



Medicare Utilization Review Version

KEY CONCEPTS OUTLINE

Module 9: Overview of Inpatient Payment Systems and Patient Liability

I. Part A Payment for Hospital Inpatient Services

A. Overview of Inpatient Prospective Payment System (IPPS)

1. Applicability of the IPPS

The Inpatient Prospective Payment System (IPPS) applies to most acute care hospitals, except:

- Psychiatric hospitals: Inpatient Psychiatric Facility (IPF) PPS
- Rehabilitation hospitals: Inpatient Rehab Facility (IRF) PPS
- Long-term care hospitals: Long Term Care Hospital (LTCH) PPS
- Designated children's hospitals and cancer hospitals: reasonable cost
- Critical Access Hospitals (CAHs): reasonable cost
- Hospitals in US territories: TEFRA reasonable cost
- Maryland hospitals under the Health Services Cost Review Commission (HSCRC): Total Cost of Care demonstration

2. The IPPS pays hospitals a prospectively determined fixed payment amount for each discharge covered by Medicare, regardless of the costs incurred by the hospital to treat the patient.
 - a. The IPPS payment constitutes payment in full for all covered services provided directly or under arrangement by the admitting hospital and furnished in connection with the admission. <42 CFR § 412.2(b)>
 - b. Under IPPS, hospitals are "at risk" if the cost of a given inpatient case exceeds the Medicare payment amount for the case. Conversely, the hospital earns a "profit" when its costs are less than the Medicare payment. <42 CFR § 412.1(a)(1)>

B. Pre-admission Payment Window

1. Certain outpatient services provided prior to an inpatient admission are considered to be covered costs of the inpatient admission and are paid under the MS-DRG. <42 C.F.R. 412.2(c)(5); Medicare Claims Processing Manual, Chapter 3 § 40.3>
 - a. The diagnosis codes, procedures, and charges for outpatient services subject to the payment window should be combined on to the inpatient claim and may affect MS-DRG assignment. <63 Fed. Reg. 6866; Medicare Claims Processing Manual, Chapter 3 § 40.3 C>

Tip: The pre-admission payment window does not apply if the inpatient stay is not covered under Part A (e.g., because of exhaustion of benefits or lack of medical necessity). Outpatient services prior to a non-covered inpatient stay should be billed separately on an outpatient claim for Part B payment.

2. The three-day window applies to outpatient services furnished by the same IPPS hospital to which the patient was admitted as an inpatient; or furnished by an entity that is “wholly owned or operated by the hospital”, including freestanding clinics. <C.F.R. 412.2(c)(5)(i); 63 Fed. Reg. 6866; 76 Fed. Reg. 73281>

- Maryland hospitals under the HSCRC have a three-day pre-admission window
- Non-IPPS (IPF, IRF, LTCH) hospitals have a one-day pre-admission window
- CAHs do not have a pre-admission window

3. The pre-admission payment window applies to two specific timeframes before the patient’s admission.
 - a. All outpatient services provided on the calendar day of admission are included on the inpatient claim, regardless of whether they are clinically related to the admission. <42 C.F.R. 412.2(c)(5)(ii) and (iv); 42 C.F.R. 412.405 (a)(2) and (3)>

- b. All outpatient diagnostic services, and related non-diagnostic services provided in the three calendar days before the admission are included on the inpatient claim. <42 C.F.R. 412.2(c)(5)(ii) and (iv)>
 - i. Related is defined as being clinically associated with the reason for the patient's inpatient admission. <75 Fed. Reg. 50347>
- 4. Outpatient services excluded from the pre-admission payment window (i.e., paid separately):
 - a. Ambulance services <42 C.F.R. 412.2(c)(5)(iii)> ;
 - b. Maintenance renal dialysis services <42 C.F.R. 412.2(c)(5)(iii)> ;
 - c. Physician professional services <63 Fed. Reg. 6866>;
 - d. Part A services furnished by skilled nursing facilities, home health agencies and hospices<Medicare Claims Processing Manual, Chapter 3 § 40.3 B and C>; and
 - e. Visit services provided at a Rural Health Clinic (RHC) paid under their all-inclusive rate (AIR) or a Federally Qualified Health Center (FQHC) paid under the FQHC PPS rate that replaced the former AIR for FQHCs. <76 Fed. Reg. 73281; Medicare Benefit Policy Manual, Chapter 13 § 10.2>
 - i. Services provided at an RHC or FQHC paid under Part B rather than the AIR or FQHC PPS rate are subject to the payment window. <76 Fed. Reg. 73281-2>
 - f. Outpatient Services Not Covered or Payable under Part B
 - i. Services not covered or payable under Part B should not be bundled into a subsequent inpatient admission. <Medicare Claims Processing Manual, Chapter 3 §40.3 C>
 - ii. For example: non-covered self-administered drugs provided before the inpatient admission (i.e., the inpatient order). <Medicare Claims Processing Manual, Chapter 3 § 40.3>

II. Medicare Severity Diagnosis Related Groups (MS-DRGs)

- A. Payment under IPPS is made using “Medicare Severity Diagnosis Related Groups” (“MS-DRGs”).

1. The list of MS-DRGs is published as Table 5 to the annual IPPS final rule. Handout 12 is a sample page from Table 5.

Link: IPPS – FY2023 Final Rule Home Page under Medicare-Related Sites - Hospital

2. Every discharge is assigned only one MS-DRG in a process called “grouping”, discussed below. <42 CFR § 412.60(c)(2)>

B. MS-DRG Assignment or Grouping

1. Five Factors Driving MS-DRG Assignment

a. Principal diagnosis

- i. The “principal diagnosis” is “the diagnosis established after study to be chiefly responsible for causing the patient’s admission to the hospital.” <42 CFR § 412.60(c)(1)>

b. Complications and comorbidities

- i. Some discharges with the same principal diagnosis or procedure are subdivided into different MS-DRGs based on the presence of additional secondary diagnoses known as complications or comorbidities (“CCs”) or major CCs (“MCCs”). The CCs and MCCs are listed in Tables 6J and 6I, respectively, of the IPPS Final Rule each year.

A base MS-DRG may be sub-divided in one of three ways to recognize the patient’s severity of illness:

- The MS-DRG with MCC, with CC, or without CC or MCC
- The MS-DRG with, or without CC/MCC
- The MS-DRG with, or without MCC

ii. Hospital Acquired Conditions (HACs)

- a) The Deficit Reduction Act of 2005 required that specified conditions will not be considered CCs or MCCs when acquired at the hospital. <79 Fed. Reg. 49876-880>

- 1) The current list of DRA HAC categories is available on the CMS website. <80 Fed. Reg. 49351>

- c. Surgical procedures performed
 - i. MS-DRGs that involve surgical procedures are often referred to as “surgical MS-DRGs.”
 - d. Gender and discharge status
 - i. In some cases, MS-DRG assignment is affected by the patient’s gender (e.g., MS-DRG 707) and/or discharge status (e.g., MS-DRG 280-285).
 - e. Transplant, ECMO or Tracheostomy cases
 - i. Certain transplant, ECMO and Tracheostomy cases are assigned directly to one of the “Pre-MDC” MS-DRGs.
2. Handout 13 contains a Case Study/Group Exercise illustrating DRG Grouping.

