions to the PACT rule which now will include transfers to hospice care, per Section 53109 of the Bipartisan Budget Act of 2018, and discuss the ways to ensure that such cases are being coded and accounted for properly.

We will specifically discuss the following:

1. Why hospice is now part of the PACT rule
2. What the potential impact is with regard to this change
3. How to ensure you are not being negatively impacted

BACKGROUND

In the late 1990s, PACT was enacted because CMS believed that there were duplicate payments being made for certain cases where there were short hospital stays and the patients were being transferred to another healthcare provider to complete treatment and recovery. CMS concluded that for these patients the acute hospital should receive less than their full DRG payment to account for the short stay. This rationale laid the foundation for the PACT rule as we know it.

Originally enacted in 1998, there have been dramatic changes to the PACT rule during its evolution. Initially starting with 10 DRGs and now currently impacting 280 DRGs, we have seen the dynamic expansion of the policy and how it can affect providers. For these DRGs, Medicare pays for inpatient hospital care on a per diem basis for discharges when beneficiaries are transferred to another prospective payment system hospital or to post-acute care settings such as skilled nursing facilities, inpatient rehabilitation facilities, home health agencies, long-term care hospitals, and psychiatric hospitals.

While CMS has expanded the PACT rule to currently apply to 280 DRGs, there will be another important modification that will become effective as of October 1, 2018. The PACT rule will be revised to include transfers to hospice. This means that for any patient claim which is coded as a hospice discharge (discharge status codes 50 or 51), the hospital will be paid a per diem rate as opposed to the full DRG payment if the patient stay is less than the geometric mean length of stay. As such, hospice transfers will now be subjected to the same restrictions that apply when a patient is discharged to home health, SNF, and other post-acute care settings.

BACKGROUND CONT'D...

According to a 2013 OIG report, hospice activity was scrutinized and placed under its scope of review due to the increase in discharges from acute-care hospitals to hospice care. A review was conducted on a random sample of 100 cases from 158,623 nationwide claims from Calendar Years 2009 and 2010. This analysis indicated that about 30% of all hospital discharges to hospice care were early discharges and CMS would realize significant savings if hospice became subject to the post-acute transfer policy. You read that correctly, this change is being made based on a review of only 100 cases from 2009 and 2010 representing a 0.06% sample size (good thing the review was "comprehensive").

CHALLENGES

The most common challenge facing hospitals with the revision of this policy is the loss of reimbursement. Utilizing data for FFY 2017, we discovered that this change to the current rule will negatively impact the average health system by approximately $1,000,000 to $3,500,000 per year. This represents cases where the hospital discharged the patient to hospice care, the patient had a stay less than the geometric mean length of stay and was cared for under one of the current applicable 280 DRGs. This estimate also assumes that the initial coding of the claim by the hospital was proper and that the patient actually received the hospice care intended upon discharge from the hospital.

CMS has estimated that this new inclusion to the PACT rule will save them up to $540M annually.

Proper Payment

As with the monitoring of other discharges that fall under the PACT rule, lack of resources and time are common obstacles that hospitals face in ensuring that they are capitalizing on any lost revenue opportunities. Hospitals typically don't have the time and/or resources to verify that post-acute care was provided or not provided to the patient post-discharge. If hospice was not provided, then the hospital should have been paid the full DRG payment rather than the per diem payment.

With the increase in discharge status codes that qualify under the PACT rule, this issue is going to intensify, potentially resulting in hospitals not being paid at an appropriate level and ultimately losing revenue if patients ultimately decided not to elect hospice care post-discharge (which does happen).

Compliance Issues

Assigning incorrect discharge status codes raises the possibility of compliance issues/concerns. Whenever there is a determination that the original discharge status recorded on a given claim is incorrect, the discharge status code should always be updated to reflect the actual level of care that was received by the patient. This will eliminate further coding issues and will help to prevent incorrect payments to the hospital. In these abovementioned cases, the accurate utilization of hospice discharge codes in order to ensure that one is not being underpaid will be where such compliance concerns will arise.

INSIGHTS

As this rule will not be in effect until October 1, 2018 (FFY 2019), Providers should start to look at how they will be impacted considering the following points:

- Providers should identify all discharges to hospice care where:
  - o The stay has one of the current 280 DRGs covered by the PACT rule, and
  - o The length of stay is less than the geometric mean length of stay
- If coded as a 50 or 51, HIM or a Certified Coding Specialist should review the supporting documentation to ensure there is documentation to support that the hospice care was actually provided
  - o This will require reviewing the common working file, contacting your Medicare Administrative Contractor, and possibly contacting the hospice provider
- Review cases that fall into the population described above and calculate the difference between the full DRG Payment and the per diem payment
  - o This will provide you with a financial picture of how you could be impacted

SUMMARY

The addition of hospice discharges to the PACT rule will have a negative impact to your hospital's revenue. The comment period for the proposed rule ends June 25, 2018 and providers should be diligent in responding and getting clarification on the application of the rule.

Additionally, steps should be taken to ensure the discharges are being appropriately coded to hospice upon discharge when necessary. Providers should not rely upon the accuracy of the CMS edit to capture errors where patients who go to hospice are incorrectly coded as "Discharged to Home". Not coding these correctly in the future will result in overpayments and could result in MAC, RAC, or OIG audits.

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,
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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.

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