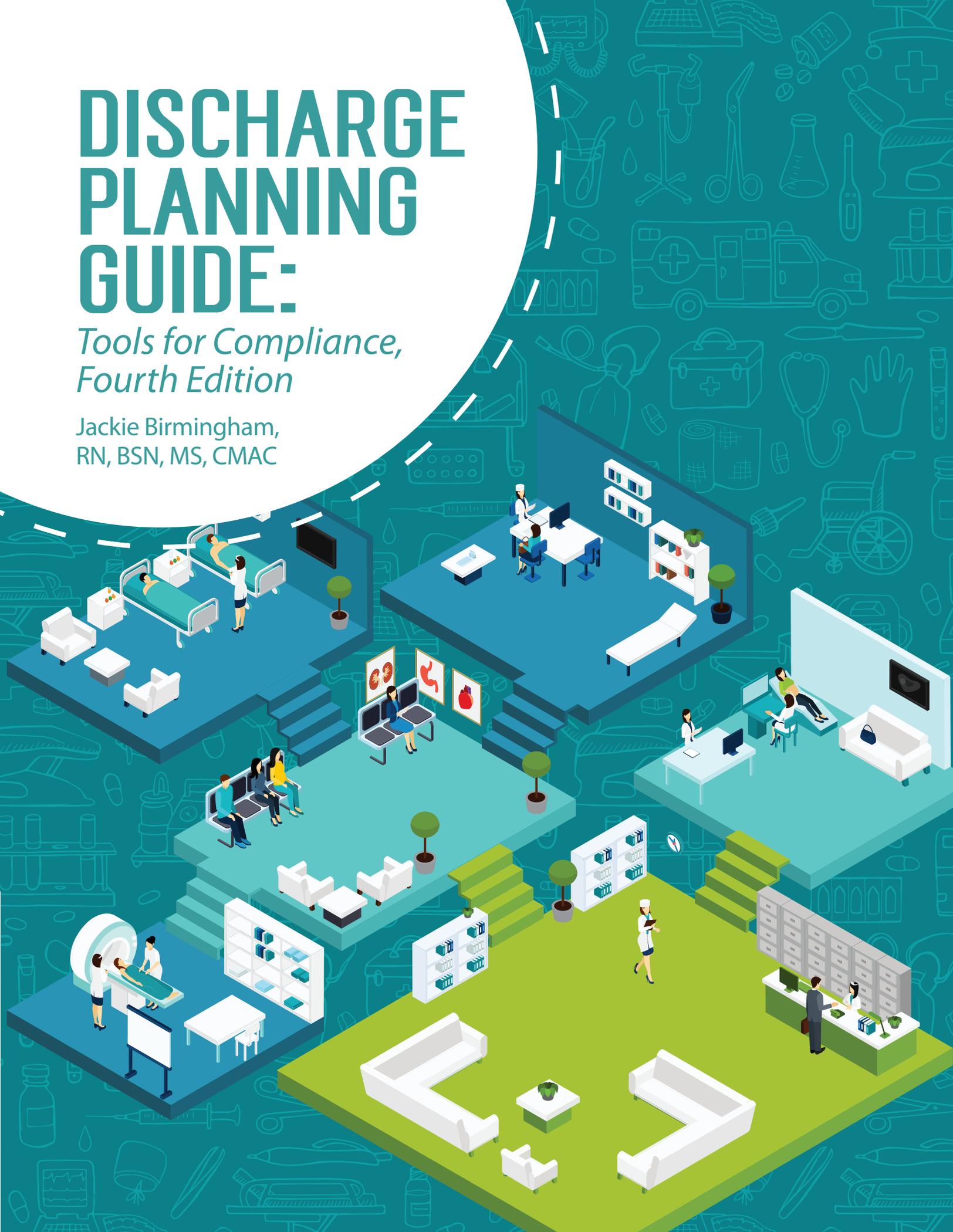


# DISCHARGE PLANNING GUIDE:

*Tools for Compliance,  
Fourth Edition*

Jackie Birmingham,  
RN, BSN, MS, CMAC



# **DISCHARGE PLANNING GUIDE:**

*Tools for Compliance  
Fourth Edition*

**Jackie Birmingham, RN, BSN, MS, CMAC**

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Jaclyn Fitzgerald, Senior Editor

Erin Callahan, Vice President, Product Development & Content Strategy

Elizabeth Petersen, Executive Vice President, Healthcare

Matt Sharpe, Production Supervisor

Vincent Skyers, Design Services Director

Vicki McMahan, Sr. Graphic Designer

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RJ Clarke, Cover Designer

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HCPro

100 Winners Circle, Suite 300

Brentwood, TN 37027

Telephone: 800-650-6787 or 781-639-1872

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**Appendix**

Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies; Requirements set forth as "Conditions of Participation" (CoPs) Proposed Revision 11/03/2015.

