Program Memorandum Intermediaries

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal A-01-39 **Date: MARCH 22, 2001**

CHANGE REQUEST 1565

SUBJECT: Postacute Care Transfer Policy

The Office of the Inspector General (OIG) recently examined the payment systems at two separate fiscal intermediaries (FIs) with regard to the implementation of Medicare's Post Acute Care Transfer Policy. OIG's review of these two FIs indicated that sampled claims were erroneously coded by some hospitals as discharges instead of transfers and, as a result, overpayments were made. As a result of these OIG reports, this Program Memorandum (PM) is requiring that you publish instructions in your next regularly scheduled provider bulletin, to hospitals and postacute care facilities, with respect to their responsibility for ensuring correct and appropriate discharge status coding on claims, according to the 10 Diagnosis Related Group (DRG) postacute care transfer provision in §1886(d)(5)(I) of the Social Security Act (Act).

Instructions for Discharge Status Coding According to The 10 Postacute Care Transfer Provision

Under §1886(d)(5)(I) of the Act, a discharge is a situation in which a beneficiary leaves a PPS acute care hospital after receiving complete acute care treatment. A transfer is a situation in which the beneficiary is transferred to another acute care PPS hospital for related care. Section 4407 of the Balanced Budget Act of 1997 (BBA) added section 1886(d)(5)(J) to the Act. Under this provision, if a beneficiary has a qualified discharge from one of 10 DRGs to a postacute care provider, the discharge will be treated as a transfer case. Section 1886(d)(5)(J)(ii) of the Act, defines ***qualified discharge*** as a discharge from a PPS hospital of an individual whose hospital stay is classified in one of the 10 selected DRGs if, upon discharge, the individual is:

- admitted to a hospital or hospital unit that is not reimbursed under PPS;
- admitted to a SNF; or
- provided home health services if the services relate to the condition or diagnosis for which the individual received inpatient hospital services and if these services are provided within an appropriate period as defined by the Secretary. According to 42 CFR 412.4 (c) (3), the transfer policy is applicable if the individual was discharged to home under a written plan of care for the provision of home health services and the services begin within three days after the date of discharge.

According to 42 CFR 412.4 (d), the 10 DRGs selected by the Secretary pursuant to this authority, are as follows:

DRG	Title
014	Specific Cerebrovascular Disorders Except Transient Ischemic Attack
113	Amputation for Circulatory System Disorders Excluding Upper Limb and Toe
209	Major Joint Reattachment Procedures of Lower Extremity
210	Hip and Femur Procedures Except Major Joint Age>17 with Complications and Cormorbidities (CC)
211	Hip and Femur Procedures Except Major Joint Age > 17 Without CC
236	Fractures of Hip and Pelvis
263	Skin Graft and/or Debridement for Skin Ulcer or Cellulitis With CC
264	Skin Graft and/or Debridement for Skin Ulcer or Cellulitis Without CC
429	Organic Disturbances and Mental Retardation
483	Tracheostomy Except for Face, Mouth, and Neck Diagnoses

Hospitals should be coding discharge claims based on the discharge plan for a patient; i.e., a ***qualified discharge***. If hospitals subsequently learn that postacute care was provided to a patient for whom they submitted a claim with a discharge status code 01; i.e., discharge to home with no postacute treatment, then hospitals should submit adjustments to those claims. Discharge status code 01 is only appropriate for the 10 DRGs in instances where a patient is discharged from an inpatient facility, and (1) is not admitted on the same day to another inpatient facility or SNF, or (2) does not receive any home health services within a 3-day period from the date of discharge.

In addition, all postacute care facilities and hospitals, especially those that submit large volumes of claims for these services, should have clear communication between themselves and patient physicians regarding the use of subsequent home health services. Hospitals should be able to ensure that when physicians authorize postacute care in a patient's medical records, that the physician also indicates postacute care on the patient's discharge documents.

The *effective date* for this PM is March 22, 2001.

The *implementation date* for this PM: Notification to be included in your next regularly scheduled bulletin.

These instructions should be implemented within your current operating budget.

This PM may be discarded after February 28, 2002.

If you have any questions, contact Mary Loane at (410) 786-1405.