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2022 NGS Medicare Spring Virtual Conference **Medicare for You**

Discovering Acute Care Hospital Inpatient Claims – Let's Get Ready!

5/11/2022

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

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Agenda

- General IP ACH information
- Preparing claims for submission to Medicare
- FL review
  - Review claim form (CMS-1450/UB-04) FLs
- Wrap up
- Resources
- Questions and answers

Objective

- Assist ACHs in understanding how to properly complete IP claims for Medicare so that fewer claims will be RTP or rejected

General IP ACH Billing Information

Medicare Part A

- Referred to as “Hospital Insurance”
- Covers IP stays
- Five major benefits
  - **IP hospital services**
  - IP SNF care
  - Skilled services by HHA
  - Hospice care
  - Blood transfusions

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Inpatient Hospital Coverage Conditions

- Hospital must
  - Have a signed provider agreement with Medicare to be a participating hospital
- Beneficiary must
  - Be enrolled in Medicare Part A
  - Have Medicare IP hospital benefit days available in benefit period
  - Be receiving care that can only be provided in a hospital and that is medically R&N

Inpatient Hospital Coverage Conditions

- Physician must
  - Formally admit beneficiary as IP via IP order
    - Expectation is that beneficiary will remain at least overnight even if he/she is transferred and does not use a bed overnight
    - CMS Two-Midnight Rule
      - CMS Fact Sheet about the Two-Midnight Rule
      - MLN Matters® *MM10080 Revised: Clarifying Medical Review of Hospital Claims for Part A Payment*

Tip – Verify Beneficiary Has Medicare

- Hospital admissions/registration staff
  - Collect insurance information/cards from beneficiary
  - Determine if beneficiary has Medicare and/or any coverage that replaces or is primary to Medicare
    - Beneficiary (Medicare card, other insurance cards, MSP questions)
    - Medicare's records (FISS DDE/CWF, HETS, IVR and/or NGSConnex)
  - Determine proper order of insurance per MSP Provisions

Benefit Period

- Period of time for measuring use of IP benefit days
  - Medicare pays for limited number of days per benefit period
    - For hospitals, up to 150 days
    - For SNFs, 100 days
    - Both days are used separately but are linked to same benefit period
- Has beginning and ending circumstances
- Reference
  - CMS IOM Publication 100-01, *Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 3

Benefit Period – Beginning and Ending

- Benefit period **begins**
  - When beneficiary is admitted as an IP to a qualified hospital or SNF after his/her Medicare entitlement date
- Benefit period **ends**
  - 60 consecutive days from date of beneficiary's last IP discharge
  - Beneficiary was not an IP in a hospital or receiving IP skilled care in a SNF for 60 days in a row

Benefit Period Facts

- A benefit period
  - Does not begin when beneficiary has a new illness/injury
  - Does not end if beneficiary is admitted as IP to a hospital or SNF prior to 60th consecutive day from last IP discharge
    - Beneficiary continues to use any remaining IP benefit days available
  - Is not bound by a calendar year
    - Can last for years if beneficiary is not facility-free for 60 consecutive days or does not have a 60 consecutive-day break in skilled care (from SNF)

Benefit Period Examples

- Who gets a new benefit period?
  - It is 1/17/2022 and you work at Typical Hospital
  - Three patients are waiting to be admitted and it is up to you to decide whether they are eligible for a new benefit period
  - Review most recent IP summaries for each beneficiary on next two slides

Does Beneficiary Get a New Benefit Period With this Admission?

- **Mrs. A** had IP hospital stay 3/3/2021-3/10/2021 and was not IP in any other hospital or SNF since 3/10/2021
  - Yes, more than 60 days passed (3/10/2021 to 1/17/2022)
- **Mr. B** had IP hospital stay 12/14/2021-12/23/2021 and was not IP in any other hospital or SNF since 12/23/2021
  - No, less than 60 days passed (12/23/2021 to 1/17/2022)

Does Beneficiary Get a New Benefit Period With this Admission?