Download the Appendix of this book at: [www.hcpro.com/downloads/12541](http://www.hcpro.com/downloads/12541).



# About the Author

**Jackie Birmingham, RN, BSN, MS, CMAC**, is the vice president, emerita, of clinical leadership and regulatory monitoring for Curaspan Health Group. In her role, Birmingham works with industry leaders to monitor federal laws that impact the process and practice of discharge planning, transition management, and case management. Her more than 30 years' experience in transition-of-care healthcare settings with other organizations include director of discharge planning, director of quality improvement, and faculty in schools of nursing.

Birmingham is the author of several books and journal articles about case management, discharge planning, and transition management. A frequent speaker, she has presented programs throughout the United States and in Great Britain and Spain. She also serves as an educator for providers and payers, focusing on discharge planning, transition-of-care management, and continuity of care.

A member of the American Case Management Association (ACMA), she served on the committee to develop standards of practice for hospital-based case managers. She has been honored by The Case Management Society of America as one of its Distinguished Case Managers of the Year.

As a member of the Editorial Board of Professional Case Management and a holder of Case Management Administrator Certification, Birmingham is constantly monitoring professional practice of transition at all levels.

Birmingham has testified before the U.S. House of Representatives Committee on Ways & Means, delivering the Statement of the Board of Directors of AACC (American Association of Continuity of Care) on "Medicare Part B Issues," and to the U.S. Senate, Special Committee on Aging, delivering the Statement of the Home Care Coalition titled "Medicare Fraud & Abuse: A Neglected Emergency," both in Washington, D.C.

Birmingham resides in Suffield, Connecticut, and can be reached at [jbirmingham62@gmail.com](mailto:jbirmingham62@gmail.com).

## **Disclosure Statement**

The planners, presenters/authors, and contributors of this continuing education activity have disclosed no relevant financial relationships with any commercial companies pertaining to this activity.

No person involved in the writing of this book is of legal authority. You are strongly encouraged to seek your own legal counsel before making changes to your policies, practices, or workflow. The material in this text was accurate at the time of publication. Healthcare regulations change rapidly; therefore, you are also strongly encouraged to bookmark important websites included throughout this book so you can keep up with rules and *Conditions of Participation*.

# Continuing Education

## Learning Objectives

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- State the purposes of the Social Security Act, the *Conditions of Participation (CoPs)* and *Conditions for Coverage*, and the Interpretive Guidelines as each relates to discharge planning
- Identify sections of the *CoPs* for discharge planning related to discharge instructions
- Explain how utilization review, discharge planning, and case management interface with transition management
- Describe steps in monitoring the progress of a patient's discharge plan
- Describe the effect of the discharge planning process on the revenue cycle—efficiency scores and preventable readmission
- Describe when to use the Medicare Outpatient Observation Notice according to the Notice of Observation Treatment and Implication for Care Eligibility Act for patients admitted to observation status
- Discuss payment rules that affect discharge planning
- Describe types of discharges and transfers from acute care hospitals, critical access hospitals, skilled nursing facilities, and home health agencies
- Outline provisions of the Improving Medicare Post-Acute Care Transformation Act of 2014
- Discuss the revenue cycle implications discharge planning has for hospitals

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# Discharge Planning From a Case Management Perspective

After reading this chapter, you will be able to:

