

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



News Flash:

REVISED product from the Medicare Learning Network® (MLN)

- ["Home Health Prospective Payment System,"](#) Fact Sheet, ICN 006816, Downloadable

MLN Matters® Number: MM7760 **Revised**

Related Change Request (CR) #: 7760

Related CR Release Date: July 18, 2012

Effective Date: October 1, 2012

Related CR Transmittal #: R2495CP

Implementation Date: October 1, 2012

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

Note: This article was revised on September 20, 2012, to reflect the revised CR7760 issued on July 18. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for hospitals that bill Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (MACs), and Regional Home Health Intermediaries (RHHIs) for services provided to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 7760, which instructs Medicare contractors to implement changes required to create an interface between the Fiscal Intermediary Shared System (FISS) and the Quality Improvement Evaluation System (QIES). Currently, the FISS does not have access to the assessment databases. This inability to validate the submitted Health Insurance Prospective Payment System (HIPPS) code(s) against the associated assessment creates significant payment vulnerability for the Medicare program.

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Background

The Balanced Budget Act of 1997 created Prospective Payment Systems (PPSs) for post-acute care settings. CR7760 will more completely implement PPSs for Skilled Nursing Facilities (SNFs) (required by regulation in 1998), Home Health Agencies (required by regulation in 2000) and Inpatient Rehabilitation Facilities (IRF) (required by regulation in 2002). All three payment systems have been subject to periodic regulatory refinement since implementation.

Current Status

The PPS case-mix groups used to determine payments under home health PPS, SNF PPS, and 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 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.

Currently, the transmission of assessment data and transmission of HIPPS codes on claims to Medicare contractors are entirely separate processes. The FISS does not have access to the assessment databases. This results in:

- An inability to validate the submitted HIPPS code against the associated assessment
- An inability to fully enforce the late submission penalty for IRF claims.

These limitations create significant payment vulnerability for the Medicare program. These vulnerabilities have been the subject of studies by the Office of Inspector General.

To prevent inaccurate payments, FISS will suspend claims with HIPPS codes and create a finder file of claim information on the mainframe at each MAC's Enterprise Data Center (EDC). A file exchange mechanism will be created to transmit these files to the Data Center where the assessments are housed. There the corresponding assessment information will be found in the QIES and an updated file returned to the EDC for further FISS processing.

The Validation Process

As mentioned, FISS will suspend claims with HIPPS codes in order to obtain corresponding assessment information in QIES. For IRF claims, Medicare will suspend Types of Bill (TOB) 111 and 117 with CMS Certification Numbers (CCNs) in the range of XX3025-XX3099, XXTXXX, or XXRXXX with a patient status code not equal to 30 and a statement covers "Through" date on or after October 1, 2012. (System changes will also be made to address HH, SNF, and SB claims by October 1, 2012, but those edits will be activated at a future date.)

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Upon receipt of the response information from QIES, Medicare will do the following with the IRF claim:

- If the submission date in the assessment response matches the occurrence code 50 date on the IRF claim, Medicare will release the claim for processing.
- If the submission date in the response information is later than the occurrence code 50 date, no Condition Code D2 is present, and greater than 27 days from the discharge date, Medicare will release the IRF claim for processing, but apply the late submission penalty.
- If the submission date is not present in the assessment response, Medicare will Return to Provider (RTP) the IRF claim indicating there is no assessment on file.
- Medicare will also compare the provider-submitted HIPPS code on the claim to the HIPPS code on the assessment response. If the HIPPS codes agree, Medicare will release the claim for processing.
- If the provider-submitted code is A5001, Medicare will release the IRF claim (though the submission date comparisons are still made).
- If the HIPPS code in the assessment is ZZZZ, Medicare will release the IRF claim for processing.
- If the HIPPS codes do not agree, Medicare will use the HIPPS code from the assessment information to calculate the payment for the IRF claim. When this occurs, the resultant remittance advice will contain a remark code of N69 (PPS (Prospective Payment System) code changed by claims processing system).

Phased Implementation of Validation Process

As proposed in the analysis, implementation of this validation process will be conducted in phases.

- The first phase, effective October 1, 2012, will implement the process for IRF claims only. Contractors will also make system changes for the HH and SNF phases in CR7760 and the resulting edits will be left inactive at the Medicare contractor sites.
- CMS will issue future instructions to test and activate the HH and SNF processes at dates to be determined.

Additional Information

The official instruction, CR7760, issued to your FI, RHHI, and A/B MAC regarding this change, may be viewed at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2495CP.pdf> on the CMS website.

If you have any questions, please contact your FI, RHHI, or A/B MAC 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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