

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1289	Date: July 13, 2007
	Change Request 5624

NOTE: This transmittal is being re-communicated to correct the implementation date. The implementation date should be January 7, 2008. The transmittal, issue date and all other information remains the same.

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

I. SUMMARY OF CHANGES: This change in editing will allow CWF to identify periods when SNF CB edits should not be applied.

NEW / REVISED MATERIAL

EFFECTIVE DATE: *April 1, 2001

IMPLEMENTATION DATE: January 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	Chapter 6/Table of Contents
R	Chapter 6/Section 110/2.2/A/B Crossover Edits
R	Chapter 6/Section 110/2.4/Edit for Ambulance Services
R	Chapter 6/Section 110/2.5/Edit for Clinical Social Workers (CSWs)

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2008 operating budgets.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

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

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B M A C	D M E M A C	F I	C A R R I E R	D M E R C	R H H I	Shared-System Maintainers				OTHER
								F I S S	M C S	V M S	C W F	
	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.											
5624.9.1	The provider education article shall notify providers that they should contact the Medicare contractor that processes their claims to have claims re-processed that they feel were erroneously subjected to the consolidated billing edits and denied.	X	X		X							
5624.9.2	The provider education article shall not include specific information on the edits being revised in BRs 5624.1 – 5624.3.	X	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:
N/A	

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

N/A

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 FY 2008 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.

Medicare Claims Processing Manual

Chapter 6 - SNF Inpatient Part A Billing

Table of Contents (Rev. 1289, 07-13-07)

110.2.2 – A/B Crossover Edits

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(Rev. 1289; Issued: 07-13-07; Effective: 04-01-01; Implementation: 01-07-08)

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.

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.

110.2.4 – Edit for Ambulance Services

(Rev.1289; Issued: 07-13-07; Effective: 04-01-01; Implementation: 01-07-08)

When a medically necessary transport from one SNF to another SNF occurs when the beneficiary is discharged from the first SNF and admitted to the second, this transport is included in consolidated billing. The first SNF is responsible for the ambulance service and the cost is included in the Part A rate. It is not separately billable. CWF will reject these services to the carrier. The carrier must deny the service with appeals rights.

Effective for claims with dates of service on or after April 1, 2001, CWF implemented revisions on January 2, 2008 to bypass edit 7275 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.

110.2.5 - Edit for Clinical Social Workers (CSWs)

(Rev.1289; Issued: 07-13-07; Effective: 04-01-01; Implementation: 01-07-08)

Per the Balanced Budget Act, services provided by CSWs to beneficiaries in a Part A SNF stay may not be billed separately to the carrier. Payment for these services is included in the prospective payment rate paid to the SNF by the intermediary. Though the policy was in effect since April 1, 2001, there were no corresponding edits. With the April 2003 release, CWF implemented a new SNF consolidated billing edit to prevent payment to CSWs for services rendered to beneficiaries in a Part A SNF stay.

Effective April 1, 2003, CWF established the new edit 7269 for services rendered to these beneficiaries with dates of service on or after April 1, 2001, for claims received on or after April 1, 2003. Once CWF determines that a beneficiary is in a Part A stay, prior to applying the edits that review procedure codes to determine if payment should be allowed, CWF will review the performing provider type of the submitting entity. If the performing provider type is 80, CWF will reject the claim to the carrier or return an unsolicited response with new error code 7269. The carrier will then take the same adjustment and recovery action as for other rejects and unsolicited responses.

When carriers receive the new reject code, they must deny the claim and use the following RA and MSN messages.

RA

Report claim adjustment reason code 96 – Non-covered charges; and

Remark code N121 - Medicare Part B does not pay for items or services provided by this type of practitioner for beneficiaries in a Medicare Part A covered skilled nursing facility stay.

MSN

13.10 – Medicare Part B does not pay for items or services provided by this type of practitioner since our records show that you were receiving Medicare Part A benefits in a skilled nursing facility on this date. The Spanish version is: La Parte B de Medicare no paga por artículos o servicios provistos por este tipo de médico ya que nuestros expedientes indican que usted estaba recibiendo beneficios de la Parte A de Medicare en una institución de enfermería especializada en esta fecha.

Effective for claims with dates of service on or after April 1, 2001, CWF implemented revisions on January 2, 2008 to bypass edit 7269 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.