

“Postacute Care Transfer Rule Review”

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Speaker

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Disclaimer

- This material is designed and provided to communicate information about clinical documentation, coding, and compliance in an educational format and manner. The author is not providing or offering legal advice, but rather practical and useful information and tools to achieve compliant results in the area of clinical documentation, data quality, and coding.
- Every reasonable effort has been taken to ensure that the educational information provided is accurate and useful. Applying best practice solutions and achieving results will vary in each hospital/facility and clinical situation.

Goals & Objectives

- **Review the PACT rule and its history**
- **Explain how to calculate payment under the PACT rule**
- **Define UB04 patient status codes**
- **Describe the effects patient status has on reimbursement**
- **Identify ways to minimize RAC recoupments for PACT noncompliance**
- **Identify revenue capture opportunities**
- **Q&A Session**

PACT Rule

- Post Acute Care Transfer (PACT) Rule
 - Applies to the Inpatient Prospective Payment System (IPPS) and Rehab PPS
- The purpose of this policy is to protect Medicare from paying for the same care twice: once as part of the hospital's payment for the MS-DRG, and then as a separate payment to the postacute facility or level of care.

Post Acute Care

- The PACT payment policy was based on the belief that it was inappropriate to pay the sending (transferring) hospital the full MS-DRG payment for less than the full course of treatment.
 - Meaning when they are discharged prior to the geometric mean length of stay (GMLOS) being met for the transferring DRG ... this is key.

Why PACT?

- Trends in utilization and expenditures
- Changes in provider supply
- Medicare eligibility and coverage policies
- Payment reforms mandated by the BBA (Balanced Budget Act)

Patient Status Code/Discharge Disposition - Basics

- It is important to select the correct patient status code/discharge disposition and in cases in which two or more patient discharge status codes apply, you should code the highest level of care known.
- Omitting a code or submitting a claim with an incorrect code is a coding/billing error and could result in your claim being rejected or your claim being cancelled and payment retracted.
- Applying the correct code will help ascertain that you receive prompt and correct payment. (Source: MedLearn Matters 2/08)

Patient Status Code/Discharge Disposition - Basics

- A patient status code/discharge disposition code is a two-digit code that identifies where the patient is at the conclusion of a health care facility encounter (this could be a visit or an actual inpatient stay) or at the time end of a billing cycle (the 'through' date of a claim). The Centers for Medicare & Medicaid Services (CMS) require patient status codes/discharge disposition codes for:
 - Hospital Inpatient Claims (type of bills (TOBs) 11X and 12X);
 - Skilled Nursing Claims (TOBs 18X, 21X, 22X and 23X);
 - Outpatient Hospital Services (TOBs 13X, 14X, 71X, 73X, 74X, 75X, 76X and 85X); and
 - All Hospice and Home Health Claims (TOBs 32X, 33X, 34X, 81X and 82X)

Post-Acute Care Transfer Payment Policy - Basics

- CMS determination...“Transfer DRGs”, the effected DRGs will increase and the criteria is the following:
 - The DRG has a least 2,050 post-acute-care transfer cases
 - At least 5.5 percent of the cases in the DRG are discharge to post-acute-care prior to the geometric mean LOS for the DRG
 - The DRG has a geometric mean LOS of at least three days
 - If the DRG is one of a paired set of DRGs based on the presence or absence of a comorbidity or complication, both paired DRGs are included if either one meets the first three criteria

IPPS History/Background on Reimbursement Changes Based on Discharge Disposition 1997-2004

- Balanced Budget Act of 1997 recommended PACT and initially began with 10 DRGs in 1997 - 1998 with an emphasis on high cost DRGs
- October 1, 1998 the BBA required that hospital discharges grouping to ten specific DRGs and having lengths of stay below the national average for those DRGs will be treated as a transfer for payment purposes. The provision applies to patients transferred from an IPPS hospital to an IPPS-exempt hospital or unit, SNF, or home health care.
- Payments are based on Medicare's current per diem rate policies affecting transfers between PPS acute care hospitals -with a "transfer" defined as any patient discharged with one of the ten DRGs that is admitted to a post-acute care provider within three days following discharge.

