CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1565	**Date: July 25, 2008**
	Change Request 6002

NOTE: Transmittal 1553, dated July 18, 2008, is rescinded and replaced with Transmittal 1565, dated July 25, 2008 to change the effective date to January 1, 2009 and the implementation date to January 5, 2009 on the Business Requirements Attachment. Also, date changes were made to the manual instruction in section 30.5. The October 1, 2008 date was changed to January 1, 2009. All other information remains the same.

SUBJECT: Clarification on the Correct Condition Code to Report on Provider Adjustment Requests to Indicate a Health Insurance Prospective Payment System (HIPPS) Code Change

I. SUMMARY OF CHANGES: This instruction clarifies the correct condition code to report on adjustment requests when changing a previously processed HIPPS code.

New / Revised Material
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

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	6/30.5/Adjustment to Health Insurance Prospective Payment System (HIPPS) Codes Resulting From Long Term Care Resident Assessment Instrument (RAI) Corrections
R	6/30.5.1/Adjustment Requests

III. FUNDING:
SECTION A: For Fiscal Intermediaries and 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.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1565	Date: July 25, 2008	Change Request: 6002

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SUBJECT: Clarification on the Correct Condition Code to Report on Provider Adjustment Requests to Indicate a Health Insurance Prospective Payment System (HIPPS) Code Change

EFFECTIVE Date: January 1, 2009

IMPLEMENTATION DATE: January 5, 2009

I. GENERAL INFORMATION

A. Background: Medicare systems currently require Skilled Nursing Facility (SNF) and Swing Bed (SB) providers to append condition code D4 to inpatient adjustment requests when a change is made to the original Health Insurance Prospective Payment System (HIPPS) code billed on the claim. The definition for condition code D4 was previously revised, by the National Uniform Billing Committee (NUBC), to indicate a change in clinical codes (ICD) for diagnosis and/or procedure codes. Due to this revision, providers shall no longer use the D4 condition code to report HIPPS code changes on SNF adjustment requests.

With the implementation of this instruction, providers shall begin using the following condition code to report HIPPS code changes on adjustment requests:

Condition Code **D2** – Change in Revenue Codes/HCPCS/HIPPS Rate Codes

In addition, Medicare systems are updated to require Inpatient Rehabilitation Facility (IRF) and Home Health (HH) to report a condition code D2 on adjustment requests that alter the existing HIPPS code on a previous paid claim. Previous instruction for the use of condition code D2 is already provided in the Inpatient Hospital and Home Health claims processing chapters.

Providers may review Chapter 25, Completing and Processing the Form CMS-1450 Data Set, of the Medicare Claims Processing Manual for further descriptions of the code sets reported on the Form CMS-1450.
http://www.cms.hhs.gov/manuals/downloads/clm104c25.pdf

B. Policy: There are no policy changes with this transmittal.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A/B	DME	FI	CAR	RHH	Shared-System Maintainers	OTHER

							FISS	MCS	VMS	CWF	
6002.1	Medicare systems shall require a condition code D2 for provider adjustment requests that change previous HIPPS codes reported with revenue codes 0022, 0023, or 0024.						X				
6002.1.1	Medicare contractors shall return to provider adjustment requests when a claim contains a HIPPS code change without a condition code D2.	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	
6002.2	A provider education article related to this instruction 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.	X		X							

IV. SUPPORTING INFORMATION

Section 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:

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

V. CONTACTS

Pre-Implementation Contact(s): Jason Kerr, Jason.Kerr@cms.hhs.gov

Post-Implementation Contact(s): Appropriate Regional Office
http://www.cms.hhs.gov/RegionalOffices/01_Overview.asp

VI. FUNDING

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

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.

30.5 - Adjustment to Health Insurance Prospective Payment System (HIPPS) Codes Resulting From Long Term Care Resident Assessment Instrument (RAI) Corrections

(Rev.1565, Issued: 07-25-08, Effective: 01-01-09, Implementation: 01-05-09)

The RAI is an assessment tool completed by facility clinical staff that is transmitted electronically to state agencies and then transferred to CMS, and is used to determine *the* RUG code. The 3-digit RUG code and the 2-digit AI make up the HIPPS code that appears on the *claim*, and is used to determine the payment rate *under* the SNF PPS. Effective for services provided on and after June 1, 2000, SNFs *and swing beds subject to the SNF PPS* must submit adjustment requests to reflect *modifications of or inactivation of* the RAI that result in changes to the RUG code (i.e., the first three digits of the HIPPS code).

Instructions on the types of errors SNFs may correct *can be found in Chapter 5 of the RAI Manual located at http://www.cms.hhs.gov/nursinghomequalityinits/20_nhqimds20.asp and Chapter 5 of the Swing Bed Manual located at http://www.cms.hhs.gov/SNFPPS/03_SwingBed.asp .* Correction to RAI data may affect items that are used in the RUG grouper calculations, and could change the RUG group for which a beneficiary qualifies. An example of a valid correction would be a change to MDS v 2.0 item M1b, number of stage two ulcers. If the facility reported zero stage two ulcers when there were really three ulcers present, the item should be corrected using this process.

