| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-04 Medicare Claims Processing | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 11140** | **Date: December 2, 2021** |
| | **Change Request 12525** |

**SUBJECT: Update to the Internet Only Manual (IOM) Publication 100-04, Chapters 3 and 17**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to update Chapters 3 and 17 of the Medicare Claims Processing Manual.

**EFFECTIVE DATE: January 4, 2022**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: January 4, 2022**

***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 |
|---|---|
| R | 3/20/20.2/Computer Programs Used to Support Prospective Payment System |
| R | 3/140/140.3/Billing Requirements Under IRF PPS |
| R | 3/190/190.4.4/Calculating the Federal Payment Rate |
| R | 17/20/20.5.6/Inherent Reasonableness for Drugs and Biologicals |

**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:**
**Business Requirements**
**Manual Instruction**

# Attachment - Business Requirements

| Pub. 100-04 | Transmittal: 11140 | Date: December 2, 2021 | Change Request: 12525 |
|---|---|---|---|

**SUBJECT: Update to the Internet Only Manual (IOM) Publication 100-04, Chapters 3 and 17**

**EFFECTIVE DATE: January 4, 2022**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: January 4, 2022**

## I. GENERAL INFORMATION

**A. Background:** This Change Request updates instructions found in Publication 100-04, Chapter 3, Sections 20.2, 140.3 and 190.4.4, as well as Chapter 17, Section 20.5.6.

**B. Policy:** There is no change in policy.

## 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 | |
| 12525.1 | Contractors shall note the revisions made to Pub. 100-04, Chapter 3, Sections 20.2, 140.3 and 190.4.4. | X | | | | | | | | |
| 12525.2 | Contractors shall note the revisions made to Pub. 100-04, Chapter 17, Section 20.5.6. | X | 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):** Shauntari Cheely, Shauntari.Cheely@cms.hhs.gov

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

## VI. FUNDING

**Section A: 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: 0**

## 20.2 - Computer Programs Used to Support Prospective Payment System

***(Rev.11140, Issued:12-02-21, Effective:01-04-22, Implementation: 01-04-22)***

**Medicare Code Editor**

The Medicare Code Editor (MCE) is a front-end software program that edits claims to detect incorrect billing data. The MCE addresses three basic types of edits which will support the DRG assignment. They include correct diagnosis and procedure coding, coverage, and clinical edits.

Built into the MCE, which is the first portion of the Grouper program, are edits which reject incomplete or impossible codes. Claims submitted with valid diagnoses and valid diagnoses-surgical procedure combinations but are incorrect in that they do not represent the actual diagnosis or procedure, cannot be detected. The responsibility for accuracy rests with the hospital. However, a post claim approval review may be conducted by the A/B MACs (A), using medical records and the approved claim.

**Grouper Program**

The Grouper program determines the DRG from data elements the hospital reported. It is used on all inpatient discharge/transfer bills received from both PPS and non-PPS facilities, including those from waiver States, long-term care hospitals, and excluded units.

**Pricer Program**

The Pricer program determines the amount to pay under prospective payment.

The Pricer program applies the DRG relative weights, hospital urban or rural and census division location, hospital specific data, and beneficiary hospital data from the bill to determine the amount payable for each PPS discharge bill.

Most hospitals should not need a Pricer program because only one rate per DRG applies unless the claim results in a cost outlier for a beneficiary *whose* benefits are exhausted during the stay. For those claims, the provider must identify the outlier threshold to properly bill covered days on an inpatient claim. See §20.7.4 below.

## 140.3 - Billing Requirements Under IRF PPS

***(Rev.11140, Issued:12-02-21, Effective:01-04-22, Implementation: 01-04-22)***

IRF PPS payment is contingent on the requirement that IRFs complete a patient assessment upon admission and discharge for Medicare patients. The August 7, 2001, Final Rule, and subsequent final rules contain detailed information regarding the assessment schedule for the patient assessment instrument (PAI) with respect to transmission requirements, encoding dates, and other pertinent information. Further, there is an item-by-item guide, which specifies detailed instructions regarding the manner in which each item on the assessment instrument needs to be completed.

