CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1554	**Date: July 18, 2008**
	Change Request 6128

Subject: Revision to Skilled Nursing Facility (SNF) Common Working File (CWF) Editing

I. SUMMARY OF CHANGES: For claims processed on or after January 5, 2009, this Change Request (CR) revises the action taken in CR 5757 to eliminate the negative impact on therapy professionals.

New / Revised Material
Effective Date: For claims processed on or after January 5, 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	6/110.2.2/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: 1554	Date: July 18, 2008	Change Request: 6128

SUBJECT: Revision to Skilled Nursing Facility (SNF) Common Working File (CWF) Editing

Effective Date: For claims processed on or after January 5, 2009

Implementation Date: January 5, 2009

I. GENERAL INFORMATION

A. Background: Change Request 5757 implemented revisions to CWF editing. It has come to our attention that this editing is negatively impacting therapy professionals. Therefore, the coding added to that edit shall be removed for claims processed on or after January 5, 2009.

B. Policy: This change represents no change to policy.

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	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6128.1	The contractor shall remove the coding added to CWF edits 7258 and 7259 with CR 5757.									X	
6128.2	Contractors shall re-open and re-process claims incorrectly denied per the changes made in CR 5757 to edits 7258 and 7259 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	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6128.3	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	X			X						

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	
	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.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A
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: 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

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

Section B: *For Medicare Administrative Contractors (MACs)*, use the following statement:

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.

110.2.2 - A/B Crossover Edits

(Rev.1554, Issued: 07-18-08, Effective: 01-05-09, Implementation: 01-05-09)

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. *For claims processed on or after January 5, 2009, this edit shall no longer be functional. Contractors shall re-open and-re-process claims previously denied due to this edit when brought to their attention should they determine that the beneficiary was not in a SNF stay during the period the therapy service was rendered.*

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.