



News Flash - The Acute Inpatient Prospective Payment System Fact Sheet (revised November 2007), which provides general information about the Acute Inpatient Prospective Payment System (IPPS) and how IPPS rates are set, is now available in downloadable format at <http://www.cms.hhs.gov/MLNProducts/downloads/AcutePaymntSysfctsh.pdf> from the Centers for Medicare & Medicaid Services Medicare Learning Network. If the url above does not take you directly to the fact sheet, please copy and paste the url in your web browser.

MLN Matters Number: SE0801 **Revised**

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

Clarification of Patient Discharge Status Codes and Hospital Transfer Policies

Note: This article was revised on July 6, 2009, to update the Web address on page 4 for accessing the list of designated cancer centers. All other information is the same.

Provider Types Affected

Providers billing Medicare Fiscal Intermediaries (FIs) or Part A/B Medicare Administrative Contractors (A/B MACs).

Provider Action Needed



STOP – Impact to You

This Special Edition article is based on information from the Centers for Medicare & Medicaid Services (CMS) regulations and transmittals and the National Uniform Billing Committee (NUBC) Official UB-04 Data Specifications Manual 2008 (Version 2.00 July 2007) Section Form Locator 17 (Patient Discharge Status) Effective Date: March 1, 2007 copyrighted by the American Hospital Association (AHA); NUBC UB-04 Version 2.00 Clarifications and Errata (as of 8/22/07). It provides clarifications and instructions on determining the correct patient discharge status code to use when completing your claims.

IMPORTANT: The NUBC is responsible for the maintenance and dissemination of guidance for the UB-04 code set. The CMS has provided a subset of information

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

below for Medicare-participating providers. For greater detail, providers should visit <http://www.nubc.org/> in order to purchase a UB-04 manual.



CAUTION – What You Need to Know

A patient discharge status code is a two-digit code that identifies where the patient is at the conclusion of a health care facility encounter or at the end time of a billing cycle. It belongs in Form Locator 17 on a UB-04 claim form or its electronic equivalent in the HIPAA compliant 837 format.



GO – What You Need to Do

See the *Background* section of this article for more details regarding instructions and clarifications for patient discharge status coding.

Background

This Special Edition article is being provided to help you determine the right discharge status code to use with your claims. Assigning the correct patient discharge status code is just as important as any other coding used when filing a claim and the same processes should be applied for patient discharge status codes as with any other coding. Choosing the patient discharge status code correctly avoids claim errors and helps you receive payment for your claim sooner.

A patient discharge status code is a two-digit code that identifies where the patient is at the conclusion of a health care facility encounter (this could be a visit or an actual inpatient stay) or at the time end of a billing cycle (the 'through' date of a claim). The Centers for Medicare & Medicaid Services (CMS) requires patient discharge status codes for:

- Hospital Inpatient Claims (type of bills (TOBs) 11X and 12X);
- Skilled Nursing Claims (TOBs 18X, 21X, 22X and 23X);
- Outpatient Hospital Services (TOBs 13X, 14X, 71X, 73X, 74X, 75X, 76X and 85X); and
- All Hospice and Home Health Claims (TOBs 32X, 33X, 34X, 81X and 82X).

It is important to select the correct patient discharge status code, and in cases in which two or more patient discharge status codes apply, you should code the highest level of care known. Omitting a code or submitting a claim with an incorrect code is a claim billing error and could result in your claim being rejected or your claim being cancelled and payment being taken back. Applying the correct code will help assure that you receive prompt and correct payment.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Identifying the appropriate Patient discharge status Code can sometimes be confusing, so be sure to read the Frequently Asked Questions (FAQ) Section at the end of this article for further guidance.

Patient discharge status Codes and Their Appropriate Use

The following describes patient discharge status codes and provides details regarding their appropriate use:

01 - Discharge to Home or Self Care (Routine Discharge)

This code includes discharge to home; jail or law enforcement; home on oxygen if DME only; any other DME only; group home, foster care, and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs; assisted living facilities that are not state-designated.

02 - Discharged/Transferred to a Short-term General Hospital for Inpatient Care

This patient discharge status code should be used when the patient is discharged or transferred to a short-term acute care hospital. Discharges or transfers to long-term care hospitals should be coded with Patient discharge status Code 63.

03 - Discharged/Transferred to a Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Skilled Care.

