American Hospital Association

Regulatory Advisory

AHA's Regulatory Advisory, a service to members, is produced whenever there is a significant development that affects the job you do in your community.

CMS Corrects Inpatient Common Working File For Post Acute Care Edit

A Message to AHA Members:

On January 1, 2004, the Centers for Medicare & Medicaid Services (CMS) implemented erroneous software changes to the Common Working File (CWF) that automatically canceled hospital claims where the inpatient discharge status field did not match services that patients later received at post-acute care facilities.

The attached *Regulatory Advisory* explains in detail the impact of the software changes, the corrective action that CMS is taking, and what hospitals can do to ensure they receive reimbursement on claims that have been denied. The AHA has worked closely with CMS to fix these inaccuracies and ensure appropriate revisions to the CWF. **CMS anticipates that the software edits will be fixed by March 15, 2004.** This should greatly reduce the volume of cancellations and minimize the impact on hospital cash flow.

After reviewing this advisory, check off the following items from your to-do-list:

- ✓ Share this advisory with your chief financial officer.
- ✓ Identify the volume and dollar amount of previously paid but now cancelled inpatient claims.
- ✓ If appropriate, correct the patient status code of canceled claims and resubmit to your fiscal intermediary to receive appropriate payment.
- ✓ Educate your medical and coding staff on the importance of properly coding a patient's discharge status.
- ✓ Determine whether accelerated payments are necessary until the new edits take effect.

The AHA will continue to work with CMS to ensure that software changes are the least burdensome possible, that an appeals process exists for denial of appropriately coded claims, and, when necessary, that financial assistance is available. We'll keep you apprised of any new developments. If you have further questions about this advisory or encounter delays or problems in receiving payments, please contact the AHA's Ashley Thompson at (202) 626-2340.

Sincerely,

Rick Pollack
Executive Vice President

March 10, 2004

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Background

On January 1, 2004, the Centers for Medicare & Medicaid Services (CMS) implemented software changes to the Common Working File (CWF) that automatically canceled hospital claims where the inpatient discharge status field did not match post-acute care services that patients later received. This edit resulted in the denial of previously paid inpatient claims, and has caused significant financial difficulties for many providers.

The edit was put in place to ensure that Medicare made proper payments or did not overpay for hospital transfers to post-acute care settings. Under regulations that took effect October 1, 2003, patients in 29 diagnosis related groups (DRGs) who are discharged with a length of stay at least one day less than the national average length of stay for the DRG to a post-acute care setting or within three days to home health are counted as "transfers," and thus paid a lesser per diem rate rather than the full DRG amount.

CMS Software Change

CMS' software change, however, canceled numerous claims that would not have been subject to a reduction in payment – even if correctly coded. First, the edit applied to all DRGs, not just the 29 DRGs subject to the transfer policy. Second, all cases triggered this payment reduction edit, not just cases where the inpatient length of stay was greater than the national average. Third, it was applied to all hospitals – including psychiatric, long-term care, rehabilitation and critical access hospitals – rather than only hospitals subject to the inpatient prospective payment system (PPS). Fourth, the software change did not account for situations where there may have been an intervening stay. And finally, the edit affected claims dating as far back as 1999.

Corrective Action

The AHA has worked closely with CMS to fix these inaccuracies and ensure appropriate revisions to the common working file (CWF). **CMS anticipates that the software edits will be fixed March 15, 2004.** Specifically, the agency will change the criteria for an automatic claim cancellation so that it applies only to the 29 post-acute care transfer DRGs when the hospital length of stay is less than the national average and when CMS has an indication that the patient status code is incorrect. The revised edits will apply only to acute care inpatient PPS hospitals, thus excluding inpatient rehabilitation facilities, long-term care hospitals, psychiatric hospitals or units, children's hospitals, cancer hospitals, and hospitals in Maryland, Puerto Rico, the Virgin

Islands, and Guam. These changes should greatly reduce the volume of cancellations and minimize the impact on cash flow.

Additional information, including questions and answers, on the revised edits can be found at the CMS' Web site, www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0408.pdf.

Hospitals must change the discharge status (if appropriate) and resubmit inadvertently canceled claims in order to receive appropriate reimbursement. The edits have resulted in improper take-backs of Medicare payments causing severe cash flow problems for some hospitals. Some facilities may require accelerated payments to make up for the large gap in Medicare revenue. These hospitals should contact their fiscal intermediary (FI) to request such payments. If a hospital does not receive an adequate response from the FI, they should contact the regional office directly and ask them to facilitate the process. The AHA has urged CMS to communicate the importance of quickly approving and promptly issuing accelerated payments to hospitals when they are caused by this processing problem. **If you encounter any problems or delays in receiving accelerated payments, please contact the AHA's Ashley Thompson at (202) 626-2340.**

Hospitals should take this opportunity to ensure that they are correctly coding a patient's discharge status. CMS' instructions on coding have been unclear in the past but it is critical that proper coding be used moving forward as the agency has indicated it may expand the edits for all hospital discharges at a later date. CMS is developing educational materials to assist hospitals in identifying the proper code for a patient's discharge status and we strongly urge hospitals to use these materials to educate both physicians and coding staff on the importance of correct coding.

We anticipate ongoing issues associated with the application of CMS' edits to the existing 29 DRGs. The AHA will continue to work with CMS to ensure that software changes are the least burdensome possible, that an appeals process exists for denial of appropriately coded claims, and, when necessary, that financial assistance is available.