



Review of Hospital Compliance with Medicare's Transfer Policy with the Resumption of Home Health Services and the Use of Condition Codes (A-04-18-04067)

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We revised this Article to provide a link to a related Article, [SE21001](#), which contains additional information on discharges and definitions. All other information is unchanged

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 beneficiaries.

What You Need to Know

The current Office of Inspector General (OIG) audit, August 2020 Report No. A-04-18-04067, <https://oig.hhs.gov/oas/reports/region4/41804067.pdf> identifies Medicare overpayments to hospitals that did not comply with Medicare's post-acute-care transfer policy (transfer policy). This article reminds hospitals of proper coding of the patient discharge status code and the use of condition codes 42 and 43.

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, [Chapter 1](#), Section 130.1.1 and [Chapter 34](#).

The OIG report stated that a transfer to home with the provision of home health services is paid using a graduated per diem rate when the beneficiary'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 home health 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 Inpatient Prospective Payment System (IPPS) post-acute care transfer policy requires hospitals to apply the correct discharge status code to claims where patients receive Home Health (HH) services within 3 days of discharge. This includes the resumption of HH services in place prior to the inpatient stay.

When a hospital transfers a Medicare beneficiary 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 is not related to the condition or diagnosis for which the individual received inpatient hospital services.
- 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 is 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>.

MLN Matters Special Edition Article SE1411, Clarification of Patient Discharge Status Codes and Hospital Transfer Policies, at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1411.pdf> has more information on post-acute transfer policies and discharge policies.

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

Date of Change	Description
January 14, 2022	We revised this Article to provide a link to a related Article, SE21001 , which contains additional information on discharges and definitions. All other information is unchanged.
December 1, 2020	Initial article released.

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