An adjustment request must be submitted if the RAI correction results in a HIPPS code that is different from that already billed and paid*, except in those cases where the default HIPPS code was used. Claims that were filed with the HIPPS default code represent payment in full and cannot be adjusted retroactively*. The adjustment request is retroactive to the first date payment was made using the original (but incorrect) HIPPS rate code. An RAI correction is not a new assessment, and can never be used as a replacement for a Medicare-required assessment.

EXAMPLE 1:

A Medicare 5-day assessment was completed timely and used to establish the HIPPS rate code for days 1-14 of the Part A covered stay. The bill was paid before the SNF found the error. (The error on that 5-day assessment was identified on day 17 while staff was completing the Medicare 14-day assessment.) The facility corrects the 5-day assessment, and submits an adjustment request for days 1-14 of the Part A stay. Use SNF adjustment condition code D2 in this situation.

EXAMPLE 2:

On day 39 of the Part A stay, the SNF identifies an error in a 30-day Medicare-required assessment. Five days of service had already been billed and paid based on the HIPPS code generated from that 30-day Medicare assessment. The SNF submits an RAI correction to the state that results in a change in the RUG group. The SNF submits an adjustment request to the FI for the five days of service using the corrected HIPPS rate

code. Then, the corrected HIPPS rate code is used for billing any remaining covered days in the applicable payment period.

The SNF must document the reason for an RAI correction and certify to the accuracy of the correction. This documentation must be kept in the medical record. Review of this documentation must be incorporated into the FI medical review process.

To meet the clinical RAI requirements, SNFs may be required to perform an SCSA or SCPA in addition to completing the RAI correction. As long as the RUG group generated from the RAI correction and the SCSA or SCPA are the same, the SNF can use the corrected assessment to derive the HIPPS rate code in order to bill any remaining covered days in the applicable payment period (e.g., days 31-60 for the 30-day assessment). However, since the SCSAs and the SCPAs require a new observation period and new ARDs, it is possible that the RUG group generated by the SCSA or SCPA assessment will be different. In this case, the corrected assessment would be used from the first day of the applicable payment period (e.g., days 31-60 for the 30-day assessment) until the ARD of the SCSA or SCPA assessment. If the ARD for the SCSA or SCPA is within the assessment window, the SCSA or SCPA must also be used as a replacement for the next Medicare-required assessment.

RAI corrections may also be processed to inactivate an RAI record. Some examples of records that should be inactivated include assessment data submitted under the Health Insurance Claim (HIC) number for a different beneficiary, or a record transmitted with the wrong reason for assessment. In most cases, the SNF will also have filed an accurate, timely RAI for the beneficiary, which can be used to derive a HIPPS rate code for billing purposes. If the SNF did not realize the error until a claim had been submitted and paid, the SNF would submit an adjustment request. However, this type of adjustment does not involve a correction of RAI clinical data, and is not subject to the clinical data correction procedures described above.

In those rare situations where an RAI *that was used to support billing for a paid claim* is inactivated and *as a consequence* there is no valid HIPPS code for that payment period, the SNF must submit an adjustment request at the default rate (AAA00) for the applicable covered days of service.

Effective for services provided on and after *January 1, 2009*, SNFs must submit adjustment requests, *with condition code D2,* to reflect corrections to the RAI that result in changes to the RUG code (i.e., the first 3 digits of the HIPPS code). *Condition code D4 must be utilized for services prior to January 1, 2009.*

30.5.1 - Adjustment Requests

(Rev.1565, Issued: 07-25-08, Effective: 01-01-09, Implementation: 01-05-09)

Adjustment request*s* based on corrected assessments must be submitted within 120 days of the service “through” date. The “through” date will be used to calculate the period during which adjustment requests may be submitted based on corrected RAI assessments. The “through” date indicates the last day of the billing period for which the HIPPS code is billed. Adjustment requests based on corrected assessments must be submitted within

120 days of the "through" date on the bill. *For HIPPS changes resulting from an MDS correction, providers must append a condition code D2 on their adjustment claim.* An edit is in place to limit the time for submitting this type of adjustment request to 120 days from the service "through" date.

The CMS expects that most HIPPS code corrections will be made during the course of the beneficiary's Medicare Part A stay. Therefore, providers that routinely submit corrections after the beneficiary's Part A stay has ended may be subject to focused medical review.

Adjustment requests to change a HIPPS code may not be submitted for any claim that has already been medically reviewed, such claims are identified in the FI's system by an indicator on the claim record. This applies whether or not the medical review was performed either pre- or post-payment. All adjustment requests submitted are subject to medical review. Information regarding medical review is located in the Medicare Program Integrity Manual.

Billing errors for an incorrect HIPPS code prior to June 1, 2000, cannot be adjusted. However, the requirement that providers may not knowingly over bill the Medicare program remains in effect. SNFs that identify patterns of errors that result in overpayments must report them to the FI, and these overpayments must be recouped. A pattern of errors includes but is not limited to software errors in transmitting RAI files, misunderstandings of RAI instructions that result in consistent miscoding of one or more RAI items used in determining the RUG group, etc.