



Review of Hospital Compliance with Medicare's Transfer Policy with the Resumption of Home Health Services & Other Information on Patient Discharge Status Codes

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PROVIDER TYPES AFFECTED

This MLN Matters Special Edition (SE) Article is for hospitals that submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare patients.

WHAT YOU NEED TO KNOW

The Office of Inspector General (OIG) has conducted several reviews identifying Medicare overpayments to hospitals that didn't comply with Medicare's post-acute care transfer policy. The OIG found that some hospitals transferred inpatients to certain post-acute care settings but coded the patient discharge status as a discharge to home. To assure proper payment under the Medicare Severity-Diagnosis Related Group (MS-DRG) payment system, hospitals must be sure to code the discharge/transfer status of patients accurately to reflect the patient's level of post-discharge care.

The OIG review, August 2020 [Report No. A-04-18-04067](#), identifies Medicare overpayments to hospitals that didn't comply with Medicare's post-acute-care transfer policy (transfer policy). In these instances, to ensure proper coding of the patient discharge status, hospitals should use condition codes 42 and 43. This article addresses these OIG reviews and provides guidance on the proper coding of patient status codes and the use of condition codes 42 and 43.

BACKGROUND

You're responsible for coding the discharge bill based on the discharge plan for the patient, and if you later learn that the patient received post-acute care, the hospital should submit an adjustment bill to correct the discharge status code following Medicare's claim adjustment criteria located in the Medicare Claims Processing Manual, [Chapter 1](#), Section 130.1.1 and [Chapter 34](#).

Patient discharge status codes are part of the Official UB-04 Data Specifications Manual and are used nationwide by institutional, private, and public providers, and payers of health care claims. The National Uniform Billing Committee (NUBC) develop and maintain the data elements and codes. To assist in the proper coding of patient discharge status code, you may access data elements, codes, and FAQs by referring to the UB-04 Data Specifications Manual at <https://www.nubc.org/subscription-information>. (Note: your organization may need to subscribe.)

Definitions and Transfer Policy

Discharge Definition

For the purpose of discussing transfers the following terms describe when a patient leaves the hospital. The definitions of discharges and transfers under the inpatient prospective payment system (IPPS) are in [42 CFR 412.4\(a\) and \(b\)](#).

A **discharge** occurs when a Medicare patient:

1. Leaves a Medicare IPPS acute care hospital after receiving complete acute care treatment or
2. Dies in the hospital

An **acute care transfer** occurs when a Medicare patient in an IPPS hospital (with any MS-DRG) is:

1. Transferred to another acute care IPPS hospital or unit for related care (Patient Discharge Status Code 02 or Planned Acute Care Hospital Inpatient Readmission Patient Status Code 82)
2. Admitted to another PPS on the same day after leaving their designated IPPS hospital against medical advice (Patient Discharge Status Code 07)
3. Transferred to a hospital that would ordinarily be paid under the IPPS, but is excluded because of participation in a state or area wide cost control program (Patient Discharge Status Code 02 or Planned Acute Care Hospital Inpatient Readmission Patient Status Code 82)
4. Transferred to a hospital or hospital unit that hasn't been officially determined as being excluded from IPPS such as:
 - a. An acute care hospital that would otherwise be eligible to be paid under the IPPS, but doesn't have an agreement to participate in the Medicare Program (Patient Discharge Status Code 02 or Planned Acute Care Hospital Inpatient Readmission Patient Status Code 82)
 - b. A Critical Access Hospital (Patient Discharge Status Code 66 or Planned Acute Care Hospital Inpatient Readmission Patient Status Code 94)
5. Discharged but then readmitted the same day to another IPPS hospital (unless the readmission is unrelated to the initial discharge). This may occur when a hospital discharges the patient to home (Patient Discharge Status Code 01), the patient goes to a doctor's appointment the same day and is then admitted to another hospital. If the first hospital was unaware of the planned admission at the second hospital, it's likely the first hospital will have to adjust the previously submitted claim to correct the patient discharge status code to indicate a transfer (02), which reflects where the patient was later admitted **on the same date**.

The transferring hospital is paid a per diem payment (when the patient transfers to an IPPS hospital) up to and including the full DRG payment. Medicare may pay the transferring hospital

a cost outlier payment. You'll find more detailed information regarding payment in the [Medicare Claims Processing Manual, Chapter 3, Section 20](#). Medicare pays the receiving hospital based on the full prospective payment rate which may include a cost outlier payment if applicable or based on the rate of its respective payment system (if not IPPS).

For unrelated admissions, a transfer case may result in treatment in the second hospital under a different MS-DRG than the transferring hospital. In this case, payment to each hospital is based on the MS-DRG under which the patient was treated.

