CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2495	**Date: July 18, 2012**
	Change Request 7760

NOTE: Transmittal 2458 , dated April 27, 2012, is being rescinded and replaced by Transmittal 2495 to revise implementation dates. Implementation dates are October 1, 2012, for all business requirements except 7760.9.4. Business requirement 7760.9.4, for conforming changes to FISS to transmit the correct HIPPS code to CWF, will be implemented January 1, 2013. Additionally, the record layout in Attachment C is revised to correct the number of filler positions at the end of the record. All other information remains the same.

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

I. SUMMARY OF CHANGES: This Change Request creates a mechanism to validate claims information using patient assessment data.

EFFECTIVE DATE: October 1, 2012

IMPLEMENTATION DATE: October 1, 2012
January 1, 2013 for FISS transmission of paid HIPPS code to CWF (Business Requirement 7760.9.4)

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	1/140.2 Systematic Validation of Claims Information Using Patient Assessments

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2495	Date: July 18, 2012	Change Request: 7760

NOTE: Transmittal 2458 , dated April 27, 2012, is being rescinded and replaced by Transmittal 2495 to revise implementation dates. Implementation dates are October 1, 2012, for all business requirements except 7760.9.4. Business requirement 7760.9.4, for conforming changes to FISS to transmit the correct HIPPS code to CWF, will be implemented January 1, 2013. Additionally, the record layout in Attachment C is revised to correct the number of filler positions at the end of the record. All other information remains the same.

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

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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 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 Fiscal Intermediary Shared System (FISS) does not have access to the assessment databases. This inability to validate the submitted HIPPS code against the associated assessment creates significant payment vulnerability for the Medicare program. This vulnerability has been the subject of studies by the Office of Inspector General.

In January 2010, CMS instructed Medicare contractors to perform an analysis of the actions needed to create a systematic validation of HIPPS codes against assessment data. Since receiving the results of this analysis, CMS has worked with stakeholders in the assessment systems to further develop plans to implement this validation. The overall design of the process is shown in flowchart form in Attachment A.

In short, 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 CMS Data Center. There the corresponding assessment information will be found in the Quality Improvement Evaluation System (QIES) and an updated file returned to the EDC for further FISS

processing. The file exchange and QIES portions of this process are outside the scope of this CR. The business requirements below detail the changes required for Medicare claims processing.

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. However, system changes for the HH and SNF phases will be made in this CR and the resulting edits 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.

