Hospital Discharge Status Codes: Risks and Rewards

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It is a well known fact that ICD-9-CM diagnosis and procedure codes impact hospital reimbursement and compliance. But there is an additional code that often flies under the radar—the discharge status code. Inaccurate discharge status code assignments for Medicare post-acute care transfers can lead to under-reimbursement, as well as compliance issues.

In 1998, Medicare enacted the post-acute care transfer (PACT) payment methodology in response to prospectively paid hospitals' attempts to reduce the cost of care by early transfer of patients to post-acute care facilities such as skilled nursing facilities and home health agencies. Because of this, the Centers for Medicare and Medicaid Services (CMS) concluded Medicare was "overpaying" for inpatient care as it was paying the acute care hospital the full DRG reimbursement, as well as a separate payment for the post-acute care transfer facility or agency within the same healthcare encounter.

Initially, only 10 DRGs (or approximately nine percent of Medicare discharges) were selected for the PACT policy. However, due to its financial success, for fiscal year 2015 the DRG list was expanded to 273 MS-DRGs (or approximately 65 percent of Medicare discharges). The discharge status codes impacted by the PACT policy are listed in Table 1 and the discharge status codes not impacted by the PACT policy are listed in Table 2.

PACT Payment Methodology

Hospitals are reimbursed a per diem payment under the PACT methodology (see Table 3). The per diem payment is determined by dividing the full DRG reimbursement by the DRG specific geometric mean length of stay (GMLOS). The first hospital day receives double the per diem payment followed by the per diem payment for the remainder of the hospital length of stay (up to the full DRG reimbursement). If the DRG is a "special-pay" DRG, the hospital receives 50 percent of the expected DRG payment on the first hospital day followed by the per diem payment for the remainder of the hospital length of stay (up to the full DRG payment).

Challenges with Discharge Status Codes

The two most common reasons for incorrect discharge status code assignments are lack of communication between the hospital and the transferring facility, and incomplete understanding of the discharge status codes by hospital personnel. Adding to this problem is the absence of Medicare edits in the common working file that detect incorrect discharge status codes resulting in underpayment to the hospital. Ironically, there are only CMS edits for overpayment.

Most discharge status code reporting errors occur with transfers to skilled nursing facilities (code 03) and home health agencies (code 06).

Skilled Nursing Facility Transfers

Several different scenarios resulting in suboptimal hospital payment often occur when a patient is transferred to a skilled nursing facility (SNF):

1. A patient is admitted to the SNF for skilled care. After evaluation, however, skilled care is not required and the patient receives non-skilled long-term care only. If the hospital had known the patient didn't require skilled care on admission to the SNF, discharge status code 04 would have been assigned, resulting in the full hospital DRG reimbursement.
2. The SNF may have multiple levels of care and the patient is admitted to an assisted living facility (04).
3. The patient may elect hospice (50, 51) on arrival at the SNF which is exempt from the PACT policy.

4. Hospitals are often unaware of the certification status of nursing home facilities such as Medicaid-certified only (64) or federal healthcare facility (VA) nursing homes (43), both of which are exempt from the PACT payment methodology.

Table 1: Inpatient Discharge Status Codes Impacted by PACT Policy

02 (All DRGs) Hospital	82 Planned re-admission
03 SNF	83 Planned re-admission
05 Cancer/children's hospital	85 Planned re-admission
06 HHA	86 Planned re-admission
62 IRF	90 Planned re-admission
63 LTCH	91 Planned re-admission
65 Psych	93 Planned re-admission

Table 2: Inpatient Discharge Status Codes Not Impacted by PACT Policy

01 Home	81 Planned re-admission
04 ICF	84 Planned re-admission
06 With condition code -42 HHA unrelated Dx	86 Planned re-admission
06 With condition code -43 HHA > 3 days	86 Planned re-admission
07 AMA	
43 VA	88 Planned re-admission
50 Hospice, home	

51 Hospice, facility	
61 Swing bed	89 Planned re-admission
64 Medicaid only	92 Planned re-admission
66 CAH	94 Planned re-admission
69 Alternative disaster care site	
70 Other	95 Planned re-admission

Table 3: Example of Hospital Reimbursement via Per Diem Payment Under PACT

MS-DRG 064 Payment GMLOS 6 Days
MS-DRG: 064: Cerebral infarction w MCC RW 1.6212 GMLOS 6.0 days Blended Rate: $5,644 Full DRG payment: $9,150 Per diem payment: $1,525 Day 1: $1,525 + $1,525 ($3,050) Day 2: $1,525 ($4,575) Day 3: $1,525 ($6,100) Day 4: $1,525 ($7,625) Day 5: $1,525 ($9,150)

