CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 752	**Date: August 13, 2010**
	Change Request 7088

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

I. SUMMARY OF CHANGES: The Centers for Medicare and Medicaid Services (CMS) implemented Change Request (CR) 6777 to provide claims processing instructions for claims to be processed that have OSCs beyond the currently billable amount of ten. 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 10 or more years.

EFFECTIVE DATE: October 1, 2002
IMPLEMENTATION DATE: January 3, 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-*Only One Per Row.*

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

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
Not Applicable.

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.*

One-Time Notification

Pub. 100-20	Transmittal: 752	Date: August 13, 2010	Change Request: 7088

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

Effective Date: October 1, 2002

Implementation Date: January 3, 2011

I. GENERAL INFORMATION

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

B. Policy: Long Term Care Hospital (LTCH), Inpatient Psychiatric Facility (IPF), and Inpatient Rehabilitation Facility (IRF) Prospective Payment Systems (PPSs) 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.

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 10 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 under the new BENE Spell Auxiliary File. This change will not impact FISS since CWF will continue to return the existing error codes and trailers based on the benefit periods. National Claims History (NCH) will also not be impacted and will continue to receive same format.

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	
7088.1	For implementation on January 3, 2011, CWF shall implement Phase I (to allow a claim to span a benefit period over ten years) that will create a new BENE Spell AUX File. NOTE: Claims will continue to return Utilization Edit 5711 (claim span benefit period of 10 or more years).									X	
7088.2	CWF shall expect to receive separate CR to implement									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	
	Phase II (to allow a claim to span a benefit period over ten years) that will create a Utility to read claim history to populate remaining spells to the new BENE Spell Aux File for the April 2011 release. NOTE: Claims will continue to return Utilization Edit 5711 (claim span benefit period of 10 or more years).										
7088.3	CWF shall expect to receive separate CR to begin work on Phase III (to allow a claim to span a benefit period over ten years) for the July 2011 release. NOTE: Claims will continue to return Utilization Edit 5711.									X	
7088.4	CWF and FISS shall expect to receive a CR providing instruction to CWF to complete the implementing of Phase III and for FISS/CWF to fully implement CR 6777. NOTE: Claims will no longer return Utilization Edit 5711.						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: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information: See CR 6777

V. CONTACTS

Pre-Implementation Contact(s):

Joe Bryson at joseph.bryson@cms.hhs.gov or 410-786-2986
Sarah Shirey-Losso at sarah.shireylosso@cms.hhs.gov or 410-786-0187
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),* and/or *Carriers*:

Not Applicable.

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.