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

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7760.1	Medicare contractors shall create an edit to temporarily suspend IRF PPS claims and adjustments prior to pricing.						X				
7760.1.1	Medicare contractors shall suspend IRF claims and adjustments that meet the following criteria: • Type of bill 111 and 117 • CMS Certification Numbers (CCNs) XX3025 - XX3099, XXTXXX, or XXRXXX • Patient status code is not equal to 30 • Statement Covers "Through" date on or after October 1, 2012.						X				
7760.2	Medicare contractors shall create an edit to temporarily suspend HH PPS claims and adjustments prior to pricing.						X				
7760.2.1	Medicare contractors shall suspend HH claims and adjustments that meet the following criteria: • Type of bill 329, 339, 327, 337 • Statement Covers "Through" date on or after October 1, 2012.						X				
7760.3	Medicare contractors shall create an edit to temporarily suspend SNF and swing bed (SB) PPS claims and adjustments prior to pricing.						X				
7760.3.1	Medicare contractors shall suspend SNF and SB claims and adjustments that meet the following criteria: • Type of bill 21X, other than 210, 218 and						X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	contractor-initiated adjustments • Type of bill 18X, other than 110, 118 and contractor-initiated adjustments • Statement Covers "Through" date on or after October 1, 2012.										
7760.4	After each daily processing cycle, Medicare contractors shall create a finder file of data from the claims suspended in requirements 7760.1 – 7760.3						X				
7760.4.1	Medicare contractors shall create a separate file for each claim type (i.e. separate files for IRF, HH & SNF/SB).						X				
7760.4.2	Medicare contractors shall create one or more records in the data file for each suspended claim.						X				
7760.4.3	Medicare contractors shall include the following data in the record for each IRF claim suspended by requirement 7760.1: • beneficiary HIC number • claim DCN • beneficiary date of birth • provider CCN • claim statement covers dates • provider-submitted HIPPS code • claim admission date.						X				
7760.4.4	Medicare contractors shall include the following data in the record for each HH claim suspended by requirement 7760.2: • beneficiary HIC number • claim DCN • beneficiary date of birth • provider CCN • claim statement covers dates • provider-submitted HIPPS code • treatment authorization code positions 1 through 9 (which correspond to OASIS start of care date, assessment date and reason for assessment).						X				
7760.4.5	Medicare contractors shall include the following data in the record for each SNF or SB claim suspended by requirement 7760.3: • beneficiary HIC number • claim DCN • beneficiary date of birth • provider CCN						X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	• claim statement covers dates • provider-submitted HIPPS code • assessment reference date captured from occurrence code 50.										
7760.4.5.1	In cases where there are multiple 0022 revenue code lines on a SNF or SB claim, Medicare contractors shall create a separate query record for each assessment reference date.						X				
7760.4.5.2	If there are more 0022 revenue code lines than occurrence 50 dates, Medicare contractors shall assign the same occurrence code 50 date to each record until the assessment indicator in the 4th and 5th positions of the HIPPS code on the 0022 revenue code line changes. NOTE: examples of this assignment are provided in attachment B.						X				
7760.4.6	Medicare contractors shall format the finder file according to the record layout shown in Attachment C.						X				
7760.4.7	Medicare contractors shall name the data file with a naming convention that includes the following: • EDC identifier • MAC contractor number • Claim type (IRF, HH or SNF/SB) • Date of file creation • File type indicator (F for finder, R for response)						X				EDC
7760.5	Medicare contractors shall release for processing any claims which are held in a suspense location for more than 4 processing cycles without receipt of a corresponding response file.						X				
7760.6	When each response file is received, Medicare contractors shall copy the response information from the file onto the corresponding suspended claims.						X				
7760.7	Medicare contractors shall validate the IRF submission date.						X				
7760.7.1	If the submission date in the response information matches the occurrence code 50 date, Medicare contractors shall release the IRF claim.						X				
7760.7.2	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 contractors shall release the IRF claim and apply the late submission penalty.						X				IRF Pricer
