Program Memorandum Intermediaries

Department of Health & Human Services (DHHS)
The Centers for Medicare & Medicaid Services (CMS)

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This Program Memorandum re-issues Program Memorandum A-01-121, Change Request 1224 dated September 27, 2001. The only change is the discard date; all other material remains the same.

This Program Memorandum re-issues Program Memorandum A-00-46, Change Request 1224 dated August 3, 2000. The only change is the discard date; all other material remains the same.

CHANGE REQUEST 1224

SUBJECT: Skilled Nursing Facility Adjustment Billing: Adjustments to HIPPS Codes Resulting From MDS Corrections

The purpose of this Program Memorandum (PM) is to inform you of billing changes that will be required as a result of the implementation of a new procedure to inactivate or correct Minimum Data Set (MDS) information. The MDS is an assessment tool completed by facility clinical staff that is transmitted electronically to state agencies and then transferred to HCFA, and is used to determine a Resource Utilization Group (RUG-III) code. The 3-digit RUG-III code and the 2-digit assessment indicator make up the Health Insurance Prospective Payment System (HIPPS) code that appears on the bill, and is used to determine the payment rate for the skilled nursing facility (SNF) Prospective Payment System (PPS). Effective for services provided on and after June 1, 2000, SNFs should submit adjustment bills to reflect corrections to the MDS data that result in changes to the RUG-III code (i.e., the first three digits of the HIPPS code).

Adjustment Billing: Changing HIPPS Codes

When the SNF PPS was implemented in July 1998, there were limited options for facilities to correct an incorrect response in the MDS record that was used to calculate the RUG-III group, even when that error resulted in an incorrect payment rate. Instructions have been issued to SNFs on the types of errors that may be corrected, and the procedures to be followed when making these corrections, and are available at http://www.hcfa.gov/medicaid/mds20/whatsnew.htm. The document is titled "March 2000 Draft Provider Instructions for Making Automated Corrections Using the New MDS Correction Request Form."

Correction of MDS data may affect items that are used in the RUG-III grouper calculations, and could change the RUG-III group for which a beneficiary qualifies. An example of a valid correction would be a change to MDS2.0 item M1b, number of stage 2 ulcers. If the facility reported zero Stage 2 ulcers when there were really 3 ulcers present, the item should be corrected using the process explained in the procedures on the HCFA Web site above. An adjustment bill would be submitted if the MDS correction results in a RUG-III code that is different from that already billed. The adjustment bill is retroactive to the first date payment was made using the original (but incorrect) RUG-III code.

Example 1: A Medicare 5-day assessment was completed timely and used to establish the RUG-III rate for days 1-14 of the Part A stay. The bill was paid before the provider found the error. (The error on that 5-day assessment was identified on day 17 while staff were completing the Medicare 14-day assessment.) The facility corrects the 5-day assessment, and submits an adjustment bill for days 1-14 of the Part A stay.

Example 2: On day 39 of the Part A stay, the facility identifies an error in a 30-day Medicare MDS. Five days of service had already been billed and paid based on the HIPPS code generated from that 30-day Medicare assessment.

The facility submits an MDS correction that results in a change in the RUG-III group. The SNF submits an adjustment bill for the 5 days of service using the corrected RUG-III group. Then, the corrected RUG-III code is used for billing any remaining covered days in the applicable payment period.

An MDS correction is not a new assessment, and can never be used as a replacement for the next regular Medicare assessment.

To meet the clinical MDS requirements, SNFs may be required to perform Significant Change in Status Assessments (SCSA) or Significant Correction of Prior Assessments (SCPA) in addition to completing the MDS correction. As long as the RUG-III group generated from the MDS correction and the SCSA or SCPA are the same, the SNF can use the corrected assessment 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 assessment reference dates, it is possible that the RUG-III 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 assessment reference date of the SCSA or SCPA assessment. If the assessment reference date for the SCSA or SCPA is within the assessment window, the SCSA or SCPA must also be used as a replacement for the next regular assessment.

Additional details and examples of situations requiring both a correction and a new assessment are being developed and will be provided to you.

MDS corrections may also be processed to inactivate an MDS 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 MDS for the beneficiary which can be used for billing purposes. If the SNF did not realize the error until a bill had been submitted and paid, the SNF would submit an adjustment bill. However, this type of adjustment does not involve a correction of MDS clinical data, and is not subject to the procedures described in this PM. This type of adjustment bill would use the regular SNF adjustment code, D9. In those rare situations where an MDS is inactivated and there is no valid MDS for that payment period, the SNF must bill the adjustment at the default rate for the applicable time period.

