Proposed Changes to Hospital Inpatient PPS Include Expanded Definition of Transfers

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The proposed rule for changes to the Medicare Hospital Inpatient Prospective Payment System (PPS) for fiscal year 1999 was published in the May 8 *Federal Register*. These changes would become effective with discharges as of October 1, 1998. A significant provision in this proposed rule is an expansion of the definition of "transfer" to encompass certain postacute services. The Balanced Budget Act of 1997 requires the Secretary of the Department of Health and Human Services to define and pay as transfers cases from one of 10 select DRGs, if the patient is discharged to a non-PPS hospital, skilled nursing facility (including swing beds), or home health.

The 10 select DRGs proposed are:

- 14—Specific Cerebrovascular Disorders Except Transient Ischemic Attack
- 113—Amputation for Circulatory System Disorders Excluding Upper Limb and Toe
- 209—Major Joint Limb Reattachment Procedures of Lower Extremity
- 210—Hip and Femur Procedures Except Major Joint Age >17 with CC
- 211—Hip and Femur Procedures Except Major Joint Age >17 without CC
- 236—Fractures of Hip and Pelvis ¥ 263—Skin Graft and/or Debridement for Skin Ulcer or Cellulitis With CC
- 264—Skin Graft and/or Debridement for Skin Ulcer or Cellulitis Without CC
- 429—Organic Disturbances and Mental Retardation
- 483—Tracheostomy Except for Face, Mouth, and Neck Diagnoses

According to HCFA's data, a large number of discharges from these DRGs receive postacute care.

Discharges to home health would only be included in this new transfer definition when the home health services are related to the condition or diagnosis for which the patient received inpatient hospital services and if the home health services are provided within an appropriate period. The Health Care Financing Administration (HCFA) is proposing that home health services be considered related to the hospital discharge if the patient is discharged from the hospital with a written plan of care for the provision of home health services from a home health agency. An 'appropriate period' is defined as three days, meaning that home health services must commence within three days after the hospital discharge for the transfer provision to apply.

The current payment methodology for transfers is to reimburse the transferring hospital a per diem rate for each day of the hospitalization, not to exceed the full DRG payment that would have been paid if the patient had been discharged instead of transferred. The per diem rate paid to a transferring hospital is determined by dividing the full DRG payment by the geometric mean length of stay. For cases that fall into one of the 10 DRGs and are transferred to a non-PPS hospital, skilled nursing facility, or home health service, the current transfer payment methodology would apply, except for DRGs 209, 210, and 211. For DRGs 209, 210, and 211, 50 percent of the DRG payment would be paid for the first day of the hospitalization and 50 percent of the per diem for the remaining days of the stay.

HCFA believes that this proposed reimbursement policy for transfers to postacute care will decrease hospitals' financial incentive to discharge patients very early in the stay (often before the full course of acute care treatment has ended) and will pay hospitals at an appropriate level when they move patients into postacute care.

Article Citation:

Prophet, Sue. "Proposed Changes to Hospital Inpatient PPS Include Expanded Definition of Transfers." *Journal of AHIMA* 69, no. 7 (1998): insert before p.17.