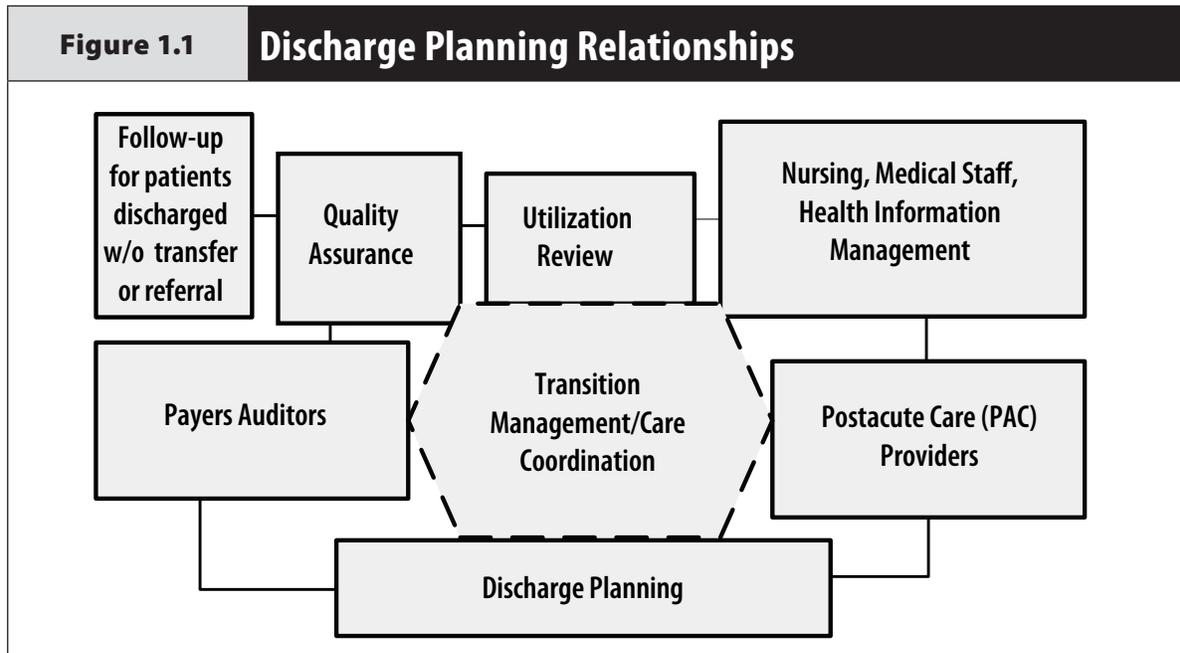
- Define utilization review (UR), discharge planning, and case management
- Explain how all three interface with transition management
- Provide a brief history of discharge planning
- Discuss how discharge planning affects revenue cycle management

## Definitions

---

Defining discharge planning in a healthcare system undergoing reform is a challenge. In particular, it's a challenge because the role and function have morphed into a process that is more encompassing within hospitals and postacute care settings. Rarely is someone's title that of discharge planner. It's often something like case manager. And rarely are staff members responsible only for discharge planning.

Discharge planning arguably remains the most patient-centric function within case management; definitions of the core functions support this view. Legislation requiring UR came first in 1972; discharge planning was next in 1988. The Centers for Medicare & Medicaid Services (CMS) considers UR and discharge planning basic hospital functions. Simply put, if hospitals accept any money from CMS, then they must provide UR and discharge planning. Case management is not subject to a dedicated regulation; instead, it is a combination of these two functions, which gives case managers great job security. Figure 1.1 illustrates the relationship of discharge planning and revenue cycle management within case management.



Source: Jackie Birmingham, RN, BSN, MS, CMAC. Reprinted with permission.

### Utilization review

The Social Security Act amendment for UR provides “(1) for the review, on a sample or other basis, of admissions to the institution, the duration of stays therein, and the professional services (including drugs and biologicals) furnished, (A) with respect to the medical necessity of the services, and (B) for the purpose of promoting the most efficient use of available health facilities and services” (42 USC §1861(k)(1)).

Access Social Security Act - §1861(k) Utilization Review Sec. 1861 42 USC 1395x  
 at: [www.ssa.gov/OP\\_Home/ssact/title18/1861.htm](http://www.ssa.gov/OP_Home/ssact/title18/1861.htm)  
 or [www.cms.hhs.gov/manuals/downloads/pim83c04.pdf](http://www.cms.hhs.gov/manuals/downloads/pim83c04.pdf).

All hospitals participating in Medicare and Medicaid must have in effect a UR plan that provides for review of services that the facility and its medical staff provide to Medicare and Medicaid patients. A CMS memorandum entitled “Utilization Review *Condition of Participation* for Hospitals” provides more information. It states in part:

*“The regulation at 42 CFR 482.30 does, however, permit two exceptions to the requirement for a hospital UR [UR] plan: (1) where the hospital has an agreement with a QIO under contract with the Secretary to assume binding review for the hospital or; (2) where CMS has determined that UR procedures established by the State under Medicaid are superior to the UR requirements for the Medicare program and has required hospitals in that State to meet the UR requirements for the Medicaid program at 42 CFR 456.50 through 456.245” (2007).*

## Discharge Planning From a Case Management Perspective

Some hospitals contract with outside physician-based services, sometimes for only certain types of cases. Regardless of how a hospital performs UR, staff members who perform discharge planning must understand the basic UR definition as it relates to duration-of-stay validation.