PACT History/Background

- Beginning October 2005 – 169 Transfer DRGs, plus 13 DRGs with "Special" payment. (Big expansion)



PACT 2007-2010 Impact

- ... 273 Transfer MS-DRGs under MS-DRGs.
- **The IPPS Post-Acute Care Transfer Policy applies to claims coded with Patient discharge status Codes 03, 05, 06, 62, 63, and 65.**
 - 2010 they added 2 additional “special” pay MS-DRGs
- 02 status is acute care transfer and applies to ALL DRGs (LOS met = full payment), not part of PACT, but remains in place
 - Transfer to short-term acute general hospital

PACT 2010-2011 Impact

- 747 DRGs (over one-third), 273, are Post-Acute Transfer DRGs.
- Twenty seven (27) of those are post acute transfer DRGs are also considered *Special Pay DRGs*.

What is the Financial Methodology for Disposition?

- MS-DRGs: the hospital that transfers the patient to another “acute care” facility (02 disposition) applies to ALL
 - 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 (length of stay does matter).
- PACT 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 (length of stay does matter).
 - But there is also the “special” payment calculation

Patient Status Code/Discharge Disposition Calculation

- The per diem rate (per day) paid is calculated by dividing the full MS-DRG payment by the geometric mean length of stay for the MS-DRG.
 - If the full DRG payment is \$8000 and the LOS is 4 days, the per diem is \$2000
- Based on an analysis that showed that the first day of hospitalization is the most expensive (60 FR 5804), CMS policy generally provides for payment that is double the per diem amount for the first day, with each subsequent day paid at the per diem amount up to the full DRG payment ($\$412.4(f)(1)$).
 - If the full DRG payment is \$8000 and the LOS is 4 days, the per diem is \$2000
 - The first day is double = \$4000
 - Each additional day is \$2000 until max DRG \$ is paid

Calculation methodology

- **Special PACT MS-DRGs (ie. MS-DRG 28 & 29):**
 - Payment methodology is 50% of the full MS-DRG payment the first day plus the per diem amount x1 and then 50% of the per diem for each additional day of the stay up to the full MS-DRG payment.
 - Often Surgical MS-DRGs
 - Refer to Table 5 of IPPS Final Rule