7760.7.3	If the submission date in the response information is not	X		X			X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	present (field is zero-filled), Medicare contractors shall Return to the Provider (RTP) the IRF claim indicating there is no assessment on file. This reason code shall have an override for contractors.										
7760.8	Medicare contractors shall compare the provider-submitted HIPPS code against the HIPPS code in the response information on IRF claims.						X				
7760.8.1	If the HIPPS code in the response information is the same as the provider-submitted HIPPS code, Medicare contractors shall release the IRF claim.						X				
7760.8.2	If the provider-submitted HIPPS code is A5001, Medicare contractors shall release the IRF claim since the HIPPS code will not match the assessment but still apply business requirements 7760.7.1 – 7760.7.3 for submission date matching.						X				
7760.8.3	If the HIPPS code in the response information is ZZZZZ, Medicare contractors shall release the IRF claim.						X				
7760.8.4	If the HIPPS code in the response information is not the same as the provider-submitted HIPPS code, Medicare contractors shall use the HIPPS code in the response information to calculate payment for the IRF claim.						X				
7760.9	Medicare contractors shall compare the provider-submitted HIPPS code against the HIPPS code in the response information on HH claims.						X				
7760.9.1	If the first four positions of the HIPPS code in the response information are the same as the first four positions of the provider-submitted HIPPS code, Medicare contractors shall release the HH claim.						X				
7760.9.2	If the HIPPS code in the response information is ZZZZZ, Medicare contractors shall release the HH claim.						X				
7760.9.3	If the first four positions of the HIPPS code in the response information are not the same as the first four positions of the provider-submitted HIPPS code, Medicare contractors shall shall use the HIPPS code in the response information to calculate payment for the HH claim.						X				
7760.9.4	Effective for claims processed on or after January 1, 2013, if the HIPPS code used in payment calculation does not change as a result of that calculation, Medicare contractors shall transmit the HIPPS code in the response information to the Common Working File.						X				
7760.10	Medicare contractors shall compare the first provider-						X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	submitted HIPPS code on the SNF or SB claim against the HIPPS code in the response information.										
7760.10.1	If the provider-submitted HIPPS code begins with 'R', Medicare contractors shall compare it to the first HIPPS code in the response information.						X				
7760.10.2	If the provider-submitted HIPPS code begins with any value other than 'R', Medicare contractors shall compare it to the second HIPPS code in the response information.						X				
7760.10.3	If the first three positions of the HIPPS code in the response information are the same as the first three positions of the provider-submitted HIPPS code, Medicare contractors shall release the SNF or SB claim.						X				
7760.10.4	If the HIPPS code in the response information is ZZZZZ, Medicare contractors shall release the SNF or SB claim.						X				
7760.10.5	If the first three positions of the HIPPS code in the response information are not the same as the first three positions of the provider-submitted HIPPS code, Medicare contractors shall place shall use the HIPPS code in the response information to calculate payment for the SNF or SB claim.						X				
7760.11	When HIPPS codes are changed by requirements 7760. 8 –7760.10, Medicare contractors shall indicate this on the remittance advice using the following remark code: N69 - PPS (Prospective Payment System) code changed by claims processing system.						X				
7760.12	Medicare contractors shall turn off the edits created by requirements 7760.2 and 7760.3.	X		X		X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7760.13	A provider education article related to this instruction	X		X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
7760.10	Initially, only the first HIPPS code on the SNF or SB claim will be validated. Additional requirements to create validation rules for SNF or SB claims with multiple HIPPS codes will be provided in a separate instruction.
7760.11	CMS will submit a request to revise this remark code definition to remove the additional language reading "Insufficient visits or therapies." This language was specific to the initial HH PPS implementation in 2000 and is now outdated.

