CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 266 **Date: JULY 30, 2004**

CHANGE REQUEST 3389

I. SUMMARY OF CHANGES: This instruction creates overrides for the Common Working File (CWF) edits 7270 and 7271. Condition code (CC) B4 has also been created to allow only claims with CC B4 to receive the CWF override for edits 7270 and 7271. In addition, CC B4 identifies these claims for future review by the Quality Improvement Organization (QIO).

NEW/REVISED MATERIAL - EFFECTIVE DATE: January 1, 2004
***IMPLEMENTATION DATE: January 3, 2005**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	3/40/2.5/Repeat Admissions

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

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

***Medicare contractors only**

Attachment - One-Time Notification

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SUBJECT: Revision of Common Working File (CWF) Editing for Same-Day, Same-Provider Acute Care Readmissions

I. GENERAL INFORMATION

A. Background:

The Office of the Inspector General (OIG) completed a report entitled "Review of Medicare Same-Day, Same-Provider Acute Care Readmissions in Pennsylvania During the Calendar Year 1998" (Common Identification #A-03-01-0001). The OIG recommended that CMS consider the feasibility of establishing an edit check in the fiscal intermediaries' (FIs) claims processing system to identify for review all same-day, same-provider acute care readmissions where the beneficiary was coded as being discharged to another provider before being readmitted.

Effective January 1, 2004, change request (CR) 2716 (Transmittal A-03-065) established CWF edits to ensure accurate payment for beneficiaries readmitted to the same Inpatient Prospective Payment System (IPPS) provider on the same day. These edits rejected subsequent claims with the same provider on the same day. Fiscal intermediaries (FIs) were also instructed to return claims to the IPPS provider for adjustment.

This instruction creates an override to the edits for claims that contain condition code (CC) B4.

B. Policy:

Only one diagnosis related group (DRG) payment should be paid for related same-day, same-provider admissions.

C. Provider Education: "A provider education article related to this instruction will be available at http://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. Contractors shall post this article, or a direct link to this article, on their Web site 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 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
3389.1	Fiscal intermediaries shall accept condition code (CC) B4.	FIs, FISS
3389.1.1	The Common Working File shall accept CC B4.	CWF
3389.2	The CWF shall create an override for CWF Edit 7270 for claims that have (CC) B4.	CWF
3389.2.1	The CWF shall create an override for CWF Edit 7271 for claims that have CC B4.	CWF
3389.3	Fiscal intermediaries should return to provider (RTP) any IPPS acute care claim that has been held due to CWF edits 7270 and 7271.	FIs, FISS
3389.3.1	Fiscal intermediaries shall create a medical policy parameter to identify claims received before February 1, 2005 with the following: • Date of discharge before January 1, 2005; and • CC B4	FIs, FISS
3389.3.2	Fiscal intermediaries shall add CC 15 to apply interest on claims, described in requirement 3389.3.1, beginning the day after the discharge date on the claim.	FIs, FISS
3389.4	The CWF shall reject intervening claims when an acute care PPS hospital claim receives CWF Edit 7270 for the same day as the intervening stay (e.g., An acute care PPS hospital transfers patient to a skilled nursing facility (SNF). SNF admits patient, but transfers patient back to the original acute care PPS hospital on the same day as the original stay).	CWF
3389.4.1	The CWF shall reject intervening claims when an acute care PPS hospital claim receives CWF Edit 7271 for the same day as the intervening stay (e.g. An acute care PPS hospital transfers patient to a skilled nursing facility (SNF). SNF admits patient, but transfers patient back to the original acute care PPS hospital on the same day as the original stay).	CWF

III. SUPPORTING INFORMATION & POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
3389.4	Providers should resubmit claims affected by CWF Edit 7270 within the timely filing period.
3389.4.1	Providers should resubmit claims affected by CWF Edit 7271 within the timely filing period.

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

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

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: January 1, 2004 **Implementation Date:** January 3, 2005 **Pre-Implementation Contact(s):** Joe Bryson at jbryson2@cms.hhs.gov or Sarah Shirey at sshirey@cms.hhs.gov **Post-Implementation Contact(s):** Regional office	**These instructions shall be implemented within your current operating budget.**

40.2.5 - Repeat Admissions

(Rev. 266, Issued 07-30-04, Effective: 01-01-04, Implementation: 01-03-05)

HO-400B

A patient who requires follow-up care or elective surgery may be discharged and readmitted or may be placed on a leave of absence.

Hospitals may place a patient on a leave of absence when readmission is expected and the patient does not require a hospital level of care during the interim period. Examples could include, but are not limited to, situations where surgery could not be scheduled immediately, a specific surgical team was not available, bilateral surgery was planned, or when further treatment is indicated following diagnostic tests but cannot begin immediately. Institutional providers may not use the leave of absence billing procedure when the second admission is unexpected.

QIOs review acute care hospital admissions occurring within 30 days of discharge from an acute care hospital if both hospitals are in the QIO's area and if it appears that the two confinements could be related. Two separate payments would be made for these cases unless the QIO denies a readmission to the same hospital.

NOTE: QIO review and the QIO's authority to deny readmissions is **not** limited to readmissions within 30 days. The QIO has the authority to deny the second admission to the same hospital no matter how many days elapsed since the patient's discharge.

Placing a patient on a leave of absence will not generate two payments. Only one bill and one DRG payment is made. The QIO does not consider leave of absence bills two admissions. It may select such bills for review for other reasons.

*When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital, and is readmitted to the same acute care PPS hospital on the same day for symptoms **related** to, or for evaluation and management of, the prior stay's medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.*

Services rendered by other entities during a combined stay must be paid by the acute care PPS hospital. The acute care PPS hospital is responsible for the other entity's services per common Medicare practice.

***NOTE:** Medicare does not reimburse other entities for services performed during two inpatient acute care PPS stays that are combined onto a single claim. However, the other entity's services may be considered and billed as covered services, when appropriate, by the acute care PPS hospital.*

*When a patient is discharged/transferred from an acute care PPS hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms **unrelated** to, and/or not for evaluation and management of, the prior stay's medical condition,*

hospitals shall place condition code (CC) B4 on the claim that contains an admission date equal to the prior admissions discharge date.

Upon the request of a Quality Improvement Organization (QIO), hospitals must submit medical records pertaining to the readmission.

For Non-PPS acute care hospitals, such as Maryland Waiver hospitals, the readmission bill (if related to original admission) does not have to be combined with the original bill if the stay spans a month. However, the original bill would have to be adjusted to change the patient status code to a 30 (still a patient). Subsequent monthly bills for this admission would be billed as interim bills, 112, 113 or 114.