SNFs must document the reason for the correction, and certify to the accuracy of the correction. This documentation must be kept in the medical record. Review of the documentation on the reason for correction must be incorporated into your medical review process.

Effective Date for Adjustment Billing: Beginning June 1,2000, when an MDS modification or inactivation results in a change in the RUG-III group and HIPPS code used on a previously paid claim, the SNF must submit an adjustment bill. As part of the pricer update for FY 2001, FI systems are being modified to accept SNF adjustment bills with the D4 condition code.

Implementation Date for Adjustment Billings: We anticipate that these changes will be completed by October 1, 2000. FIs should instruct providers to hold any adjustment billings for services on and after June 1, 2000 until these systems changes are completed. A sample provider notification statement is included at the end of this PM.

As stated above, adjustment bills based on corrected Medicare MDS assessments are eligible for payment under this procedure effective June 1, 2000. This policy only refers to Medicare skilled services that were provided in the SNF on June 1, 2000 or later. Therefore, HIPPS codes based on service dates (FL 45 on the bill) beginning prior to June 1, 2000 may not be adjusted based on a

correction to the relevant MDS. If this type of adjustment bill (condition code D4) is submitted for service dates prior to June 1, 2000, it should be returned to the provider (RTP). The report message is, "An adjustment bill based on a corrected MDS cannot be processed for service dates prior to June 1, 2000."

After the initial period of this new adjustment bill policy, the beginning date of service, the "from" date, will have little significance. The "through" date will be used to calculate the period during which adjustment bills may be submitted based on corrected MDS assessments. The "through" date indicates the last day of the billing period for which the HIPPS code is billed. Providers are required to submit adjustment bills based on corrected MDS assessments within 120 days of the "through" date on the bill. Effective January 1, 2000, an edit will be put into place to limit the time for submitting this type of adjustment bill to 120 days from the service "through" date.

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

Adjustment bills to change a HIPPS code may not be submitted for any claim that has already been medically reviewed. This applies whether or not the medical review was performed either pre- or post-payment. All adjustment bills submitted are subject to medical review.

Isolated billing errors on a single MDS 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 MDS files, misunderstandings of MDS instructions that result in consistent miscoding of one or more MDS items used in determining the RUG-III group, etc. Please instruct providers on the method they should use to report these overpayments.

FI SCPA Intermediary Requirements

If you have edits that would prohibit SNFs from submitting bill type 217, or if you otherwise cannot process bill type 217, you must make appropriate changes. Basic processing instructions are in the Medicare Intermediary Manual IM 3664. These instructions will be followed except that condition code D4 (Change in Grouper code) will be entered on the claim by the SNF to indicate that the reason for the adjustment is a HIPPS change resulting from the correction of MDS data.

Where this condition code is received, compare the HIPPS code on the 217 claim to the claim to be adjusted on your history file. If the codes are the same, return the bill to the provider with the message "At least one HIPPS code must change for condition code D4". This message should appear on the RTP report.

Then, verify that the "service from" date on the 217 claim is on or after June 1, 2000. If the 217 claim is for services prior to June 1, 2000, return the adjustment request to the provider with the message "HIPPS code adjustments resulting from an MDS correction cannot be processed from services prior to June 1, 2000". This message should appear on the RTP report.

NOTE: A single monthly billing may have multiple 0022 line items with different HIPPS codes. Each 0022 line item represents a different MDS assessment. Depending on the error that was corrected on the MDS, one or more 0022 line items may need to be adjusted.

Other edits in MIM IM 3664. 2E are applicable, as are other claim change reasons.

Billing Instructions - Paper Claims:

1. FL 4. Type of Bill is 217 (replacement debit).

2. FL 37. Internal Control Number (ICN)/ Document Control Number (DCN) Required. All providers requesting an adjustment to a previously processed claim must insert the ICN/DCN of the claim to be adjusted. Payer A's ICN/DCN must be shown on line "A" in FL 37. Similarly, the ICN/DCN for Payer's B and C must be shown on lines B and C respectively, in FL 37.

3. FLs 24, 25, 26, 27, 28, 29, and 30: Condition Code D4, Change of Grouper Code, will be used.

4. The adjustment claim will reflect the corrected RUG-III group by changing the HIPPS code associated with that assessment.

