CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1266	**Date: July 26, 2013**
	Change Request 8231

SUBJECT: Common Working File (CWF) Informational Unsolicited Response (IUR) and Reject for Hospital to Hospital Transfers.

I. SUMMARY OF CHANGES: The contractor claim data identified claims that were improperly reported as a discharge to home rather than as a transfer to another hospital resulting in an overpayment to the transferring hospital. This Change Request will prompt the Common Working File (CWF) to modify the current edit and IUR 7111 to ensure it accurately reflects the IPPS transfer policy.

EFFECTIVE DATE: January 1, 2014
IMPLEMENTATION DATE: January 6, 2014

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
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

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 obliged 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:
One-Time-Notification
**Unless otherwise specified, the effective date is the date of service.*

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1266	Date: July 26, 2013	Change Request: 8231

SUBJECT: Common Working File (CWF) Informational Unsolicited Response (IUR) and Reject for Hospital to Hospital Transfers.

EFFECTIVE DATE: January 1, 2014
IMPLEMENTATION DATE: January 6, 2014

I. GENERAL INFORMATION

A. Background: The CMS Recovery Audit Contractor (RAC) program is responsible for identifying and correcting improper payments in the Medicare Fee-For-Service payment process. The contractor claim data identified inpatient claims that were improperly reported as a discharge to home rather than as a transfer to another hospital resulting in an overpayment to the transferring hospital. When a transferring inpatient prospective payment system (IPPS) hospital indicates to Medicare that the patient is being discharged to home, the transferring hospital receives a full MS-DRG payment. In these cases, the transferring hospital should receive reimbursement per the Centers for Medicare & Medicaid Services (CMS)-defined per diem rate logic when transferring a patient to another acute care facility. An overpayment may exist when both hospital (the transferring hospital and the final discharging hospital) receive full MS-DRG payments. This Change Request will prompt the Common Working File (CWF) to modify the current edit and IUR 7111 to ensure it accurately reflects the IPPS transfer policy.

B. Policy: 1) Regulations at 42 CFR 412.4(b)

2) Pub. 100-04, Medicare Claims Processing Manual, Chapter 03, Section 40.2.4

According to Pub 100-04, Medicare Claims Processing Manual Ch. 03, IPPS Transfers between Hospitals, Section 40.2.4, 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.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8231.1	The contractor shall modify the current edit and IUR 7111 as follows to ensure it accurately reflects the IPPS transfer policy: 1. Set when IPPS claim has a Patient Status Code 07 for discharges on or after October 1, 2004 and patient is admitted to another IPPS hospital, CAH (October 1, 2010), or											X	

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	Non-participating hospital (October 1, 2010) on the same day as discharge 2. Bypass when claim contains Medicare-Severity Diagnosis Related Code (MS-DRG 789) for discharges on or after October 1, 2007 3. Bypass when claim contains DRG 385 for discharges prior to October 1, 2007 4. Bypass for Condition Code 65 (unless CAH (xx1300-xx1399) for discharges on or after October 1, 2010)												
8231.2	The CWF shall have override capability for the current edit and 7111 for a claim upon first appeal if the A MAC determines that the claim should have been paid.											X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
8231.3	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to	X							

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
	supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.								

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Carla David, 410-786-4799 or carla.david@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):
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