

Old Rule, New Risks: Transfer DRGs and the Medicare PACT Policy

To Our Healthcare Clients and Friends:

Affecting many and understood by few, the Post-Acute Care Transfer (PACT) Policy has hidden risks that, if left unchecked, could result in costly paybacks ranging from \$500,000 to \$1.66 million. In working with over 1,200 hospitals nationwide for Transfer DRG revenue recovery services, we routinely identify and monitor compliance “hotspots” as it relates to the PACT policy and report such trends to our clients.

In this edition of *Revint Insights*, we will focus on two key areas that have become costly targets of the latest OIG investigation activity. These areas are discharges to home subject to the PACT policy and the utilization of condition code 42, a code that hospitals can append to home health claims to designate that such services are not related to the hospital stay.

BACKGROUND

The PACT policy was originally enacted in 1998 to prevent CMS from “paying twice” for a patient’s care. At the time, CMS targeted a list of 10 “high risk” DRGs for which it believed hospitals were discharging patients early and subsequently sending patients to receive post-acute services to continue their treatment and recovery. In these cases, CMS was paying the hospital the full DRG rate, regardless of the patient’s length of stay (LOS), and also paying the post-acute provider their full case rate. CMS concluded that, for these cases, the acute hospital should receive a per diem payment instead of the full DRG rate to account for the short stay. Since the enactment of the PACT policy over 20 years ago, the rule has expanded from 10 DRGs to 280 DRGs and, in turn, has put a significant portion of a hospital’s Medicare revenue at risk.

The PACT policy is triggered when an inpatient claim meets the following criteria:

1. The DRG is one of the 280 “Transfer DRGs,”
2. The LOS is less than the geometric mean length of stay (GMLOS) for that DRG, and
3. The patient was discharged to a qualifying post-acute facility, namely a home health agency or skilled nursing facility.

When these criteria are met, CMS automatically applies a per-diem payment to the claim to account for the short stay.

To help hospitals ensure compliance with the PACT policy and to ensure that Medicare has not **overpaid** according to the rule, CMS maintains a **one-way edit** that is intended to capture any claims that meet the first two criteria, but were paid at the full DRG rate as a result of the discharge status code used (i.e. a code that is NOT subject to penalties under the rule). The most common occurrence of this is discharges to home (status code “01”). For example, if a hospital codes a claim indicating that a patient is going home, but the patient receives home health care the next day, the edit **should** pick up the home health stay and return the claim to the provider for correction. While the edit catches most coding errors, it does not catch everything. Not surprisingly, OIG audit activity has been focused on the areas known to slip through the cracks.

CHALLENGES

Hospitals are responsible for coding claims on the basis of their discharge plan for the patient and should adjust claims if they find out that the patient received post-acute care after discharge. While seemingly straightforward, it is common for patients to resume prior services, such as home health, without the hospital's knowledge. Even when providers do get it right, the determination surrounding home health discharges can become more challenging thanks to the complexity of condition codes 42 and 43.

Condition Code Usage

Condition code 42 can be used when home health services are received after discharge, but the services are not related to the hospital stay. Condition code 43 can be used when home health services are received, but after the intended three-day window post discharge. Appending these codes will result in the full DRG payment instead of the per-diem rate. While these codes provide an opportunity for hospitals to avoid Transfer DRG penalties for select home health claims, they also present a significant risk. These codes bypass CMS edits entirely and, as a result, are typically only identified as incorrect through an audit. We have seen instances where overpayments have occurred without the knowledge of the hospital due to keying errors, system errors, mapping errors, and/or bad advice provided by external sources.

Discharges to Home

Given that there is not a "transfer", discharges to home are not subject to penalties under the PACT policy. These claims are, however, vetted by the CMS edits in place when they have one of the 280 "Transfer DRGs" and a short LOS. The edits scan for any services after discharge that would result in a penalty, such as a transfer to a home health agency or skilled nursing facility. Unfortunately, the edits miss things. A 2014 OIG report stated that Medicare overpaid hospitals by nearly \$32 million as a result of such edits not working properly. A large majority of what was missed was discharges to home health, with the edit inadvertently miscalculating days after discharge to determine whether care was received within the three-day window. While efforts were likely made since the 2014 report, we still see cases slipping through the cracks.

