Report on Medicare Compliance Volume 29, Number 29. August 17, 2020

More Recoupment for PACT Errors Is Coming; CMS Has Added Edits

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Medicare administrative contractors (MACs) will again be recouping millions of dollars from hospitals for noncompliance with the post-acute care transfer (PACT) payment policy, this time in connection with patient discharges to home health care and the related use of condition codes 42 and 43, according to a new report[1] from the HHS Office of Inspector General (OIG). This stubborn compliance problem may finally start to recede, however, because CMS said it added edits to the Common Working File (CWF) in April to prevent full MS-DRG payments when patients receive home health care within three days of discharge.

According to the PACT payment policy, acute-care hospital patients who get post-acute care are classified as transfers, not discharges, and hospitals are paid per diems instead of MS-DRGs up to the full amount of the MS-DRG. Post-acute care is defined as home health care provided within three days of discharge for a related diagnosis or condition, same-day admission to skilled nursing facilities and other hospital units that are not reimbursed under the inpatient prospective payment system (e.g., psych, inpatient rehab), and same-day hospice admissions. Hospitals are required to use discharge status codes on all Medicare claim forms, such as 06 for home health, which tells Medicare the PACT payment policy is in play. When hospitals find out later that a patient was discharged to post-acute care rather than home, they are supposed to submit an adjusted bill to Medicare. The CWF has prepayment and postpayment edits that should prevent Medicare overpayments under the PACT policy, although they don't always do the trick.