

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11189	Date: January 12, 2022
	Change Request 12360

Transmittal 10952, dated August 19, 2021, is being rescinded and replaced by Transmittal 11189, dated, January 12, 2022 to correct the patient discharge status in publication 100-04, chapter 3 section 40.2.4 (A) to Patient Discharge Status Code 82 when a readmission is planned. All other information remains the same.

SUBJECT: Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04, Chapter 3, Section 40.2.4 Inpatient Prospective Payment System (IPPS) Transfers Between Hospitals

I. SUMMARY OF CHANGES: This Change Request (CR) updates Chapter 3 Inpatient Hospital Billing, Section 40.2.4 IPPS Transfers Between Hospitals of the Medicare Claims Processing Manual Pub. 100-04.

EFFECTIVE DATE: September 20, 2021

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: September 20, 2021

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/40/40.2.4/IPPS Transfers Between Hospitals

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 11189	Date: January 12, 2022	Change Request: 12360
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SUBJECT: Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04, Chapter 3, Section 40.2.4 Inpatient Prospective Payment System (IPPS) Transfers Between Hospitals

EFFECTIVE DATE: September 20, 2021

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IMPLEMENTATION DATE: September 20, 2021

I. GENERAL INFORMATION

A. Background: This Change Request (CR) updates language regarding Acute Care and Post-Acute Care transfers and discharge Patient Status Codes in the Medicare Claims Processing Manual Pub. 100-04, Chapter 3, Section 40.2.4 to be consistent with the definitions of discharges and transfers under the Inpatient Prospective Payment System (IPPS) as defined in 42 CFR 412.4(a) and (b).

B. Policy: No policy changes.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	H		F	M	V	C	
			M	I	C	M	W			
			A	S	S	S	F			
12360.1	The Medicare contractors shall be aware of the manual updates in Pub 100-04, Chapter 3, Section 40.2.4.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME	CEDI
		A	B	H		
			M	A	C	
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
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Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Yvette Rivas, Yvette.Rivas@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

40.2.4 - IPPS Transfers Between Hospitals

(Rev. 11189, Issued: 01-12-22, Effective: 09-20-21, Implementation: 09-20-21)

A discharge of a hospital inpatient is considered to be a transfer if the patient is admitted the same day to another hospital. A transfer between acute inpatient hospitals occurs when a patient is admitted to a hospital and is subsequently transferred from the hospital where the patient was admitted to another hospital for additional treatment once the patient's condition has stabilized or a diagnosis established. The following procedures apply. See [§20.2.3](#) for proper Pricer coding to ensure that these requirements are met.

Note: CMS established Common Working File Edits (CWF) edits in January 2004 to ensure accurate coding and payment for discharges and/or transfers.

A. - Transfers Between IPPS Prospective Payment Acute Care Hospitals

For discharges occurring on or after October 1, 1983, when a hospital inpatient is discharged to another acute care hospital, as described in [42 CFR 412.4\(b\)](#), payment to the transferring hospital is based upon a graduated per diem rate (i.e., the prospective payment rate divided by the geometric mean length of stay for the specific MS-DRG into which the case falls; hospitals receive twice the per diem rate for the first day of the stay and the per diem rate for every following day up to the full MS-DRG amount). If the stay is less than 1 day, 1 day is paid. A day is counted if the patient was admitted with the expectation of staying overnight. However, this day does not count against the patient's Medicare days (utilization days), since this Medicare day is applied at the receiving hospital. Deductible or coinsurance, where applicable, is also charged against days at the receiving hospital (see [§40.1.D](#)). If the patient is treated in the emergency room without being admitted and then transferred, only Part B billing is appropriate. Payment is made to the final discharging hospital at the full prospective payment rate.

The prospective payment rate paid is the hospital's specific rate. Similarly, the wage index values and any other adjustments are those that are appropriate for each hospital. 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 is based upon the MS-DRG under which the patient was treated. For transfers on or after October 1, 1984, the transferring hospital may be paid an outlier payment. For further information on outlier payments for transfer cases, see section 20.1.2.4 of this manual.