Effective with cost reporting periods beginning on or after January 1, 2002, IRFs are required to report billing data with a new revenue code and a Health Insurance PPS (HIPPS) Rate Code on the ASC X12 837 institutional claim or, in rare cases, on the Form CMS-1450 for all Part A inpatient claims (Type of Bill 11X) to their A/B MACs (A). The new revenue code, 0024, is used in conjunction with the HIPPS Rate Code to identify the CMG payment classification for the beneficiary. In addition to all entries previously required on a Part A claim, the following additional instructions must be followed to accurately price and pay a claim under the IRF PPS. These claims must be submitted on Type of Bill 11X. The last four digits of the provider number for rehabilitation hospitals is from 3025 to 3099, and for rehabilitation distinct part units the third digit will be a T if the unit is located in an acute care hospital or an R if the unit is located in a CAH.

- The Revenue code must contain revenue code 0024. This code indicates that this claim is being paid under the PPS. This revenue code can appear on a claim only once.

- The following Patient Discharge Status codes are applicable under the transfer policy for IRF PPS: 02, 03, 61, 62, 63, and 64.

**NOTE**: IRFs that transfer a beneficiary to a nursing home that accepts payment under Medicare and/or Medicaid should use PS 03, discharged/transferred to a SNF. IRFs that transfer a beneficiary to a nursing facility that does not accept Medicare or Medicaid, should code PS 04, discharged/transferred to an ICF, until such time that a new PS code is established to differentiate between nursing facilities that do not accept Medicare and/or Medicaid and those that do. PS 04 does not constitute a transfer under the IRF PPS policy.

- For typical cases, the HCPCS/Rates must contain a five digit HIPPS Rate/CMG Code (AXXYY-DXXYY). The first position of the code is an A, B, C, or D. The HIPPS rate code beginning with A in front of the CMG is defined as without comorbidity. The HIPPS rate code containing a B in front of the CMG is defined as with comorbidity for Tier 1. The HIPPS rate code containing a C in front of the CMG is defined as with comorbidity for Tier 2. The HIPPS rate code containing a D in front of the CMG is defined as with comorbidity for Tier 3. The (XX) in the HIPPS rate code is the Rehabilitation Impairment Category (RIC). The (YY) in the HIPPS rate code is the sequential numbering system within the RIC.

- For atypical cases effective January 1, 2010, the HCPCS/Rates must contain a five digit HIPPS Rate/CMG Code A5001. An atypical case occurs under the new IRF coverage requirements that became effective January 1, 2010, where an IRF is eligible to receive the IRF short stay payment for 3 days or less (HIPPS Rate/CMG A5001) if a patient's thorough preadmission screening shows that the patient is an appropriate candidate for IRF care but then something unexpected happens between the preadmission screening and the IRF admission such that the patient is no longer an appropriate candidate for IRF care on admission and the day count is greater than 3. In this scenario only, if the patient is discharged/transferred on or after day 4, we are instructing IRFs to bill HIPPS Rate/CMG A5001. Thus, whether or not the IRF is able to discharge the patient to another setting of care within 3 days, the IRF will only be eligible for and receive the IRF short stay payment for 3 days or less (HIPPS Rate/CMG A5001).

Covered Charges should contain zero covered charges when the revenue code is 0024. For accommodation revenue codes (010x-021x), covered charges must equal the rate times the units. The IRF Pricer will calculate and return the payment amount for the line item with revenue code 0024. Non-outlier payments will not be made based on the total charges shown in Revenue Code 0001.

- IRF providers will submit one admit through discharge claim for the stay. Final PPS payment is based upon the discharge bill.

- Should the patient's stay overlap the time in which the PPS applies to the facility, PPS payment will still be based on discharge. If the facility submitted an interim bill, a debit/credit adjustment must be made prior to PPS payment. If the facility submits multiple interim bills, the provider will need to submit cancels and then rebill once the cancels are accepted.

- IRFs can submit adjustment bills (even to correct the CMG), but late charge bills will not be allowed (Type of bill 115).