### **Case management**

Use of the term health professionals in discharge planning rules indicates that nurses or social workers can perform this function. The rules don't designate a specific profession or department. The same is true with respect to UR. This flexibility fosters, and appropriately so, case management departments with nurses and social workers with overlapping responsibilities.

Various definitions of case management exist, with origins in social work, nursing, and professional organizations whose members represent multiple professions. A generic definition helps explain the relationship of case management to UR and discharge planning. Case management is a process designed to accommodate an individual's specific health services through a coordinated effort to achieve the desired health outcome in a cost-effective manner. The desired health outcome is a safe, timely, agreed upon plan for discharge.

### **Discharge planning**

The Social Security Act provides that, "The Secretary [of Health and Human Services] shall develop guidelines and standards for the discharge planning process in order to ensure a timely and smooth transition to the most appropriate type of and setting for post-hospital or rehabilitative care" (42 USC §1395x(ee)(2), 2011).

Discharge planning is the process that healthcare professionals in hospitals use to facilitate patients' transition from one level of care to another. It most often applies when a patient transitions from an acute care setting to another level of care. This book discusses the rules that apply to hospitals and their patients, including those who are inpatient, outpatient/observation, and in the emergency department (ED). The *Conditions of Participation (CoPs)* also apply to critical access hospitals (CAH) and home health agencies (HHA). However, the process of transitioning patients from one level to another occurs in all settings, including inpatient rehabilitation hospitals, skilled nursing facilities (SNF), and home healthcare—anywhere patients receive healthcare. Patients transition from one level to another until they are independent in self-care.

Access this section of the Social Security Act at:  
[www.ssa.gov/OP\\_Home/ssact/title18/1861.htm](http://www.ssa.gov/OP_Home/ssact/title18/1861.htm).  
Search for "discharge planning."

## Chapter 1

### Unique characteristics of discharge planning

National initiatives aim to improve the transition process for patients and improve safety during the process. Some groups want to use the term *transition planning* instead of discharge planning. This concept has merit, but the Social Security Act amendment of 1988 uses the term *discharge planning*. Discontinuing its use would not serve compliance efforts. Unless and until Congress amends the law, which is doubtful, the term *discharge planning* must be used in reference to moving patients out of the hospital and to the next level of care. The CMS Survey and Certification section discusses the relationship between discharge planning and care transition, and the term care transition is now widely used.

Access the *State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals* at: [www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_a\\_hospitals.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf).

As part of the implementation of the Affordable Care Act (ACA), CMS proposed a revision of the discharge planning *CoPs* in November 2015 (see the *CoPs* on the download page—link in table of contents). The revision expanded the definition of discharge planning and officially introduced the relationship between discharge planning and transition of care. This proposed rule includes references to transition management, so now it is an accepted part of the definition.

*“The hospital must develop and implement an effective discharge planning process that focuses on the patient’s goals and preferences and prepares patients and their caregivers/support person(s), to be active partners in post-discharge care, planning for post-discharge care that is consistent with the patient’s goals for care and treatment preferences, effective transition of the patient from hospital to post-discharge care, and the reduction of factors leading to preventable hospital readmissions.” (CMS, 2015.)*

Discharge planning is a process or a function. However, it is not a clinical specialty or assigned to a distinct profession. Its basis is the patient-centered aspects of healthcare, which include hospital-based services used to diagnose and treat illnesses, diseases, and accidents. Discharge planning is a direct person-to-person function. Determining who should perform discharge planning or which profession should be the dominant one depends on the needs of the patient population an organization, such as a hospital, serves. For example, a psychiatric service may employ more social workers, whereas an orthopedic service may employ more nurses.

Healthcare professionals must be in direct contact with patients and their families to perform discharge planning in a patient-centric way. The primary purpose of the process is to evaluate a patient’s capacity for self-care and continuing-care needs. The goal is to plan a course of action to meet patients’ clinical, medical, nursing, psychosocial, therapeutic, supply, and pharmaceutical needs as they leave one healthcare setting and move on to the next level of care.

## Discharge Planning From a Case Management Perspective

Being family-centered requires the process to be more than a medical diagnosis or a surgical procedure. It must address the needs of the whole person. A healthcare professional uses methods of diagnosis, treatment, and education that address patients' physical, mental, emotional, and spiritual well-being. Family-centered discharge planning also considers the social, cultural, ethnic, and financial aspects of healthcare. The term *family* in this context encompasses the nuclear family, extended family, adoptive family, significant others, or persons deemed part of the family by legal decision.

