

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 274	Date: APRIL 27, 2007
	Change Request 5587

Subject: Invalid Skilled Nursing Facility (SNF) Informational Unsolicited Responses (IURs) from CWF.

I. SUMMARY OF CHANGES: The purpose of this One-Time Notification is to notify Medicare contractors to correct any claims that were adjusted as a result of an invalid SNF IUR to re-issue payments.

New / Revised Material

Effective Date: April 27, 2007

Implementation Date: July 2, 2007

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
N/A	

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 274	Date: April 27, 2007	Change Request: 5587
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SUBJECT: Invalid Skilled Nursing Facility (SNF) Informational Unsolicited Responses (IURs) from CWF

Effective Date: April 27, 2007

Implementation Date: July 2, 2007

I. GENERAL INFORMATION

A. Background: CMS has identified an issue with Skilled Nursing Facility (SNF) Informational Unsolicited Responses (IUR). CR 4292, Transmittal 930, (Benefits Exhaust and No-Payment for Medicare FIs and SNFs) was implemented with the October 2006 release. System changes relating to this change request have caused outpatient, Part B, and DME paid claims that overlap non-pay SNF claims to reject in error and are to be automatically adjusted. The intent of CR 4292 was to mandate providers to submit all SNF non-pay claims after benefits have exhausted. In the process of implementing CR 4292 coding changes were made which incorporated 210 bill types into the consolidated billing criteria which will send an IUR back to the contractor rejecting outpatient bills, Part B, and DME claims in error. The CWF coding change to fix the problem was effective in production on January 29, 2007, and CWF will be providing a list of claims to the applicable contractors to allow for corrections and payment to be made.

B. Policy: The purpose of this One-Time Notification is to notify Medicare contractors to correct any claims that were adjusted as a result of an invalid SNF IUR to re-issue payments.

II. BUSINESS REQUIREMENTS TABLE

“Shall” denotes a mandatory requirement

Number	Requirement	Responsibility (place an “X” in each applicable column)										
		A / B M A C	D M M A C	F I I E R	C A R R I C R	D M R R I	R E H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F		
5587.1	CWF shall search claims history, identify all the impacted claims, and create a report listing all impacted claims.										X	
5587.2	CWF shall forward an electronic version of the report to each contractor.										X	
5587.3	FISS shall create a utility to automate the adjustment process of claims identified in the						X					

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B	D M E	F I	C A R R E R	D M R I C	R E H I	Shared-System Maintainers				OTHER
		M A C	M A C		I E R			F I S	M C S	V M S	C W F	
	CWF report under requirement 5587.1.											
5587.4	Contractors upon receipt of the CWF report shall compare the report claim information to claim history to determine the status of the impacted claim.	X	X	X	X	X	X					
5587.4.1	Contractors on HIGLAS shall provide this information to HIGLAS for analysis.			X	X							
5587.5	Contractors shall not initiate the SNF IUR adjustment if the impacted claim has not been adjusted.	X	X		X	X						
5587.6	Contractors shall adjust the claim to reissue payment to providers if the impacted payment has been recovered.	X	X	X	X	X	X					
5587.6.1	Prior to adjusting these claims, Contractors on HIGLAS shall work with HIGLAS to ensure that the claim payments are processed correctly.											HIGLA S
5587.7	Contractors shall stop the recoupment process and delete the adjustment if the adjustment is pending in a suspense location.	X	X	X	X	X	X					
5587.8	Contractors may allow the offset to occur or discontinue the recovery, if the adjustment has been completed, but the recovery is not finalized.	X			X							
5587.9	Contractors shall waive any interest accrued in error due to the invalid information and timing of a solution.	X	X	X	X	X	X					
5587.9.1	Contractors shall repay to the providers any interest that was offset or recouped against the impacted claims.	X	X	X	X	X	X					
5587.10	Contractors shall retain the CWF reports to serve as an audit trail in the event of an audit.	X	X	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B	D M E	F I	C A R R E R	D M R I C	R E H I	Shared-System Maintainers				OTHER
		M A C	M A C		I E R			F I S	M C S	V M S	C W F	

									F I S S	M C S	V M S	C W F	
5587.11	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 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.	X	X	X	X	X	X						

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): For Part A contact Kelly Dehne, 410-786-7401, for Part B contact Linda Shanabrough, 410-786-1137, for HIGLAS contact Donna Sanders, 410-786-0289.

Post-Implementation Contact(s): For Part A contact Kelly Dehne, 410-786-7401, for Part B contact Linda Shanabrough, 410-786-1137, for HIGLAS contact Donna Sanders, 410-786-0289.

VI. FUNDING

A. No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. *For Medicare Administrative Contractors (MAC):*

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 specified 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.