- **Mrs. C** had IP hospital stay 9/30/2021-10/8/2021, then was transferred to a SNF on 10/8/2021 where she was at a covered LOC through her discharge to home on 12/1/2021
- She was not IP in any other hospital or SNF since 12/1/2021
  - No, less than 60 days passed (12/1/2021 to 1/17/2022)

IP Benefit Days under Medicare Part A

- Per benefit period, a beneficiary receives
  - 100 IP SNF benefit days
    - 20 full days and 80 coinsurance days (renewable)
  - Up to 150 IP hospital benefit days
    - 90 regular days (renewable)
      - First 60 days = full days; deductible applies
      - Next 30 days = coinsurance days; daily coinsurance applies
    - 60 LTR days (not renewable)
      - Daily coinsurance applies

Lifetime Reserve Days

- Beneficiary
  - Can elect not to use LTR days
  - May be responsible for cost of stay past regular benefit days
- Provider
  - Must inform beneficiary of their right not to use LTR days
- References
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 5
  - MLN Matters® *SE0663 Revised: Notifying Medicare Patients about Lifetime Reserve Days (LRDs)*

Tip – Verify Benefit Period and Inpatient Hospital Benefit Days Available

- Determine if beneficiary was IP in a hospital or SNF (at skilled level of care) within past 60 days
  - If **yes**, he/she is in a **benefit period**
    - Determine **IP hospital benefit days** used and remaining
    - Obtain name/address of provider(s)
  - If **no**, he/she is not in a benefit period
    - This IP admission starts benefit period

Medicare Beneficiary Responsibility

- Beneficiary's IP hospital liability is limited to
  - Deductible
    - 2022 = $1556
  - Regular day coinsurance (days 31-60)
    - 2022 = $389 per day
  - LTR day coinsurance (days 61-90)
    - 2022 = $778 per day
  - Services not medically R&N (beneficiary liability only)
  - Statutorily excluded services

Inpatient Hospital Services

- Covered services – treat patient's illness/injury
  - Room and board
    - Semiprivate room
    - Private room under certain conditions
  - Ancillary services
    - Drugs/medications
    - Laboratory, X-ray and radiology services

General Exclusions from Medicare

- Include but are not limited to
  - Services not R&N
  - Custodial care
  - Dental services
  - Routine foot care
  - Cosmetic surgery
- References
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 16
  - MLN® Booklet: *Items and Services Not Covered Under Medicare*

Inpatient Hospital Discharge Planning

- Hospitals must
  - Have discharge planning process for all patients
  - Include discharge planning evaluation in patient's medical records
    - Evaluation must include evaluation of likelihood of patient needing post-hospital services and availability of services
  - Discuss results of evaluation with patient or individual acting on his/her behalf

Hospital Issued Notices of Noncoverage

- Provide to beneficiaries
  - Prior to admission
  - At admission
  - At any point during IP stay
- If you determine items or services are not covered
  - Not medically R&N necessary
  - Not delivered in the most appropriate setting or
  - Custodial in nature
- CMS' Beneficiary Notices Initiative (BNI)

Inpatient Hospital Claims Are Subject to Review

- Medical review
  - Targeted Probe and Educate
- Entities contracted with CMS
  - Comprehensive Error Rate Testing (CERT)
  - Quality Improvement Organizations
  - Medicare Fee for Service Recovery Audit Program
  - Supplemental Medical Review Contractor

Medicare Reimbursement for IP Hospital Services

- Made under IPPS
- Based on MS-DRGs
- Subject to IP hospital deductible and coinsurance
- Acute Inpatient PPS
- Inpatient PPS Web Pricer

Preparing Claims for Submission to Medicare

Billing Instructions

- Complete claims per CMS IOM Publication 100-04, *Medicare Claims Processing Manual*
  - Chapter 1, Section 50.2.1, Frequency of Billing
  - Chapter 3, Inpatient Hospital Billing
  - Chapter 25, Section 75, Billing Code Fields
    - FL 1 to FL 81
      - Each FL states required, not required or situational
        - » Situational = CMS requires, if applicable

Claim Form, Fields and Codes

- Claim form = UB-04/CMS-1450
  - MLN® Booklet *Medicare Billing: Form CMS-1450 and the 837 Institutional* (ICN MLN006926)
- Complete claim fields for IP hospital services
  - Some are self-explanatory, others require an explanation
- Claim codes – For all options, refer to NUBC's Official UB-04 Data Specifications Manual on National Uniform Billing Committee (NUBC) website
  - Manual has mapping from UB-04 to 837I claim

Prior to Submitting Claims to Medicare

- Check with internal departments to ensure all services are reported on claim
- Verify all required data elements are entered accurately and completely
- Check if a claim was already submitted
- Consider our one-year timely filing requirement
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 1, Section 70