This code indicates that the patient is discharged/transferred to a Medicare certified nursing facility in anticipation of skilled care. For hospitals with an approved swing bed arrangement, use Code 61- Swing Bed.

This code should be used regardless of whether or not the patient has skilled benefit days and regardless of whether the transferring hospital anticipates that this SNF stay will be covered by Medicare. For reporting other discharges/transfers to nursing facilities see codes 04 and 64.

Code 03 should **not** be used if:

- The patient is admitted to a non-Medicare certified area.

04 - Discharged/Transferred to an Intermediate Care Facility (ICF)

Patient discharge status code 04 is typically defined at the state level for specifically designated intermediate care facilities. It is also used:

- To designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification, or
- For discharges/transfers to state designated Assisted Living Facilities.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

05 - Discharged/Transferred to Another Type of Health Care Institution Not Defined Elsewhere in This Code List

Cancer hospitals excluded from Medicare PPS and children's hospitals are examples of such other types of health care institutions.

NEW DEFINITION FOR PATIENT DISCHARGE STATUS CODE 05- Effective, per NUBC, on April 1, 2008**05 - Discharged/Transferred to a Designated Cancer Center or Children's Hospital**

Usage Note: Transfers to non-designated cancer hospitals should use Code 02. A list of (National Cancer Institute) Designated Cancer Centers can be found at http://cancercenters.cancer.gov/cancer_centers/cancer-centers-names.html on the Internet.

06 - Discharged/Transferred to Home Under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care

This code should be reported when a patient is:

- Discharged/transferred to home with a written plan of care for home care services (tailored to the patient's medical needs) -- whether home attendant, nursing aides, certified attendants, etc.
- Discharged/transferred to a foster care facility with home care; and
- Discharged to home under a home health agency with DME.

This code should **not** be used for home health services provided by a:

- DME supplier or
- Home IV provider for home IV services.

07 - Left Against Medical Advice or Discontinued Care

The important thing to remember about this patient discharge status code is that it is to be used when a patient leaves against medical advice or the care is discontinued. According to the NUBC, discontinued services may include:

- Patients who leave before triage, or are triaged and leave without being seen by a physician; or
- Patients who move without notice, and the home health agency is unable to complete the plan of care.

08 - Reserved for National Assignment

This patient discharge status code is reserved for national assignment.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

09 - Admitted as an Inpatient to this Hospital

This code is for use only on Medicare outpatient claims, and it applies only to those Medicare outpatient services that begin greater than three days prior to an admission.

10-19 - Reserved for National Assignment

These patient discharge status codes are reserved for national assignment.

20 - Expired

This code is used only when the patient dies.

21-29 - Reserved for National Assignment

These patient discharge status codes are reserved for national assignment.

30 - Still Patient or Expected to Return for Outpatient Services

This code is used when the patient is still within the same facility and is typically used when billing for leave of absence days or interim bills. It can be used for both inpatient or outpatient claims,

It is used for inpatient claims when billing for leave of absence days or interim billing (i.e., the length of stay is longer than 60 days).

On outpatient claims, the primary method to identify that the patient is still receiving care is the bill type frequency code (e.g., Frequency Code 3: Interim - Continuing Claim).

31-39 - Reserved for National Assignment

These patient discharge status codes are reserved for national assignment.

Hospice Patient discharge status Codes - Hospice Claims Only (TOBs: 81X & 82X)

The following patient discharge status codes should only be used when submitting hospice claims:

- **40 - Expired at Home;** This code is for use only on Medicare and TRICARE claims for hospice care.
- **41 - Expired in a Medical Facility, such as a Hospital, Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), or Free-standing Hospice;** and
- **42 - Expired - Place Unknown;** This code is for use only on Medicare and TRICARE claims for hospice care

43 - Discharged/Transferred to a Federal Hospital

This code applies to discharges and transfers to a government operated health care facility including:

- Department of Defense hospitals;
- Veteran's Administration hospitals; or

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

- Veteran's Administration nursing facilities.

This patient discharge status code should be used whenever the destination at discharge is a federal health care facility, whether the patient resides there or not.

The NUBC has also clarified that this code should also be used when a patient is transferred to an inpatient psychiatric unit of a Veterans Administration (VA) hospital.

44-49 Reserved for National Assignment

These patient discharge status codes are reserved for national assignment.

