Getting Discharge Status Right

Do You Know Where Your Patient is Really Going?

Linda Coe, Director Coding and Reimbursement
Ed Emnett, Director Case Management
Linda Coe, RN, CCS  
Director, Coding and Reimbursement  
QHR Consulting Services

Linda has been with QHR for 15 years; her current position is as Director, Coding and Reimbursement. She is an R.N., and also holds the CCS credential. Linda uses her broad range of hospital and corporate experience in coding-specific consultations with hospital staff in the clinical, health information, and patient financial services settings. Her skills are concentrated in the areas of ICD-9-CM and CPT/HCPCS coding, DRG validation, case manager and coder education, chargemaster review, and clinical staff education.

She has conducted numerous coding workshops both in person and through distance learning for physicians, nurses, and other clinicians, in addition to those for health information coders and patient financial services representatives. Her strong clinical background and astute clinical skills are a definite asset in these endeavors.

Her past experience has included serving as Manager of DRG Documenter Services, Charge Auditor, Instructor, Pinellas County Health Occupations Education, as well as over 10 years of bedside experience as an IV therapist and charge nurse.
Charles Edward Emnett, RN, MBA, CPHQ  
Director, Case Management  
QHR Consulting Services

Mr. Emnett is a Director of Case Management in QHR’s Consulting Group specializing in Case Management systems and clinical process improvement. He has extensive experience in the hospital and managed care industry including the development, implementation, and management of hospital based Case Management programs, the development and implementation of programs to manage and prevent claims denials, and the development and implementation of programs that address regulatory compliance issues such as Observation Status.

Mr. Emnett received his Masters in Business Administration, Management from St. Leo University. He holds a Bachelor of Science Degree in Health Care Administration from St. Leo University and has been a registered nurse since 1979.

EXPERIENCE
Manager, Patient Care Coordination/Resource Management, South Florida Baptist Hospital
Manager, Clinical Resource Management, St. Joseph’s Hospital (Baycare)

Developed and implemented system wide comprehensive denial management system including appeals, intervention, and prevention

Coordinated clinical aspects of the CMS QI projects, PEPP projects, and facility specific QI projects and integration of those projects with the Case Management process

Redesigned Case Management Departments with integration of Case Management, Utilization Review, Social Work, and Inpatient Admitting and Registration as a single department for optimal efficiency and effectiveness.

Implemented clinical documentation improvement programs

Analyzed physician patterns to identify and communicate “best practices”
Original Definition

Discharge vs. Transfer

- Discharge – Situation in which a beneficiary leaves a PPS acute care hospital after receiving complete acute treatment

- Transfer – Situation in which a beneficiary is transferred to another acute care PPS hospital for related care
Qualified Discharge

- Balanced Budget Act of 1997 (BBA) added a new type of discharge: qualified
- Qualified discharge was defined as a discharge of a beneficiary from a PPS hospital with one of 10 select DRGs; this discharge will be treated as a transfer.
- Went into effect 10/01/98
Qualified Discharge

- On 10/01/03, two of the original qualified discharges were taken off the list and 21 new were added, bringing the total to 29.
- On 10/01/04, one of the DRGs “split” into 2 new DRGs giving us a total of 30.
- The final 2006 rule that is in effect as of 10/01/05 **JUMPED** to 182 qualified discharges.
Who Documents Discharge Status at your Facility?

- Nursing Staff/Unit Secretary
- Case Management/Utilization Review
- Health Information Management/Coders
- Admissions/Registration/PFS
- Don’t Know
Where Is Discharge Status Documented?

- Nurse’s Notes
- Utilization Review/Case Management Notes
- Physician Orders
- Discharge Instructions
- Don’t Know
Criteria for Qualified Discharge

- DRG must have a Geometric Length of Stay (G-LOS) of at least 3 Days
- DRG must have at least 2,050 post-acute transfer cases
- At least 5.5% of cases in the DRG are discharged to post-acute care prior to the G-LOS for the DRG
Criteria for Qualified Discharge

- If the DRG is one of a paired set of DRGs (based on with CC or without CC), both paired DRGs are included if either one meets the three previous criteria.

