CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1365	**Date: NOVEMBER 2, 2007**
	Change Request 5757

SUBJECT: Additional Common Working File (CWF) Editing for Skilled Nursing Facility (SNF) Consolidated Billing (CB) - Part II

I. SUMMARY OF CHANGES: This CR will further revise CWF SNF CB editing to ensure that all therapy services are subjected to SNF consolidated billing edits when provided in a covered or non-covered SNF stay.

NEW / REVISED MATERIAL
**EFFECTIVE DATE: ***April 1, 2001
IMPLEMENTATION DATE: April 7, 2008

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	6/110.2.2/A/B Crossover Edits

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: 1365	Date: November 2, 2007	Change Request: 5757

SUBJECT: Additional Common Working File (CWF) Editing for Skilled Nursing Facility (SNF) Consolidated Billing (CB) – Part II

Effective Date: April 1, 2001

Implementation Date: April 7, 2008

I. GENERAL INFORMATION

A. Background: For claims processed on or after April 7, 2008, with dates of service on or after April 1, 2001, this CR provides instructions for additional CWF editing. As therapy services provided in a SNF must be consolidated when a beneficiary is in either a covered or non-covered stay, CWF will reject claims with dates of service after the posted SNF claim containing Occurrence Code 22 (Date Active Care Ended) and Patient Status 30 (Still patient or expected to return for outpatient services) until a 21x (SNF inpatient) bill type discharge claim is processed. The entity furnishing the therapy services must look to the SNF for reimbursement rather than the Medicare contractor.

Providers will be notified that they can contact their Medicare contractors to have inappropriately denied claims reprocessed. However, should providers have previously received payment directly from the SNF; they must return that payment to the SNF before requesting payment through the Medicare contractor.

B. Policy: This CR does not change policy for SNF CB.

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	
5757.1	As it did for Part A claims processing in CR 4292, BR 4292.5, the contractor shall modify the existing CWF SNF CB therapy edits 7258 and 7259 for Part B claims processing for non-covered SNF stays to read claims history to look for a 21x (SNF Inpatient) bill type that contains an Occurrence Code 22 (Date Active Care Ended) and a Patient Status Code 30 (Still patient or expected to return for outpatient services) where there is no subsequent 21x (SNF inpatient) bill type discharge claim from the same provider.										X	
5757.1.1	The contractor shall reject claims with dates of service after the posted SNF claim										X	

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	containing Occurrence Code 22 (Date Active Care Ended) and Patient Status 30 (Still patient or expected to return for outpatient services) until a 21x (SNF inpatient) bill type discharge claim is processed.											
5757.1.1.1	The contractor shall not apply the edit to claims received with dates of service after the date of service of a 21x (SNF inpatient) bill type discharge claim in history.										X	
5757.1.2	The contractor shall make any necessary changes to the Information Unsolicited Response process based on the changes implemented in this CR.										X	
5757.1.3	Contractors shall reopen and reprocess inappropriately processed claims with dates of service on or after 04/01/2001 through 04/06/2008 when brought to their attention.	X			X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5757.2	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 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. 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

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:
5757.1	Revise original BR4292.5 to include Part B processing.

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

V. CONTACTS

Pre-Implementation Contact(s): Leslie Trazzi at leslie.trazzi@cms.hhs.gov.

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

VI. FUNDING

A. *For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC),* use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. *For Medicare Administrative Contractors (MAC),* use the following statement:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does 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 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.

110.2.2 – A/B Crossover Edits

(Rev. 1365, Issued: 11-02-07, Effective: 04-01-08, Implementation: 04-07-08)

Effective April 1, 2002, CWF implemented the following crossover edits for carrier submitted claims. Carriers implemented automated processes for the resolution of these edits based on the codes returned in the trailers from CWF.

A. Edits 7258 and 7259 - Carrier Part B Physical Therapy Claim Against an Inpatient SNF 21x and Inpatient Part B 22x Claim

Reject if a carrier Part B claim is received containing physical therapy (type of service of W), occupational therapy, or speech-language pathology and From/Thru Dates overlap or are within the From/Thru Dates on an SNF inpatient claim (21x) or an inpatient Part B claim (22x).

Use separate error codes where (1) dates are within (contractor will reject claim) or (2) where dates overlap (contractor will automate a separate denial message to provider).

Bypass the edit in the following situations:

- The 21x or 22x type of bill contains a cancel date.
- The incoming claim from date equals the SNF 21x or 22x history claim discharge date or incoming through date equals the SNF 21x or 22x history claim admission date.

Effective for claims with dates of service on or after April 1, 2001, CWF implemented revisions on January 2, 2008 to bypass the edits 7258 and 7259 when a therapy claim with a date of service on or after April 1, 2001 is submitted and the date of service is within the From/Thru dates of an occurrence Span code date of 74 reported on a SNF inpatient claim 21x in history. This will allow for services to be separately payable outside of SNF consolidated billing during non-covered periods in the SNF.

Effective for claims with dates of service on or after April 1, 2001, CWF implemented revisions on April 7, 2008 to modify the existing therapy edit for Part B claims processing for non-covered SNF stays to read claims history to look for a 21x (SNF Inpatient) bill type that contains an Occurrence Code 22 (Date Active Care Ended) and a Patient Status Code 30 (Still patient or expected to return for outpatient services) where there is no subsequent 21x (SNF inpatient) bill type discharge claim from the same provider. As therapy services provided in a SNF must be consolidated when a beneficiary is in either a covered or non-covered stay, CWF will reject claims with dates of service after the posted SNF claim containing Occurrence Code 22 (Date Active Care Ended) and Patient Status 30 (Still patient or expected to return for outpatient services) until a 21x (SNF inpatient) bill type discharge claim is processed. The entity furnishing the therapy services must look to the SNF for reimbursement rather than the Medicare contractor.

B. Edits 7260 and 7261 - Carrier Part B Claim Without Therapy Against an Inpatient SNF

Reject if a carrier Part B claim is received with From/Thru Dates overlapping or are within the From/Thru Dates on an SNF Inpatient claim (21x). If the SNF 21x claim on

history has patient status 30 and occurrence code 22 (Date Active Care Ended), use occurrence 22 date instead of the through date.

Use separate error codes where (1) dates are within (contractor will reject claim); or (2) where dates overlap (contractor will automate a separate denial message to provider).

Bypass the edit in the following situations:

- The 21x history claim contains a cancel date.
- The incoming Part B claim from date equals the SNF 21x history claim discharge date. The incoming Part B claim through date equals the SNF 21x history claim admission date.
- A diagnosis code in any position on the incoming claim is for renal disease.
- The Part B claim contains ambulance codes per the files supplied to CWF in the annual and quarterly updates with modifiers other than N (SNF) in both the origin and destination on the same claim.
- The Part B claim is a CANCEL ONLY (Action Code 4) claim.
- The Part B claim is denied.
- The Part B service has a Payment Process Indicator other than A (allowed).
- The Part B claim contains only separately payable services per the files supplied to CWF in the annual and quarterly updates.

Effective for claims with dates of service on or after April 1, 2001, CWF implemented revisions on January 2, 2008 to bypass the edits 7260 and 7261 when a claim with a date of service on or after April 1, 2001 is submitted and the date of service is within the From/Thru dates with an occurrence Span code date of 74, 76, 77, 79, or M1 reported on a SNF inpatient claim 21x in history or the date of service is greater than the occurrence date on a SNF inpatient claim 21x in history with an occurrence code date of A3, B3, or C3. This will allow for services to be separately payable outside of SNF consolidated billing during non-covered periods in the SNF.