50 and 51 - Discharged/Transferred to a Hospice

These two patient discharge status codes are used to identify when a patient is discharged or transferred to hospice care.

The level of care that will be provided by the hospice upon discharge is essential to determining the proper code to use. NUBC clarified the following Hospice Levels of Care:

- Routine or Continuous Home Care. Patient discharge status **code "50: Hospice home"** should be used if the patient went to his/her own home or an alternative setting that is the patient's "home," such as a nursing facility, and will receive in-home hospice services.
- General Inpatient Care. Patient discharge status **code "51 Hospice medical facility"** should be used if the patient went to an inpatient facility that is qualified and the patient is to receive the general inpatient hospice level of care.
- Inpatient Respite. Patient discharge status **code "51 Hospice medical facility"** should be used if the patient went to a facility that is qualified and the patient is receiving hospice inpatient respite level of care. Unless a patient has already been admitted to/accepted by a hospice, level of care can not be determined. Therefore, it is recommended that, if a patient is going home or to an institutional setting with a hospice "referral only," (without having already been accepted for hospice care by a hospice organization) the patient discharge status code should simply reflect the site to which the patient was discharged, not hospice (i.e. **01: home or self care, or 04: an intermediate care nursing facility, assuming it is not a Medicare SNF admission**).

Additional Guidance on Use of Patient discharge status Code 50 or 51:

- Patient discharge status Code 50 should be used if the patient went to his/her own home or an alternative setting that is the patient's "home," such as a nursing facility, and will receive in-home hospice services.

Patient discharge status Code 51 should be used when a patient is:

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

- Discharged from acute hospital care but remains at the same hospital under hospice care,
- Transferred from an inpatient acute care hospital to a Medicare-certified SNF under the following conditions:
 - The patient has elected the hospice benefit and will be receiving hospice care under arrangement with a hospice organization; the patient is receiving residential care only.
 - The patient does not qualify for skilled level of care outside the hospice benefit for conditions unrelated to the terminal illness.
 - Admitted from home (a private residence) to an acute setting. Upon discharge, the patient is transferred as a new nursing home placement to a designated hospice unit/bed.

52-60 - Reserved for National Assignment

These patient discharge status codes are reserved for national assignment.

61 - Discharged/Transferred to a Hospital-based Medicare Approved Swing Bed

This code is used for reporting patients discharged/transferred to a SNF level of care within the hospital's approved swing bed arrangement.

When a patient is discharged from an acute hospital to a Critical Access Hospital (CAH) swing bed, use Patient discharge status Code 61. Swing beds are not part of the post acute care transfer policy

62 - Discharged/Transferred to an Inpatient Rehabilitation Facility Including Distinct Part Units of a Hospital

Inpatient rehabilitation facilities (or designated units) are those facilities that meet a specific requirement that 75% of their patients require intensive rehabilitative services for the treatment of certain medical conditions. This code should be used when a patient is transferred to a facility or designated unit that meets this qualification.

63 - Discharged/Transferred to Long Term Care Hospitals

This code is for hospitals that meet the Medicare criteria for LTCH certification as follows: Long term care hospitals are facilities that provide acute inpatient care with an average length of stay of 25 days or greater. This code should be used when transferring a patient to a long term care hospital. If you are not sure whether a facility is a long term care hospital or a short term care hospital, you should contact the facility to verify their facility type before assigning a patient discharge status code.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

64 - Discharged/Transferred to a Nursing Facility Certified Under Medicaid but not Certified Under Medicare

Nursing facilities may elect to certify only a portion of their beds under Medicare, and some nursing facilities choose to certify all of their beds under Medicare. Still others elect not to certify any of their beds under Medicare. When a patient is transferred to a nursing facility that has no Medicare certified beds, this code should be used. If any beds at the facility are Medicare certified, then the provider should use either Patient discharge status Code 03 or 04, depending on:

- The level of care the patient is receiving; and
- Whether the bed is Medicare certified or not.

65 - Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital

This code should be used when a patient is transferred to an inpatient psychiatric unit or inpatient psychiatric designated unit.

Note: This code should not be used when a patient is transferred to an inpatient psychiatric unit of a federal hospital (e.g. Veterans Administration Hospitals). In this case, see Patient discharge status Code 43.

66 - Discharged/Transferred to a Critical Access Hospital (CAH)

Patient discharge status Code 66 is used to identify a transfer to a critical access hospital (CAH) for inpatient care. Providers will need to establish a process for identifying whether a hospital is paid under the prospective payment system (PPS) or whether the facility is designated as a CAH.