- CMS does not plan to review these annually; may be every 5 years.
Qualified Discharge

- Patient is discharged to:
  - Hospital or hospital unit that is non-IPPS
  - SNF (does not include Swing beds)
  - Home Health services for a related condition provided within 3 days of discharge.
    - Does not include resuming Home Health services for a non-related condition.
Non-IPPS Facility

- Discharge Status 05 -- Non-Medicare PPS Children’s Hospital or Non-Medicare PPS Cancer Hospital for Inpatient Care
- Discharge Status 62 -- Inpatient Rehabilitation Facility (IRF) including Rehabilitation Distinct Part Unit of a Hospital
  - Provider # XX-TXXX, last 4 digits 3025 – 3099
- Discharge Status 63 -- Medicare Certified Long Term Care Hospital (LTCH)
  - Provider # last 4 digits 2000 – 2299
- Discharge Status 65 -- Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital
  - Provider # XX-SXXX, last 4 digits 4000 - 4499
Skilled Nursing Facility

- Discharge status 03 SNF with Medicare Certification
- Originally thought to be an admission to a SNF within 14 days of Discharge
  - Per Medlearn Matters SE0408 (1/1/04), this was an error in Transmittal 73, CR2716
  - Only edit is for patient admitted to SNF on the same day as discharge.
Home Health Agency

- Discharge status 06 Home Under Care of Organized Home Health Service Organization
- Includes services provided within 3 days after discharge
- If home health is unrelated to hospital admission, use condition code 42
- If home health is related to hospital admission but care did not start within 3 days, use condition code 43
Revisions to Patient Status Codes

- If hospital learns, after the fact, that patient assumed to be discharged home was admitted the same day to another acute care facility, SNF, or received home health services within 3 days of discharge, an adjusted claim with the correct discharge status must be submitted.
Revisions to Patient Status Codes

- Hospitals expressed concern over changing patient status codes when their medical records do not support such changes
- Transmittal 140, Pub 100-04, April 16, 2004
- Intermediaries notified hospitals they will not be penalized by the OIG when they change the patient status code to indicate a transfer
Transfers Between IPPS Hospitals

- Payment to the transferring hospital is based on a per diem rate
- Discharge status 02 Discharged/Transferred to a Short-Term General Hospital for Inpatient Care
- Effective 10-01-03, patients who leave against medical advice but are admitted to another IPPS hospital on the same day will be treated as transfers and the transfer payment policy will apply
Transfer DRG Payment

Two formulas have been developed for payment:

- **# 1 All DRGs except 7, 8, 210, 211, 233, 234, 471, 497, 498, 544, 545, 549, & 550.**
  - Day 1 - Twice the per diem
  - Day 2 thru Geometric LOS* - Daily per diem up to the DRG rate
  - * Payment is determined by dividing the geometric mean length of stay into the full DRG rate to determine the per diem.

- **# 2 DRGs 7, 8, 210, 211, 233, 234, 471, 497, 498, 544, 545, 549, & 550**
  - Day 1 - 50% of full DRG rate plus one per diem
  - Day 2 thru GMLOS - One-half daily per diem up to the DRG rate
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<thead>
<tr>
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<th>Example 1</th>
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<td>Day Eleven</td>
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OIG Review of Compliance with Postacute Care Transfer Policy

- April 11, 2005
- Reviewed cases in 2001 and 2002
- Of 400 claims sampled, 381 were improperly coded
- Potential overpayments in sample were $1,034,588
- Estimated overpayment for 2001 and 2002 was $72.4 million
  - At that time, only 10 DRGs involved.
IG Recommendations to MS

Instruct intermediaries to recover the potential overpayments.

Instruct intermediaries to identify and recover additional overpayments estimated at $71.3 million.

Monitor hospitals that have a high number of claims adjusted as a result of the recently implemented system edits and perform follow-up reviews, as appropriate, at specific hospitals.
CMS Response

CMS agreed to implement the first and last recommendations.

CMS is working on a strategy to identify and collect the remaining overpayments.
Do HIM coders perform quality check on accuracy of discharge status?

Yes

No

Don’t Know
Discharge Status is changed by HIM coders, is that change reflected on the UB-92?

Yes  No  Don’t Know
Separate but Related

Two subjects for operations

- Getting an accurate discharge disposition on the chart and in the system
- Managing to get AN ACCURATE AND TIMELY discharge DISPOSITION at the right time for Medicare Transfer DRGs
Capturing Discharge Disposition a Problem?

Do you have discharge disposition work in:
- HIM?
- Billing?

Do you have – and enforce – a Policy and Procedure for reporting the discharge disposition?

Is this process audited?
Have Claim Rejections Occurred Due to Incorrect Discharge Status?

- Yes
- No
- Don’t Know
Discharge Disposition defined?

Should be well defined by Policy and Procedure.

Case Management should identify the discharge disposition in their Progress Note.

- If the initial assessment indicates Home as the discharge disposition and that does not change, the admission note will suffice.
- Otherwise, the Case Managers final note should indicate the final disposition.
- Should be discussed in Interdisciplinary Team Meetings.
Barriers

Accurate documentation of the discharge disposition

Knowledge level of the team members involved

Physician compliance with establishing a discharge plan
Goal: Accurate Collection of the Discharge Disposition
There Problems with transfer DRGs at your Hospital?