III. Transfer Payment for Discharges

A discharge will be paid as a transfer if:

- The patient is admitted to another hospital on the day of discharge; OR
- The patient is discharged with a qualifying MS-DRG to a post-acute care setting

A. Patient admitted to another hospital on the day of discharge

1. A case will be treated as a transfer for payment purposes if a patient is admitted on the day of discharge to another acute IPPS hospital, critical access hospital, or a hospital eligible to be paid under IPPS but does not have a participation agreement with Medicare. <42 CFR § 412.4(b)>
 - a. Exception: The case will be treated as a discharge rather than a transfer if the readmission is unrelated to the discharge.
 - i. CMS has suggested that for the readmission to be considered unrelated “the hospital can present documentation showing that the patient’s care associated with the [first admission] was completed before discharge.” <68 Fed. Reg. 45405>

Example: A patient is discharged from one hospital and later that is in an auto accident and is admitted to another hospital.

- b. Patients who leave against medical advice and are admitted to another hospital on the same day are also treated as transfers. <Medicare Claim Processing Manual, Chapter 3 § 40.2.4(A)>

2. Patient readmitted on the day of discharge
 - a. If a patient is readmitted on the day of discharge for symptoms related to, the earlier stay's medical condition, the hospital must combine the original and subsequent stay onto a single claim. <Medicare Claim Processing Manual, Chapter 3 § 40.2.5>
 - b. If a patient is readmitted on the day of discharge for symptoms unrelated to the earlier stay's medical condition, the hospital should treat the readmission as a new admission and should report condition code "B4" on the claim for the second admission. <Medicare Claim Processing Manual, Chapter 3 § 40.2.5>

Case Study 1

Facts: A patient was discharged from one acute care IPPS hospital (Hospital #1) and admitted to a different acute care IPPS hospital (Hospital #2) later that day. Under what circumstances should Hospital #1's claim be treated as a discharge rather than a transfer? How will Hospital #2 be paid?

B. Post-Acute Care Transfer

A post-acute care transfer payment is triggered when:

- *The case is assigned to a designated post-acute care transfer MS-DRG; and*
- *The patient is discharge to a specific post-acute care setting.*

1. Post-Acute Care Transfer MS-DRGs
 - a. For FY 2023, there are 280 designated post-acute care transfer MS-DRGs. The list of post-acute care transfer MS-DRGs is published in Table 5 of the IPPS Final Rule.
2. The post-acute care settings, as indicated by the Patient Status code (see below) in Field 17 of the UB-04, which trigger the "post-acute care transfer" rule are:
 - a. A non-IPPS hospital or a distinct part non-IPPS unit on the day of discharge. <Medicare Claim Processing Manual, Chapter 3 § 40.2.4(C)>
 - i. Inpatient rehabilitation facilities and units (Patient Status 62)
 - ii. Long-term care hospitals (Patient Status 63)
 - iii. Psychiatric hospitals and units (Patient Status 65)

- iv. Children’s hospitals and cancer hospitals (Patient Status 05)
- b. A Medicare certified skilled nursing facility or SNF unit within a hospital, (Patient Status 03) on the day of discharge.
 - i. A discharge to a SNF is considered a transfer under this policy if the patient is directly admitted to the SNF from the hospital. <63 Fed. Reg. 40978>
 - ii. Swing Beds (Patient Status 61)
 - a) A swing-bed is not a SNF for purposes of the post-acute care transfer provisions. <63 Fed. Reg. 40977>
 - iii. Non-covered SNF Admissions
 - a) A discharge to a SNF bed is still considered to be a post-acute care transfer (assuming a qualifying DRG), regardless of whether or not the SNF admission was covered or paid by Medicare, as long as the patient qualified for skilled nursing care. <63 Fed. Reg. 40978, See MedLearn Matters Article MM4046>
 - b) The following discharges to a SNF are not considered post-acute care transfers:
 - 1) A patient discharged at a non-skilled level of care,
 - 2) A patient discharged to a non-Medicare certified bed, and
 - 3) A patient discharged to a non-skilled bed within a SNF. <See MedLearn Matters Article MM4046>
- c. Home health care, beginning within 3 days of the discharge, (Patient Status 06).
 - i. If the patient is admitted to home health for a condition unrelated to the hospital stay, condition code 42 (“Continuing care not relate (i.e. condition or diagnosis) to inpatient admission”) should be reported on the claim. <MLN Matters SE1411>
 - ii. If the patient is admitted to home health outside the post-discharge window, condition code 43 (“Continuing care not provided within the prescribed post-discharge window”) should be reported on the claim. <MLN Matters SE1411>

iii. If Patient Status code 06 is reported with condition code 42 or 43, full DRG payment is made, rather than post-acute care transfer payment. <MLN Matters SE1411>

d. Hospice care provided by a hospice program (Patient Status 50 – Discharged/Transferred to Hospice – Routine or Continuous Home Care; or Patient Status 51 – Discharged/Transferred to Hospice – General Inpatient Care or Inpatient Respite). <83 Fed. Reg. 41393-392>

C. Transfer Payment

1. Payment to the transferring hospital:

- a. A “per diem” rate is determined by dividing the full payment for the discharge DRG by the geometric mean length of stay (“GMLOS”) for the discharge DRG.
 - i. The GMLOS for each DRG is listed in Table 5 of the IPPS final rule.
- b. The first day of the admission is paid at twice the per diem rate in recognition of the extra expenses incurred on the day of admission.
- c. All subsequent days are paid at the per diem, up to the full DRG amount.

Case Study 2

Facts: A patient is discharged from a hospital to a skilled nursing facility for skilled care following a stay assigned to a designated post-acute care transfer MS-DRG. Full payment to the hospital for the MS-DRG would be \$10,000 and the GMLOS for the MS-DRG is 5 days. How much would the hospital be paid if the patient is discharged after four days in the hospital.

2. Special payment rules apply to 42 post-acute care transfer MS-DRGs identified on Table 5 of the IPPS Final Rule. <42 CFR § 412.4(f)(6)>
 - a. The “special payment rules” only apply to post-acute care transfers and do not apply to other transfers. <42 CFR § 412.4(f)(6)>
 - b. A “special pay” post-acute care transfer is paid:
 - i. 50% of the full DRG payment plus 50% of the calculated per diem for the first day.
 - ii. 50% of the calculated per diem for each subsequent day up to the full DRG payment.

3. The final discharging hospital (i.e., the hospital to which the patient is considered to have been transferred) is paid at the full payment rate based on the final discharge DRG. <Medicare Claims Processing Manual, Chapter 3 § 40.2.4>

Case Study 3

Modified Facts: A patient is discharged from a hospital to a skilled nursing facility for skilled care following a stay assigned to a designated special pay post-acute care transfer MS-DRG. Full payment to the hospital for the MS-DRG would be \$10,000 and the GMLOS for the MS-DRG is 5 days. How much would the hospital be paid if the patient is discharged after four days in the hospital.

IV. Inpatient Deductibles and Coinsurance

A. Benefit Periods

1. The inpatient deductible and coinsurance are based on a “benefit period” concept.
 - a. The benefit period begins to run when the patient is first admitted to a hospital or SNF for inpatient care. The benefit period ends when the patient has not been an inpatient of a hospital or SNF for 60 consecutive days. <42 CFR §§ 409.60(a), 409.60(b)>
 - i. SNF admissions and discharges affect the benefit period determination regardless of whether or not the beneficiary’s SNF care qualified for Medicare coverage. <Medicare General Information, Eligibility, and Entitlement Manual, Chapter 3 § 10.4.3.2 (Example 3)>

A benefit period can be as short as 61 days and there can be multiple benefit periods in a calendar year, resulting in payment of the deductible multiples times in a single calendar year.