- If a beneficiary has 1 day of Medicare coverage during their IRF stay, an entire CMG payment will be made.

- IRFs will be paid under the IRF PPS beginning on the first day of their cost reporting period that begins on or after January 1, 2002. Units established in a CAH will be paid under the IRF PPS beginning with CAH cost reporting periods on or after October 1, 2004.

For interim bills, if the stay is greater than 60 days, the interim bill should include the lowest level of the HIPPS code from the admission assessment. The final claim will be adjusted to reflect data from the discharge assessment.

When coding PPS bills for ancillary services associated with a Part A inpatient stay, the traditional revenue codes will continue to be shown, e.g., 0250 - Pharmacy, 042x - Physical Therapy, in conjunction with the appropriate entries in Service Units and Total Charges.

- IRFs are required to report the number of units based on the procedure or service.

- IRFs are required to report the actual charge for each line item, in Total Charges.

If a beneficiary's Part A benefits exhaust during the stay, code an occurrence code A3-C3. If benefits are exhausted prior to the stay, submit a no pay claim, which will be coded by the A/B MAC (A) with no pay code B. Report any services that can be billed under the Part B benefit using 12X TOB.

**NOTE**: For more information on outlier payments when benefits are exhausted, please see §20.7.4. Although this references an expired instruction specific to inpatient hospital PPS billing, the information presented provides important general information.

## 190.4.4 - Calculating the Federal Payment Rate

***(Rev.11140, Issued:12-02-21, Effective: 01-04-22, Implementation: 01-04-22)***

To calculate an IPF PPS payment, follow the steps below:

1 - Multiply the Federal per diem base rate by the labor share.

2 - Multiply the resulting amount by the appropriate wage index factor.

3 - Multiply the Federal per diem base rate by the non-labor share.

4 - Multiply the resulting amount from this by any applicable cost-of-living adjustment (COLA) (Alaska or Hawaii).

5 - Add the adjusted labor portion of the Rate to the adjusted non-labor portion of the Rate (Add the results of steps 2 and 4). This is the Federal rate.

You must multiply this sum (step 5) by the all applicable facility and patient level adjustment factors described in §§190.5 and 190.6, to calculate the final payment.

## 20.5.6 - Inherent Reasonableness for Drugs and Biologicals

***(Rev.11140, Issued: 12-02-21, Effective :01-04-22, Implementation: 01-04-22)***

Section 4316 of the Balanced Budget Act of 1997 permits A/B MACs (B) to establish realistic and equitable payment amounts for drugs when the existing payment amounts are inherently unreasonable because they are either grossly excessive or deficient. Refer to chapter 23, for a complete description of Inherent Reasonableness rules.

Examples of the factors that may result in grossly deficient or excessive payment amounts include, but are not limited to the following:

1. Payment amounts for drugs or biologicals are grossly higher or lower than acquisition or production costs for the category of items or services.

2. There have been increases in payment amounts that cannot be explained by inflation or technology.

In some instances, the calculation of the AWP may lead to a payment limit that is not reasonable for the purpose of paying for drugs and biologicals. A/B MACs (B) can apply the principal of inherent reasonableness in selecting the drugs to be included in the calculation. For instance in situations where there are some drugs in a HCPCS grouping that are significantly more expensive due to having preservatives added, there is no effect on the quality of the drug whether or not there are preservatives. Therefore, leave the drugs with preservatives out of the calculation.

While A/B MACs (A) and (B) may determine under their inherent reasonableness authority that a greater than 15 percent increase or decrease in payment amounts is warranted, they may not increase or decrease the payment amounts for any item by greater than 15 percent in any given year. However, a contractor may determine that a 25 percent reduction is warranted, and accomplish the adjustment over 2 years, e.g., 15 percent applied the first year, and 10 percent applied the following year.

In addition, a contractor must inform CMS of any inherent reasonableness determinations. The CMS will then acknowledge receipt of the notification. The payment adjustment may not take effect until the contractor has notified CMS and received CMS's acknowledgment of the notification.