Have you been audited?
Do you have an internal audit process in place?
Who is responsible for oversight in this area?
- Compliance Officer
- Case Management
- HIM
- Billing

Have you assessed financial impact?
Shift in the Operations Mindset

From “beating to meeting” the Medicare GMLOS

From 10 to 182 DRGs that cannot “beat” the Medicare GMLOS by one day or more

Although the transfer policy applies to all Post Acute Care (PAC) transfer cases in the designated DRGs, hospitals are effectively only paid on a per diem basis or patients discharged to PAC at least a day short of the National GMLOS.”
Measuring Transfer DRG Impact

Two methodologies

- Review of DRGs for short overall LOS – fastest and easiest, but may miss cases
- Review of “short stay” patients by DRG – most accurate

Can be linked to your current short stay audit – if one is in place

Calculated per diem rate
## TRANSFER DRG TABLE

**Financial Analysis Tool**

<table>
<thead>
<tr>
<th>Description</th>
<th>DRG Wt</th>
<th>Blended Rate</th>
<th>DRG Value</th>
<th>GMLOS</th>
<th>Per Diem</th>
<th>Paid Day 1</th>
<th>Paid Day 2</th>
<th>Paid Day 3</th>
<th>Paid Day 4</th>
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### Measuring Transfer DRG Impact

<table>
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<tr>
<th>Vol</th>
<th>ALOS¹</th>
<th>GMLOS²</th>
<th>Var³</th>
<th>Total Var⁴</th>
<th>RW⁵</th>
<th>Exp Reimb/Case⁶</th>
<th>Per Diem⁷</th>
<th>Total Exp Reimb⁸</th>
<th>Txp Transfer DRG Reimb⁹</th>
<th>Reimb Var/Case¹⁰</th>
<th>Total Exp Transfer DRG Reimb¹¹</th>
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1. Vol: Volume
2. GMLOS: General Medical LOS
3. Var: Variance
4. Total Var: Total Variance
5. RW: Relative Weights
6. Exp Reimb/Case: Expected Reimbursement per Case
7. Per Diem: Per Diem rate
8. Total Exp Reimb: Total Expected Reimbursement
9. Txp Transfer DRG Reimb: Txp Transfer DRG Reimbursement
10. Reimb Var/Case: Reimb Var/Case
11. Total Exp Transfer DRG Reimb: Total Expected Transfer DRG Reimbursement

- Hospital ALOS as calculated and rounded to 2 decimal places
- Medicare GMLOS minus Hospital ALOS
- Total number of days in excess of the GMLOS for the given DRG
- Medicare Relative Weights
- Expected Medicare reimbursement based on the assumed based rate
- Per diem rate calculated using the GMLOS and expected reimbursement amount per case
- Expected Medicare reimbursement for DRG
- Expected reimbursement per case based on the Medicare transfer rule
- Expected reimbursement minus expected transfer rule reimbursement
- Total expected transfer rule reimbursement
One Facility

486 Cases
6,098 days
Estimated Medicare overpayment of $1,133,732

Hospital Size – 149 beds

They had no idea that it was this big
Transfer DRG Process

Medicare assumes good communication between the physician and the process.

Not practical to try to look at every discharge.

Probably the best tactic is to educate by product line and monitor by physician within product lines.
Case Management Implications

Accepting that Case Management cannot control Transfer DRG process on a daily operations basis

Being aware of the rules, at the time of discharge, transfer DRGs impact patients:

- Admitted to a hospital or hospital unit that is not reimbursed under PPS
- Admitted to a SNF
- Provided Home Health services related to the condition that they received inpatient care for, within 3 days from the date of discharge

The rules for reimbursement
Ortho and Neuro cases are among the most commonplace (DRG 12, 14, 24, 25, 210, 211, 236, 239)

A product line approach:
- Allows consistent staff and physician education
- Facilitates oversight and intervention
Technology Limitations?

Communication between the HIM software and the mainframe computer

Ability to obtain data
- Stratified LOS reports by DRG
- Stratified LOS reports by physician
Current Transfer DRG Process

Internal audit process – best practice

Some facilities calling patients on the third day – hard to justify based on time and cost

Most hospitals missed transfer DRGs or didn’t “get it right” with 30 DRGs.

What will happen now that it is at 182 DRGs?

Many facilities do not report the discharge disposition accurately
How Is Follow-Up Performed to determine if Patient was Admitted to SNF or Home Health post discharge?

Phone Call by Case Management/Utilization Review to patient post-discharge

Depend on SNF or HHC agency to let us know

There is no follow-up

Don’t Know
The Future

Bounty hunters” – the new FI contracted review process

Increased focus on repaying the FI, not on action plans - Claims have been paid in full thus far

Internal audit will become a necessity

Major operations shift with the move from 30 to 182 DRGS in the program