B. Deductible and Coinsurance Amounts

1. The first 60 inpatient hospitalization days of a benefit period are considered full benefit days and the patient is only responsible for paying the inpatient deductible. <42 CFR § 409.61(a)(1)(i)>
 - a. For 2023, the inpatient deductible is \$1600 per benefit period. <87 Fed. Reg. 59096>

- b. The deductible is based on the calendar year in which the benefit period began. <Medicare General Information, Eligibility and Entitlement Manual, Chapter 3 § 10.3>
2. Inpatient hospitalization days 61 to 90 in a benefit period are considered coinsurance days and the patient pays a daily coinsurance. <42 CFR § 409.61(a)(1)(ii)>
 - a. For 2023, the daily coinsurance is \$400 (25% X \$1600) per day. <87 Fed. Reg. 59096>

Case Study 4

Facts: A Medicare beneficiary who had never before been hospitalized was admitted to and stayed in a hospital for 58 days (Admission #1). The patient was discharged from Admission #1 to a skilled nursing facility for 14 days. Thirty days after leaving the SNF, the patient was admitted (Admission #2) to a hospital for a four-day stay and then discharged to home. All services were provided during 2022.

What is the patient's hospital deductible and/or coinsurance liability for Admission #1? For Admission #2?

Modified Facts: The patient is admitted for a third time (Admission #3) 65 days after discharge from Admission #2. The length of stay for Admission #3 was 5 days. What is the beneficiary's total deductible and coinsurance liability for Admission #3?

3. Lifetime reserve days <42 CFR §409.61(a)(2)>
 - a. Medicare beneficiaries have 60 "lifetime reserve days" that may be used after the full benefit and coinsurance days for a particular benefit period have been used.

Full benefit and coinsurance days are renewed each benefit period, but once the 60 lifetime reserve days are used, they are exhausted forever.

 - b. For each lifetime reserve day, the patient is responsible for a daily coinsurance. <Medicare General Information, Eligibility, and Entitlement Manual, Chapter 3 §§ 10.2.1, 10.3>
 - i. For 2023, the lifetime reserve day coinsurance is \$800 (50% X \$1600) per day. <87 Fed. Reg. 59096>

- c. Use of Lifetime Reserve Days for Admissions with Exhaustion of Regular Benefits
 - i. If the beneficiary has at least one regular benefit day at the beginning of the stay and exhausts their benefits *during* the stay, the beneficiary will be deemed not to use their lifetime reserve days for the *non-outlier* portion of the stay. <Medicare Benefit Policy Manual, Chapter 5 § 30.1 (2)>
 - ii. If the admission reaches outlier status, the beneficiary may elect not to use their lifetime reserve days for the days after the outlier is reached. If the beneficiary elects not to use their lifetime reserve days, Medicare will not make an outlier payment to the hospital and the hospital may charge the beneficiary for the charges that would have been paid as outlier by Medicare. <Medicare Benefit Policy Manual, Chapter 5 § 30.4.2>
- d. Election Not to Use Lifetime Reserve Days
 - i. Hospitals are required to notify beneficiaries that they may elect not to use their lifetime reserve days for all or part of a stay. <Medicare Benefit Policy Manual, Chapter 5 § 30.1, MLN Matters Article SE0663>
 - a) Ideally, the notice should be given when the beneficiary has five regular coinsurance days left and is expected to be hospitalized beyond that period. <Medicare Benefit Policy Manual, Chapter 5 § 30.1, MLN Matters Article SE0663>
 - b) CMS provides model language for use by beneficiaries in making an election not to use lifetime reserve days. <Medicare Benefit Policy Manual, Chapter 5 § 40.1, MLN Matters Article SE0663>
 - c) A retroactive election not to use lifetime reserve days may be made if certain criteria are met. <Medicare Benefit Policy Manual, Chapter 5 § 30.3, MLN Matters Article SE0663>
 - ii. If the beneficiary elects not to use lifetime reserve days, then the hospital may bill the patient for any services provided after the beneficiary's full benefit days and coinsurance days are exhausted. <42 CFR §409.65(a)(4)>

CASE STUDIES

Case Study 1

Facts: A patient was discharged from one acute care IPPS hospital (Hospital #1) and admitted to a different acute care IPPS hospital (Hospital #2) later that day. Under what circumstances should Hospital #1's claim be treated as a discharge rather than a transfer? How will Hospital #2 be paid?

Analysis: The claim should be treated as a discharge rather than a transfer if Hospital #2's admission was unrelated to the discharge from Hospital #1. Regardless of whether Hospital #1 claim is paid as a discharge or transfer, Hospital #2 will be paid the full payment rate based on the patient's final discharge MS-DRG

Refer to 42 C.F.R.412.4(b); *Medicare Claims Processing Manual*, Chapter 3 § 40.2.4(A).

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Case Study 2

Facts: A patient is discharged from a hospital to a skilled nursing facility for skilled care following a stay assigned to a designated post-acute care transfer MS-DRG. Full payment to the hospital for the MS-DRG would be \$10,000 and the GMLOS for the MS-DRG is 5 days. How much would the hospital be paid if the patient is discharged after four days in the hospital.

Analysis: The full payment rate of \$10,000 is divided by the GMLOS of 5 days to calculate a per diem of \$2000. The hospital receives \$4000 for day one, and \$2000 for days 2, 3 and 4 for a total of \$10,000. In this case, transfer payment was not less than the full discharge payment.

Refer to 42 C.F.R.412.4(f)(1).

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Case Study 3

Modified Facts: A patient is discharged from a hospital to a skilled nursing facility for skilled care following a stay assigned to a designated special pay post-acute care transfer MS-DRG. Full payment to the hospital for the MS-DRG would be \$10,000 and the GMLOS for the MS-DRG is 5 days. How much would the hospital be paid if the patient is discharged after four days in the hospital.

Analysis: The full payment rate of \$10,000 is divided by the GMLOS of 5 days to calculate a per diem of \$2000. The hospital receives \$6000 for day one (\$5000 + \$1000), and \$1000 for days 2, 3 and 4 for a total of \$9,000.

Refer to 42 C.F.R.412.4(f)(6).

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Case Study 4

Facts: A Medicare beneficiary who had never before been hospitalized was admitted to and stayed in a hospital for 58 days (Admission #1). The patient was discharged from Admission #1 to a skilled nursing facility for 14 days. Thirty days after leaving the SNF, the patient was admitted (Admission #2) to a hospital for a four-day stay and then discharged to home. All services were provided during 2023.

What is the patient's hospital deductible and/or coinsurance liability for Admission #1? For Admission #2?

Analysis: For Admission #1, the patient would pay the deductible of \$1,600 on day one of the stay and it covers all 58 days of the admission. For Admission #2, the patient would pay \$400 for day three and four, for a total of \$800. Note that day one and two of Admission #2 are paid for with the deductible paid during Admission #1.

Refer to *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 3 § 10.1 and 10.3.

Modified Facts: The patient is admitted for a third time (Admission #3) 65 days after discharge from Admission #2. The length of stay for Admission #3 was 5 days. What is the beneficiary's total deductible and coinsurance liability for Admission #3?

Analysis: For Admission #3, the patient would pay the deductible of \$1,600. The patient began a new benefit period with the 60-day break between Admission # 2 and #3.

Refer to *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 3 § 10.1 and 10.3.



ACUTE CARE HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM



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Learn about these Acute Care Hospital Inpatient Prospective Payment System (IPPS) topics:

- Background
- IPPS payment basis
- Payment rates
- Setting payment rates
- Payment updates
- Hospital Inpatient Quality Reporting (IQR) Program and Promoting Interoperability (PI) Program (formerly the Electronic Health Record [EHR] Incentive Programs)
- Resources

BACKGROUND

Hospitals contract with Medicare to furnish acute inpatient hospital care and agree to accept pre-determined acute IPPS rates as payment in full.

The inpatient hospital benefit covers 90 days of care per episode of illness with an additional 60-day lifetime reserve. Patient illness episodes begin on admission and end after 60 days post-hospitalization or after Skilled Nursing Facility (SNF) discharge.

