CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 87 **Date: FEBRUARY 6, 2004**

CHANGE REQUEST 2934

I. SUMMARY OF CHANGES: This CR implements a new policy on acute hospital transfer for patients who leave against medical advice. We are also rewording some of the section titles to better describe transfer situations.

NEW/REVISED MATERIAL - EFFECTIVE DATE: July 1, 2004
***IMPLEMENTATION DATE: July 6, 2004**

Disclaimer: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. SCHEDULE OF CHANGES (R = REVISED, N = NEW, D = DELETED)

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

III. FUNDING: *Medicare contractors only:

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification

Business Requirements

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I. GENERAL INFORMATION

The APASS maintainer and associated FIs are waived from implementing this requirement on July 6, 2004, due to their upcoming transition to the FISS system. However, they must implement this requirement upon transitioning to the FISS system.

A. Background: A discharge of an acute hospital inpatient is considered to be a transfer for purposes of payment if the discharge is made from the acute hospital to the care of another inpatient prospective payment system (IPPS) hospital. This policy will also be in effect for patients who leave against medical advice, known as LAMAs. For patients who are admitted to another IPPS hospital on the same day they leave an IPPS hospital, the "transferring" hospital will be subject to the payment outlined by the transfer policy. Only IPPS hospitals are subject to this policy.

Please note that these systems changes are effective upon the implementation date of July 6, 2004, not the discharge date.

B. Policy: 42 CFR 412.4(b) and Federal Register/Vol. 68, No. 148/Friday, August 1, 2003, page 45404-45406

C. Provider Education: A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. FIs shall post this article to their website, and include it in a listserv message if applicable, within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin."

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
2934.1	CWF shall add patient status code 07 to edit 7111 and alert 7531.	CWF
2934.2	The fiscal intermediary (FI) shall change the patient status code on the CWF 7111 reject claim from 07 to 02. NOTE: FIs have permission to alter the claims for this situation.	FIs

2934.3	The FI shall debit the history claim and change the patient status code on the CWF alert 7531 claim from 07 to 02. NOTE: FIs have permission to alter the claims for this situation.	FIs

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
2934.1 – 2934.4	Applicable type of bill is 11X.

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. OTHER CHANGES: N/A

Citation	Change

SCHEDULE, CONTACTS, AND FUNDING

Effective Date: July 1, 2004 **Implementation Date: July 6, 2004** **Pre-Implementation Contact(s): Sarah Shirey** **Post-Implementation Contact(s): Regional Office**	**These instructions should be implemented within your current operating budget.**

40.2.4 – IPPS Transfers Between Hospitals

(Rev. 87, 02-06-04)

A3-3610.5, HO-415.8

A transfer between *acute inpatient* hospitals occurs when a patient is admitted to a hospital and is subsequently transferred to another 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 Hospitals

Payment is made to the final discharging hospital at the full prospective payment rate. Payment to the transferring hospital is based upon a per diem rate (i.e., the prospective payment rate divided by the average length of stay for the specific DRG into which the case falls and multiplied by the patient's length of stay at the transferring hospital). If less than l day, l day is paid. A day is counted if the patient was admitted with the expectation of staying overnight. A per diem payment is appropriate. 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.

The prospective payment rate paid is the hospital's specific rate. Similarly, the wage indexes 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 DRG different than the DRG in the transferring hospital, payment to each is based upon the DRG under which the patient was treated. Day outlier payments are payable based upon the admission and discharge dates. For transfers on or after, October 1, 1984, the transferring hospital may be paid a cost outlier payment but may not be paid a day outlier payment (Day outliers were discontinued at the end of FY 1997).

An exception to this policy applies to DRGs 385 and 456. The weighting factors for these assume that the patient will be transferred, since a transfer is part of the definition. Therefore, a hospital that transfers a patient classified into one of these DRGs 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.

B - Transfers *from an IPPS Hospital* to Hospitals or Units Excluded from *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 prospective payment (IRF or LTCH). (See exceptions in paragraph C of this section).*

A per diem payment is made to the transferring hospital when patients are transferred to a Maryland hospital or to a New York Finger Lakes hospital that would ordinarily be paid under prospective payment, but is excluded because of participation in a state or area wide cost control program. Also, a per diem 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.

C – IPPS Transfers – 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 diagnosis-related groups (DRGs) listed 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 CRF 412). *Some facilities excluded from IPPS are inpatient rehabilitation facilities and units, long term care hospitals, psychiatric hospitals and units, children's hospitals, and cancer hospitals.*
- To a skilled nursing facility.
- 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.

D - Qualifying DRGs

The *original* qualifying DRGs for purposes of paragraph (c) of this section are DRGs 14, 113, 209, 210, 211, 236, 263, 264, 429, and 483.

Effective October 1, 2003, DRGs 263 and 264 are deleted from the postacute care transfer policy.

Effective for discharges on or after October 1, 2003, the following DRGs were added to the policy: 12, 24, 25, 88, 89, 90, 121, 122, 127, 130, 131, 239, 277, 278, 294, 296, 297, 320, 321, 395, and 468.