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, 410-786-6148, wilfried.gehne@cms.hhs.gov (HH)
Jason Kerr, 410-786-2123, jason.kerr@cms.hhs.gov (SNF/SB)
Fred Rooke, 404-562-7205, fred.rooke@cms.hhs.gov (IRF)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

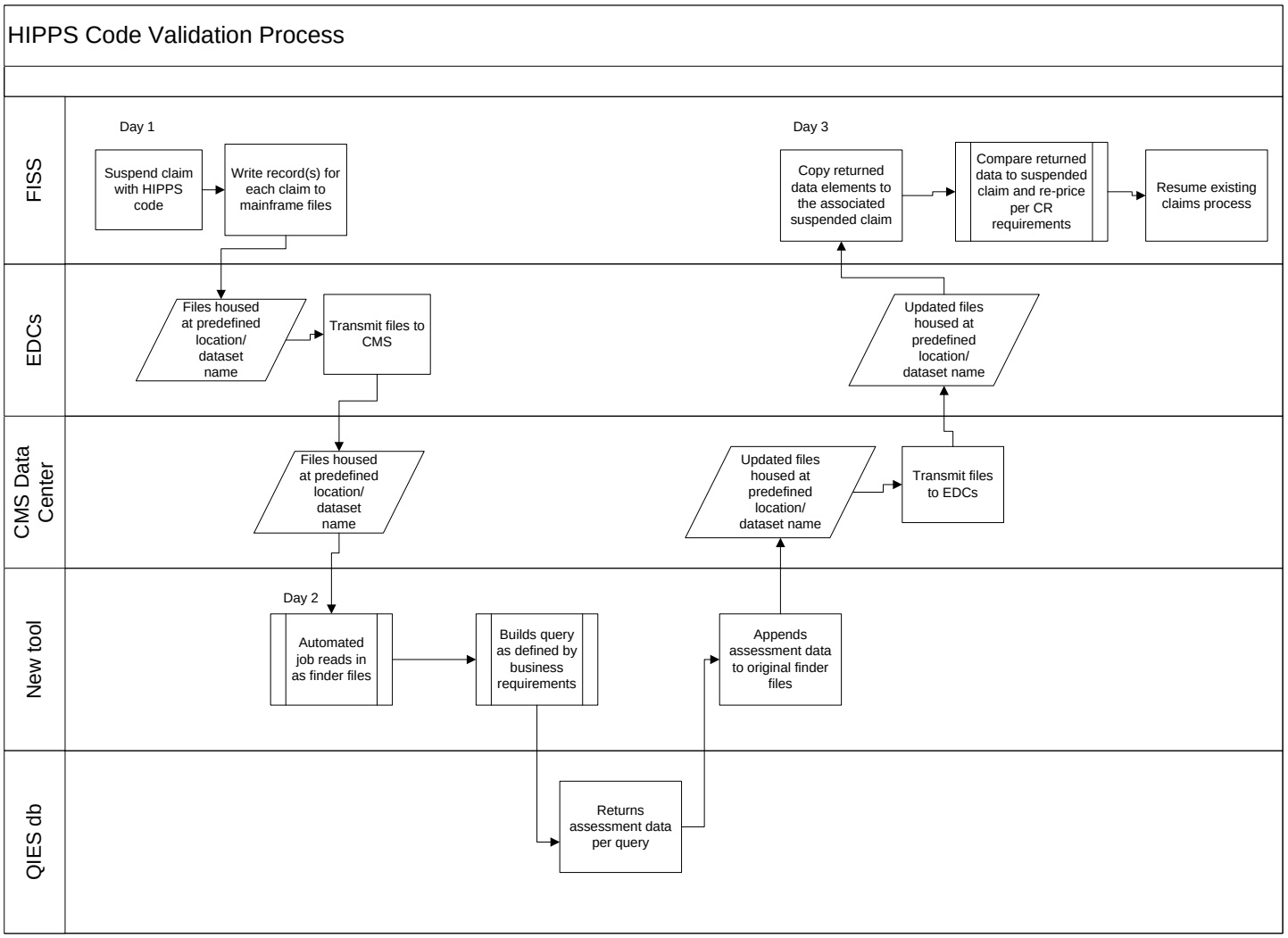
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *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.

ATTACHMENTS

Attachment A: Overall Process Design



Attachment B: Examples of assessment reference data assignment on SNF or SB claims.

In certain cases, a single Minimum Data Set may serve as the basis for more than one HIPPS code that is billed on a SNF or SB claim. In these cases, the assessment reference date for this assessment will appear on the claim only once as an occurrence code 50 date. This date must be assigned to more than one record in the finder file. The indicator for which two HIPPS code correspond to the same assessment is that the assessment indicator (last two positions of the SNF/SB HIPPS code will match.

Example 1: Occurrence code 50 dates: 1/1/2013, 1/10/2013, 1/25/2013

HIPPS codes: RUX11, SE211, RUC21, RUC31

Medicare systems shall apply the first occurrence code 50 date to the first HIPPS code and then also to the second one, since the assessment indicator (11) did not change. Resulting assignment:

RUX11	1/1/2013
SE211	1/1/2013
RUC21	1/10/2013
RUC31	1/25/2013

Example 2: Occurrence code 50 dates: 1/1/2013, 1/10/2013, 1/25/2013

HIPPS codes: RUX11, SE221, RUC21, RUC31

Medicare systems shall apply the first occurrence code 50 to the first HIPPS code and not to the second one, since the assessment indicator changed from 11 to 21. The second occurrence code 50 date is assigned to the second HIPPS code and then also to the third one, since the assessment indicator (21) did not change. Resulting assignment:

RUX11	1/1/2013
SE221	1/10/2013
RUC21	1/10/2013
RUC31	1/25/2013

Attachment C: Record Layout for Data File:

