CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1450	**Date: FEBRUARY 15, 2008**
	Change Request 5872

SUBJECT: Update to the Common Working File (CWF) to Allow the Posting of Skilled Nursing Facility (SNF) and Swing Bed (SB) Claims to the Beneficiary's Spell of Illness When Qualifying Stay Criteria are Not Met

I. SUMMARY OF CHANGES: This instruction modifies CWF to allow the posting of SNF and SB claims when qualifying stay criteria are not met.

NEW / REVISED MATERIAL
EFFECTIVE DATE: *July 1, 2008
IMPLEMENTATION DATE: July 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/Table of Contents
N	6/40.8.2/Billing When Qualifying Stay or Transfer Criteria are Not Met

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: 1450	Date: February 15, 2008	Change Request: 5872

SUBJECT: Update to the Common Working File (CWF) to allow the Posting of Skilled Nursing Facility (SNF) and Swing Bed (SB) Claims to the Beneficiary's Spell of Illness When Qualifying Stay Criteria are Not Met

Effective Date: July 1, 2008

Implementation Date: July 7, 2008

I. GENERAL INFORMATION

A. Background: When a beneficiary is receiving skilled care in a SNF, the spell of illness in the CWF should be updated. Currently, claims that are denied due to not meeting the prior qualifying stay criteria are not updating the beneficiary's spell of illness in the CWF. This instruction modifies the CWF to allow these claims to update the beneficiary's spell of illness.

NOTE: The CWF will only update the spell of illness dates for claims that do not meet the qualifying stay criteria. Benefit days will not be deducted from the beneficiary.

B. Policy: There are no policy changes with this instruction.

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	
5872.1	Medicare contractors shall update qualifying stay and transfer requirement reason codes to include A6 "Prior hospitalization or 30 day transfer requirement not met" in the ANSI adjustment reason code field.	X		X			X				
5872.1.1	Medicare contractors shall ensure that ANSI reason code A6 is transmitted to CWF in the 3rd and 4th positions of the ANSI information sent in the CWF transmit file.						X				
5872.2	Medicare systems shall update the beneficiary's spell of illness dates for 21x and 18x bill types containing ANSI adjustment reason code A6.									X	
5872.3	Medicare systems shall NOT deduct days from the beneficiary for 21x and 18x bill types containing ANSI adjustment reason code A6									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	
5872.4	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							

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:
5872.1	Medicare contractors shall update reason codes 13313, 19904, 11503 and any other necessary reason codes.

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

V. CONTACTS

Pre-Implementation Contact(s): Jason Kerr, Jason.Kerr@cms.hhs.gov

Post-Implementation Contact(s): Appropriate Regional Office
http://www.cms.hhs.gov/RegionalOffices/01_Overview.asp

VI. FUNDING

A. *For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC)*:
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)*:
The Medicare Administrative Contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC 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.

Medicare Claims Processing Manual

Chapter 6 - SNF Inpatient Part A Billing

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(Rev. 1450, 02-15-08)

40.8.2 – Billing When Qualifying Stay or Transfer Criteria are Not Met

40.8.2 - Billing When Qualifying Stay or Transfer Criteria are Not Met

(Rev. 1450; Issued: 02-15-08; Effective: 07-01-08; Implementation: 07-07-08)

SNF providers are required to submit claims to Medicare for beneficiaries that receive a skilled level of care. This includes beneficiaries that do not meet the qualifying stay or transfer criteria. Although these claims will not be paid by Medicare, providers must submit these claims as covered in order to update the beneficiary's spell of illness in CWF. SNFs shall follow the billing instructions for benefits exhaust claims provided in section 40.8 of this chapter. This includes the submission of covered claims in order to allow the Medicare systems to deny the claim for the appropriate reason.