CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1485	**Date: April 10, 2015**
	Change Request 9132

SUBJECT: Continuation of Systematic Validation of Payment Group Codes for Prospective Payment Systems (PPS) Based on Patient Assessments

I. SUMMARY OF CHANGES: : This Change Request (CR) continues to implement the Fiscal Intermediary Standard System (FISS) changes required to refine the interface between FISS and Quality Information Enterprise System (QIES).

EFFECTIVE DATE: July 1, 2015 - Claims Received on or after
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2015

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

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I. GENERAL INFORMATION

A. Background: The PPS case-mix groups used to determine payments under home health (HH) PPS, skilled nursing facilities (SNF) PPS and inpatient rehabilitation facility (IRF) PPS are based on clinical assessments of the beneficiary.

In all three payment systems, the assessments are entered into software at the provider site that encodes the data from the individual assessments into a standard transmission format and transmits the assessments to the State survey agency or a national repository. In addition, the software runs the data from the individual assessments through grouping software that generates a case-mix group to be used on Medicare PPS claims via a Health Insurance PPS (HIPPS) code. Although the Centers for Medicare & Medicaid Services (CMS) provides grouping software, many providers create their own software due to their need to integrate these data entry and grouping functions with their own administrative systems.

B. Policy: The Balanced Budget Act of 1997 created prospective payment systems (PPSs) for post-acute care settings. This project will more completely implement PPSs for Skilled Nursing Facilities (required by regulation in 1998), Home Health Agencies (required by regulation in 2000) and Inpatient Rehabilitation Facilities (required by regulation in 2002). All three payment systems have been subject to periodic regulatory refinement since implementation.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9132.1	Medicare systems shall exclude Critical Access Hospital Swing Bed (18x) claims from edit 37070.					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Jason Kerr, jason.kerr@cms.hhs.gov , Fred Rooke, fred.rooke@cms.hhs.gov , Wil Gehne, wil.gehne@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0