CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 581	**Date: October 28, 2009**
	Change Request 6584

Subject: For Analysis Only --Clarification on the Proper Billing of the Statement Covers From and Admission/Start of Care Dates on Institutional Claims

I. SUMMARY OF CHANGES: This instruction modifies system edits to allow the "From" date of an initial claim to be reported prior to the "Admission/Start of Care" date, for those claims which require "Admission/Start of Care" dates.

New / Revised Material
Effective Date: April 1, 2010
Implementation Date: April 5, 2010

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:
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:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 581	Date: October 28, 2009	Change Request: 6584

SUBJECT: For Analysis Only - Clarification on the Proper Billing of the Statement Covers From and Admission/Start of Care Dates on Institutional Claims

Effective Date: April 1, 2010

Implementation Date: April 5, 2010

I. GENERAL INFORMATION

A. Background: Medicare system edits currently require the "From" date to be equal to or after the "Admission/Start of Care" date on initial provider claims. The National Uniform Billing Committee (NUBC) recently clarified that the "From" date is the date that services actually started for the submitted claim and the "Admission/Start of Care" date is distinctly different.

The "From" date referenced on the UB-04 should represent the beginning date associated with the services as indicated on the particular bill. FL 6 also includes an adjacent block for the "Through" date; they are reported as paired dates on the UB-04. The NUBC specifically names this field the "Statement Covers Period" because it is intended to represent the date span for all billed services found on the claim. Therefore, the "From" date is not necessarily the same as the "Admission/Start of Care" date and it should not be used as a proxy for something else.

The "Admission/Start of Care" date (FL 12) is another field on the UB-04 that is specifically meant to capture the admission or start of care in a facility. It is distinctly different in meaning from the "From" date. On most initial inpatient claims the same dates are reported in each of these fields, however, the meaning of each specific FL should not be mistaken.

This instruction implements system changes to allow initial claims, those which require "Admission/Start of Care" date reporting, to have a "From" date reported prior to the "Admission/Start of Care Date", when applicable.

For this analysis, the CMS needs the Fiscal Intermediary Shared System (FISS) and the Common Working File (CWF) maintainers to compile lists of affected edits and the actions needed to conform to the requirements below as well as proposals on how to segregate these changes over multiple releases.

B. Policy: The background section presents possible reporting changes of the "From" date on the UB-04 due to clarifications presented by the NUBC. This instruction is applicable for hardcopy and electronic billing.

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	
6584.1	Medicare systems shall allow the reported "From" date on all initial claim types that require an "Admission/Start of Care" date to be prior to the reported "Admission/Start of Care" date, for claims with "Admission/Start of Care" dates on or after the effective date of this instruction.						X			X	MCE, COBC
6584.1.1	Medicare systems shall note the applicable bill types are 011x, 012x, 018x, 021x, 022x, 034x, 041x, 081x, and 082x where "x" equals 0, 1 or 2 and bill types 032x, 033x where "x" equals 0, 2 or 9.						X			X	
6584.1.2	Medicare systems shall note this also includes adjustments to initial claim types identified in 6584.1.1.						X			X	
6584.2	Medicare systems shall use the "Admission/Start of Care" date reported on initial claims requiring an "Admission/Start of Care" date when applying system edits.						X			X	
6584.2.1	Medicare systems shall note this includes adjustments to initial claim.						X			X	
6584.2.2	Medicare systems shall be aware this includes any hospital bundling edits in which the "From" date was previously used to enforce the bundling rules for 11x bill types.						X			X	
6584.3	Medicare systems shall use the reported "Admission/Start of Care" date on initial claims requiring an "Admission/Start of Care" date to calculate the total days reported on the claim.						X			X	
6584.3.1	Medicare systems shall note this includes adjustments to initial claims.						X			X	
6584.4	Medicare systems shall use the reported "Admission/Start of Care" date on initial claims requiring an "Admission/Start of Care" date to update the "Earliest Billing" date field in the beneficiary's spell of illness.									X	
6584.4.1	Medicare systems shall note this includes initial SNF and SB claims (i.e. 181, 182, 211 and 212 bill types) and adjustments to these bill types.									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	
6584.4.2	Medicare systems shall continue to use the "From" date on subsequent SNF and SB claims (i.e. 183, 184, 213 and 214 bill types) and adjustments to these bill types for updating benefit period dates.									X	
6584.5	Medicare systems shall compile a list of affected edits and provide the action needed to conform to all requirements above.						X			X	
6584.6	Medicare systems shall provide a proposal on how to segregate the required changes over multiple releases.						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	
	None.										

IV. SUPPORTING INFORMATION

Section 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:
6584.2	Medicare systems shall note that existing processing procedures/edits in pre-entitlement situations are not affected by this instruction.

Section 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

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

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.