CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3001	**Date: August 1, 2014**
	Change Request 8654

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

I. SUMMARY OF CHANGES: This CR implements the FISS changes required to modify the criteria of claims selected to be sent via the interface between FISS and QIES.

EFFECTIVE DATE: October 1, 2012
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 5, 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
R	1/140.2/Systematic Validation of Claims Information Using Patient Assessments

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 obliged 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

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I. GENERAL INFORMATION

A. Background: FISS suspends claims with HIPPS codes and creates a finder file of claim information on the mainframe at each MAC's Enterprise Data Center (EDC). A file exchange mechanism transmits these files to the CMS Data Center. There, the corresponding assessment information is found in the Quality Improvement Evaluation System (QIES) and an updated file is returned to the EDC for further FISS processing. The automated selection criteria for claims selected by FISS to suspend for this process needs to be modified for Skilled Nursing Facilities and Inpatient Rehabilitation Facilities to not include Medicare Advantage claims.

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) and Inpatient Rehabilitation Facilities (required by regulation in 2002). Both 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	
8654.1	Medicare contractors shall adjust the criteria for IRF claims selection to no longer include Medicare Advantage claims.					X				
8654.2	Medicare contractors shall adjust the criteria for SNF claims selection to no longer include Medicare Advantage claims.					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): Fred Rooke, fred.rooke@cms.hhs.gov (for IRF claims processing) , Jason Kerr, jason.kerr@cms.hhs.gov (for SNF claims processing)

Post-Implementation Contact(s): Contact your Contracting Office Representative (COR)

VI. FUNDING

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

140.2 – Systematic Validation of Claims Information Using Patient Assessments

(Rev. 3001, Issued: 08-01-14, Effective: 10-01-12, Implementation: 01-05-15)

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 Medicare PPS claims paid under these payment systems (Medicare Advantage claims are excluded), 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.