Submitting Claims to Medicare

- UB-04/CMS-1450 hardcopy claim form
  - Must have approved ASCA waiver
  - ASCA Requirements for Paper Claim Submission
- Via FISS DDE or through clearinghouse
- Using 837I electronic claim form
  - EDI and How it Works on our website

Claims Status/Locations in FISS

- When claim is submitted for processing
  - It receives a status/location
    - Basic status/locations include
      - P B9997 – Claim processed
      - S XXXXX – Claim suspended
      - R B9997 – Claim rejected
      - T B9997 – Claim RTP
      - D B9997 – Claim denied

Claim Status and Provider Action

- If claim RTP (T B9997)
  - Log into FISS/DDE
  - Make necessary claim corrections
    - Select PF9 to resubmit claim
- If claim rejected (R B9997)
  - No action may be needed, determined by reason code
  - May have to resubmit (or adjust) claim, if appropriate
- If claim denied (D B9997)
  - Determine if an appeal is needed
  - Documentation must support services rendered

FL Review

FLs 1, 3A, 3B, 5, 8, 9, 10 and 11

FL	Required?	Description
1	Required	Provider Name, Address, Telephone Number
3A	Required	Patient Control Number (assigned by provider)
3B	Situational	Medical/Health Record Number (assigned by provider)
5	Required	Federal Tax Number; format NN-NNNNNNN
8	Required	Patient's Name (last, first, any middle initial) and Identifier
9	Required	Patient's Address (full mailing address)
10	Required	Patient's Birth Date (Month, Day, Year – MMDDCCYY)
11	Required	Patient's Sex (M = Male; F = Female)

FL 4 – Type of Bill

- Required
  - Four-digit alphanumeric code
    - First digit – zero (ignored)
    - Second digit – type of facility
    - Third digit – type of care
    - Fourth digit – sequence of bill in episode of care; frequency code
- IP claim submissions = one-claim-per-stay
  - Submit through final discharge/death even if IP hospital benefit days exhaust or care becomes noncovered

TOBs for IP Hospital Claims

- TOB 111 = Admission to discharge claims
- TOB 112 = First 60-day interim claim
- TOB 117 = Adjustments & 60-day interim claims
- TOB 118 = Cancel claims
- TOB 110 = No-payment claims
- TOB 12X = IP ancillary claims

FL 6 – Statement Covers Period (From-Through)

- FL 6 – Required
  - Beginning and ending dates of period on bill (MMDDYY)
    - From date = earliest DOS **(consider payment window)**
    - Through date = ending of claim
- Tip: Total number of days in statement covered period = covered days + noncovered days
  - If not equal, claim RTP with reason code 12206
    - If beneficiary is discharged/transferred, through date is not included
    - If beneficiary is still a patient (PSC = 30), through date is included

FL 12 – Admission/Start of Care Date

- Required
  - Date beneficiary is formally admitted as an IP for IP care
  - MMDDYY

FL 14 – Priority (Type) of Admission

- Required
  - Options
    - 1 = Emergency
    - 2 = Urgent
    - 3 = Elective
    - 4 = Newborn
    - 5 = Trauma Center
    - 9 = Not available

FL 15 – Point of Origin for Admission

- Required
  - Code indicating source of referral for admission; options
    - 1 = Non-Health Care Facility Point of Origin
    - 2 = Clinic or Physician's Office
    - 4 = Transfer from Hospital (Different Facility)
    - 5 = Transfer from SNF, Assisted Living, ICF or other Nursing Facility
    - 6 = Transfer from Another Health Care Facility
    - 8 = Court/Law Enforcement
    - 9 = Information Not Available
    - D = Transfer from hospital IP same facility resulting in separate claim

FL 17 – Patient Discharge Status

- Required
  - As of “through” date of billing period (FL 6)
  - Two-digit code that can affect payment (e.g.; Transfers)
  - Select carefully and report accurately
    - What do your internal records indicate?
    - What is receiving facility’s provider type?
    - Does your ACH plan to readmit as IP? (Use options 81-95)
    - Be prepared to change it if we cancel or RTP claim with reason code C7272, resubmit claim with correct patient discharge status code

Patient Discharge Status Codes – Examples

Code	Definition
01	Discharged to home or self-care
02	Discharged/transferred to short-term general hospital for IP care
03	Discharged/transferred to SNF for covered skilled care
04	Discharged/transferred to intermediate care facility
05	Discharged/transferred to cancer or children's hospital
06	Discharged to home for covered home health services
07	Left against medical advice or discontinued care
20	Patient expired
21	Discharged/transferred to court/law enforcement
30	Still a patient