Billing Instructions - Electronic Claims Using the UB-92 National Format (Version 060):

1. Type of bill 217 is placed in Record type 40, Field No. 4.

2. Submit the ICN/DCN of the original bill in Record Type 31, Field No. 14.

3. Condition Codes will be entered in Record Type 41, Field No. 4-10. Other condition codes may be necessary on the claim and can be repeated 10 times.

4. The adjustment claim will reflect the corrected RUG-III group by changing the HIPPS code associated with that assessment.

Billing Instructions - Electronic Claims Using the 837 (Version 3051):

1. Type of bill is placed in 2-130-CLM05-01 and 2-130-CLM05-03.

2. Submit the ICN/DCN of the original bill in 2-180.A-REF02 and 2-355.AC-REF02.

3. The Condition Code (D4) will be placed in 2-225.E-HI01-02. Other condition codes may be necessary on the claim and can be repeated up to 9 times.

4. The adjustment claim will reflect the corrected RUG-III group by changing the HIPPS code associated with that assessment.

The *effective date* for this PM is June 1, 2000.

The *implementation date* for this PM is October 1, 2000.

These instructions should be implemented within your current operating budget.

This PM may be discarded after October 1, 2003.

If you have any questions, contact Dana Burley (410) 786-4547 or Susan Burris (410) 786-6655.

Attachment

ATTACHMENT I

Skilled Nursing Facility Adjustment Billing: Adjustments to HIPPS Codes Resulting From MDS Corrections

Provider Fact Sheet

Background

There is a new policy that allows corrections to MDS assessments. The instructions that explain the types of error that may be corrected and the procedures to be followed are available at http://www.hcfa.gov/medicaid/mds20/whatsnew.htm.

The web site does not include any instruction regarding billing changes that are required as a result of an MDS correction. Effective for services provided on and after June 1, 2000, providers must submit adjustment bills whenever a correction of an MDS results in a change in a billed HIPPS code. The adjustment bill is retroactive to the first day payment was made based on the original (but incorrect) MDS assessment or June 1, 2000, whichever is earlier.

Unlike the Significant Correction of a Prior Full Assessment that has been available to facilities for some time, an MDS correction is not a new assessment and can never be used as a replacement for any required MDS.

Facts about the adjustment bill process

- Providers may start submitting adjustment bills on _____, 2000.

- Providers must use condition code **D4** (Change in Grouper Code) for adjustment bills that result from corrections to an MDS. This code indicates that the reason for the adjustment is a HIPPS code change resulting from the correction of MDS data.

- Adjustment bills based on corrected MDS assessments are eligible for payment under this procedure effective June 1, 2000. This policy only refers to Medicare skilled services that were provided in the SNF on June 1, 2000 or later. HIPPS codes for dates of service (FL 45) prior to June 1, 2000 may not be adjusted based on a correction to the relevant MDS.

- After the initial period of this new adjustment bill policy, the beginning date of service, the "from" date, will have little significance. The "through" date will be used to calculate the period during which D4 type adjustment bills may be submitted based on corrected MDS assessments. The "through" date indicates the last day of the billing period for which the HIPPS code is billed. Providers are required to submit adjustment bills based on corrected MDS assessments within 120 days of the "through" date on the bill.

- Once the fiscal intermediary has medically reviewed a bill, no adjustment bill may be submitted. The MDS may be corrected, but no adjustment bill may be sent.

- 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 MDS files, misunderstandings of MDS instructions that result in consistent miscoding of one or more MDS files, misunderstandings of MDS instructions that result in consistent miscoding of one or more MDS items used in determining the RUG-III group, etc.

- The procedure you should use to report this type of overpayment is _____ _____.

Examples

1. A Medicare 5-day assessment was completed timely and used to establish the RUG-III rate for days 1-14 of the Part A stay. The bill was paid before the provider found the error, on day 16. The facility corrected the 5-day assessment and submitted an adjustment bill for days 1 through 14 of the Part A stay.

2. On day 39 of the Part A stay, the facility identified an error in a 30-day Medicare MDS. Five days of service had already been billed and paid based on the HIPPS code generated from that 30-day Medicare assessment. The facility submitted an MDS correction that resulted in a change in the RUG-III group (and of course, the HIPPS code). Then, the correct RUG-III classification was used to generate the adjustment bill for the remaining covered days in the applicable payment period.