Note: Discharges or transfers to a critical access hospital (CAH) swing bed should still be coded with Patient discharge status Code 61.

67-69 - Reserved for National Assignment

These patient discharge status codes are reserved for national assignment.

NEW PATIENT DISCHARGE STATUS CODE 70 – Per NUBC, Effective April 1, 2008:**70 – Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List**

New patient discharge status code 70 was created in order for providers to be able to indicate discharges/transfers to another type of health care institution not defined elsewhere in the code list. This code is effective for use by providers for discharges/to dates on or after April 1, 2008. (See Code 05)

71-99 - Reserved for National Assignment

These patient discharge status codes are reserved for national assignment.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Patient Discharge Status Codes Affected by the Hospital Transfer Policies for Inpatient PPS and IRF PPS

The IPPS Acute to Acute Transfer policy applies to transfers coded with patient discharge status code 02 and applies to ALL DRGs and when the length of stay is less than the average length of stay for the DRG.

Under Medicare's Post Acute Care Transfer policy (42 CFR 412.4), a discharge of a hospital inpatient is considered to be a post acute care transfer when the patient's discharge is assigned to one of the qualifying diagnosis-related groups (DRGs), and the discharge is made under any of the following circumstances:

- To a hospital or distinct part hospital unit excluded from the inpatient prospective payment system (IPPS) (includes: Inpatient Rehabilitation Facilities, Long Term Care Hospitals, psychiatric hospitals, cancer hospitals and children's hospitals);
- To a skilled nursing facility (not swing beds); and
- To home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge.

Note: A list of the FY2008 DRGs is available in Table 5 of the IPPS final rule for 2008. That table is available at <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/FY2008FinalRuleTable5.zip> on the CMS website.

Based on the above, the IPPS Post-Acute Care Transfer Policy applies to claims coded with Patient discharge status Codes 03, 05, 06, 62, 63, and 65.

Inpatient Rehabilitation Facilities (IRFs) : 42 CFR 412.624(f) The following Patient discharge status Codes are applicable under the IRF Transfer Policy for IRF PPS: 02, 03, 61, 62, 63, and 64.

NUBC Frequently Asked Questions (FAQs) and Answers

1) Q: A patient is discharged from our facility (disposition code 01) and is to go to a doctor's appointment the same day. The patient is then admitted to another hospital after seeing the doctor. What disposition code is appropriate, 01 or 02?

*A: Based on the information the hospital had at discharge, the patient was discharged to **home (01)**. If your facility was unaware of the planned admission at the second facility, it is likely that you will have to provide support for your coding decision when the fiscal intermediary receives the claim for admission to another hospital on the same day you discharged the patient.*

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

2) Q: If a facility discharges a patient to a personal care home, which is similar to assisted living facilities, are they most appropriately coded as **01** or **04**?

*A: If the personal care home is the person's place of residence, even temporarily, use **Code 01**, discharged to home or self care.*

3) Q: What discharge status code should be used when a patient is sent to another acute care facility for an outpatient procedure later in the day? This occurs when we do not have the equipment to perform the procedure and the intention is that the patient will not be returning to our facility after the procedure.

*A: Since this is a discharge to outpatient treatment, and it is expected that the patient will go home afterward, use discharge **status 01**, discharged to home or self care.*

4) Q: We have a Home Health Agency with DME. Often we find the orders reads "Home with Walker". We do not see a physician order for home health care nor has there been an assessment documented by the receiving home health nurse. The nursing discharges instructions check "home". Is the Patient discharge status **Code still 06**?

*A: No. "Home with Walker" does not imply a discharge to home under care of organized home health service organization in anticipation of covered skilled care. Accordingly, **Code 01**, discharged to home or self care (routine discharge) would be appropriate.*

5) Q: What is the difference between residential care and assisted living care?

*A: In terms of patient discharge status codes, there is no difference. Discharges to residential care and private (non-state designated/supported) assisted living facilities are coded alike (**01**).*

6) Q: An established nursing home patient (i.e. the nursing home is their permanent residence) is transferred to an acute setting. Upon discharge, they are sent back to the same nursing home with a hospice referral only. What patient discharge status code would be appropriate?