Patient Discharge Status Codes – Examples

Code	Definition
43	Discharged/transferred to federal health care facility (e.g., VA hospital)
50	Discharged/transferred to Hospice (home)
51	Discharged/transferred to Hospice (medical facility)
61	Discharged/transferred to Swing Bed
62	Discharged/transferred to IRF
63	Discharged/transferred to LTCH
64	Discharged/transferred to nursing facility (Medicaid)
65	Discharged/transferred to IPF
66	Discharged/transferred to CAH
70	Discharged/transferred to another type of health care institution

FLs 18 to 28 – Condition Codes

- Situational
  - Two-digit code describing certain conditions or events
    - Common IP CCs (not an all-inclusive list)
      - 04 = Informational-only claim
      - 07 = Hospice patient services not related to terminal illness
      - 40 = Same day transfer
      - 66 = Hospital does not wish to receive HCO
      - 67 = Beneficiary elects not to use LTR days
      - 69 = IME, DGME & N&AH only
      - B4 = Admission unrelated to discharge on same day

CCs for Adjustments

CODE	DESCRIPTION
D0 (zero)	Change to service dates
D1	Change to charges
D2	Change in revenue codes/HCPCS/HIPPS rate code
D3	Second or subsequent interim PPS bill
D4	Change in clinical codes (ICD) for diagnosis and/or procedure codes, Grouper PRICER Input (DRG) IP Hospital
D7	Change to make Medicare secondary
D8	Change to make Medicare primary
D9	Any other change (clearly state reason in remarks)
E0 (zero)	Change in patient status

CCs for Cancels

CODE	DESCRIPTION
D5	Incorrect MID/provider number
D6	Duplicate/Overpayment (do not use for MSP reasons)

FLs 31 to 34 – Occurrence Codes and Dates

- Required
  - Two-digit code for certain events or occurrences and date in MMDDYY format
    - Common IP OCs (not an all-inclusive list)
      - 31 and date of written notice to patient – they are not at covered LOC
      - 32 and date of written notice to patient – service/treatment is not covered
      - 47 and date on which claim exceeded HCO threshold
      - 55 and date of death
      - A3 and benefits exhaust date

FLs 35 Through 36 – Occurrence Span Codes and Dates

- Required
  - Two-digit code for certain events related to services
  - Associated from and through dates in MMDDYY format
    - Common IP OSCs (not an all-inclusive list)
      - 70 and nonutilization dates (inlier); applied by Medicare
      - 72 and number of midnights occurring before IP admission
      - 74 and LOA dates
      - 76 and patient liability dates

FLs 39 Through 41 – Value Codes and Dollar or Unit Amounts

- Required
  - Two-digit code and dollar or unit amount (number)
  - Up to nine numeric digits (0000000.00)
  - Four lines of data, line A through line A
  - Use FLs 39A through 41A before 39B through 41B
    - Common VCs include (not an all-inclusive list)
      - 31 = Patient liability amount
      - VC 80 = Covered days and VC 81 = Noncovered days
      - VC 82 = Coinsurance days and VC 83 = LTR days

FL 42 – Revenue Codes

- Required
  - Revenue codes for services provided to patient directly or under arrangement
    - Accommodations (010X–012X)
    - Ancillary charges (022X–099X)
    - Alternative therapy services (210X)
    - Add total charges line (0001)
- Tip: Claims submitted with noncovered revenue codes RTP with reason code 32242

FL 44 – HCPCS/Rates/HIPPS Rate Codes

- Required
  - Accommodations rate for each accommodation revenue code on claim
  - When reporting revenue code 0636, report valid HCPCS code
    - Drugs requiring detailed coding, including hemophilia clotting factors

FL 46 – Units of Charges

- Required
  - Units of service for each revenue code on claim
  - Quantifies services provided
  - For accommodations
    - Units must = number of days
    - If not, claim will RTP with reason code 15202
- When HCPCS codes are required
  - Units = number of times procedure/service was performed

FLs 47 and 48 – Required

- FL 47 – Total Charges
  - Not applicable for electronic billers
  - Sum of charges for each revenue code on claim
    - Place total of all charges next to revenue code 0001
  - Tip: If covered day count = 0 but total covered charges > 0, claim RTP with reason code 31090
- FL 48 – Noncovered Charges
  - Sum of noncovered charges, if any, for each revenue code
    - Place total of all noncovered charges next to revenue code 0001