Federal Register Table 5 – PACT

	A	B	C	D	E	F	G	H	I
	MS-DRG	FY 2011 Final Rule Post-Acute DRG	FY 2011 Final Rule Special Pay DRG	MCC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
2	001	No	No	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W MCC	26.3441	31.6	41.9
3	002	No	No	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W/O MCC	13.6127	17.6	22.6
4	003	Yes	No	PRE	SURG	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	18.1239	30.1	36.6
5	004	Yes	No	PRE	SURG	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	11.2403	22.2	27.1
6	005	No	No	PRE	SURG	LIVER TRANSPLANT W MCC OR INTESTINAL TRANSPLANT	10.1771	14.9	19.9
7	006	No	No	PRE	SURG	LIVER TRANSPLANT W/O MCC	4.8353	8.3	9.3
8	007	No	No	PRE	SURG	LUNG TRANSPLANT	3.3350	15.4	18.6
9	008	No	No	PRE	SURG	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	4.9632	10.1	11.7
10	010	No	No	PRE	SURG	PANCREAS TRANSPLANT	3.7831	8.6	9.7
11	011	No	No	PRE	SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES W MCC	4.7666	12.3	15.5
12	012	No	No	PRE	SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES W CC	3.1311	8.5	10.1
13	013	No	No	PRE	SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES W/O CC/MCC	1.9505	5.7	6.8
14	014	No	No	PRE	SURG	ALLOGENIC BONE MARROW TRANSPLANT	11.5947	21.1	28.2
15	015	No	No	PRE	SURG	AUTOLOGOUS BONE MARROW TRANSPLANT	5.9504	16.7	19.3
16	020	No	No	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W MCC	8.2479	14.1	17.3
17	021	No	No	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W CC	6.2886	12.1	13.9
18	022	No	No	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W/O CC/MCC	4.1581	6.7	8.4
19	023	No	No	01	SURG	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W MCC OR CHEMO IMPLANT	5.0883	8.2	11.8
20	024	No	No	01	SURG	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W/O MCC	3.4952	5.7	8.1
21	025	Yes	No	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W MCC	4.7575	8.8	11.5
22	026	Yes	No	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W CC	2.9825	5.8	7.3
23	027	Yes	No	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W/O CC/MCC	2.1307	3.0	3.9
24	028	Yes	Yes	01	SURG	SPINAL PROCEDURES W MCC	5.3549	10.1	13.1
25	029	Yes	Yes	01	SURG	SPINAL PROCEDURES W CC OR SPINAL NEUROSTIMULATORS	2.8741	4.7	6.6
26	030	Yes	Yes	01	SURG	SPINAL PROCEDURES W/O CC/MCC	1.6433	2.5	3.3
27	031	Yes	No	01	SURG	VENTRICULAR SHUNT PROCEDURES W MCC	4.1261	8.6	12.3
28	032	Yes	No	01	SURG	VENTRICULAR SHUNT PROCEDURES W CC	1.9220	3.6	5.3
29	033	Yes	No	01	SURG	VENTRICULAR SHUNT PROCEDURES W/O CC/MCC	1.3626	2.1	2.6
30	034	No	No	01	SURG	CAROTID ARTERY STENT PROCEDURE W MCC	3.5242	4.7	7.0
31	035	No	No	01	SURG	CAROTID ARTERY STENT PROCEDURE W CC	2.1437	2.2	3.2
32	036	No	No	01	SURG	CAROTID ARTERY STENT PROCEDURE W/O CC/MCC	1.6390	1.3	1.5
33	037	No	No	01	SURG	EXTRACRANIAL PROCEDURES W MCC	3.1543	5.7	8.4
34	038	No	No	01	SURG	EXTRACRANIAL PROCEDURES W CC	1.5462	2.4	3.5
35	039	No	No	01	SURG	EXTRACRANIAL PROCEDURES W/O CC/MCC	1.0185	1.4	1.7
36	040	Yes	Yes	01	SURG	PERIPHERAL NERVE & OTHER NERV SYST PROC W MCC	3.3353	9.0	12.1
37	041	Yes	Yes	01	SURG	PERIPHERAL NERVE & OTHER NERV SYST PROC W CC OR PERIPH NEUROSTIM	2.1430	5.0	6.7
38	042	Yes	Yes	01	SURG	PERIPHERAL NERVE & OTHER NERV SYST PROC W/O CC/MCC	1.6905	2.4	3.2

Patient Status Codes

- It is considered to be a post acute transfer when the patient is transferred to one of the following:
 - **03** Skilled nursing facility
 - **05** Another type health care institution not defined elsewhere
 - **06** Home health
 - Within 3 days following discharge
 - **62** Inpatient rehabilitation
 - Includes distinct part unit of a hospital
 - **63** Long term care hospitals
 - **65** Psychiatric hospital
 - Includes distinct part unit of a hospital

PACT

- PACT if one of the following postacute care settings occur:
- A hospital or hospital unit that is not a subsection 1886(d) hospital. (Section 1886(d)(1)(B) of the Act identifies the hospitals and hospital units that are excluded from the term “subsection (d) hospital” as psychiatric hospitals and units, rehabilitation hospitals and units, children’s hospitals, long-term care hospitals, and cancer hospitals.)
- A skilled nursing facility (as defined at section 1819(a) of the Act).
- Home health services provided by a home health agency, if the services relate to the condition or diagnosis for which the individual received inpatient hospital services, and if the home health services are provided within an appropriate period (as determined by the Secretary).
- CMS specified that a patient discharged to home would be considered transferred to postacute care if the patient received home health services within 3 days after the date of discharge.

PACT Scenario

- Patient admitted for treatment of dehydration, and also has comorbidities of CHF (428.0) and COPD (496). The patient stays for **2 days (LOS)** and is discharged to Home Health services for further recovery.
- MS-DRG 641 Nutritional & Misc metabolic disorders w/o MCC
 - **RW .6916 GMLOS 2.9**
 - **RW * Hospital Base Rate (\$6000) = Full MS-DRG payment \$4149.60**
 - $6000 \times .6820 = 4149.60$
- **PACT Rule Applies ... GMLOS = Per Diem \$1420.89**
 - **GMLOS 2.9 with a 2-day LOS**
- **Per Diem rate x 2 the first day \$ = \$2841.78**
- **Per Diem rate x 1 Subsequent Days (1 day) = \$1420.89**
 - **Add 2841.78 + 1420.89 = 4262.67**
- **THE TOTAL MS-DRG REIMBURSEMENT = Max. allowed \$1469.60**

Patient Status – 01 Home

- **01- Discharge to Home or Self Care (Routine Discharge)**
- This code includes discharge to home;; home on oxygen if DME only; any other DME only; group home, foster care, and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs; assisted living facilities that are not state-designated.

