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In Unusual Move, MACs Recoup Whole DRG Payment for PACT Errors; Rebuttals May Help

By Nina Youngstrom

Some hospitals are getting large-dollar demand letters from their Medicare administrative contractors (MACs) for overpayments caused by noncompliance with the post-acute care transfer (PACT) payment policy, but they're dismayed that Medicare wants more than what they say is the actual overpayment. MACs should only recover the difference between the MS-DRG payments and per diem payments, compliance professionals and physician advisers say. That's how it normally works when hospitals submit claims of any type that Medicare thinks should be reimbursed at a lower dollar amount. Because of the unusual situation, the medical director for one MAC suggested hospitals submit rebuttals to shut down the recoupment, according to a physician advisor.

Phillip Baker, M.D., medical director of case management at Self Regional Healthcare in South Carolina, said the medical director for Palmetto GBA, a MAC, told him she expects "to get a large number of rebuttals," which the MAC will "escalate" to CMS. The MACs are following CMS's instructions in terms of pursuing the entire DRG payment, Baker said the medical director told him. "Their hands are tied," he explained. Baker hopes a swarm of rebuttals will get CMS to change course. CMS didn't respond to *RMC*'s request for comment by press time.

Palmetto sent Self Regional Healthcare a demand letter for $300,000, including one case worth $60,700. "There's not an audit out there that has been like this. That's why everyone is so bent out of shape," Baker said.

In some cases, the net effect of the difference may be no overpayment.

Even when the wrong discharge disposition codes are on the claims, there's no reason for MACs to take back the entire Part A payment, compliance professionals and physician advisors say. Vidant Health in Greenville, North Carolina, received a demand letter Jan. 27 from Palmetto for a total of about $560,000, said Darren Anderson, director of clinical denials management. "We probably don't disagree the discharge disposition code was incorrect, but it doesn't negate the whole payment," he said. "It's crazy."

The demand letters apparently stem from a November 2019 HHS Office of Inspector General (OIG) audit[1] of Medicare overpayments related to the PACT payment policy. OIG found that Medicare improperly paid almost $54.4 million to acute-care hospitals for inpatient claims under the PACT policy, and CMS said in a written response that it would direct MACs to recover the funds. OIG's audit covered claims submitted from 2016 through 2018.

According to the PACT payment policy, acute-care hospital patients who receive 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 Common Working File has prepayment and postpayment edits that should prevent Medicare overpayments under the PACT policy.

Hospitals may be overpaid if they report patients as discharges when they're considered transfers to post-acute care. They should get a reduction in the discharge payment, said Joanne Liptock, compliance clinical data specialist at Mon Health Medical Center in Morgantown, West Virginia. "However, they're taking the entire payment back with no explanation," she noted.

Ronald Hirsch, M.D., vice president of R1 RCM, said the OIG audit doesn't compute. Potentially there was no overpayment with a lot of the claims. He doesn't see any effort "to calculate what the per diem payment would be if the claim was coded correctly" or recognition the per diem payment could equal the DRG payment.

'Time Will Tell' Whether Rebuttals Work

Because hospitals filed the claims two or three years ago—and sometimes four years ago—they are outside the one-year timely filing deadline. That means hospitals generally can't refile. Rebuttals are one option for preserving the reimbursement they say they are entitled to. According to a Palmetto demand letter to a hospital, which said it had "received a Medicare payment in error" in connection with the PACT payment policy, providers and suppliers have 15 days from the date of this letter to submit a rebuttal according to 42 C.F.R. § 405.374 . "The rebuttal process provides the debtor the opportunity, before the suspension, offset or recoupment takes effect, to submit any statement (to include any pertinent information) as to why it should not be put into effect on the date specified in the notice," the letter said. "A rebuttal is not intended to review supporting medical documentation nor disagreement with the overpayment decision. A rebuttal shall not duplicate the redetermination process. This is not an appeal of the overpayment determination…We will review your rebuttal documentation and determine whether the facts justify ceasing the recoupment or offset." The MAC said it would inform the hospital of its decision in 15 days.

Baker said the claims can't be appealed the usual way because the discharge disposition code was wrong. But he will submit a rebuttal to Palmetto to point out it should only collect the difference between the DRG payments and the per diems. "Everybody should be doing a rebuttal based on their recouping the entire amount," Baker said.

Using rebuttals to stop recoupments is generally an uphill battle, says attorney Jessica Gustafson, with The Health Law Partners in Farmington Hills, Michigan. "I have had success using the rebuttal process to prevent a recoupment in a post-payment audit scenario where a demand letter was issued by the MAC in a different amount than that contained in the review results letter from the auditor, but the MAC still recouped the amount contained in the review results letter. It just corrected its demand," she said. "Time will tell whether the rebuttal process will be successful for providers in the PACT payment policy scenario."

Gustafson will be surprised if it works because the MACs are carrying out CMS policy. "It sounds to me that the Palmetto medical director is suggesting that if enough providers utilize the rebuttal process to dispute CMS's current policy to recover the entire DRG amount instead of the actual overpayment, CMS may feel pressure to back off its aggressive recovery position."

It's also conceivable to refile the claims even though they're outside the one-year timely filing deadline, says Richelle Marting, an attorney in Overland Park, Kansas. "Filing an adjustment claim is probably the best option," she said. "It allows corrected information to be submitted for a claim that was previously filed timely. There are indicators on the Type of Bill field to indicate it's an adjustment claim." Because this situation is unique, however, Marting recommends hospitals contact their MAC for specific claim-filing instructions.

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1 Nina Youngstrom, "CMS Will Recover PACT Policy Overpayments After OIG Audit," *Report on Medicare Compliance* 28, no. 40 (November 11, 2019), http://bit.ly/319ese7.