Discharge planning is also *transitional*—that is, it is focused on transitioning the patient to the next level of care. Comparing discharge planning to case management illustrates why the term transitional is used. Many healthcare professionals who perform discharge planning have the title of case manager or care coordinator, which implies that their job functions involve more than discharge planning. They suggest a broader expectation that can include UR, following patients through and after discharge, managing the patient's response to illness or disease, and performing other functions. Discharge planning is a legally mandated function, however, so case managers—or whoever is assigned discharge responsibilities—must understand the transitional nature of discharge planning. This understanding helps ensure regulatory compliance and provides a service that will improve the patient's outcome.

Approaching discharge planning from a door-to-door perspective helps professionals understand that the scope of responsibility focuses singularly on transitioning the patient to the next level of care.

### The regulatory history of discharge planning

The Social Security Act was enacted in 1935, but 30 years passed before legislation established health insurance for the aged and disabled. The signing of Medicare and Medicaid legislation (Title XVIII and Title XIX of the Social Security Act) in 1965 signaled the beginning of a healthcare system that would change the delivery of healthcare forever. Effective in 1966, Title XVIII, also known as Medicare, guarantees healthcare to individuals who are 65 or older and to those who have paid into the healthcare system. Title XIX, also known as Medicaid, provides a mechanism for eligible disabled individuals to receive medical care that is paid for by a combined state and federal program.

Both Title XVIII and Title XIX are entitlement programs, which means that individuals who meet eligibility criteria are entitled to receive the programs' healthcare benefits. Once the programs were in place, their costs quickly outstripped expectations. There were also concerns about how healthcare workers made care decisions. Concerns about reasonableness and medical necessity of care led to enactment of a provision that requires a utilization and quality control and peer review. This was the beginning of UR. The functions of UR, as described in the provision, require scrutiny of admissions and continued stay. Providers must ask whether admission and continued stay are reasonable and medically necessary.

During the early days of UR, not much was being done to move patients to another level of care when they no longer needed inpatient care and could receive care in a less restrictive, more economical setting. Physicians were responsible for determining the medical necessity of inpatient care and the

## Chapter 1

appropriateness of discharge. Staff members performing UR had neither the time nor the information to become involved in the process we now call *discharge planning*.

Before the advent of diagnosis-related groups (DRG), discharge planning occurred mostly in social service departments because most patient discharge needs were social rather than medical. For example, patients who underwent a total hip replacement usually stayed in the hospital until they could go directly home. If that was not possible, a social worker undertook the daunting task of selecting a nursing home or visiting nurse association for the patient. These were generally the only postacute care options available.

### The Arrival of IPPS, DRGs, and Discharge Planning

---

Prior to passage of the 1982 Tax Equity and Fiscal Responsibility Act, which included provisions for the inpatient prospective payment system (IPPS) and DRG method of payment for hospitals, discharge planning was performed as a value-added service rather than as a survival technique.

With the introduction of IPPS, hospitals began to receive a set payment regardless of the patient's length of stay (LOS). This served as a financial incentive for hospitals to provide discharge planning, which would help discharge patients as quickly as possible. Doing so would reduce the cost of care, particularly the overhead costs of hospital care, if patients could be treated in a different, less intensive setting. The LOS of Medicare-age patients dropped considerably.

Access statistics on hospital utilization at: [www.cdc.gov/nchs/fastats/hospital.htm](http://www.cdc.gov/nchs/fastats/hospital.htm).

As a shorter LOS required moving patients to the next level of care more efficiently, discharge planning became a critical service in hospitals. This planning helped ensure that patients' continuing-care needs were identified and that a plan was established to meet them. These needs were also shifting toward continuing the medical (clinical) plan of care in other settings. Consequently, nurses began to partner with social workers in the process of discharging patients.

### Effect of DRGs: Shortened LOS and Monitoring Admission

---

As hospitals worked to provide an efficient healthcare experience, the LOS for acute care began to drop. IPPS and DRGs affected hospital LOS and all levels of care, especially those in the postacute healthcare-delivery systems.

IPPS/DRGs also affected hospital admission policies. Reviewing diagnoses for appropriateness—even for patients admitted through an ED—became a strategy for preempting denial of admission. This meant that

## Discharge Planning From a Case Management Perspective

more patients were being discharged from EDs to home care, to the care of family members, or directly to SNFs instead of being admitted as inpatients.

