CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11075	**Date: October 28, 2021**
	Change Request 12500

SUBJECT: Revision to Chapter 3 to Update Instructions for Handling Inpatient Rehabilitation Facility (IRF) Claims

I. SUMMARY OF CHANGES: This Change Request updates instructions to Chapter 3 into the Medicare Claims Processing Manual Pub-100-04 for actions when a claim does not match the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI).

EFFECTIVE DATE: December 1, 2021 - Unless otherwise specified, it is effective for all dates of service.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 1, 2021 - Unless otherwise specified, the effective date is the date of service.

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	3/140.3.1- Shared Systems and CWF Edits
N	3/140.3.1.1- Actions When a Claim Does Not Match the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI)

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: 11075	Date: October 28, 2021	Change Request: 12500

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I. GENERAL INFORMATION

A. Background: This Change Request updates instructions to Chapter 3, Section 140.3.1 and adds a new sub-section 140.3.1.1 into the Medicare Claims Processing Manual (Pub.100-04).

This change provides actions when a claim does not match the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI).

B. Policy: This CR creates no new 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	
12500.1	The Medicare contractors shall be aware of the manual updates in Pub 100-04, Chapter 3, Sections 140.3.1 and 140.3.1.1.	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): Kajol Balani, 410-786-0878 or kajol.balani@cms.hhs.gov , William Gehne, 410-786-6148 or Wilfried.Gehne@cms.hhs.gov , Fred Rooke, 404-562-7205 or Fred.Rooke@cms.hhs.gov

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

VI. FUNDING

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

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

Table of Contents

(Rev. 11075; Issued: 10-28-21)

140.3.1- Shared Systems and CWF Edits

(Rev. 11075; Issued: 10-28-21; Effective: 12-01-21; Implementation: 12-01-21)

To ensure that revenue code 0024 is not reported more than once on bill type 11X;

- *To ensure the claim can be matched to the corresponding Inpatient Rehabilitation Facility – Patient Assessment Instrument (IRF-PAI) assessment in the internet Quality Improvement Evaluation System (iQIES*)

- To compare applicable inpatient claims with post-acute claims that will allow erroneous claims to be reviewed and appropriate adjustments to be made on an ongoing basis to the discharging hospital's inpatient claim.

- To check the incoming claims admission date to the history discharge date for the same provider except when patient status code is 30 (CWF);

- To check the incoming claim's discharge date to the history admission date for the same provider (CWF);

- To reject subsequent claims with the same PPS provider on the same day (CWF);

- Ensure accurate coding of patient status codes by checking the incoming claim's admission date to the history discharge date;

    - CWF accepts the incoming claim and sends an informational unsolicited response to the A/B MAC (A) on the history claim if the patient status code does not match the incoming provider number

    - The A/B MAC (A) cancels the history claim to the provider

- To check incoming claim's discharge date to the history admission date to ensure the appropriate use of the patient status code on the incoming claim;

- CWF rejects the incoming claim if the patient status code does not match the provider number;

- A/B MAC (A) returns the incoming claim to the provider for correction of the patient status code.

- To insure that revenue code 0024 is only on claims submitted by IRF providers. Bills submitted incorrectly will be returned to the provider.

- To insure that a valid HIPPS/CMG rate code is always present with revenue code 0024;

- Units entered on the 0024 must be accepted, but are not required.

- To insure that revenue code total charges line 0001 must equal the sum of the individual total charges lines;

- To insure that the length of stay in the statement covers period, from and through dates equals the total days for accommodations revenue codes 010x-021x, including revenue code 018x (leave of absence)/interrupted stay,

- To insure that Occurrence Span Code 74 is present on the claim if there is an interrupted stay $\leq$ 3 days. If the interruption is greater than 3 days, the bill should be considered a discharge. If the patient returns to the IRF by midnight of the 3rd day, the bill continues under the same CMG. CWF

will need to edit to ensure that if another IRF bill comes in during the interrupted stay, it is rejected, as it should be associated with the original CMG; and

- If HIPPS rate code is 5101, 5102, 5103, or 5104 patient status must be 20 (Expired)/
- The accommodation revenue code 018x (leave of absence) will continue to be used in the current manner including the appropriate occurrence span code 74 and date range.

140.3.1.1 Actions When a Claim Does Not Match the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI)

(Rev. 11075; Issued: 10-28-21; Effective: 12-01-21; Implementation: 12-01-21)

The following outcomes are possible when a claim does not match the IRF-PAI HIPPS:

- *A matching assessment is found. The claim HIPPS code does not match the IRF-PAI HIPPS code, but the transmission date matches causing the claims processing system to use the assessment HIPPS code documented in iQIES for claims processing purposes;*
- *A matching assessment is found. The claim HIPPS code does not match IRF-PAI HIPPS code, and the transmission date is different causing the claims processing system to use the assessment HIPPS code and date documented in iQIES for claims processing purposes;*
- *A matching assessment is not found. This causes the claim to Return to Provider (RTP) with Reason Code 37096.*

IRFs should be sure to have an IRF-PAI that has completed processing at iQIES before submitting an IRF claim to the Medicare Administrative Contractor. The IRF can verify this by reviewing their IRF-PAI validation report.

If an IRF has inadvertently submitted their claim prior to the corresponding IRF-PAI being accepted in iQIES and the claim has RTP'd with Reason Code 37096, simply resubmit the claim once the IRF-PAI has completed processing. This will require communication between the provider's billing office and their clinical staff that submits their IRF-PAI.

If a claim is returned because Medicare systems do not find the matching assessment, there is no need to call the QIES Technical Support Office (QTSO) help desk for such billing issues.

If a provider has submitted an IRF-PAI prior to submission of the claim with information that is different from the claim submission for any of the following information:

- *Medicare Beneficiary Identifier (IRF-PAI item 2);*
- *Beneficiary date of birth (IRF-PAI item 6);*
- *Provider CCN (IRF-PAI item 1B);*
- *Claim statement covers through dates (IRF-PAI item 40); and*
- *Claim admission date (IRF-PAI item 12).*

The claim or the IRF-PAI should be corrected (depending on which item had the error) and then the claim resubmitted. If the claim is resubmitted without correcting the appropriate information, the claim will be returned to the provider again.

In most cases the claim is being submitted one (1) day prior to the finalization of the IRF-PAI. IRFs may want to add an additional claim hold day(s) on their claim submission to allow IRF-PAI completing processing and to avoid claims being RTP'd with Reason Code 37096.