Impact to Hospitals

In 2018, several large hospitals and health systems were cited by the OIG for failures in the above areas and faced paybacks ranging from \$500,000 to \$1.66 million. In a report for a 659-bed teaching hospital in Raleigh, NC, the OIG determined that the hospital incorrectly billed Medicare for 37 of the 263 inpatient claims reviewed. The audit found that these 37 discharges should have been billed as transfers to home health, but were coded as discharges to "home". Further, the audit identified that, of the 37 claims, 30 of the claims were for services that were related to the hospital stay and, therefore, should have been coded as discharges to home health. For the remaining seven claims, the OIG found that the home health services received were not related to the hospital stay and that the hospital could have used condition code 42 to receive their full payment; however, the discharge status as to "home" was not compliant. Since the PACT policy allows Medicare to go back up to four years, penalties to hospitals can be extrapolated for multi-year periods.

INSIGHTS

Hospitals code claims based on information available at the time of discharge, which is not always complete and does not take into account patient behavior after discharge. As such, providers rely on CMS edits to identify instances they may have missed, only to learn that those safeguards can fail. Given that the resumption of home health services and the use of condition code 42 is cited as a key item on the OIG's 2019 work plan, it is critical that hospitals get it right.

Below are key recommendations to closely monitor and improve compliance in these two areas:

INSIGHTS CONT'D...

Condition Code Usage

1. Regularly run reports to identify if and when condition codes 42 and 43 are being used and who is applying them (coding, HIM, case management, external vendor). Quarterly reviews are encouraged, but annual checks should be conducted at a minimum.
2. Put processes in place to gather key information upfront to support the use of such codes. Ask patients upon admission if they are being seen by a home health provider and, if so, why. Upon discharge, document whether or not the patient will resume home health services and, if so, whether the plan of care is related to the hospital stay.
3. Employ the right resources for condition code 42 audits. Audits should ideally be conducted by individuals who are certified in clinical coding and who thoroughly understand the PACT policy and the implications of condition code 42. When auditing for relatedness, ensure that there is documentation in the medical record to support usage of the code and contact the home health agency to confirm the plan of care.

Discharges to Home

1. Identify all discharges to home that have one of the 280 Transfer DRGs and a LOS less than the GMLOS for that DRG. For these claims, review key information in the common working file or contact your MAC to determine if post-acute care services were received post discharge.
2. If the audit identifies that home health services were received, conduct a further review to determine whether the home health services were related or unrelated to the hospital stay.

If you anticipate a problem in one of these areas, we strongly recommend that you notify your Compliance department and legal counsel BEFORE conducting internal reviews. It is important that this review be performed independently from the staff responsible for the initial billing.

SUMMARY

Compliance related to the PACT policy remains a hot topic and hospitals must be vigilant in monitoring for risks. Two areas of focus for the OIG are discharges to home and the utilization of condition code 42. Understanding these issues and being able to navigate your way around them will ensure that your organization stays clear of penalties and is not raising any “red flags”.

We are pleased to have the opportunity to present this information to you. If you have any questions or need assistance evaluating your hospital’s performance in this area, please contact me at 610-742-4442.

Truly Yours,
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Meet the Author | Danielle LaBraico

Danielle is the Director of the Revenue Recovery practice at Revint Solutions. Danielle is a results-oriented healthcare professional with a successful track record of meeting and exceeding organizational goals. She has worked across various functional areas including hospital and physician practice operations, front-end revenue cycle and finance. She has developed skills in strategic planning and design, business process improvement, provider operations, complex data analysis and financial modeling that contribute to overall performance objectives.



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