Patient Status – 02 Transfer to Short Term General Hospital

- **02 - Discharged/Transferred to a Short-term General Hospital for Inpatient Care**
- This patient discharge status code should be used when the patient is discharged or transferred to a short-term **acute care hospital**. Discharges or transfers to long-term care hospitals should be coded with Patient discharge status Code 63.
 - Includes any transfer to another PPS acute short term care facility for continuing care

Always impacts the MS-DRG when LOS is less than GMLOS

Patient Status – 03 Discharged/ Transferred to a SNF

- **03 - Discharged/Transferred to a Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Skilled Care.**
- This code indicates that the patient is discharged/transferred to a Medicare certified nursing facility in anticipation of skilled care. For hospitals with an approved swing bed arrangement, use Code 61-Swing Bed.
- This code (03) should be used regardless of whether or not the patient has skilled benefit days and regardless of whether the transferring hospital anticipates that this SNF stay will be covered by Medicare. For reporting other discharges/transfers to nursing facilities see codes 04 and 64.
 - (licensed as SNF) For Medicare this can be a facility owned SNF or a SNF separately owned and separately located
 - Sometimes called transitional care facility or unit (TCU)
- Code 03 should **not** be used if:
 - The patient is admitted to non-skilled care

Applies to PACT Rule

Patient Status – 04 Discharged/ Transferred to ICF

- **04 - Discharged/Transferred to an Intermediate Care Facility (ICF)**
- Patient discharge status code 04 is typically defined at the state level for specifically designated intermediate care facilities. It is also used:
 - To designate patients that are discharged/
transferred to a nursing facility for non-skilled care, or
 - For discharges/transfers to state designated Assisted Living Facilities.

Not impacted by PACT Rule

Patient Status – 05 Discharged/Transferred to Cancer or Children’s Hospital

- **05 - Discharged/Transferred to Designated Cancer Center or Children’s Hospital**
- Usage Note: Transfers to non-designated cancer hospitals should use Code 02. A list of (National Cancer Institute) Designated Cancer Centers can be found at <http://www3.cancer.gov/cancercenters/centerslist.html> on the Internet.

Applies to PACT Rule

Patient Status – 06 Discharged/ Transferred to Home Health

- **06 - Discharged/Transferred to Home Under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care**
- This code should be reported when a patient is:
 - Discharged/transferred to home with a written plan of care for home care services (tailored to the patient's medical needs) -- whether home attendant, nursing aides, certified attendants, etc.
 - Discharged/transferred to a foster care facility with home care; and
 - Discharged to home under a home health agency with DME.
- This code should **not** be used for home health services provided by a:
 - DME supplier or Applies to PACT Rule
 - Home IV provider for home IV services.

Home Health Evaluation vs. Visits

- Per CMS, home health evaluation is classified as discharge disposition = Home (01)
- Per CMS, home health visits are classified as discharge disposition = Home Health (06)
- You can see that the “evaluation” of HH results in a patient status code that allows the MS-DRG to be paid in full.
 - But what if you assigned 06 for HH evaluation?

Postacute Care Transfer Condition Codes – HH and Condition Codes

- If the continuing care plan is **not** related to the inpatient hospital admission (SNF or HH):
 - Use condition code 42 on the UB
- If the continuing care plan “is” related to the inpatient hospital admission BUT did not start within the 3 day window:
 - Use condition code 43 on the UB (locator field 24-30)
- This will ensure that the hospital will receive full payment (PM A-98-26).

PFS/Billing will need to apply the condition codes. 3M encoder does ask the coder to indicate whether it is related or not or within 3 days, but coding staff would not know this without going into the Common Working File (CWF).

