Medicare Hospital Manual

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

Transmittal 767 **Date: DECEMBER 19, 2000**

REFER TO CHANGE REQUEST 1410

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
460 (Cont.) – 460 (Cont.)	4-509 – 4-510 (2 pp.)	4-509 – 4-510 (2 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: April 1, 2001*
IMPLEMENTATION DATE: April 1, 2001

Section 460, Completion of Form HCFA-1450 For Inpatient and/or Outpatient Billing, Form Locator 22, Patient Status is revised to modify the structure of four existing codes and to add three new codes to enable you to more accurately code a patients' status. These changes are primarily necessary because of the exclusion of transfers to swing beds from §4407 of Public Law 105-33 which created new rules for discharges from PPS hospitals to postacute care providers. The words "for inpatient care" were added to Code 02. Reference to the new swing bed code 61 was added to Code 03. Reference to outpatient care was removed from Code 05. The words "or expected to return for outpatient services" was removed from Code 30. A new Code 61 was added for discharges/transfers within this institution to a hospital based Medicare approved swing bed. Codes 71 and 72 were added for discharges/transfers/referrals to another (Code 71) or this (Code 72) institution for outpatient services.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

Code	Structure
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to SNF (For hospitals with an approved swing bed arrangement, use Code 61-Swing Bed. For reporting discharges/transfers to a non-certified SNF, use Code 04-ICF.)
04	Discharged/transferred to an Intermediate Care Facility (ICF)
05	Discharged/transferred to another type of institution (including distinct parts)
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
*09	Admitted as an inpatient to this hospital
20	Expired (or did not recover - Christian Science Patient)
30	Still patient
40	Expired at home (Hospice claims only)
41	Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice (Hospice claims only)
42	Expired - place unknown (Hospice claims only)
50	Hospice - home
51	Hospice - medical facility
61	Discharged/transferred within this institution to a hospital-based Medicare approved swing bed
71	Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care
72	Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care

*In situations where a patient is admitted before midnight of the third day following the day of an outpatient diagnostic service or service related to the reason for the admission, the outpatient services are considered inpatient. Therefore, code 09 would apply only to services that began longer than 3 days earlier or were unrelated to the reason for admission, such as observation following outpatient surgery, which results in admission.

FL 23. Medical Record Number
Required. Enter the number assigned to the patient's medical/health record. If you enter a number, the intermediary must carry it through their system and return it to you.

FLs 24, 25, 26, 27, 28, 29, 30. Condition Codes
Required. Enter the corresponding code to describe any of the following conditions that apply to this billing period.

Code	Title	Definition
02	Condition is Employment Related	Enter this code if the patient alleges that the medical condition causing this episode of care is due to environment/events resulting from his employment. (See §289ff. for WC and BL.)
04	Patient is HMO Enrollee	Enter this code to indicate the patient is a member of an HMO. (See §310.)
05	Lien Has Been Filed	Enter this if you have filed legal claim for recovery of funds potentially due to a patient as a result of legal action initiated by or on behalf of a patient.

Code	Title	Definition
06	ESRD Patient in the First 18 Months of Entitlement Covered By Employer Group Health Insurance	Enter this code if Medicare may be a secondary insurer if the patient is also covered by employer group health insurance during his first 18 month of end stage renal disease entitlement.
07	Treatment of Nonterminal Condition for Hospice Patient	Enter this code to indicate the patient has elected hospice care, but you are not treating the patient for the terminal condition and are, therefore, requesting regular Medicare payment.
08	Beneficiary Would Not Provide Information Concerning Other Insurance Coverage	Enter this code if the beneficiary would not provide you with information concerning other insurance coverage.
09	Neither Patient Nor Spouse is Employed	Enter this code to indicate that in response to development questions, the patient and spouse have denied employment.
10	Patient and/or Spouse is Employed but no EGHP Coverage Exists	Enter this code to indicate that in response to development questions, the patient and/or spouse indicated that one or both are employed but have no group health insurance under an EGHP or other employer sponsored or provided health insurance that covers the patient.
11	Disabled Beneficiary But no LGHP	Enter this code to indicate that in response to development questions, the disabled beneficiary and/or family member indicated that one or more are employed, but have no group coverage from an LGHP or provided health insurance will not report them.
12-16	Payer Codes	Codes reserved for internal use only by third party payers.
20	Beneficiary Requested Billing	Enter this code to indicate the services on this bill are at a noncovered level of care or otherwise excluded from coverage, but the beneficiary has requested a formal determination.
21	Billing for Denial Notice	Enter this code to indicate you realize services are at a noncovered level of care or excluded, but you are requesting a denial notice from Medicare in order to bill Medicaid or other insurers.
26	VA Eligible Patient Chooses to Receive Services in a Medicare Certified Facility	Enter this code if a patient is VA eligible and chooses to receive services in a Medicare certified facility instead of a VA facility.