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Chart: Coding Errors, Lack of CMS Edits Contributed to PACT Overpayments

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In a new report[1] on Medicare overpayments to hospitals for patients who receive home health care within three days of discharge, the HHS Office of Inspector General contends that both hospitals and CMS contribute to errors under the post-acute care transfer (PACT) payment policy.[2] When hospitals don't report the home health discharge disposition code or bypass the policy with condition codes 42 or 43, they receive the full MS-DRG payment instead of per diem payments. The Common Working File (CWF) has edits to detect home health claims associated with hospital discharges, but there are flaws. CWF edits weren't designed to prevent MS-DRG payments when home health care was provided to a patient within three days of discharge for a readmission "because the CWF edits would look only at the first line of the home health claim" for the first admission, OIG said. Overpayments may be on their way down, however, because CMS explained in the OIG report that it improved edits in April.

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