*A: If the patient has not made a hospice election, and has a referral only, use **Code 01**, Discharged to Home.*

7) Q: A patient was discharged to home with home health services. Two days later the patient was readmitted to our hospital. We were notified by the discharge planner of the patient's readmission and the fact that home health services were not started for the patient and the discharge status code needed to be changed to 01. By the time of the discharge planner's notification, we had already submitted the patient's bill with the discharge status code of 06. In this instance what should the correct discharge status code be on this patient?

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

*A: To ensure accurate reimbursement and reporting, send a replacement claim with the correct discharge status **code (01)**.*

8) Q: What status code should be used for a patient transferred to a SNF rehabilitation unit? This unit is within the SNF. Is this considered a transfer to a SNF or to a rehabilitation facility?

*A: A rehabilitation unit that is part of a skilled nursing facility is paid under the SNF prospective payment system. Moving a patient from one unit to another does not constitute a transfer for billing purposes and should not result in separate claims. If a patient is discharged from an acute inpatient hospital to a Medicare-certified SNF in anticipation of skilled care, **use 03**. Status **code 03** is also used if the patient moves from an acute inpatient hospital to a rehab unit in a SNF.*

9) Q: What is the appropriate patient discharge status code for a patient transferred from an acute care hospital to a nursing facility for a non-skilled/custodial/residential level of care? For example:

The patient is discharged to a facility that is only certified with skilled beds but the patient does not qualify for a skilled level of care.

The Medicare certified nursing facility is licensed for both skilled and intermediate care beds, and the patient is transferred to intermediate care.

The patient resides at a Medicare certified SNF but only receives non-skilled services.

*A: **Code 04**, discharged/transferred to an intermediate care facility (ICF) would be the appropriate patient status discharge code for all of the examples above.*

10) Q: If a patient is discharged from a hospital based Transitional Care Unit (i.e., skilled nursing unit) to the acute hospital under Observation Status, what is the Discharge Status for the TCU claim?

*A: Use **Code 05**, discharged/transferred to another type of health care institution not defined elsewhere in this code list.*

11) Q: If a patient is discharged to home for the provision of home health services, but, the continuing care is either 1) not related to the condition or diagnosis for which the individual received inpatient hospital services or 2) is related, but, not provided within the post-discharge window, what is the correct patient status code to use?

*A) **Code 06** would be the appropriate patient discharge status code. In addition, the provider should append one of the following condition codes, as appropriate, to the claim:*

- **Condition Code 42** – Continuing care not related (i.e. condition or diagnosis) to inpatient admission or;*
- **Condition Code 43** – Continuing care not provided within prescribed post-*

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

discharge window.

12) Q: If a patient is discharged from an acute care hospital and PT/OT is arranged to be done in the home by a rehabilitation agency that is not affiliated with the home health care agency that made the arrangements, what is the appropriate code to use -- 01 or 06?

A: If the therapy services are being provided under the home health benefit (e.g. Medicare Part A), use Code 06; if the therapy is provided under the outpatient therapy benefit (e.g., Medicare Part B), use Code 01.

13) Q: If a patient is discharged from acute hospital care but remains at the same hospital under hospice care, what status code should be used for the acute stay discharge?

A: Use Code 51 Hospice - medical facility

14) Q: What discharge status code should be used when a patient is discharged to a chemical dependency treatment facility that is not part of a hospital?

A: If the chemical dependency treatment facility is not a psychiatric hospital or psychiatric distinct part unit of a hospital, and the patient is undergoing inpatient/residential treatment, use Code 05, discharged/transferred to another type of health care institution not defined elsewhere in this code list. (Note: The NUBC has approved the establishment of a new code (70) to take effect April 1, 2008 for other types of health care facilities not defined elsewhere in the code list.)

Additional Information

If you have any questions, please contact your Medicare FI or A/B MAC at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

News Flash - It's Not Too Late to Get the Flu Shot. We are in the midst of flu season and a flu vaccine is still the best way to prevent infection and the complications associated with the flu. But re-vaccination is necessary each year because flu viruses change each year. Please encourage your Medicare patients who haven't already done so to get their annual flu shot. – And don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. Get Your Flu Shot – Not the Flu! Remember - Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. Health care professionals and their staff can learn more about Medicare's coverage of adult immunizations and related provider education resources, by reviewing Special Edition MLN Matters article SE0748 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0748.pdf> on the CMS website.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.