IPPS PAYMENT BASIS

Generally, Medicare pays acute care hospitals an IPPS payment on a per inpatient case or per inpatient discharge basis. The claim for the inpatient stay **must** include all outpatient diagnostic services and admission-related outpatient non-diagnostic services the admitting hospital, or an entity wholly owned or operated by the admitting hospital, furnished to the patient during the 3 days preceding the date of the patient's hospital admission. Acute care hospitals **cannot** separately bill these services to Medicare Part B.

The Centers for Medicare & Medicaid Services (CMS) assigns discharges to diagnosis-related groups (DRGs). A DRG is a grouping of similar clinical conditions (diagnoses) and the service procedures furnished during the inpatient hospital stay. The patient's principal diagnosis and up to 24 secondary diagnoses, including any comorbidities or complications, determine the DRG assignment. Up to 25 procedures furnished during the stay can affect the DRG. Other factors influencing DRG assignment include a patient's gender, age, or discharge status disposition.

CMS annually reviews the DRG definitions to ensure each group continues to include cases with clinically similar conditions that require similar amounts of inpatient resources. If reviews show subsets of clinically similar cases within a DRG use significantly different amounts of resources, CMS may reassign them to a different DRG with similar resource use or create a new DRG. To better account for Medicare patients' severity of illness and resource consumption, CMS uses the DRG system called Medicare Severity DRGs (MS-DRGs).

The three levels of severity in the MS-DRG system based on secondary diagnosis codes include:

1. **MCC:** Major Complication/Comorbidity, the highest level of severity
2. **CC:** Complication/Comorbidity, the next level of severity
3. **Non-CC:** Non-Complication/Comorbidity, this level does not significantly affect severity of illness and resource use

CMS applies a recoupment adjustment to acute care hospital payments to account for changes in MS-DRG documentation and coding that do not reflect real changes in case-mix. In Fiscal Year (FY) 2020, a **0.5 percentage point** adjustment is applied to the standardized amount.

PAYMENT RATES

CMS bases the IPPS per-discharge payment on two national base payment rates (standardized amounts): one for operating costs and the other for capital-related costs. CMS adjusts these payment rates for:

- The costs associated with the patient's clinical condition and related treatment compared to the costs of the average Medicare case (the DRG relative weight, described in the [Setting Payment Rates](#) section)
- Market conditions in the hospital's location compared to national conditions (the wage index, described in the [Setting Payment Rates](#) section)

Other IPPS Hospital Payments

Acute care hospitals can qualify for outlier payments for extremely costly cases.

Hospitals that train residents in approved Graduate Medical Education (GME) programs get a separate payment for the direct cost of training residents, referred to as direct GME. Medicare increases the operating and capital payment rates of hospitals paid under the IPPS to reflect the teaching hospitals' higher indirect patient care costs compared to non-teaching hospitals, referred to as indirect medical education (IME).

Effective with portions of cost reporting periods beginning October 1, 2019, a hospital may include FTE residents training at a Critical Access Hospital (CAH) in its Full-Time Equivalent (FTE) count as long as it meets the non-provider setting requirements in [42 Code of Federal Regulations \(CFR\) § 412.105\(f\)\(1\)\(ii\)\(E\)](#) and [§ 413.78\(g\)](#). If a hospital is at some point in its 5-year cap building period as of October 1, 2019, and as of that date is sending residents in a new program to train at a CAH, the time spent by FTE residents training at the CAH on or after October 1, 2019 will be included in the hospital's facility response team (FRT) cap calculation.

Medicare increases operating and capital payment rates to hospitals treating a disproportionate share of low-income patients, and they get additional payments for uncompensated care. For fiscal year (FY) 2020, CMS revised the definition of [uncompensated care](#) (health care of services provided by hospitals or health care providers that do not get reimbursed) and the method for calculating it.

Medicare may also pay acute care hospitals for treating patients with certain newly approved, costly technologies that offer a substantial clinical improvement over existing treatments.

Finally, Medicare reduces payment in some cases when a patient has a short length of stay (LOS) and is transferred to another acute care hospital, or in certain circumstances, to a post-acute care setting. This transfer policy applies to patients assigned to one of the MS-DRGs subject to this policy who transfer to a Skilled Nursing Facility, Long Term Care Hospital, Inpatient Rehabilitation Facility, Inpatient Psychiatric Facility, Cancer Hospital, Children's Hospital or to get home health care from a Home Health Agency or hospice care by a hospice program.

IPPS discharge payments reflect applicable adjustments under the Hospital Value-Based Purchasing (VBP) and Hospital Readmissions Reduction Program (HRRP). Medicare adjusts a portion of operating IPPS payments to acute inpatient hospitals upward or downward for hospitals eligible for value-based incentive payments, based on their performance on a set of quality measures. Medicare reduces a portion of eligible hospitals' operating IPPS payments for excess readmissions.

The Hospital-Acquired Condition (HAC) Reduction Program reduces overall payments by 1 percent for applicable hospitals with the worst-performing quartile of risk-adjusted quality measures for reasonably preventable HACs.

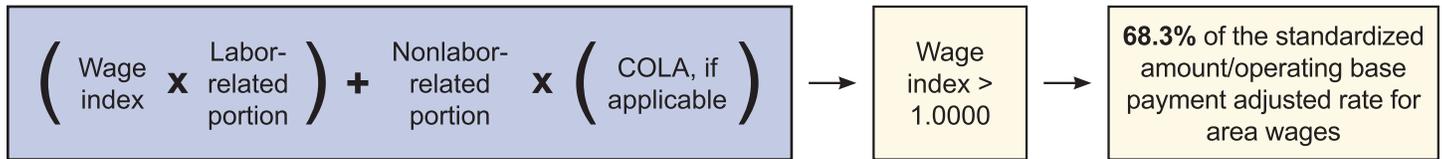
To determine an IPPS payment:

1. The hospital submits a bill to their Medicare Administrative Contractor (MAC) for each Medicare patient treated. Based on the billing information, the MAC categorizes the case into a DRG.
2. The base payment rate, or standardized amount (a dollar figure), includes a labor-related and nonlabor-related share. CMS adjusts the labor-related share by a wage index to reflect area differences in labor costs. If the area wage index is greater than 1.0000, the labor share equals **68.3 percent**. The law requires the labor share to equal **62 percent** if the area wage index is less than or equal to 1.0. The nonlabor-related share is adjusted by a cost-of-living adjustment (COLA) factor equal to 1.0 for all States except hospitals located in Alaska or Hawaii.
3. CMS multiplies the wage-adjusted standardized amount by a DRG weighting factor. The weight is specific to each DRG (761 DRGs for FY 2020). Each DRG relative weight represents the average resources to care for those DRG cases compared to the average resources to treat cases in all DRGs.
4. If applicable, CMS adds these amounts to the IPPS payment:
 - The hospital engages in teaching medical residents to reflect the higher indirect teaching hospital patient care costs compared to non-teaching hospitals
 - The hospital treats a disproportionate share of low-income patients including incurred, uncompensated care costs
 - Certain newly-approved technology cases
 - High-cost outlier cases
5. The Hospital VBP Program, HRRP, and HAC Reduction Programs adjust the IPPS payment.

