



Related MLN Matters Article #: MM3417

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Related CR #: 3417

Instructions for Completion of CMS-1450 Billing Form

Keywords

MM3417, CR3417, R311CP, CMS-1450, Form

Provider Types Affected

All providers who bill Medicare Fiscal Intermediaries (FIs), including Regional Home Health Intermediaries (RHHIs)

Key Points

- The effective date for the instruction is January 3, 2005.
- The implementation date is January 5, 2005.
- The National Uniform Billing Committee (NUBC) has approved the use of new value codes with an effective date of January 1, 2005.
- Key revisions to the *Medicare Claims Processing Manual* clarify the following Forms Locators (FL):
 - FL8 – Required for inpatient claims, non-covered days: Non-covered days include the days after the date of covered services ended, such as non-covered level of care, or emergency services after the emergency has ended in a non-participating institution.
 - FL22 – Required for all Part A inpatient Skilled Nursing Facility (SNF), hospice, home health agency, and outpatient hospital services: The patient status code indicates the patient's status as of the "Through" date of the billing period (FL6). The patient status code revisions follow:
 - Code 02 – Modified to show that the patient was discharged/transferred to a short-term general hospital for inpatient care.
 - Code 05 – Indicated that the patient was discharged/transferred to a non-Medicare Prospective Payment System (PPS) children's hospital or non-Medicare PPS cancer hospital for inpatient care.

Note, that with regard to use of patient status code 05, a Medicare distinct part unit/facility must meet certain Medicare requirements and is exempt from the inpatient prospective payment system; children's hospitals and cancer hospitals are two examples.

- Providers may refer to page 2 of MLN Matter article MM3417 for a list of other distinct part units/facilities' specific patient status codes, 62, 63, and 65.
- Also, the use of patient status code 43 relates to a discharge/transfer to a government operated health care facility. It is used when the destination of a discharge is a federal health care facility, whether or not the patient resides there.
- FL 24-30 – contain condition codes that apply to the relevant billing period:
 - Condition code 59 (effective, October 1, 2004), non-primary ESRD facility – may be used. This indicates that an End Stage Renal Disease (ESRD) beneficiary received non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD facility.
 - Condition code B4 – now used for an admission not related to a discharge on the same day. This code is for discharges on or after January 1, 2004, but not effective until January 1, 2005.
 - Condition code D4 – expanded for use in long term care hospitals, inpatient rehabilitation facilities, and inpatient SNFs in addition to inpatient acute care hospitals.
- FL 39-41 – refers to value codes and has included two new codes that will become effective January 1, 2005:
 - A8 – Weight of patient in kilograms
 - A9 – Height of patient in centimeters.

Important Links

The related MLN Matters article can be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3417.pdf> on the CMS website.

The official instruction (CR3417) regarding this change may be viewed at

<http://www.cms.gov/Transmittals/downloads/R311CP.pdf> on the CMS website.

If providers have any questions, they may contact their FI or RHHI at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.