As patient movement between levels of care became more rapid, the alternative care market blossomed, diversified, and became more competitive within its own ranks. Healthcare shifted from the three most available levels of care (acute, SNF, and home health) to multiple levels with varying degrees of intensity within them. This growth in postacute care services was stimulated by an increase in the number of patients with acute or near-acute care needs for which third-party payers (including Medicare) were willing to pay. Private health insurers began to notice that discharging elderly Medicare patients was effective. They began to embrace the idea of decreasing LOS and the use of alternative care for their relatively well and actively employed members.

### ***Shifting levels of care prompt hospital expansion into postacute care market***

When LOS dropped, however, hospital censuses also dropped, and hospitals began to lose their market share. Hospitals strived to stem this loss of income by diversifying; they entered the SNF rehabilitation and home-health businesses.

The pressure on frontline staff members to keep patients within the hospital system grew, and from a business perspective, this pressure was appropriate. However, there was great concern that hospitals would not give patients a choice about their care and that they would limit referrals to agencies in which they had a financial interest, rather than to other similar, qualified providers. This led to action by Medicare to guarantee free choice as outlined in the Medicare *CoPs* for discharge planning. Refer to Chapter 4 for more information about patients' freedom of choice.

## Social Security Act and Discharge Planning

---

Professional organizations of nurses and social workers carefully monitored the drop in LOS due to financial incentives. Public outcry over matters related to decreased LOS, such as “discharge quicker and sicker” and “premature discharge,” attracted legislators' attention. The result was greater oversight by the federal government and, in some cases, by states and professional groups concerned with quality patient care. Accrediting bodies also addressed the matter by establishing standards for continuity of care that included the concept of discharge planning.

The Social Security amendment requiring discharge planning was enacted in 1988. This relatively short piece of legislation overhauled the process. Fortunately, it was based on nursing and social work practices already in place, and these practices were incorporated into discharge planning standards.

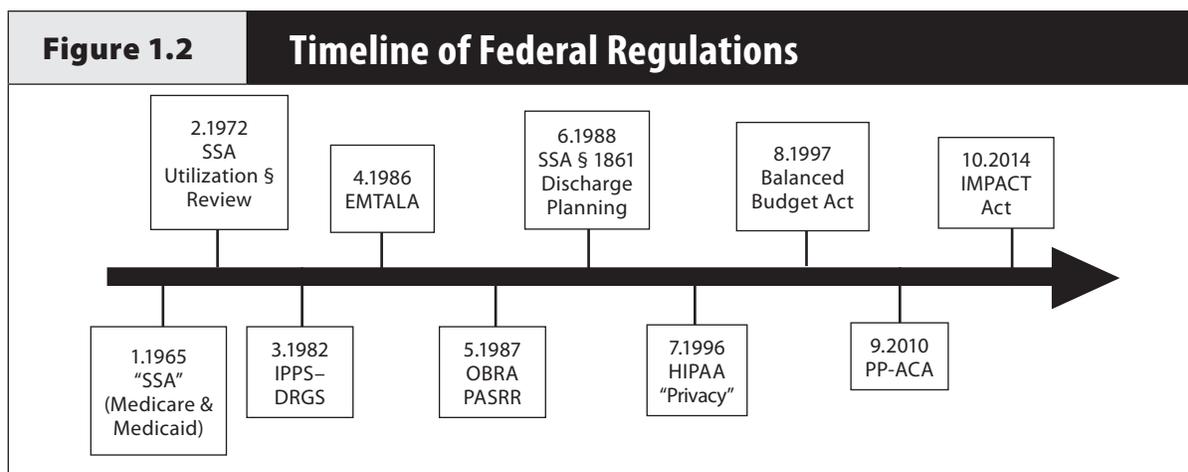
Discharge planning standards can be seen as the forerunners of case management standards. Note that the Social Security amendment for discharge planning applies only to patients who are admitted to Medicare- and Medicaid-participating hospitals; short-term psychiatric, rehabilitation, and long-term

## Chapter 1

care facilities; children's hospitals; and alcohol/drug treatment facilities. These specific rules for discharge planning did not apply to patients who present to an ED or outpatients who receive observation services, but other rules do. Refer to Chapter 6 for information about observation services and to Chapter 7 for information about ED discharges.

### Other Legislative Initiatives

Several other laws and regulations may actually be the ones that make discharge planning so complicated. The laws already listed here didn't affect every patient, meaning that discharge planners must be able to determine to which patient/patient population these rules apply, when they apply, and how to apply them. Figure 1.2 includes the timeline of each law or regulation that plays a part in discharge planning. Figure 1.3 spells out each acronym of federal regulations, which are discussed here and in later chapters.