Ironically, skilled nursing facility transfers also represent a compliance risk. This occurs when the hospital or a consulting vendor incorrectly assumes the patient did not receive skilled nursing care because there is no charge for skilled care in the Medicare eligibility file. Medicare patients often receive skilled care, but due to various reasons may not be Medicare-eligible for skilled nursing care benefits—for example, if the patient did not have a qualifying hospital stay. Therefore, when patients receive skilled nursing care paid by means other than Medicare, there is no evidence of skilled nursing care in the Medicare eligibility file as no payment is provided by Medicare. This results in the full DRG payment being incorrectly paid by Medicare.

The rule regarding assignment of discharge status code 03 (skilled nursing facility) is discussed in the IPPS Final Notice that appeared July 31, 1998 in the *Federal Register*, when the original PACT policy was finalized. It is also delineated in the revised definition of discharge status code 03 in the National Uniform Bill Committee Specifications Manual of July 2009.

Home Health Agency (HHA) Transfers

Home health agency transfers represent another problem area where multiple instances of incorrect discharge status code assignment may occur, such as:

1. The patient either refuses care or does not meet criteria for home healthcare. Discharge status code 01 (home) is assigned, resulting in full DRG reimbursement.
2. The patient may elect hospice care (50), which supersedes the home health discharge status code.
3. Hospitals may also confuse discharges with physical therapy, infusion therapy, or DME supplies as a home health transfer even when a patient is not under the care of a home health agency. When this occurs, discharge status code 06 (home health care) is incorrectly assigned rather than the correct code 01 (home).
4. Frequently, the patient does not receive home health services within three days of the hospital discharge and condition code -43 (Continuing care not provided within prescribed post-discharge window) is appended to the discharge status code 06, resulting in the full DRG reimbursement.
5. Home healthcare is unrelated to the reason for hospitalization and condition code -42 (Continuing care not related (i.e. condition or diagnosis) to inpatient admission) is appended to the discharge status code 06 resulting in the full DRG reimbursement. The assignment of condition code -42 often requires an evaluation by a clinician and also escapes the Medicare payment edits, making it highly scrutinized by CMS.

Addressing Discharge Status Code Challenges

A hospital may address the problem of inaccurate discharge status codes by developing an internal action plan or consulting with an outside vendor.

Internal Action Plan

Involve case managers, discharge planners, Medicare billers, and coders to develop an internal auditing and monitoring protocol for Transfer DRGs concentrating on at least discharge status codes 03 and 06. The protocol should focus on the Transfer DRGs with a hospital length of stay of at least 1.1 days less than the DRG-specific GMLOS. This action plan will also involve communicating with the transfer facilities to determine the actual care provided.

The impact of internal audit efforts can be demonstrated by monitoring the positive trend of the following discharge status code ratios, attempting to increase the ratio value:

- 01/06
- 06-42/06
- 06-43/06
- 04/03

External Audit

Another way to improve the accuracy of discharge status code assignments is through an external audit. Choosing a vendor can be difficult, and bigger is not always better.

The following questions should be asked of perspective vendors:

1. Does the vendor identify errors based on Medicare eligibility file analysis only, or does the vendor also contact the appropriate transfer facilities to determine the level of care? If a Medicare-certified SNF is not contacted for confirmation before submitting discharge status code 04, then the hospital could be subject to potential billing fraud if the Medicare patient received skilled care. If it is assumed a patient did not receive home health services due to absence of

home health services in the Medicare eligibility file, the hospital may expose themselves to a billing error as home health agencies have up to one year to submit a bill.
2. Does the vendor provide an educational component to their audit? If the vendor only provides a list of accounts to be rebilled with the revised discharge status code, then the hospital will always be dependent on the external vendor as there is no explanation as to how or why the discharge status code errors occurred. An educational exit review should be provided and include all interested parties, such as case managers, discharge planners, Medicare billers, and health information coders, to understand how to avoid future discharge status code reporting errors.
3. How often and under what circumstances is condition code -42 appended to discharge status code 06 (home health agency)? The failure to make a clinical determination as to whether the home health services are related to the hospitalization could result in potential loss of revenue.

The discharge status code assignment and the resultant post-acute care transfer payment methodology is a seductively simple system which is filled with financial opportunities as well as compliance risks. These problems can be addressed through education and communication among the involved parties.

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