Clarifying Patient Status Code

by Gloryanne Bryant, RHIA, CCS

The patient status code reflects the level of care a patient was discharged or transferred to when leaving an acute care hospital as an inpatient or outpatient (i.e., emergency department or emergency room). A recent Centers for Medicare and Medicaid Services *MLN Matters* publication provides additional clarification that should help coding professionals with accuracy in this data field. This article provides an overview of the patient status code information in the fact sheet as it relates to payment accuracy and compliance.

Getting the Calculation, Policy Right

Under the Inpatient Prospective Payment System (IPPS), the patient status, also called the discharge status code, can affect the MS-DRG payment calculation. Because the Post-Acute Care Transfer Rule, often called the PAC rule, comes under IPPS, this policy protects Medicare from paying for the same care twice: once as part of the hospital's payment for the DRG and then as a separate payment to the postacute facility.

Hospital inpatient payments are calculated from Medicare's current per diem rate policies that affect transfers between PPS acute care hospitals. A transfer is defined as any patient discharged as a transfer DRG and admitted to a postacute care provider in less than the geometric mean length of stay or to a skilled nursing facility, rehabilitation facility, or home health facility within three days.

The IPPS PAC policy applies to claims coded with patient discharge status codes 03, 05, 06, 62, 63, and 65 (see MLM SE 801 for details on each code). For inpatient rehabilitation facilities, the following patient status codes are applicable under the IRF Transfer Policy for IRF PPS: 02, 03, 61, 62, 63, and 64.

The Discharge Patient Status Codes

Close attention must be paid to the use of disposition code 04. Per the MLN notice, if the patient does not receive skilled care at the skilled nursing facility (03), code 04 or 64 should be assigned. Code 03, Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care, indicates that the patient is discharged or transferred to a Medicare-certified nursing facility in anticipation of skilled care.

Hospitals with an approved swing bed arrangement should use code 61, Swing bed. The code is to be used regardless of whether the patient has skilled benefit days and whether the transferring hospital anticipates that the stay will be covered by Medicare. For reporting other discharges or transfers to nursing facilities, see codes 04 and 64. Code 03 should not be used if the patient is admitted to a non-Medicare certified area.

Patient discharge status code 04, Discharged/transferred to an intermediate care facility, is typically defined at the state level for specifically designated intermediate care facilities. It is also used to designate patients discharged or transferred to a nursing facility with neither Medicare nor Medicaid certification or for discharges or transfers to state-designated assisted living facilities.

Nursing facilities may elect to certify all, a portion, or none of their beds under Medicare. When a patient is transferred to a nursing facility that has no Medicare-certified beds, code 64, Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare, should be used. If any beds at the facility are certified, the provider should use code 03 or 04, depending on the level of care the patient is receiving and whether the bed is Medicare-certified or not.

Take for example a 76-year-old man admitted for alcoholic cirrhosis. His length of stay is two days. He is then discharged to a skilled nursing facility for "nonskilled" care (04 discharge disposition patient status code). The patient has a complication

comorbidity documented, and alcoholic cirrhosis is the diagnosis.

This encounter would fall under MS-DRG 442, Disorders of Liver except Malignancy, Cirrhosis, Alcoholic Hepatitis w CC. The relative weight is 1.0935; geometric mean length of stay, four days. The relative weight hospital base rate ($6,000) equals a full DRG payment of $6,561. The PAC rule does not apply. Full MS-DRG payment would be received. Disposition code 04 is not included in the PAC rule for IPPS transfers.

However, if the patient were transferred to a skilled nursing facility (03 for skilled care), the geometric mean length of stay would equal per diem $1,640. The per diem rate x2 the first day would equal $3,280. The per diem rate x1 for subsequent days (one day) would equal $1,640. The total DRG reimbursement for this two-day stay would be $4,920.

In addition, the definition has changed for disposition code 05, Discharged/transferred to a designated cancer center or children's hospital. Transfers to nondesignated cancer hospitals should use code 02. A list of National Cancer Institute Designated Cancer Centers can be found at www3.cancer.gov/cancercenters/centerslist.html.

The final new patient status code 70 was created in order for providers to indicate discharges or transfers to another type of healthcare institution not defined elsewhere in the code list. This code is effective for use by providers for discharges/to dates on or after April 1, 2008.

Communication, Documentation Key

Documentation may not provide specifics about the actual level of care the patient will receive upon discharge. However, it is necessary for coding professionals to obtain this information. Coders should discuss this with their case managers, discharge planners, and utilization review staff so they are aware. Good communication and documentation between the postacute provider and the hospital is key.

The "Acute Inpatient Prospective Payment System" fact sheet (revised in November 2007) provides general information about the acute IPPS and how IPPS rates are set. It is now available from the Centers for Medicare and Medicaid Services Medicare Learning Network at www.cms.hhs.gov/MLNProducts/downloads/AcutePaymtSysfctsht.pdf.

HIM professionals should review this guidance and share it with their coding staff or others in the hospital who assign patient status codes (discharge disposition). Without an accurate patient status code an organization could be overpaid or underpaid for the transfer MS-DRG, which can raise compliance issues.

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