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## Discharge Planning From a Case Management Perspective

<b>Figure 1.3</b>		<b>Industry Acronyms</b>
This table identifies the related acronym and its full definition. These acronyms will be used throughout the book.		
Year	Acronym	Name of Law or Rule
1965	SSA	Social Security Act – Title XVIII (Medicare) & Title XIX (Medicaid)
1972	UR	Utilization Review
1982	TEFRA IPPS DRG MS-DRG	Tax Equity and Fiscal Responsibility Act Inpatient Prospective Payment System Diagnosis-Related Groups Medicare-Severity Diagnosis-Related Group
1986	EMTALA	Emergency Medical Treatment and Active Labor Act
1987	OBRA'87 PASRR	Omnibus Budget Reconciliation Act Preadmission Assessment and Resident Review
1988	DP	Discharge Planning
1996	HIPAA	Health Insurance Portability and Accountability Act
1997	BBA	Balanced Budget Act
1997	CHIP	State Children's Health Insurance Program SSA Title XXI (21)
2010	PP-ACA	Patient Protection and Affordable Care Act
2010	VBP	Value-Based Purchasing
2014	IMPACT	Improving Post-Acute Care Transformation Act

*Source: Jackie Birmingham, RN, BSN, MS, CMAC. Reprinted with permission.*

## Revenue Cycle Management and Discharge Planning

Today, LOS is not the only statistic that is followed. One-day (short stays), observation services, readmission, and a host of other payment regulations affect the revenue cycle from a discharge planning perspective. Changes in the DRG system to the Medicare-severity diagnosis-related group (MS-DRG) system, especially the DRGs that are called short stay or transfer DRGs, directly affect what discharge planners must know to support the revenue cycle.

CMS uses the billing program called Uniform Billing 04 (UB-04). It requires hospital coders to know what happened to patients after discharge, and in detail. The ability to submit a clean claim and receive

## Chapter 1

payment—the revenue cycle—is dependent on what the physician writes for determining codes on the claim and on what the clinician writes about the patient’s discharge plan for the next level of care.

External auditors are bringing the message home. The *Medicare Integrity Program Manual* includes initiatives that directly affect how and why hospitals perform proactive discharge planning.

Access Chapter 4 “Benefit Integrity” of the *Medicare Program Integrity Manual* at:  
[www.cms.hhs.gov/manuals/downloads/pim83c04.pdf](http://www.cms.hhs.gov/manuals/downloads/pim83c04.pdf).

### Split of QIOs Into BFCCs and QIO-QINs

In order to better define the work of external auditors and to split the audit function from the quality improvement function, CMS endorsed entities called Beneficiary and Family Centered-Quality Improvement Organizations (BFCC-QIO) to improve healthcare services and protect beneficiaries through expeditious statutory review functions, including complaints and quality of care reviews for people with Medicare. The BFCC-QIOs ensure consistency in the case review process while taking into consideration local factors and local needs for general quality of care, medical necessity, and readmissions.

Quality Innovation Network (QIN)-QIOs improve healthcare services using the following practices:

- Education
- Outreach
- Sharing practices that have worked in other areas
- Using data to measure improvement
- Working with patients and families
- Convening community partners for communication and collaboration

QIN-QIOs also work to improve the quality of healthcare for targeted health conditions and priority populations and to reduce the incidence of hospital-acquired conditions (HAC) to meet national and local priorities.

Access “Quality Improvement Organization” at:  
[www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/index.html?redirect=/qualityimprovementorgs](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/index.html?redirect=/qualityimprovementorgs).

Auditors affect the revenue cycle after hospitals receive payment. Recouping money already received, and most likely spent, is forcing hospitals to view the revenue cycle from a patient flow perspective. Discharge planning is a process that requires widespread support. When hospital level of care is no longer required for a patient, discharge action involving other clinicians, the patient’s attending

## Discharge Planning From a Case Management Perspective

physician, and a physician at the next level of care, as well as bed availability (if one is needed) are necessary. This may sound simple, but discharge plans must withstand the scrutiny of surveyors and auditors; they also must prevent avoidable readmissions.

Access Chapter 1 (“Medicare Improper Payments: Measuring, Correcting, and Preventing Overpayments and Underpayments”) of the *Medicare Program Integrity Manual* at: [www.cms.hhs.gov/manuals/downloads/pim83c01.pdf](http://www.cms.hhs.gov/manuals/downloads/pim83c01.pdf).

