

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services



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### **Clarification of Patient Discharge Status Codes and Hospital Transfer Policies**

Note: This article was reissued on November 17, 2015 to clarify language on pages 2 and 3. All other information remains the same.

### **Provider Types Affected**

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

### **What You Need to Know**

The Office of Inspector General (OIG) conducted several reviews identifying Medicare overpayments to hospitals that did not comply with the post-acute care transfer policy. 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 level of post-discharge care to be received by the patient.

### **Background**

Hospitals are responsible for coding the discharge bill based on the discharge plan for the patient, and if the hospital subsequently learns that post-acute care was provided, 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," (<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs>)

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[Items/CMS018912.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending](#)) **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 data elements and codes are developed and maintained by the National Uniform Billing Committee (NUBC). To assist in the proper coding of patient discharge status code, providers may access data elements, codes, and frequently asked questions by referring to the UB-04 Data Specifications Manual. Information on obtaining a manual is located at <http://www.nubc.org> on the Internet.

For the purpose of discussing transfers the following terms describe when a patient leaves the hospital. Discharges and transfers under the inpatient hospital prospective payment system (IPPS) are defined in **42 CFR 412.4(a) and (b)**.

A “**discharge**” occurs when a Medicare beneficiary:

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

Medicare makes full MS-DRG payments to Inpatient Prospective Payment system (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).

An “acute care **transfer**” occurs when a Medicare beneficiary 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 82 when an Acute Care Hospital Inpatient Readmission is planned); or
2. Leaves against medical advice - Patient Discharge Status Code 07 but is admitted to another PPS hospital on the same day; or
3. Transferred to a hospital that would ordinarily be paid under prospective payment, but is excluded because of participation in a state or area wide cost control program - Patient Discharge Status Code 02 (or 82 when an Acute Care Hospital Inpatient Readmission is planned); or
4. Transferred to a hospital or hospital unit that has not been officially determined as being excluded from PPS such as:
  - a. An acute care hospital that would otherwise be eligible to be paid under the IPPS, but does not have an agreement to participate in the Medicare program (Patient Discharge Status Code 02 or 82 when an Acute Care Hospital Inpatient Readmission is planned);
  - b. A Critical Access Hospital (Patient Discharge Status Code 66 or 94 when an Acute Care Hospital Inpatient Readmission is planned).

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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 (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 is 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. The transferring hospital may be paid a cost outlier payment. For more detailed information regarding payment, please refer to the [“Medicare Claims Processing Manual,” Chapter 3, Section 20](#). The receiving hospital is paid 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, where a transfer case results in treatment in the second hospital under a MS-DRG different than the MS-DRG in the transferring hospital, payment to each hospital is based upon 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 is not subject to the post acute care transfer policy, the transferring hospital is paid the full IPPS rate including an outlier payment if applicable. The outlier threshold and payment are calculated 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.

A **“post-acute care transfer”** occurs when a Medicare beneficiary in an IPPS hospital stay is grouped to one of the MS-DRGs listed in Table 5 of the applicable Fiscal Year IPPS Final Rule Home Page (<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>) and the transfer occurs to:

1. A hospital or distinct part hospital unit excluded from IPPS:
  - Inpatient rehabilitation facilities and units - Patient Discharge Status Code 62 (or 90 when an Acute Care Hospital Inpatient Readmission is planned.),
  - Long term care hospitals - Patient Discharge Status Code 63 (or 91 when an Acute Care Hospital Inpatient Readmission is planned ),
  - Psychiatric hospitals and units - Patient Discharge Status Code 65 (or 93 when an Acute Care Hospital Inpatient Readmission is planned ),
  - Cancer hospitals - Patient Discharge Status Code 05 (or 85 when an Acute Care Hospital Inpatient Readmission is planned), and
  - Children's hospitals - Patient Discharge Status Code 05 (or 85 when an Acute Care Hospital Inpatient Readmission is planned ); or
2. A skilled nursing facility - Patient Discharge Status Code 03 (or 83 when an Acute Care Hospital Inpatient Readmission is planned ); or

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3. Home under a written plan of care for the provision of home health services from a home health agency and those services occur within 3 days after the date of discharge - Patient Discharge Status Code 06 (or 86 when an Acute Care Hospital Inpatient Readmission is planned).

**Note:** Condition Code 42 may be used to indicate that the care provided by the Home Care Agency is *not* related to the Hospital Care and therefore, will result in payment based on the MS-DRG and not a per diem payment. Condition Code 43 may be used to indicate that Home Care was started more than three days after discharge from the Hospital and therefore payment will be based on the MS-DRG and not a per diem payment.

The transferring hospital is paid based upon 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.

A ‘**special payment post-acute care transfer**’ occurs when a Medicare beneficiary in an IPPS hospital stay is grouped to one of the MS-DRGs in the column titled, “Special Pay DRG” in Table 5 of the applicable Fiscal Year IPPS Final Rule Home Page on the CMS website (<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>). For these cases, the transferring hospital is paid 50 percent of the appropriate inpatient prospective payment rate and 50 percent of the appropriate transfer payment.

## Additional Information

If you have any questions, please contact your MAC at their toll-free number, which is available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

## Document History

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