FLs 50A, B, C – Payer Identification

- A – Primary payer (Required)
- B – Secondary payer (Situational)
- C – Tertiary payer (Situational)
  - Lines B and C – Required when other plans are known to be involved in paying claim
  - Report **Medicare** on line that identifies order in which Medicare is a payer
    - If you enter Medicare in FL 50A, this indicates provider determined Medicare is primary payer

FLs 51A, B, C – Health Plan ID

- A – Primary payer (Required)
- B – Secondary payer (Situational)
- C – Tertiary payer (Situational)
  - ID number used to identify payer
  - National health plan identifier if established
  - Otherwise number Medicare assigned
  - Lines B and C – Required when other plans are known to be involved in paying claim

FLs 52A, B and C – Release of Information Certification Indicator

- A – Primary payer (Required)
- B – Secondary payer (Situational)
- C – Tertiary payer (Situational)
  - Options
    - Y = Provider has signed statement on file permitting it to release data to other organizations to process claim
    - I = Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes

FLs 54A, B, C – Prior Payments

- Situational
  - Required when indicated payer has paid an amount to provider toward bill
    - A – Primary payer
    - B – Secondary payer
    - C – Tertiary payer
      - Amount

FL 56 – NPI

- Required
  - Billing Provider NPI

FLs 58A, B, C – Insured's Name

- A – Primary payer (Required)
- B – Secondary payer (Situational)
- C – Tertiary payer (Situational)
  - Name of individual under whose name insurance is carried
  - For Medicare line, report beneficiary's name (Last, First and Middle Initial, if any)

FLs 59A, B, C – Patient Relationship to Insured

- A – Primary payer (Required)
- B – Secondary payer (Situational)
- C – Tertiary payer (Situational)
  - Lines B and C – Required when other plans are known to be involved in paying claim
  - Code options = 01 (spouse), 18 (self), 19 (child), 20 (employee), 21 (unknown), 39 (organ donor), 40 (cadaver donor), 53 (life partner), G8 (other relationship)
    - For Medicare line, report 18

FLs 60A, B, C – Insured's Unique ID

- A – Primary payer (Required)
- B – Secondary payer (Situational)
- C – Tertiary payer (Situational)
  - Lines B and C – Required when other plans are known to be involved in paying claim
  - Certificate/Social Security Number/MBI
    - Unique number assigned by health plan
  - For Medicare line, report MBI

FLs 61A, B, C – Insurance Group Name

- A – Primary payer (Situational)
- B – Secondary payer (Situational)
- C – Tertiary payer (Situational)
  - Name of group/plan through which insurance is provided
    - Line A – Required if available
    - Lines B and C - Required when other plans are known to potentially be involved in paying claim

FLs 62A, B, C – Insurance Group Number

- A – Primary payer (Situational)
- B – Secondary payer (Situational)
- C – Tertiary payer (Situational)
  - Number or code assigned by insurance carrier to identify group under which insured individual is covered
    - Line A – Required when insured's ID card shows group number
    - Lines B and C – Required when other plans are known to be involved in paying claim and when plan ID card shows group number

FL 63 – Treatment Authorization Code

- Situational
  - Required when an authorization or referral number is assigned by payer and then services on this claim AND either
    - Services on this claim were preauthorized or
    - A referral is involved
  - Pre-procedure
    - Authorization number required for all approved admissions or services whenever QIO review is performed

FL 64 - DCN

- Situational
  - For adjustments (TOB 117) and cancels (TOB 118)
    - Report control number assigned to original claim by health plan or health plan's fiscal agent as part of their internal control

FLs 65A, B, C – Employer Name

- A – Primary payer (Situational)
- B – Secondary payer (Situational)
- C – Tertiary payer (Situational)
  - Policy holder's (insured) employer name
    - Lines A, B, C – Required when employer of insured is known to be involved in paying claim

FL 66 – Diagnosis and Procedure Code Qualifier (ICD Version Indicator)

- Required
  - Denotes version of ICD reported
  - Qualifier codes reflect edition portion of the ICD
    - 0 – Tenth Revision

FL 67 – Principal Diagnosis Code and Present on Admission Indicator

- Required
  - ICD-10-CM code for principal diagnosis
  - Also known as primary diagnosis code
    - Condition established after study to be chiefly responsible for this admission, even if another diagnosis may be more severe
- References
  - CMS Hospital-Acquired Conditions (Present on Admission Indicator)
  - CMS POA Indicator Options and Definitions