Medicare Administrative Contractors (MAC), Comprehensive Error Rate Testing contractors (CERT), Recovery Auditors, program safeguard contractors, and Zone Program Integrity Contractors (ZPIC) are among the auditors that currently address how Medicare pays providers.

The intent of all auditing is to ensure that Medicare outlays are made to the appropriate provider on behalf of eligible beneficiaries for covered services. Figure 1.4 explains the relationship of audit criteria to discharge planning and the revenue cycle.

## Chapter 1

<b>Figure 1.4</b>	<b>Relationship of Audit Criteria to Discharge Planning</b>
<b>Audit Criteria</b>	<b>How Discharge Planning Supports the Revenue Cycle</b>
<p>The appropriate provider</p>	<p>When a patient no longer requires hospital level of care, the patient must be discharged to the next appropriate provider.</p> <p>Selecting the next appropriate provider—home health, long-term care hospital, skilled nursing facility (SNF), or hospice—is done by discharge planners along with the patient’s physician.</p> <p><b>Example:</b> Documenting the evidence that there is no appropriate provider at a specific time will strengthen the appeal process. If no bed is available at an appropriate level of care, the patient can’t be discharged.</p>
<p>On behalf of eligible beneficiaries</p>	<p>Understanding coverage for patients along the continuum is critical for the revenue cycle.</p> <p><b>Example:</b> If a patient does not meet the qualifying three acute care days for SNF Part A coverage, the patient is not eligible for that coverage. Not knowing this and falsely communicating that the patient did meet the requirement for eligibility to have a SNF accept the patient can affect the patient’s plan of care along the continuum.</p>
<p>For covered services</p>	<p>Working with utilization review to determine whether an inpatient admission—or more important to discharge planners, continued stay—would be a covered service will ensure that the patient stayed only as long as necessary.</p> <p><b>Example:</b> A patient is admitted because there is no other option. This is commonly called a social admission. The hospital stay would not be covered. Thus, the discharge planner needs to move quickly to find the appropriate level of care for the patient.</p> <p>The discharge planner should also develop a tracking method to find trends in this problem, identify where gaps in service exist for those patients, and implement a workable plan to avoid the problem.</p>

*Source: Jackie Birmingham, RN, BSN, MS, CMAC. Reprinted with permission.*

### Medicare Integrity Program Auditors

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Discharge planners need to be aware of Recovery Auditors and other audit contractors as well.

Access “Medicare Integrity Program: Agency Approach for Allocating Funds Should Be Revised,” a Government Accountability Office Report to the Chairman, Committee on Finance, U.S. Senate, at: [www.gao.gov/new.items/d06813.pdf](http://www.gao.gov/new.items/d06813.pdf).

Current examples of auditors that most closely involve discharge planning are:

- The Recovery Auditor program, designed to identify improper Medicare payments and fight fraud, waste, and abuse in the Medicare program.
- The Medicare Secondary Payer Recovery Auditor program, designed to ensure that Medicare has been appropriately billed when it is not the primary payer.
- The ZPIC program, designed to conduct medical reviews, including for physicians, SNFs, durable medical equipment suppliers, and physical therapy services. This type of auditor also looks for potential Medicare fraud.

Access *Medicare Program Integrity Manual*, Chapter 2, “Data Analysis,” at: [www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c02.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c02.pdf).

This chapter and Chapters 2–9 address the effect of discharge planning on the revenue cycle and the health of organizations. Most work done by clinicians in discharge planning involves moving patients to the next level of care at the appropriate time. This is possible only with an informed team of clinicians who understand assessment of patient needs, patient choice, timely implementation of discharge plans, and the need to document each and every specific element of a plan.

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# DISCHARGE PLANNING GUIDE:

*Tools for Compliance, Fourth Edition*

Jackie Birmingham, RN, BSN, MS, CMAC

Discharge planning has long been a challenge for organizations, but proposed revisions to Medicare's *Conditions of Participation (CoPs)* will increase the burden on healthcare facilities, especially in case management departments, by expanding the number and type of discharge plans that must be created. ***Discharge Planning Guide: Tools for Compliance, Fourth Edition***, is a comprehensive resource on the changes to the CoPs, which are set to revamp discharge planning not just for hospitals, but for postacute providers as well.

This book provides guidance on developing a discharge planning workflow during a time when hospitals must create discharge plans for a larger percentage of patients than ever. Essential functions of discharge planning, including patient choice, health literacy, communicating with caregivers, and delivery of notices, are presented in a clear and concise format. The book also covers the connection between discharge planning and the revenue cycle, including payment rules, billing and coding implications, and the appropriate use of several claims forms and condition codes.

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