Audio Title: Post-Acute Care Transfer--Underpayments
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Welcome to Medicare Learning Network Podcasts at the Centers for Medicare and Medicaid Services, or "CMS". These podcasts are developed and produced by the Medicare Learning Network® within CMS, and they provide official information for health care professionals.

Are you a physician, health care professional, or claims processor working in an inpatient hospital submitting claims to Medicare Administrative Contractors, or MACs? If yes, then you will definitely benefit from this podcast!

It provides guidance you can use to bill correctly and to avoid improper payments, and is based on the Medicare Claims Processing Manual Chapter 3, Sections 20.1.2.4 and 40.2.4 implemented by CMS to satisfy Section 412.4 of the Code of Federal Regulations or CFR 42.

Keep in mind that Medicare Administrative Contractors or (MACs) process claims payment for services to Medicare beneficiaries.

Let's begin with some critical points for you to consider on underpayments in post-acute care transfer:

Medicare's Recovery Auditors conducted an automated review of inpatient claims with qualifying Diagnosis-Related Groups, or DRGs, that were identified with discharge disposition to six (6) facilities, which include:
One, acute care inpatient

Two, Skilled Nursing

Three, home health,

Four, inpatient rehabilitation,

Five, long-term care, and

Six, a psychiatric facility.

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.

As we just discussed, Recovery Auditors examine hospital claims that indicated the beneficiary was discharged to another facility.

However, in a number of cases, the auditors do not find a claim from a separate facility showing that these beneficiaries were received by another facility.

There are instances where this can legitimately occur. For example, a patient may die on the way to another 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 still 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 the staff to code claims as transfers only if the beneficiary is discharged to another facility.

A Medicare contractor may reopen an initial determination made on a claim between 1 to 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, then that may constitute new and material evidence, as it relates to good cause for reopening the claims.

Justification for reopening a claim was due to improper payments found in the results of the data analysis.

When Medicare reopens such claims and the analysis shows that 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 the six (6) facilities we discussed earlier.

To download the MLN Matters® Article on this topic, go to the CMS website at www.cms.gov and click on "Outreach and Education" at the top of the page. From that page, scroll down to the Medicare Learning Network section and click on the MLN Matters® Articles link. Follow the links to "2012 MLN Matters® Articles" and search for MM article number "SE1317."

More questions? To learn more about **Post-Acute Transfer - Underpayments** contact your Medicare Administrative Contractor or visit our website at www.cms.gov.

Be on the lookout for future MLN podcasts on subjects of interest to you.

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