

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



**Video Slideshow Presentation from April 18 “Begin Transitioning to ICD-10 in 2013”
National Provider Call Now Available**

Are you ready to transition to ICD-10? Now is the time to prepare. The Centers for Medicare & Medicaid Services has released a YouTube video slideshow presentation from the April 18 call on “Begin Transitioning to ICD-10 in 2013.” The call presentation is now available on the [CMS YouTube Channel](#) as a video slideshow that includes the call audio. Visit the [April 18](#) call web page for access to all of the related call materials, including the slide presentation, complete audio recording, and written transcript.

MLN Matters® Number: SE1317

Related Change Request (CR) #: Not applicable

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

Post-Acute Care Transfer - Underpayments

Provider Types Affected

This MLN Matters® Special Edition is intended for inpatient hospitals submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and A/B Medicare Administrative Contractors (MACs)) for services to Medicare beneficiaries.

What You Need to Know

This article informs you that Medicare’s Recovery Auditors conducted an automated review of inpatient claims with qualifying Diagnosis-Related Groups (DRGs) that were identified with discharge disposition to an acute care inpatient facility (02), Skilled Nursing Facility (03), home health (06), inpatient rehab facility (62), long-term care facility (63), or psychiatric facility (65). These inpatient claims fall under the Post-Acute Care Transfer (PACT) policy and are reimbursed on a per diem rate, up to full Medicare Severity Diagnosis Related Group (MS-DRG) code reimbursement.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2012 American Medical Association.

Specifically, the Recovery Auditors examined hospital claims that indicated the patient was discharged to another facility as noted in the preceding paragraph. However, in a number of cases, the auditors did not find a claim from a separate facility showing these patients were received by another facility. There are instances where this can legitimately occur, such as the patient dies en route to the other facility or the other facility is a non-Medicare participating facility. In such situations, Medicare may not receive a subsequent claim, but the transfer to another facility coding could be correct.

The key point is that a claim coded to show transfer to another facility is paid differently from a claim where no discharge to another facility occurs. If the discharge disposition is miscoded, the miscoded claim may be paid incorrectly. To avoid payment errors, please remind staff to code claims as transfers only if the beneficiary is discharged to another facility.

Background

The "Medicare Claims Processing Manual," Chapter 3, Sections 20.1.2.4 and 40.2.4, present necessary information for proper claims submissions as they relate to patient transfers. This manual chapter is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

PACT rules are found in the Code of Federal Regulations (CFR) at 42 CFR Section 412.4 .

The Code of Federal Regulations (CFR) at 42 CFR Sections 405.980 (b) and (c), and Section 405.986, states that a Medicare contractor may reopen an initial determination made on a claim between 1 year and 4 years from the date of the initial determination when good cause exists. If a contractor performs data analysis on claims and finds potential claims errors, that may constitute new and material evidence, as it relates to good cause for reopening the claims. Justification for reopening these claims was due to improper payments found in the results of the data analysis.

When Medicare reopens such claims and the resulting analysis shows an error occurred, Medicare will adjust the initial claim accordingly. To avoid this situation, providers should strive to ensure accuracy in submitting inpatient claims with discharge disposition to an acute care inpatient facility (02), skilled nursing facility (03), home health (06), inpatient rehab facility (62), long-term care facility (63), or psychiatric facility (65).

Additional Information

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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