File Position	Format	Title	Description
FISS-Updated Elements in the Finder File			
1-12	X(12)	HIC	The beneficiary HIC number from the claim. Updated identically on all 3 claim types.
13 -35	9(23)	DCN	The claim's document control number. Updated identically on all 3 claim types.
36 -43	9(8)	DOB	The beneficiary date of birth from the claim. Updated identically on all 3 claim types.
44-49	X(6)	CCN	The provider CCN from the claim. Updated identically on all 3 claim types.
50-57	9(8)	FROM	The Statement Covers "From" date from the claim. Updated identically on all 3 claim types.
58-65	9(8)	THRU	The Statement Covers "Through" date from the claim. Updated identically on all 3 claim types.
66-70	X(5)	PROV-HIPPS	The provider-submitted HIPPS code SNF/SB claims: updated from the HCPCS field of the revenue code 0022 line. HH claims: updated from the HCPCS field of the revenue code 0023 line. IRF claims: updated from the HCPCS field of the revenue code 0024 line.
71-79	X(9)	ASSES-DATE	Assessment date information from the claim. SNF/SB claims: updated from the occurrence code 50 date that corresponds to the HIPPS code in the PROV-HIPPS field and the filler character A. HH claims: updated from the first 9 positions of the claim treatment authorization code. IRF claims: updated from the admission date on the claim and the filler character A.
80-82	9(3)	LINE-NUMBER	The line number of the service line to which the response information should be associated.
QIES Tool-Updated Elements Added to the Response File			
83-87	X(5)	RETURN-HIPPS1	One of two system-generated HIPPS codes copied from the assessment record, if found.

File Position	Format	Title	Description
			SNF/SB claims: updated from the therapy HIPPS code on the assessment. HH & IRF claims: updated from the re-calculated HIPPS code on the assessment. All claims: Updated with ZZZZZ if no corresponding assessment is found.
88-92	X(5)	RETURN-HIPPS2	Second of two system-generated HIPPS codes copied from the assessment record, if found: SNF/SB claims: updated from the non-therapy HIPPS code on the assessment. HH & IRF claims: zero filled. All claims: Updated with ZZZZZ if no corresponding assessment is found.
93-100	9(8)	SUB-DATE	The assessment submission date from the assessment record. Zero filled if no corresponding assessment is found.
101-108	9(8)	ASSES-DATE-CONV	HH claims: The assessment date converted from the hexavigesimal coded date sent in the finder file. IRF & SNF/SB claims: Zero filled.
109-118	X(10)	ASSES-ID	The assessment unique identifier from the assessment record. Zero filled if no corresponding assessment is found.
119-150	X(32)	Filler	

Medicare Claims Processing Manual
Chapter 1 - General Billing Requirements

Table of Contents
(Rev.2495, Issued: 07-18-12)

140.2 – Systematic Validation of Claims Information Using Patient Assessments

(Rev.2495, Issued: 07-18-12, Effective, 10-01-12, Implementation: 10-01-12, 01-01-13, for FISS transmission of paid HIPPD code to CWF (Business Requirement 7760.9.4)

The case-mix groups used to determine payments under several Medicare prospective payment systems (PPS) are based on clinical assessments of the beneficiary. Each payment system uses a different patient assessment tool:

Payment System	***Assessment Used***
Skilled Nursing Facility – SNF PPS	*Minimum Data Set*
Home Health – HH PPS	*Outcomes and Assessment Information Set*
Inpatient Rehabilitation Facility – IRF PPS	*IRF Patient Assessment Instrument*

In all three payment systems, the assessments are entered into software at the provider site that encodes the data into a standard transmission format and transmits the assessments to quality improvement systems. In addition, the software runs the data from the assessments through grouping software that generates a case-mix group to be used on Medicare PPS claims. These case mix groups are reported on claims using a Health Insurance PPS (HIPPS) code.

CMS provides free grouping software to perform this function, but many providers create their own software due to their need to integrate these data entry and grouping functions with their own administrative systems. In some cases, this results in HIPPS codes reported on claims that differ from the HIPPS code calculated by the assessment system.

In the interest of payment accuracy, Medicare claims processing systems may temporarily hold claims paid under these payment systems, in order to validate the claim information against the assessment record. If the information found in the assessment system differs from the claim information, the assessment information will be used to pay the claim. This process will occur within the payment floor period.

This process may be used for various purposes, including:

- *Validating the provider-submitted HIPPS code*
- *Ensuring timely assessment submission requirements are met*
- *Ensuring conditions of payment are met.*