CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 843	**Date: January 21, 2011**
	Change Request 7150

SUBJECT: Processing Claims Spanning More than Ten Years with Unlimited Occurrence Span Codes (OSCs): Phase III

I. SUMMARY OF CHANGES: This CR provides the Common Working File (CWF) with system hours to complete the first part of Phase III implementation to eventually allow a claim to span a benefit period over ten years.

EFFECTIVE DATE: * October 1, 2002
IMPLEMENTATION DATE: July 5, 2011

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-

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:

N/A

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. ATTACHMENT:
One-Time Notification
**Unless otherwise specified, the effective date is the date of service.*

One-Time Notification

Pub. 100-20	Transmittal: 843	Date: January 21, 2011	Change Request: 7150

SUBJECT: Processing Claims Spanning More than Ten Years with Unlimited Occurrence Span Codes (OSCs): Phase III

Effective Date: October 1, 2002

Implementation Date: July 5, 2011

I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) implemented (Change Request (CR) 6777, Transmittal 1934, dated March 19, 2010, to provide claims processing instructions for claims to be processed that have OSCs beyond the currently billable amount of ten.

The Common Working File (CWF) will need to implement changes in three phases over a period of three releases to comply with allowing a claim where the Dates of Service span a benefit period of ten or more years. Once the implementation is complete for the three phases, CWF will no longer return Utilization edit 5711 to the Contractors, but process them under the new BENE Spell Auxiliary File. This will not impact FISS since CWF will continue to return the existing error codes and trailers based on the benefit periods. The National Claims History will also not be impacted and continue to receive same format.

NOTE: Phase I was instituted in CR 7088, Transmittal 752, dated August 13, 2010. Phase II was implemented in CR 7112, Transmittal 2051, dated September 17, 2010. This July release CR provides the CWF with system hours to complete the first part of Phase III implementation. An October release CR is forthcoming to instruct FISS and CWF to complete Phase III implementation (to allow a claim to span a benefit period over ten years).

B. Policy: Long Term Care Hospital, Inpatient Psychiatric Facility, and Inpatient Rehabilitation Facility Prospective Payment Systems requires a single claim to be billed for an entire stay. Interim claims may be submitted to continually adjust all prior submitted claims for the stay until the beneficiary is discharged. In some instances, significantly long stays having numerous OSCs may exceed the amount of OSCs allowed to be billed on a claim.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes 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	
7150.1	CWF shall begin work on implementing Phase III (to allow a claim to span a benefit period over ten years).									X	
7150.2	CWF shall expect to receive separate CR to complete the coding and implementation stages for Phase III (to allow a									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	
	claim to span a benefit period over ten years). **NOTE**: Claims will no longer return Utilization Edit 5711.										

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	
	None.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements:
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

Section B: For all other recommendations and supporting information: (See CR 6777, CR 7088, and CR 7122.)

V. CONTACTS

Pre-Implementation Contact(s):
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Jason Kerr at Jason.kerr@cms.hhs.gov or 410-786-2123

Post-Implementation Contact(s):
Same as Pre-Implementation Contacts

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs)*: N/A

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.