For transfers from an IPPS hospital to a hospital or unit excluded from IPPS with a DRG that isn't subject to the post-acute care transfer policy, Medicare pays the transferring hospital the full IPPS rate including an outlier payment if applicable. The outlier threshold and payment calculations are the same as any other discharge without a transfer. The payment to the final discharging hospital or unit is made at the rate of its respective payment system.

Post-acute Care Transfers

A **post-acute care transfer** occurs when a IPPS hospital stay is grouped to one of the MS-DRGs identified in the Post-Acute DRG column in Table 5 of the applicable [Fiscal Year IPPS Final Rule](#) and the patient is transferred/discharged to either:

1. A hospital or distinct part hospital unit excluded from IPPS:
 - Inpatient rehabilitation facilities and units (Patient Discharge Status Code 62 or Planned Acute Care Hospital Inpatient Readmission Patient Status Code 90)
 - Long-term care hospitals (Patient Status Code 63 or Planned Acute Care Hospital Inpatient Readmission Patient Status Code 91)
 - Psychiatric hospitals and units (Patient Discharge Status Code 65 or Planned Acute Care Hospital Inpatient Readmission Patient Status Code 93)
 - Cancer hospitals (Patient Discharge Status Code 05 or Planned Acute Care Hospital Inpatient Readmission Patient Status Code 85)
 - Children's hospitals (Patient Discharge Status Code 05 or Planned Acute Care Hospital Inpatient Readmission Patient Status Code 85)
2. A skilled nursing facility (Patient Discharge Status Code 03 or Planned Acute Care Hospital Inpatient Readmission Patient Status Code 83) or
3. Hospice care at home (Patient Status Code 50) or Hospice Medical Facility (Certified) Providing Hospice Level of Care (Patient Status Code 51)
4. Home under a written plan of care for the provision of home health (HH) services from a HH agency and those services occur within 3 days after the date of discharge (Patient Discharge Status Code 06 or Planned Acute Care Hospital Inpatient Readmission Patient Status Code 86).

The transferring hospital is paid based on a per diem rate up to and including the full DRG

payment which may include a cost outlier payment if applicable. The final discharging hospital is paid based on the full prospective payment rate which may include a cost outlier payment if applicable.

Transfers to a Home with Home Health Services

The OIG audit stated that a transfer to home with the provision of HH services is paid using a graduated per diem rate when the patient's stay is assigned to a MS-DRG subject to the post-acute care transfer policy and the discharge is to home under a written plan of care for HH services provided within 3 days of discharge and the services are related to the hospital admission based on [Section 1886\(d\)\(5\)\(J\)](#) of the Social Security Act and [42 CFR 412.4\(c\)](#). As the OIG states, by applying an incorrect patient discharge status code, hospitals receive the full MS-DRG payment, instead of the graduated payment rate.

Medicare's IPPS post-acute care transfer policy requires hospitals to apply the correct discharge status code to claims where patients receive HH services within 3 days of discharge. This includes the resumption of HH services in place prior to the inpatient stay.

Medicare makes full MS-DRG payments to IPPS hospitals when the patient is discharged to their home (Patient Discharge Status Code 01) or certain types of health care institutions (such as Patient Discharge Status Code 04 to an Intermediate Care Facility).

When a hospital transfers a Medicare patient to a setting subject to the post-acute-care transfer policy, its claim should reflect the patient discharge status code for the type of post-acute care setting.

In addition to the correct discharge status code, the IPPS hospital may add one of the following condition codes to the claim, as appropriate, to receive the full MS-DRG payment:

- Condition Code **42** - used if a patient is discharged to home with HH services, but the continuing care isn't related to the condition or diagnosis for which the individual received inpatient hospital services. The hospital would be expected to include documentation supporting this selection in the patient's medical record.
- Condition Code **43** – used if the continuing care is related, but no HH services are furnished within 3 days of hospital discharge.

Medicare's claims processing system reviews all line item dates of service on HH claims to determine if the post-acute care transfer payment policy should apply when any HH service dates are within 3 days after the IPPS discharge date.

If an acute-care hospital submits a bill based on its belief that it's discharging a patient to home or another setting not included in the post-acute-care transfer policy but subsequently learns that post-acute care was provided, the hospital should submit an adjusted bill.

ADDITIONAL INFORMATION

If you have questions, your MACs may have more information. Find their website at <http://go.cms.gov/MAC-website-list>.

The OIG report detailing the errors some hospitals are making on this coding issue is available at <https://oig.hhs.gov/oas/reports/region4/41804067.pdf>.

DOCUMENT HISTORY

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February 22, 2021	Initial article released.

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