POA Indicators – IP Claims

- ACHs must submit **with each diagnosis code**
  - POA – present at time order for IP admission occurs
  - Conditions that develop during OP encounter considered
  - Codes Y, N, U, W or blank when exempt from reporting
  - Reason codes 34929, 34931, and 34031 indicate an error in POA reporting
- NGS article
  - Hospital Acquired Conditions and Present on Admission Resource for Acute Care Hospital Facilities

FLs 67A to 67Q – Other Diagnosis Codes

- Situational
  - ICD-10-CM codes for up to eight more conditions if they
    - Coexist at time of admission or developed subsequently
    - Had an effect upon treatment or length of stay
- Do not duplicate principal diagnosis
- References
  - CMS 2022 ICD-10-CM
    - ICD-10-CM Official Guidelines for Coding and Reporting FY 2022

FL 69 – Admitting Diagnosis

- Required
  - ICD-10-CM code for admitting diagnosis
  - Condition identified by physician at time of admission requiring hospitalization

FL 74 and FLs 74A Through 74E – Procedures/Dates

- FL 74 – Situational
  - ICD-10-PCS Principal procedure code/date
  - Required when procedure was performed
- FLs 74A-74E – Situational
  - Other ICD-10-PCS procedure codes/dates
  - Required when additional procedures were performed
- References
  - CMS 2022 ICD-10 PCS
    - ICD-10-PCS Official Guidelines for Coding and Reporting 2022

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FL 76 – Attending Provider Name and Identifiers (Including NPI)

- Situational
  - Required when claim has services other than nonscheduled transportation
  - Individual with overall responsibility for patient's medical care and treatment on claim

FL 77 – Operating Provider Name and Identifiers (Including NPI)

- Situational
  - Required when surgical procedure code is on claim
  - Individual with primary responsibility for performing surgical procedure(s)

FLs 78 and 79 – Other Provider (Individual) Name and Identifiers (Including NPI)

- Situational
  - Name and ID number of individual corresponding to qualifier category indicated in this section of claim
  - Provider Type Qualifier Codes/Definition/Situational Usage Notes
    - ZZ - Other Operating Physician
    - Individual performing secondary surgical procedure or assisting Operating Physician
    - When another Operating Physician is involved

FLs 80 and 81 – Situational

- FL 80 – Remarks
  - Special annotations
  - Information not shown elsewhere on bill but needed for payment
  - Certain MSP situations
  - Certain RTP situations
- FL 81 – Code-Code Field
  - Additional codes related to a FL

What You Should Do Now

- Share information with other staff members
- Follow instructions for submitting IP claims
- Develop and implement policies that ensure that claims are correctly submitted to Medicare
- Be familiar with resources for ACHs
- Check our Events calendar
- Sign up for our Email Updates

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Resources

NGS Resources

- Appeals
- CBT modules in Medicare University
- Contact Us
  - NGSConnex, IVR, Mailing Addresses and PCC
- Fiscal Intermediary Standard System/Direct Data Entry Provider Online Guide
- Top Claim Errors

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CMS Resources

- Fiscal Year (FY) 2022 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Hospital (LTCH) Rates Proposed Rule (CMS-1752-P)
- Acute Inpatient PPS
- CERT Task Force Article: Patient Discharge Status Codes Matter
- CMS Website
- MLN Matters® *SE1411 Reissued: Clarification of Patient Discharge Status Codes and Hospital Transfer Policies*

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CMS Resources

- CR6385 *New Patient Discharge Status Code 21 to Define Discharges or Transfers to Court/Law Enforcement*
- CR6801 *Point of Origin for Admission or Visit Codes Update to the UB-04 (CMS-1450) Manual Code List*
- CR7690 *Updates to Editing of Patient Discharge Status Codes on Hospice Claims*

CMS Resources

- ICD-10
- Internet-Only Manuals (IOMs)
- Web Pricers
- Medicare Payment Systems
- MLN Connects® Newsletter
- MLN Matters® Articles
- MLN® Publications & Multimedia

CMS Resources

- MLN® Web-Based Training
- Open Door Forums
- Hospital-Acquired Conditions (Present on Admission Indicator)
- Transmittals/CRs

Additional Resources

- CDC ICD-10 Coding Guidelines
- NUBC's Website

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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