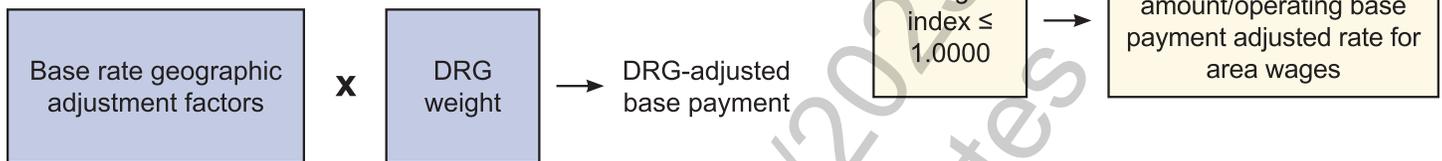
See the [Acute Care Hospital: IPPS Operating Base Payment Rate](#) and [Acute Care Hospital: IPPS Capital Base Payment Rate](#) formulas to understand how CMS calculates them.

ACUTE CARE HOSPITAL IPPS: OPERATING BASE PAYMENT RATE

Adjusted for geographic factors

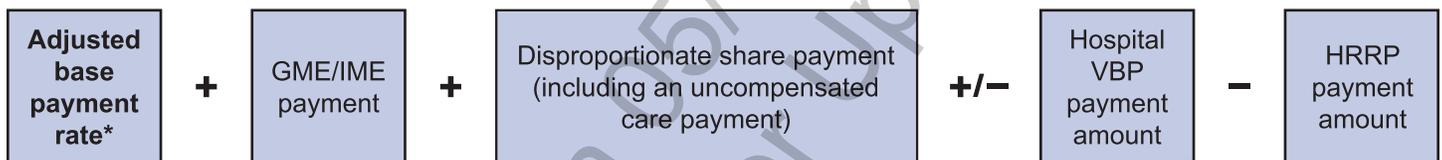


I. Adjusted for case mix

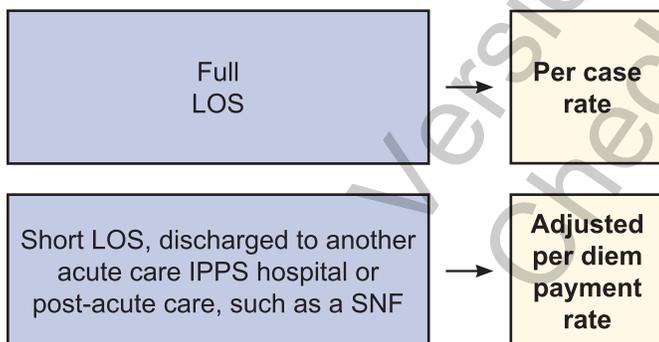


Qualifying hospitals' policy adjustments:

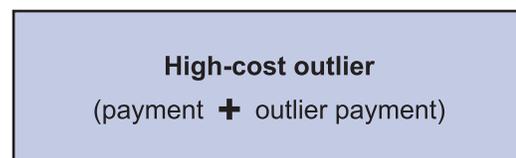
I. Additional operating amounts



II. Transfer adjustments



III. If extraordinarily costly case



IV. If case qualifies for new technology add-on

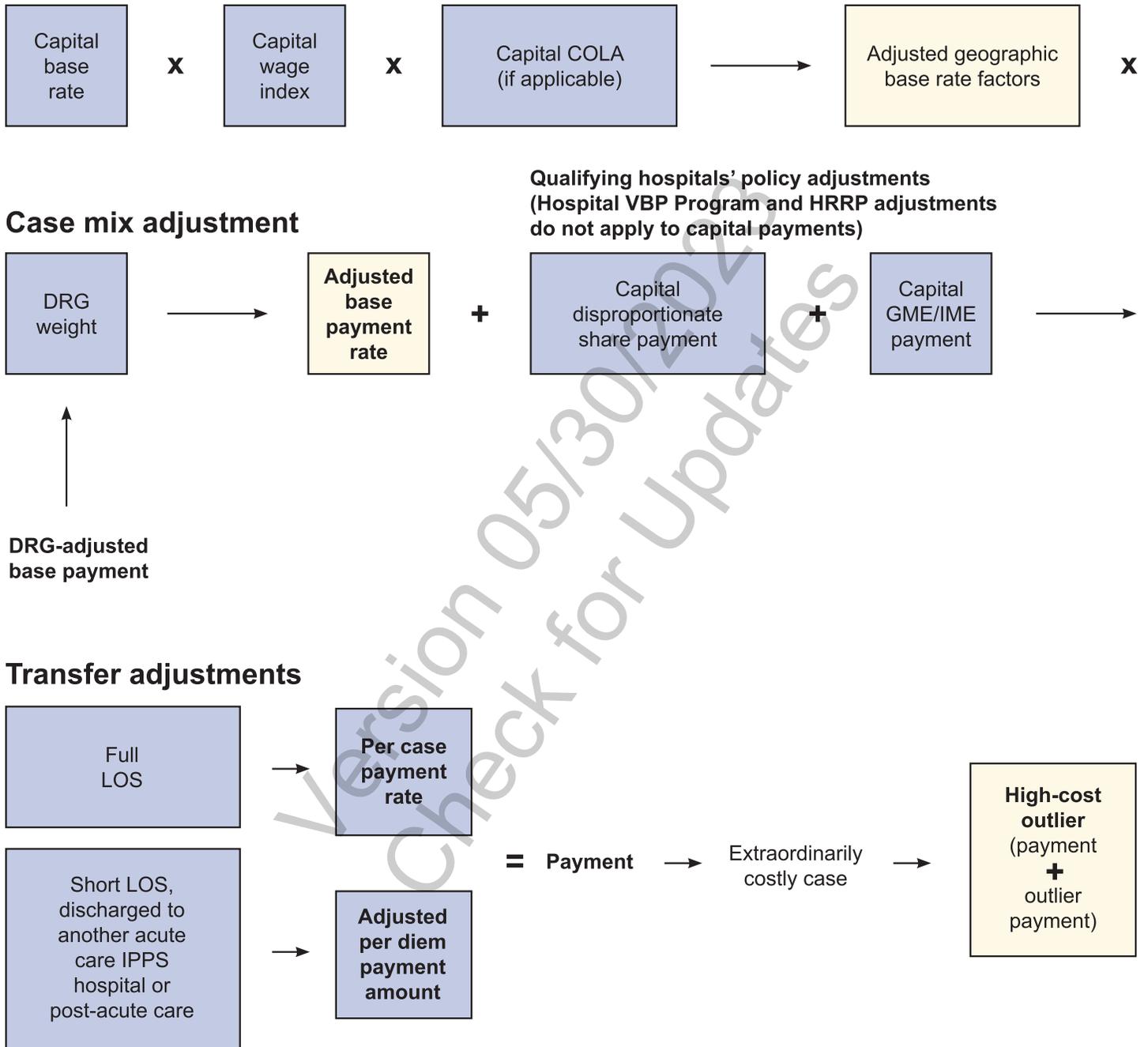


V. If hospital ranks in lowest performing HAC quartile

(overall payment is -1%)

* Reflects the applicable Hospital IQR and Promoting Interoperability Programs payment adjustments.

ACUTE CARE HOSPITAL IPPS: CAPITAL BASE PAYMENT RATE



SETTING PAYMENT RATES

CMS determines IPPS payments through a series of adjustments to separate operating and capital base payment rates. CMS annually updates the base rates, and unless CMS makes additional policy changes, the update raises all payment rates proportionally.

Base Payment Amounts

CMS sets discharge base rates (the standardized payment amount) for the operating and capital costs they expect efficient hospitals to incur while furnishing inpatient services. Medicare excludes some costs, such as direct GME program operating costs and organ acquisition costs, from IPPS rates and pays them separately. Capital payments cover depreciation, interest, rent, and property-related insurance and tax costs.