Guidelines from CMS - HH

- *The transfer policy is applicable if the individual was discharged to home under a written plan of care for the provision of home health services and the services begin within three days after the date of discharge.*
- *In addition, all Postacute care facilities and hospitals, especially those that submit large volumes of claims for these services, should have clear communication between themselves and patient physicians regarding the use of subsequent home health services. Hospital should be able to ensure that when physicians authorize Postacute care in a patient’s medical record, that the physician also indicates Postacute care on the patient’s discharge documents.*

UB Committee FAQ

- Q: If a patient is discharged to home for the provision of home health services, but, the continuing care is either 1) not related to the condition or diagnosis for which the individual received inpatient hospital services or 2) is related, but, not provided within the post-discharge window, what is the correct patient status code to use?

A: Code 06 would be the appropriate patient discharge status code. In addition, the provider should append one of the following condition codes, as appropriate, to the claim:

- UB Condition Code 42 - Continuing care not related (i.e. condition or diagnosis) to inpatient admission or;
- UB Condition Code 43 - Continuing care not provided within prescribed post-discharge window.

Hospice Care Disposition

- Important to note that patients can be discharged to SNF for hospice care.
 - In this situation, the correct disposition is hospice care - care is provided by a licensed hospice organization.
- Watch for documentation: “ The patient is being discharged to a SNF under the care of a Medicare licensed hospice who will be billing for the patient services”.
- Communicate with discharge planning/ Case management/UR to identify licensed hospice beds or facilities.

Hospice Care Disposition

- Important to note that patients can be discharged to home health with hospice care.
 - In this situation, the correct disposition is hospice care
 - care is provided by a licensed hospice organization.
- Watch for documentation: “ The patient is being discharged to home health under the care of a Medicare licensed hospice who will be billing for the patient services”.
- Communicate with discharge planning/Case management/UR to identify licensed hospice beds or facilities.

Patient Status – Additional Medicare Discharge Disposition Codes

- 40 Expired at home (Hospice claims only)
- 41 Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice (Hospice claims only)
- 42 Expired - place unknown (Hospice claims only)
- 43 Discharge/transferred to a Federal Hospital (I.e.VA Hospital)
- 61 Discharged/transferred within this institution to a hospital-based Medicare approved swing bed
- 62 Discharged/transferred to inpatient rehabilitation facility including Rehabilitation distinct part units of a hospital
- 63 Discharge/transfer to long term hospital (ie. Kindred)
- 64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
- 65 Discharge/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
- 66 CAH (Critical Care Hospital)

Patient Status – 70 Discharged/ Transferred to Another Type of Healthcare

- **PATIENT DISCHARGE STATUS CODE Per NUBC, Effective April 1, 2008:**
- **70 – Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List**
- Status code 70 was created in order for providers to be able to indicate discharges/transfers to another type of health care institution not defined elsewhere in the code list.

Change in Disposition ... 10/09

- Jail or law enforcement discharge....

Q: What code is used for patients discharged to jail?

A: Use Code 21, Discharged/transferred to court/law enforcement.

UB Committee FAQ

- **Q:** What code is used for patients discharged/transferred to residential care?
- **A:** Use discharge status 01, discharged to home or self care.

- **Q:** What code is used for patients discharged/transferred to a foster care facility?
- **A:** Use discharge status 01, discharged to home or self care.

- **Q:** What code is used for patients discharged/transferred to a foster care facility with home care?
- **A:** Use discharge status 06, discharged/transferred to home under care of organized home health services in anticipation of covered skilled care.

UB Committee FAQ

- **Q:** What status code should be used for a patient transferred to a SNF rehabilitation unit? This unit is within the SNF. Is this considered a transfer to a SNF or to a rehabilitation facility?
- **A:** A rehabilitation unit that is part of a skilled nursing facility is paid under the SNF prospective payment system. Moving a patient from one unit to another does not constitute a transfer for billing purposes and should not result in separate claims. If a patient is discharged from an acute inpatient hospital to a SNF, use 03. Status code 03 is also used if the patient moves from an acute inpatient hospital to a rehab unit in a SNF.

Patient Status - DISCHARGE DISPOSITION Compliance and RAC

- Accuracy is ***extremely important for all discharges especially for the Post Acute Care (PAC) Transfer MS-DRGs.***
- Reimbursement is affected if the LOS (length of stay) for MS-DRG is not met.
- RAC has been data mining thru the Common Working File (CWF)



Compliance Specifics to Home Health

- Incorrectly reporting the post-acute care discharge as “home” is a compliance risk.
- There is a 3-day window for initiating post-acute care home health services after discharge, that applies and ideally validated before billing.
- A specific billing condition code is required on the billing side (UB-04) which tells the FI (CMS) that the HH was not within the 3-days.