An exception to the transfer policy applies to MS-DRG 789. The weighting factor for this MS-DRG assumes that the patient will be transferred, since a transfer is part of the definition. Therefore, a hospital that transfers a patient classified into this MS-DRG is paid the full amount of the prospective payment rate associated with the DRG rather than the per diem rate, plus any outlier payment, if applicable.

Effective for discharges on or after October 1, 2003, patients who leave against medical advice (LAMA), but are admitted to another inpatient PPS hospital on the same day as they left, will be treated as transfers and the transfer payment policy will apply.

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

- 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 Discharge Status Code 82).
- Admitted to another IPPS on the same day after leaving their designated IPPS hospital against medical advice (Patient Discharge Status Code 07).
- Discharged but then readmitted on the same day to another IPPS hospital (unless the readmission is unrelated to the initial discharge).

B. - Transfers from an IPPS Acute Care Hospital to Hospitals or Hospital Units Excluded from the IPPS

When patients are transferred to hospitals or units excluded from IPPS, the full inpatient prospective payment is made to the transferring hospital. The receiving hospital is paid on the basis of reasonable costs or is made at the rate of its respective payment system (see exceptions in paragraph C of this section).

A transfer payment is made to the transferring hospital when patients are transferred to a hospital that would ordinarily be paid under prospective payment, but that is excluded because of participation in a state or area wide cost control program. Also, a transfer payment is made where a patient is transferred to a hospital or hospital unit that has not been officially determined as being excluded from PPS and certain hospitals that are excluded from IPPS. These include:

- 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 Planned Acute Care Hospital Inpatient Readmission Patient Discharge Status Code 82).
- A critical access hospital (Patient Discharge Status Code 66 or Planned Acute Care Hospital Readmission Patient Discharge Status Code 94).

C. - Postacute Care Transfers (Previously Special 10 DRG Rule)

For discharges occurring on or after October 1, 1998, a discharge of a hospital inpatient is considered to be a transfer for purposes of this part when the patient's discharge is assigned, as described in 42 CFR 412.4(c), to one of the qualifying Postacute MS-DRGs referenced in paragraph (D) of this section and the discharge is made under any of the following circumstances:

- To a hospital or distinct part hospital unit excluded from the inpatient prospective payment system (under subpart B of 42 CFR 412). Facilities excluded from IPPS are inpatient rehabilitation facilities and units (Patient Discharge Status Code 62 or Planned Acute Care Hospital Inpatient Readmission Patient Discharge Status Code 90), long term care hospitals (Patient Discharge Status Code 63 or Planned Acute Care Hospital Inpatient Readmission Patient Discharge Status Code 91), psychiatric hospitals and units (Patient Discharge Status Code 65 or Planned Acute Care Hospital Inpatient Readmission Patient Discharge Status Code 93), children's hospitals, and cancer hospitals (Patient Discharge Status Code 05 or Planned Acute Care Hospital Inpatient Readmission Patient Discharge Status Code 85).
- To a skilled nursing facility (Patient Discharge Status Code 03 or Planned Acute Care Hospital Inpatient Readmission Patient Discharge Status Code 83).
- To Hospice care at home (Patient Discharge Status Code 50) or Hospice Medical Facility (Certified) Providing Hospice Level of Care (Patient Discharge Status Code 51).
- To home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge (Patient Discharge Status Code 06 or Planned Acute Care Hospital Inpatient Readmission Patient Discharge Status Code 86).

Specific transfer cases under this paragraph qualify for payment under an alternative methodology. These include transfer cases in which the patient's discharge is assigned, as described in 42 CFR 412.4(f)(2), (f)(5) and (f)(6), to one of the qualifying Special Pay MS-DRGs referenced in paragraph (D) of this section. 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.

Medicare's IPPS Postacute care transfer policy requires hospitals to apply the correct Patient 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.

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

In addition to the correct Patient 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.

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 Postacute care transfer policy but subsequently learns that Postacute care was provided, the hospital should submit an adjusted bill.

D. - Qualifying MS-DRGs

Refer to Table 5 of the applicable Fiscal Year IPPS Federal Register for the list of qualifying Postacute MS-DRGs and Special Pay Postacute MS-DRGs.