DRG Relative Weights

CMS assigns a weight to each MS-DRG that reflects the average case cost in that group compared to the average Medicare case cost and uses the same MS-DRG weights for operating and capital payment rates. CMS annually adjusts the MS-DRG weights without affecting overall payments, based on standardized charges and all IPPS case costs in each MS-DRG. CMS standardizes hospitals' billed charges to improve comparability by:

- Adjusting charges to remove differences associated with hospital wage rates across labor markets
- Adjusting the sizes and intensity of the hospital's resident training activities
- Adjusting the number of low-income hospital patients treated

NOTE: CMS reduces charges to costs using national average hospital cost ratios to charges for 19 different hospital departments.

Market Condition Adjustments

CMS adjusts rates based on operating and capital rates by an area wage index to reflect the differences in local labor market prices. CMS measures differences in hospital wage rates among labor markets by comparing the average hourly wage (AHW) for hospital workers in each urban or statewide rural area to the nationwide average.

CMS uses the Office of Management and Budget's Core-Based Statistical Area definitions, with some modifications, to define each labor market area, and annually revises the wage index based on IPPS hospital wage data. If a hospital believes it competes for labor in a different area than the one where located, it may request geographic reclassification. For more information about requesting reclassification, refer to the [Medicare Geographic Classification Review Board](#) webpage.

CMS applies the wage index to the whole capital base rate, and raises it to a fractional power, narrowing the geographic variation in wage index values among market areas. CMS applies a COLA, which reflects the higher costs of supplies and other nonlabor resources, to the base operating and capital rates of IPPS hospitals in Hawaii and Alaska. CMS also applies the COLA to the nonlabor-related portion of the operating base rate and to the whole capital base rate.

Bad Debts

Hospitals get patient bad debt reimbursement at 65 percent. CMS attributes bad debts to coinsurance and deductible nonpayment amounts after the hospital makes a reasonable collection effort. Providers claiming Medicare bad debt reimbursement must submit a detailed bad debt listing that corresponds to the bad debt amounts claimed in the cost report. CMS will reject a cost report they get without the detailed bad debt listing for lack of supporting documentation.

PAYMENT ADJUSTMENTS

Direct Graduate Medical Education

Teaching hospitals or hospitals that train residents in approved medical allopathic, osteopathic, dental, or podiatry residency programs get direct graduate medical education (DGME) payments. These payments reflect the approved residency training programs' direct operating costs. CMS makes these payments separately from the IPPS and generally bases the DGME payments on:

- Updated hospital-specific costs per resident in a historical base year
- The number of residents a hospital trains
- The hospital's Medicare patient load (the proportion of Medicare inpatient days to total inpatient days)

Indirect Graduate Medical Education Costs

Teaching hospitals or hospitals that train residents in approved medical allopathic, osteopathic, dental, or podiatry residency programs also get IME adjustments to reflect the higher indirect patient care costs of teaching hospitals compared to non-teaching hospitals. CMS calculates the IME adjustment factor using a hospital's residents-to-beds ratio.

Medicare Disproportionate Share Hospitals

Hospitals that treat a disproportionate share of low-income patients get additional operating and capital payments. Hospitals get 25 percent of the amount they previously got under the "traditional" Medicare Disproportionate Share Hospital (DSH) operating payments statutory formula. The remainder, equal to 75 percent of what Medicare otherwise would have paid as Medicare DSH operating payments, goes toward an uncompensated care payment after reducing the amount for the percentage change of uninsured individuals.

Each hospital eligible for DSH payments gets an uncompensated care payment based on its share of uncompensated care costs relative to all Medicare DSH-eligible hospitals. CMS annually updates the factor estimates used to determine each eligible hospital's uncompensated care payments.

CMS audited data from Worksheet S-10 of the FY 2015 cost report and used it to calculate uncompensated care costs for FY 2020.

NOTE: CMS continues to use data regarding low-income days (Medicaid days for FY 2013 and Supplemental Security Income (SSI) days for FY 2017) to determine the amount of uncompensated care payments for Puerto Rico hospitals, Indian Health Service and Tribal hospitals.

Sole Community Hospitals

Sole Community Hospitals (SCHs) can get operating payments based on the higher of their hospital-specific payment rate or the Federal rate, while capital payments are solely based on the capital base rate (like all other IPPS hospitals). Medicare makes operating payments to SCHs based on which of the following yield the greatest cost reporting period aggregate payment:

- The applicable hospital IPPS Federal rate
- The updated hospital-specific rate based on FY 1982 costs per discharge
- The updated hospital-specific rate based on FY 1987 costs per discharge
- The updated hospital-specific rate based on FY 1996 costs per discharge
- The updated hospital-specific rate based on FY 2006 costs per discharge

SCHs may also get a payment adjustment if they experience a significant volume decrease. For more information about the volume decrease payment adjustment, refer to [42 CFR § 412.92\(e\)](#).

A Medicare IPPS hospital is eligible for SCH classification if it meets **one** of these criteria:

1. The hospital is at least 35 miles from other like hospitals
2. The hospital is rural, located between 25 and 35 miles from other like hospitals, and meets one of these criteria:
 - No more than 25 percent of hospitalized inpatient residents, or no more than 25 percent of hospitalized inpatient Medicare patients in the hospital's service area, are admitted to other like hospitals within a 35-mile radius of the hospital or, if larger, within its service area
 - The hospital has fewer than 50 beds and would meet the 25 percent criterion except some patients get specialized care unavailable in the hospital service area
3. The hospital is rural and between 15 and 25 miles from other like hospitals but inaccessible because of local topography or periods of prolonged severe weather conditions for at least 30 days in each of 2 out of 3 years
4. The hospital is rural and because of distance, posted speed limits, and predictable weather conditions, travel time between the hospital and the nearest like hospital is at least 45 minutes

A like hospital:

- Furnishes short-term, acute care
- Is paid the Medicare Acute Care Hospital IPPS
- Is not a CAH

A hospital's service area is the area it draws at least 75 percent of its inpatients during the most recent 12-month cost reporting period ending before it applies for classification as an SCH.

CMS treats certain hospitals formerly designated as Essential Access Community Hospitals (EACHs) as SCHs for IPPS payment purposes. For more information about EACHs, refer to [42 CFR § 412.109](#).

Medicare Dependent Hospitals

Medicare Dependent Hospitals (MDHs) can get operating payments based on the higher of the Federal rate or the Federal rate plus 75 percent of the difference between the Federal rate and the hospital-specific rate. The hospital-specific rate is based on FY 1982, FY 1987, or FY 2002 costs per discharge (whichever yields the greatest aggregate payment).

An MDH's capital payments are solely based on the capital base rate. MDHs may also qualify for a payment adjustment if the hospital experiences a significant volume decrease. For more information about the volume decrease payment adjustment, refer to [42 CFR § 412.108\(d\)](#).

