Medlearn Matters
Information for Medicare Providers

Effective Date: January 1, 2004
Implementation Date: March 15, 2004

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Modification of Requirements in CR 2716, CWF Edits to Ensure Accurate Coding and Payments for Discharge and/or Transfer Policies

Provider Types Affected

Hospitals

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) is making emergency revisions to their claims processing systems to modify some edits previously set forth in PM A-03-065 (CR 2716), published on August 1, 2003, regarding inpatient claims and subsequent post-acute claims. **The anticipated date of these revisions is March 15, 2004.**

Background

As a result of reports from the Office of the Inspector General, CMS had indications that hospitals were incorrectly coding the patient status code field in regards to transfers to post-acute care facilities. In some cases, this resulted in overpayments to the hospital. On January 1, 2004, CMS initiated Common Working File (CWF) edits to identify incorrectly coded hospital claims. CMS also instructed the Medicare intermediaries to automatically cancel hospital claims with an incorrect code in the patient status field.

It has been brought to our attention that the volume of cancellations is causing financial difficulties for many providers. Many of the cancelled claims would not be subject to a reduction in payment even if incorrectly coded. Post-acute claims that might come in out of sequence also caused some hospital claims to be inappropriately canceled. We are now in the process of revising the edit criteria so that only claims with the potential to be overpaid will be cancelled.

CMS regrets this adverse impact on the hospital community and is working to modify its edits on March 15, 2004. The sequencing issue has already been corrected. Obviously, the impact on hospitals has prompted a number of questions regarding this change and the impact of the previous change. Following are some of the most frequently raised questions and CMS answers.

Questions and Answers

What is currently being done by CMS to remedy this problem?

The Medicare claims processing system has been modified to limit automatic cancellation of inpatient claims only to inpatient hospital claims with a patient status code indicating the patient was sent home upon

receipt of a claim from another facility. We have also corrected the issue of canceling claims where a home health claim is received within three days and there may have been an intervening stay (e.g., SNF stay).

What else will be done by CMS?
CMS has established new criteria for an automatic claim cancellation. Once the CWF edits are revised (expected March 15, 2004), the only claims that will be canceled will be inpatient hospital (IPPS) claims paid under one of the 29 post acute care DRGs, with an actual length of stay (LOS) less than the average length of stay for the assigned DRG, and where CMS has an indication the patient status code is incorrect. This will greatly reduce the volume of cancellations that have no payment implications. CMS is also developing education materials to instruct hospitals on the coding of patient status. Hospitals will be required to code patient status correctly as CMS intends to expand upon these edits for all hospitals at a later date.

Is there a 14-day reference in the inpatient transfer rule?
No. This reference was incorrectly communicated in CR 2716.

Has the CWF ever edited for the 14-day window for subsequent SNF claims, as referenced in CR 2716?
The CWF has never edited for such a rule. We only edited for SNF claims if the patient was in a SNF on the same day as their discharge from a hospital.

If the effective date for CR 2716 is January 1, 2004, why are some claims that were paid and/or processed prior to January 1, 2004, being cancelled?
The effective date is not date of service specific. Any incoming claim that enters the CWF, on or after the effective date, will initiate a history search and potential cancellation of claims. The new edits will only search for and cancel claims with discharges on or after October 1, 2003.

What hospitals are excluded from these edits?
Hospitals not paid under the Inpatient Prospective Payment System (IPPS) are excluded.

When will these edits take effect?
The expected date is March 15, 2004.

Does CMS realize that hospitals are out of compliance if they change the patient status code on the claim to a transfer as directed by CMS, even if the medical records or hospital physician orders do not support this? Families and personal physicians often place patients in post-acute settings without the hospital having any knowledge.
CMS believes that if a patient is receiving post-acute care on the same day as discharge or within three days of discharge in the case of home health care, the post-acute admission is related to the inpatient stay. Physicians and coding staff must be educated on the impact of correct coding.

What should hospitals be doing with canceled claims?
Hospitals should be correcting the patient status code and resubmitting these claims ASAP to receive the appropriate reimbursement.

Can a hospital receive accelerated payments if the impact of CR 2716's implementation is causing financial difficulties?
Hospitals should contact their intermediary to determine if they are eligible for accelerated payments.

Can you provide the current list of valid patient status codes?

Below is the list of Patient Status codes with short Medicare descriptions. This is a required field 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. It is important to note that the patient status code indicates a destination (as in where the patient is discharged or transferred to) and not a level or type of care received.

Description	Patient Status Code
Home	01
Short term acute hospital	02
Skilled Nursing Facility (SNF)	03
Intermediate Care Facility (ICF) (also nursing facility with neither Medicare nor Medicaid certification)	04
Inpatient Psychiatric Hospital, Inpatient Psychiatric Distinct Part Unit of a Hospital, Children's Hospital, Cancer Hospital	05
Home Health	06
Home IV Provider	08
Admitted as Inpatient to this Hospital (for use only on Medicare outpatient hospital claims)	09
Expired	20
Still Patient	30
Expired at home (for hospice use only)	40
Expired in a medical facility (for hospice use only)	41
Expired-place unknown (for hospice use only)	42
Federal Hospital (such as VA)	43
Hospice-home	50
Hospice-medical facility	51
Medicare Approved Swing Bed *	61
Inpatient Rehabilitation Facility, including rehabilitation distinct part unit of a hospital	62
Long Term Care Hospital	63
Medicaid-only nursing facility	64
Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital	Future 65 (Providers should continue to use 05 until otherwise notified by CMS-expected 2005.) Instructions are forthcoming.

* There has been some confusion in the provider community regarding the description of 61. CMS advises providers to use 61 for both discharges/transfers to a Medicare approved swing bed within the hospital's approved swing bed arrangement or to another Medicare approved swing bed in another location.