CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1099	**Date: NOVEMBER 2, 2006**
	Change Request 5354

SUBJECT: New Edits Established to Enforce Proper Transfer Coding and Payment in Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) Claims

I. SUMMARY OF CHANGES: Two recent Office of Inspector General (OIG) reports were published this year describing overpayments made by the Medicare program because of improperly coded IRF PPS claims (claims coded as discharges that were found to be transfers). The OIG recommended that CMS implement edits within the Common Working File (CWF) that "match beneficiary discharge dates with admission dates to other providers to identify potentially miscoded claims". Claims identified as transfers will be canceled back to the provider for correction and thus ensure proper payment.

NEW / REVISED MATERIAL
EFFECTIVE DATE: April 1, 2007
IMPLEMENTATION DATE: April 2, 2007

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	

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-04	Transmittal 1099	Date: November 2, 2006	Change Request 5354

SUBJECT: New Edits Established to Enforce Proper Transfer Coding and Payment in Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) Claims

Effective Date: Discharges on or after April 1, 2007

Implementation Date: April 2, 2007

I. GENERAL INFORMATION

A. Background: Two recently published Office of Inspector General (OIG) reports A-04-04-00008 and A-04-04-00013 were published this year describing overpayments made by the Medicare program because of improperly coded IRF PPS claims (claims coded as discharges that were found to be transfers). The OIG recommended that CMS implement edits within the Common Working File (CWF) that "match beneficiary discharge dates with admission dates to other providers to identify potentially miscoded claims".

B. Policy: For the IRF PPS, transfer cases are defined as those in which a Medicare beneficiary is transferred to either another rehabilitation facility (patient status code 62), a long term care hospital (patient status code 63), an inpatient hospital (patient status code 02), or a nursing home that accepts payment under either the Medicare program and/or the Medicaid program (patient status codes 03, 61, or 64) AND the length of stay of the case is less than the average length of stay for a given CMG. The transfer policy consists of a per diem payment amount calculated by dividing the per discharge CMG payment rate by the average length of stay for the CMG. Medicare will pay transfer cases a per diem amount and include an additional half day payment for the first day. Transfer payments will be calculated by first adding the length of stay of the case to 0.5 (to account for the addition of the half day payment for the first day) and then multiplying the result by the CMG per diem amount.

For purposes of this One Time Notification, only claims coded incorrectly as discharges, which are in fact transfers will be cancelled.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5354.1	Contractor shall ensure accurate coding of transfer patient status codes in IRF PPS.										X	
5354.1.1	Contractor shall reject an incoming IRF PPS claim when the following										X	

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	conditions are met: • Incoming claim TOB is 11X, provider number range is XX-3025 – XX-3099, XX-TXXX, or XX-RXXX and Condition Code 65 is not present. • Incoming claim patient status code is 01, 05, 06, 07, 08, 20, 43, 50, 51, 65, or 66. • Incoming claim IRF Pricer return code is NOT 02, 03, 12, or 13. • Incoming claim discharge date is on or after April 1, 2007. • History claim is acute care hospital, swing bed, SNF, another IRF, or LTCH. • History claim admission date equals incoming claim discharge date.											
5354.1.2	Contractor shall send an informational unsolicited response to the FI and A/B MAC contractor on a history IRF PPS claim when the following conditions are met: • History claim TOB is 11X, provider number range is XX-3025 – XX-3099, XX-TXXX, or XX-RXXX, and Condition Code 65 is not present. • History claim patient status code is 01, 05, 06, 07, 08, 20, 43, 50, 51, 65, or 66. • History claim IRF Pricer return code is NOT 02, 03, 12, or 13. • History claim discharge date is on or after April 1, 2007. • Incoming claim is acute care hospital, swing bed, SNF, another IRF, or LTCH.										X	

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	• Incoming claim admission date equals history claim discharge date.											
5354.1.2.1	Contractor shall cancel the history IRF claim.	X		X				X				
5354.1.2.2	Contractor shall instruct IRFs to correct patient status code and resubmit their claims. The normal timely filing rules will apply to rebills.	X		X								
5354.1.2.3	Contractor shall notify IRF that they will not be penalized by the OIG when they change the patient status code to indicate a transfer, even if it does not correspond with the hospital's medical records.	X		X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5354.2	A provider education article related to this instruction will be available at 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 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are	X		X								

Number	Requirement	Responsibility (place an “X” in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	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

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

B. For all other recommendations and supporting information, use the space below:

V. CONTACTS

Pre-Implementation Contact(s): Sarah Shirey-Losso at sarah.shirey-losso@cms.hhs.gov and Valeri Ritter at Valeri.ritter@cms.hhs.gov

Post-Implementation Contact(s): Appropriate CMS Regional Office

VI. FUNDING

A. ***For TITLE XVIII Contractors*, use only one of the following statements:**
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. ***For Medicare Administrative Contractors (MAC)*, use only one of the following statements:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. We do not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.