Rural Referral Center Program

CMS established the Rural Referral Center (RRC) Program to support high-volume rural hospitals. [42 CFR § 412.96](#) describes the criteria for RRCs. In general, CMS classifies a Medicare participating acute care hospital as an RRC if it is in a rural area and it meets one of these criteria:

1. It has 275 or more usable beds available during its most recently completed cost reporting period. If the hospital's bed count changed, the hospital may submit written documentation with the application on one or more of these reasons for the change:
 - The merger of two or more hospitals
 - Acute care beds previously closed for renovation reopen
 - The hospital transfers acute care beds to the IPPS that were previously classified as part of an excluded unit
 - The hospital expands the number of acute care beds for use and permanently maintains them for inpatients. The expansion does not include beds in corridors or other temporary beds.
2. It shows one of these elements:
 - Non-staff physicians or other hospitals refer at least 50 percent of the hospital's Medicare patients
 - At least 60 percent of the hospital's Medicare patients live more than 25 miles from the hospital
 - The hospital furnishes at least 60 percent of all services to Medicare patients living more than 25 miles from the hospital

3. If a hospital does not meet the criteria in numbers 1 or 2, it is classified as an RRC if located in a rural area, meets the criteria specified in a and b below, and meets at least one of the criteria specified in c or d below:
 - a. Discharges during the most recent Federal FY ended at least 1 year prior to the beginning of the cost reporting period the hospital is seeking RRC status, and its Case-Mix Index (CMI) equals one of these:
 - The lower of the median CMI value for all urban hospitals nationally
 - The median CMI urban hospital's value for urban hospitals in its region, excluding those hospitals getting indirect medical education payments specified in [42 § CFR 412.105](#)
 - b. Its number of discharges is at least one of these:
 - 5,000 (3,000 for an osteopathic hospital)
 - The median urban hospital's number of discharges in the census region it is located, set annually by CMS in Acute Care Hospital IPPS rulemaking, according to [42 CFR § 412.96\(c\)\(2\)](#)
 - c. Medical staff: More than 50 percent of its active medical staff are specialists who meet the conditions specified at [42 CFR § 412.96\(c\)\(3\)](#)
 - d. Source of inpatients: At least 60 percent of all inpatient discharges reside more than 25 miles from the hospital
 - e. Volume of referrals: Other hospitals or non-staff physicians refer at least 40 percent of all inpatients treated

In FY 1998 CMS grandfathered hospitals designated RRCs in FY 1991 and each subsequent year.

Current hospitals, or those that once had RRC status, get certain advantages:

1. Proximity:

- A hospital currently designated an RRC need not demonstrate a proximity to the area where it seeks reclassification
- The hospital can apply for reclassification to the closest urban or rural area

2. AHW Data Comparison:

- Any hospital ever designated an RRC is exempt from the 106/108 percent AHW comparison test
- Any hospital ever designated an RRC must meet the 82 percent AHW comparison regardless of its location in an urban or rural area

3. DSH Cap:

- Any hospital designated an RRC is exempt from the 12 percent cap on DSH payments applicable to other rural hospitals

Low-Volume Hospitals

Currently, Medicare makes add-on payments to qualifying low-volume hospitals more than 15 road miles from the nearest subsection (d) hospital if the hospital discharges fewer than 3,800 total patients based on the hospital's most recently submitted cost report. Qualifying hospitals get an adjustment of up to an additional 25 percent for each patient discharge. Medicare bases a qualifying hospital's low-volume payment adjustment on the following:

- For low-volume hospitals with 500 or fewer total discharges during the FY, the low-volume hospital payment adjustment is an additional 25 percent for each Medicare discharge
- For low-volume hospitals with total discharges during the FY of more than 500 and fewer than 3,800, the adjustment for each Medicare discharge is an additional percentage calculated using the formula $[(95/330) \text{ minus } (\text{number of total discharges}/13,200)]$

Outlier Payments

To promote seriously ill patients' access to high quality inpatient care, CMS makes additional payments for extremely costly outlier cases. CMS identifies these cases by comparing their estimated operating and capital costs to a fixed-loss threshold. CMS annually sets the fixed-loss threshold and adjusts it to reflect labor costs in the hospital's local market.

CMS pays outliers by offsetting reductions in the operating and capital base rates (reducing the payment rates to all cases so the amount paid as outliers does not increase or decrease estimated aggregate Medicare spending). CMS established the national fixed-loss threshold at **5.1 percent** of total FY payments.



Transfer Policy

Medicare reduces DRG payments when:

- The patient's LOS is at least 1 day less than the geometric mean DRG LOS
- The hospital transfers the patient to another IPPS-covered acute care hospital, or for certain MS-DRG patients, a post-acute setting
- The hospital transfers the patient to a hospital not participating in the Medicare Program
- The hospital transfers the patient to a CAH

CMS' transfer policy includes these post-acute care settings:

- Long-term care hospitals
- Rehabilitation facilities
- Psychiatric facilities
- SNFs
- Home health care, when the patient gets clinically related care that begins within 3 days after a hospital stay
- Rehabilitation distinct part units located in an acute care hospital or a CAH
- Psychiatric distinct part units located in an acute care hospital or a CAH
- Cancer hospitals
- Children's hospitals
- Hospice care, effective October 1, 2018

Hospital Readmissions Reduction Program

The HRRP allows an adjustment for discharges to the base operating DRG payment to account for excess readmissions. CMS bases the reduction on a hospital's risk-adjusted readmission rate during a 3-year period for:

- Acute myocardial infarction
- Heart failure
- Pneumonia
- Chronic obstructive pulmonary disease
- Total hip/knee arthroplasty
- Coronary artery bypass graft surgery

A readmission generally means an acute care hospital admission within 30 days of discharge from the same or another Medicare-IPPS acute care hospital.

Hospital Value-Based Purchasing Program

The Hospital VBP Program provides upward, downward, or neutral adjustments to participating hospitals' base operating DRG payments, based on their performance on a set of quality measures. CMS funds value-based incentive payments by reducing hospitals' base operating DRG payment amounts. Hospitals may earn back more than, all, or less than the applicable reduced percent each year. The Hospital VBP Program generally applies to all acute IPPS hospitals, with certain exceptions. The applicable reduction to base operating DRG payment amounts is 2.00 percent.

Hospital-Acquired Condition Reduction Program

An HAC is a condition a patient gets during hospitalization (the condition was not present on admission). The HAC Reduction Program reduces overall payments by 1 percent for applicable hospitals with the worst-performing quartile of risk-adjusted quality measures for reasonably preventable HACs.

PAYMENT UPDATES

CMS annually updates the operating and capital payment rates. Congress sets the operating update by considering the projected increase in the market basket index. The market basket index measures the price increases of goods and services hospitals buy to produce patient care. For more information about payment updates, refer to the [FY 2020 Acute Care Hospital IPPS Final Rule](#).

INPATIENT QUALITY REPORTING AND PROMOTING INTEROPERABILITY PROGRAMS

For FY 2020, the increase in operating payment rates for general acute care hospitals that report specific quality data, meet all other requirements of the Hospital IQR Program, and promote interoperability is approximately 3.0 percent.

Hospitals that do not report specific quality data but promote interoperability get a reduction of one-quarter of the applicable percentage increase to the market basket update. Hospitals that report specific quality data but do not promote interoperability get a reduction of three-fourths of the applicable increase to the market basket update.



RESOURCES

Table 1. IPPS Resources

For More Information About...	Resource
Acute Care Hospital IPPS	CMS.gov/Medicare/Medicare-Fee-For-Service-Payment/AcuteInpatientPPS CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673 CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912
HAC Reduction Program	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program Qualitynet.org/inpatient/hac
Hospital Readmissions Reduction Program	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program
Hospital VBP Program	CMS.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing
Sole Community Hospitals	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929 (Chapter 28, Section 2810)
Medicare Dependent Hospitals	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf

Table 2. Hyperlink Table

Embedded Hyperlink	Complete URL
§ 413.78(g)	https://www.ecfr.gov/cgi-bin/text-idx?SID=d0a5e77ce27fc0e37df65d0454ac3000&mc=true&node=pt42.2.413&rgn=div5#se42.2.413_178
42 Code of Federal Regulations (CFR) § 412.105(f)(1)(ii)(E)	https://www.ecfr.gov/cgi-bin/text-idx?SID=d0a5e77ce27fc0e37df65d0454ac3000&mc=true&node=se42.2.412_1105&rgn=div8
42 § CFR 412.105	https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=133edc1b2d24b2d18d4e21ea10e5a806&mc=true&r=SECTION&n=se42.2.412_1105
42 CFR § 412.109	https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=133edc1b2d24b2d18d4e21ea10e5a806&mc=true&r=SECTION&n=se42.2.412_1109
42 CFR § 412.108(d)	https://www.ecfr.gov/cgi-bin/text-idx?SID=abd5fdec6f7e59fd8b4ef6aa70eed53&mc=true&node=se42.2.412_1108&rgn=div8
42 CFR § 412.96 42 CFR § 412.96(c)(2) 42 CFR § 412.96(c)(3)	https://www.ecfr.gov/cgi-bin/text-idx?SID=133edc1b2d24b2d18d4e21ea10e5a806&mc=true&node=se42.2.412_196
FY 2020 Acute Care Hospital IPPS Final Rule	https://www.federalregister.gov/d/2019-16762
Medicare Geographic Classification Review Board	https://www.cms.gov/Regulations-and-Guidance/Review-Boards/MGCRB

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- All Hospice and Home Health Claims (TOBs - 32X, 33X, 34X, 81X and 82X).