RAC FOCUS....

Internal Validation is key

- Validation of the patient status is **complex but not a complex review, via data mining**
- Incorrect patient status code is a compliance issue
 - You are at risk for overpayment
 - PFS services has received take backs from the FI/MAC
 - You are at risk for underpayment
 - We are entitled to appropriate reimbursement based on supporting documentation, nothing more, nothing less
 - RAC is monitoring
 - **#1 provider underpayment identified in RAC pilot program in CA and FL**
 - » \$19.6 million
 - » 8500 claims
- Validation is time consuming

The RAC Program Mission

- **The RACs detect and correct past improper payments so that CMS, Carriers, FIs, and MACs can implement actions that will prevent future improper payments**
- **Providers can avoid submitting claims that do not comply with Medicare rules**
- **CMS can lower its error rate**
- **Taxpayers and future**
- RAC will be validating the formula used to determine DRG payment by the MACs
- RAC will also validate hospital assigned patient status disposition
- Going back to paid claims as of 10/1/2007 and forward

With all these audits going on, will the RAC target the same claims already being audited?

- CMS created a RAC data warehouse to track information about claims reviewed by the RACs.
- Other Medicare contractors use this data warehouse to designate which claims have been previously reviewed and are therefore excluded from review by the RACs.

CWF is Essential

- The CWF IS an essential component to ensuring that accurate payments are made for only medically necessary services and are provided only to eligible Medicare beneficiaries by qualified providers.
- The CWF also is vital to minimizing fraud and abuse in the Medicare program and ensuring quality care is provided to Medicare beneficiaries.
- All claims are received and processed the same day. CWF maintains data from 1989 to the Present.

CWF (con't)

- The CWF lists effective dates for both Medicare Part A and Part B coverage, as well as termination dates.
- The CWF also provides the beneficiary's demographic information, including date of birth, date of death (if applicable), mammogram and Pap test frequency indicators, and other information used to determine the correct use of Medicare benefits.
- The CWF also contains information about secondary insurance.
- Access the CWF through Medicare's online software, which an FI/MAC provides to facilities

RAC & CWF

- The CWF provides insight into patient movement from different levels of care. This is a link for RACs into improper payment specific to discharge patient status codes.
- However, the majority of healthcare institutions, both acute inpatient and acute rehabilitation, don't conduct audits comparing the CWF to their reported patient status codes within their abstractions or coded data.
- RAC is using the CWF to validate patient status/ discharge position.
 - Underpayments and overpayments

Example #1


- Medicare female patient is seen at a small hospital due to a fall resulting in a severe head injury and a hematoma of the brain. She has a "loss of consciousness" - coma for 7 mins. Due to the nature of the intracranial injury, the patient needs surgery to remove the hematoma which they do not perform. Patient also has Heart Failure, Chronic diastolic.
- The patient is transferred after 2 days to another acute care hospital for surgery and continued care (documentation in the medical record).
- First Hospital - MS-DRG 086 Traumatic Stupor & Coma less than one hour with CC
 - **RW: 1.2051 GMLOS: 3.7**
 - **RW X Hospital Base Rate (\$6000) = Expected MS-DRG Full Reimbursement \$7230.60**
- **Transfer Rule... Expected Reimbursement / GMLOS = Per Diem \$1954.21**
- **Per Diem x2 on Day 1 = \$3908.43**
- **Per Diem X # Subsequent Days = \$1954**
- **Add day one and subsequent days together: TOTAL MS-DRG REIMBURSEMENT = \$5862.43**
- **Difference 7230 -5862 = 1368**

Example #2

- Medicare male patient is seen for Congestive Heart Failure (CHF). The length of stay is 3 days. A home health evaluation is ordered by the MD. It is determined that the patient would qualify for home health services, thus they are discharged to Home Health for visits to begin within 3 days of discharge (documentation in the medical record). Patient BMI is greater than 40.
- MS-DRG 292 Heart Failure/Shock with CC
 - **RW: 1.0302 GMLOS: 4.0**
 - **RW X Hospital Base Rate (\$6000) = Expected Reimbursement \$6181**
- **PAC Rule Applies... Expected Reimbursement / GMLOS = Per Diem \$1545**
- **Per Diem on Day 1 = \$3090 (2x the per diem)**
- **Per Diem X # Subsequent Days = \$1545 x2 add'l days = \$ 3090**
 - **Receive \$3090 + \$3090 = \$6181**
- **TOTAL MS-DRG REIMBURSEMENT = \$6181 max DRG amount due to LOS**

