

MLN Matters Number: MM3829

Related Change Request (CR) #: 3829

Related CR Release Date: May 13, 2005

Effective Date: Discharges/"to" dates on or after January 1, 2006

Related CR Transmittal #: 156

Implementation Date: October 3, 2005 (relates to Medicare system implementation date)

New Patient Status Code to Define Discharges or Transfers to a Critical Access Hospital (CAH)

Note: This article was updated on February 7, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Providers that bill Medicare fiscal intermediaries (FIs) for patients discharged or transferred to critical access hospitals (CAHs)

Provider Action Needed



STOP – Impact to You

Effective for claims with discharge/ "to" dates on or after January 1, 2006, stop using a generic code when discharging or transferring to a CAH.



CAUTION – What You Need to Know

The new patient code of "66" must be entered on a claim when a patient is discharged or transferred to a CAH



GO – What You Need to Do

Use code 66 as defined by the National Uniform Billing Committee (NUBC) for discharges/transfers to a CAH

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Background

Critical access hospitals (CAHs), created by Congress in the Balanced Budget Act of 1997, are hospitals with limited services located in rural areas. Their charge is to provide emergency care services, have an average stay of 96 hours or less, **and** are located more than 35 miles from a hospital or another CAH, or are located more than 15 miles from hospitals in areas with mountainous terrain or only secondary roads, or are certified by the state as being a "necessary provider" of healthcare services to residents in the area. More information about CAHs is available at <http://www.cms.gov/Center/Provider-Type/Critical-Access-Hospitals-Center.html> on the CMS website.

Previous to the introduction of this new code, there was no patient status code to define discharges or transfers to a CAH. Providers used 01, 05, or some other code since there was no specific code available. Effective for claims with discharge dates or "to" dates on January 1, 2006, or later, the patient status code of 66 must be used.

While there are no Medicare payment implications for the use of this code at this time for transfers, the patient status code is a required field and providers must code it correctly.

Additional Information

You may view the official instruction that was released to your intermediary at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R156OTN.pdf> on the CMS website.

If you have any questions, please contact your Medicare intermediary at their toll free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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