The patient status code belongs in Field 22 on the UB-92 claim form (or its electronic equivalent) in the Health Insurance Portability and Accountability Act (HIPAA)-compliant 837 format for all Part A inpatient, SNF, hospice, home health agency (HHA) and outpatient hospital services. This code indicates the patient's status as of the "Through" date of the billing period (FL 6).

For providers who file claims in the Fiscal Intermediary Shared System (FISS), the patient status code is entered on Claim Page 1. It is important to select the correct patient status code, and if two or more patient status codes could apply, then code to the highest level of care known. Omitting the code or submitting a claim with the incorrect code is a claim billing error and could result in your claim being rejected or your claim being cancelled and payment taken back. Applying the correct code will help ensure that you receive prompt and correct payment.

Patient Status Codes Affected by the Transfer and Post Acute Care Transfer Policy

The following describes these patient status codes and provides details regarding their appropriate use:

Patient Status Code 02 - Discharged/Transferred to a Short-Term General Hospital for Inpatient Care
This patient status code should be used when the patient is discharged or transferred to a short-term acute care hospital. Discharges or transfers to long term care hospitals should be coded with Patient Status Code 63.

Patient Status Code 03 - Discharged/Transferred to a Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Covered Skilled Care

This patient status code should only be used when a patient is discharged or transferred to a Medicare certified skilled nursing bed and qualifies for skilled nursing care. This code should be used whether or not the patient has skilled benefit days. (Also, see Code 61 below.)

This code includes transfers to a rehabilitation unit that is located within a skilled nursing facility (SNF).

This code should not be used:

- If the patient is at a non-skilled level of care; or
- The patient is admitted to a non-Medicare certified bed.
- For a patient who is discharged to a facility that has both skilled and non-skilled (intermediate) bed and the patient is transferred to a non-skilled bed.
- For a patient who resides at a Medicare certified skilled nursing facility but does not receive skilled care services.

Patient Status Code 05 - Discharged/Transferred to Another Type of Institution Not Defined Elsewhere in this Code List

Cancer hospitals excluded from the Medicare PPS and children's hospitals are examples of such other types of institutions.

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The National Uniform Billing Committee (NUBC), as well as CMS, has provided additional situations in which patient status code 05 should be used, other than transfers to non-Medicare certified children's hospitals or cancer hospitals. These situations are as follows:

Patient Status Code 05 – NUBC: Discharged/Transferred to a Non-Medicare PPS Children's Hospital or Non-Medicare PPS Cancer Hospital for Inpatient Care

The NUBC has clarified that patient status code 05 should be used when:

- A patient is discharged to a chemical dependency treatment facility that is not part of a hospital;
- A patient is transferred or discharged from a hospital-based skilled nursing unit (SNU) to the acute care hospital under observation status; or
- A patient is discharged from one acute care facility to another acute care facility for an outpatient procedure with the intention that the patient will not be returning to the first acute care facility following the procedure.

Patient Status Code 06 - Discharged/Transferred to Home Under Care of Organized Home Health Service Organization in Anticipation of Covered Skills Care

This patient status code should be used when a patient is discharged to home, with home health services that will be provided within three days of the patient's discharge. The NUBC has clarified that this would include:

- Follow-up care by visiting nurses;
- Home health care where the patient is also receiving home oxygen; or
- Home health care where the patient is receiving Durable Medical Equipment (DME) services.

Patient Status Code 07 - Left Against Medical Advice or Discontinued Care (This code affects the regular transfer policy if the patient is admitted into another acute care hospital on the same day.)

The important thing to remember about this patient status code is that it is to be used when a patient leaves against medical advice or the care is discontinued. According to the NUBC, discontinued services may include:

- Patients who are triaged and leave without being seen by a physician or non-physician practitioner; and
- Patients who move without notice and the home health agency is unable to complete the plan of care.

Patient Status Code 62 - Discharged/Transferred to an Inpatient Rehabilitation Facility Including Distinct Part Units of a Hospital

Inpatient rehabilitation facilities (or designated units) are those facilities that meet a specific requirement that 75% of their patients require intensive rehabilitative services for the treatment of certain medical conditions. This code should be used when a patient is transferred to a facility or designated unit that meets this qualification.

Patient Status Code 63 - Discharged/Transferred to Long Term Care Hospitals

Long term care hospitals are facilities that provide acute inpatient care with an average length of stay of 25 days or greater. This code should be used when transferring a patient to a long term care hospital. If you

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are not sure whether a facility is a long term care hospital or a short term care hospital, you should contact the facility to verify their facility type before assigning a patient status code.



Patient Status Code 65 - Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital

Although this patient status code has been valid since April 1, 2004, the Medicare system has only accepted this code since January 1, 2005. This code should be used when a patient is transferred to an inpatient psychiatric unit or inpatient psychiatric designated unit.

Note: This code should not be used when a patient is transferred to an inpatient psychiatric unit of a federal hospital (e.g., Veterans Administration Hospitals).



See CR3364, Transmittal 237, dated July 23, 2004, "Implementation of Patient Status Code 65, Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital," at http://www.cms.hhs.gov/manuals/pm_trans/R237CP.pdf on the CMS web site. A Medlearn Matters article is available at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3364.pdf> on the CMS web site.

New Technology Add-On Payment

This is effective for discharges on or after October 1, 2005. In addition to Kinetra® (which was effective October 1, 2004), there are two "new" new technology add-on payments:

- Restore Rechargeable Implantable Neurostimulator, and
- GORE TAG.

Note: OP-1, InFUSE™, and CRT-D are no longer eligible for the new technology add-on payment.

Under 42 CFR 412.88 (p. 440) of the regulations, an add-on payment is made for discharges involving approved new technologies, if the total covered costs of the discharge exceed the DRG payment for the case (including adjustments for indirect medical education (IME), disproportionate share (DSH), transfers, and so on, but excluding outlier payments.) (See Publication 100-4, Chapter 3, Section 160, for specific payment methodology regarding the new technology add-on payment.)

In order to pay the add-on technology payment for the **Restore Rechargeable Implantable Neurostimulator**, Pricer will look for the presence of ICD-9-CM procedure code 86.98: the maximum add-on payment for the neurostimulator is \$9,320.00.

In order to pay the add-on technology payment for **GORE TAG**, Pricer will look for the presence of ICD-9-CM procedure code 39.73: the maximum add-on payment for GORE TAG is \$10,599.00.

In order to pay the add-on technology payment for **Kinetra®**, Pricer will look for the presence of ICD-9-CM procedure codes 02.93 AND 86.95: the maximum add-on payment for Kinetra® is \$8,285.00.

It is possible to have multiple new technologies on the same claim. Should multiple new technologies be present, Pricer will calculate each separately and then total the new technology payments.

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