Example #3

- A patient with terminal cancer and diabetes was discharged from the acute care hospital to a SNF.
- The documentation in the medical record indicates hospice care to be provided at the SNF by a licensed hospice organization.
- What discharge disposition code should be selected or assigned?: _____



Information for Medicare For-Service Health Care Professionals

News Flash - The Acute Inpatient Prospective Payment System Fact Sheet (revised November 2007), which provides general information about the Acute Inpatient Prospective Payment System (IPPS) and how IPPS rates are set, is now available in downloadable format at www.cms.hhs.gov/MLNProducts/downloads/acutepaymentfactsheet.pdf from the Centers for Medicare & Medicaid Services Medicare Learning Network. If the url above does not take you directly to the fact sheet, please copy and paste the url in your web browser.

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Clarification of Patient Discharge Status Codes and Hospital Transfer Policies

Note: This article was revised on September 14, 2010, to revise the answer to the first frequently asked question at the bottom of page 9. All other information is the same.

Provider Types Affected

Providers billing Medicare Fiscal Intermediaries (FIs) or Part A/B Medicare Administrative Contractors (AB MACs).

Provider Action Needed

STOP - Impact to You

This Special Edition article is based on information from the Centers for Medicare & Medicaid Services (CMS) regulations and transmittals and the National Uniform Billing Committee (NUBC) Official US-04 Data Specifications Manual 2008 (Version 2.00 July 2007) Section Form Locator 17 (Patient Discharge Status) (Effective Date: March 1, 2007) copyrighted by the American Hospital Association (AHA). NUBC US-04 Version 2.00 Clarifications and Errata (as of 8/2/2010). It provides clarifications and instructions on determining the correct patient discharge status code to use when completing your claims.

IMPORTANT: The NUBC is responsible for the maintenance and dissemination of guidance for the US-04 code set. The CMS has provided a subset of information

Steps to Take...

- **Educate yourself by reviewing the CMS RAC web site at <http://www.cms.hhs.gov/RAC/>:**
- **RAC process: from demand letter to Recoupment The Medicare Appeals Process**
- **Create a RAC Rapid Response Team at your facility – this team been created at each Kaiser Medical Center**
- **Include “patient status” disposition in audits**
 - Regional Coding Review Mgrs
 - External auditors will include validation for all inpatients
- **Ask questions when not sure of the correct patient status code to assign.**

Develop a Patient Status - Validation Project & Process

- Review publicly available information on Medicare system to determine post acute claim activity
- Conduct retrospective data mining/audits
- Validated patient status code/discharge disposition through the electronic claim data
 - Medicare Common Working File (CWF)
 - Going back to 2008
 - Using external vendor

Summary

- Under Medicare's Post Acute Care Transfer policy (42 CFR 412.4), a discharge of a hospital inpatient is considered to be a post acute care transfer when the patient's discharge is assigned to one of the qualifying diagnosis-related groups (MS-DRGs), and the discharge is made under certain circumstances.
- IP Coding staff must validate the patient status and make appropriate change if needed.

Summary

- The IPPS Post-Acute Care Transfer Policy applies to claims coded with Patient discharge status Codes 03, 05, 06, 62, 63, and 65.
- PACT is a "compliance" and RAC focused area.
- Educate all coding staff
- Educate Case Management, UR and Discharge Planning even your Home Health Agency staff
 - Documentation
- Physician and other medical record documentation is key – review carefully.
- Understand the financial impact!

Question?

- Questions and Answers



References and Resources

- August 2005, Federal Register web site at:
http://www.access.gpo.gov/su_docs/fedreg/a040811c.html.
- National Center for Health Statistics (NCHS)
- www.cdc.gov/nchs
- MedLearn Matters
- RAC Status Reports, 2006, 2007 and 2008
- August 2009, IPPS Final Rule, Table 5
- National Uniform Billing Committee (NUBC) Official UB-04 Data Specifications Manual

Thank you!!