CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 407

Department of Health & Human Services

Center for Medicare and & Medicaid Services

Date: DECEMBER 17, 2004

Change Request 3633

SUBJECT: Hospital Billing for Repetitive Services

I. SUMMARY OF CHANGES: To be responsive to hospital concerns, this change request (CR) revises instructions provided in Transmittal 270, CR 3382, issued on August 3, 2004. A provider education article will be sent immediately following the issuance of this CR. Also, information regarding inpatient psychiatric facilities and long term care hospitals are being updated in chapter 1, section 50.2.1 of the Claim Processing Manual.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : January 1, 2005

IMPLEMENTATION DATE : January 3, 2005

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	1/50/2.1/Inpatient Billing From Hospitals and SNFs
R	1/50/2.2/Frequency of Billing for Outpatient Services to FIs
R	4/170/Hospital and CMHC Reporting Requirements for Services Performed on the Same Day

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instructions

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 407	Date: December 17, 2004	Change Request 3633

SUBJECT: Hospital Billing for Repetitive Services

I. GENERAL INFORMATION

A. Background: On August 8, 2004, CMS issued Transmittal 270 (CR 3382 – Update to Frequency of Billing) to be effective January 1, 2005. Transmittal 270 updated instructions for hospitals billing repetitive services to allow CMS to accept more singleton claims for APC rate-setting. However, in November, 2004, CMS was notified of possible difficulties that might arise from such changes. To be responsive to hospital concerns, CMS chose to re-evaluate the policy of repetitive billing to lower hospital burden and maintain CMS' ability to achieve more accurate data for APC recalibration.

B. Policy: In the Claims Processing Manual, chapter 1, section 50.2.2, CMS is clarifying that the list of repetitive services is a complete list. Also, beginning January 1, 2005, repetitive service bills may include services paid under the clinical laboratory fee schedule. However, to allow for APC recalibration, repetitive bills may no longer include other non-repetitive services (even if both the non-repetitive service and the repetitive service are paid under OPPS). If an individual OPPS service is provided on the same day as an OPPS repetitive service, the individual OPPS service is to be billed on a separate OPPS claim containing the individual service and all packaged and/or related services. For example, if a chemotherapy drug is administered on a day a repetitive service is also rendered, then the chemotherapy drug, its administration, its related supplies, etcetera, are reported on a separate claim from the monthly repetitive services claim. Similarly, if for example, a radiation therapy treatment (which is a repetitive service because it is reported under a revenue code on the repetitive service list) is administered on the same day that an outpatient consultation and a CT scan is performed, the hospital will report the radiation therapy service on the claim with the other radiation therapy services provided in the applicable month. The visit for the consultation and the CT scan will be reported on a separate claim.

CMS is also modifying billing for chemotherapy services. Chemotherapy administration is no longer a repetitive service. However it is common for it to be administered in multiple encounters in a month. Where there are multiple encounters for chemotherapy or other non-repetitive services in a month, they may all be reported on the same claim or may be billed separately.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn 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 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3633.1	FIs shall recognize that the list of repetitive Part B services found in The Claims Processing Manual, chapter 1, section 50.2.2, is contains all repetitive Part B services.	X								
3633.2	FIs shall allow services not paid under OPPS (laboratory services), to be included on repetitive claims.	X								
3633.3	FIs shall not allow claims for repetitive services to include non-repetitive services (even if both the non-repetitive service and the repetitive service are paid under OPPS) furnished on the same date of service. (For example, if a chemotherapy drug is administered on a day a repetitive service is also rendered, then the chemotherapy drug, its administration, its related supplies, etcetera, should be reported on a separate claim from the monthly repetitive services claim.)	X								
3633.4	FIs shall allow multiple encounters of non-repetitive services, throughout multiple days in a month, to be included on one of the following: • A single claim • Separate claims	X								

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2005 **Implementation Date:** January 3, 2005 **Pre-Implementation Contact(s):** Joe Bryson at 410-786-2986 or jbryson2@cms.hhs.gov **Post-Implementation Contact(s):** Regional Office	**Medicare contractors shall implement these instructions within their current operating budgets.**

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

50.2.1 - Inpatient Billing From Hospitals and SNFs

(Rev. 407, Issued: 12-17-04, Effective: 01-01-05, Implementation: 01-03-05)

Inpatient services in TEFRA hospitals (i.e. cancer and children's hospitals) and SNFs are billed:

- Upon discharge of the beneficiary;
- When the beneficiary' benefits are exhausted;
- When the beneficiary's need for care changes; or
- Monthly.

Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to monthly billing cycles.

Providers shall submit a bill to the FI when a beneficiary in a SNF ceases to need active care (occurrence code 22), or a beneficiary in one of the hospitals ceases to need hospital level care (occurrence code 22). FIs shall not separate the occurrence code 31 and occurrence span code 76 on two different bills.

Each bill must include all applicable diagnoses and procedures. However, interim bills are not to include charges billed on an earlier claim since the "From" date on the bill must be the day after the "Thru" date on the earlier bill. No-payment bills should be submitted until the beneficiary is discharged.

Inpatient acute-care PPS hospitals, inpatient rehabilitation facilities (IRFs), long term care hospitals (LTCHs) *and inpatient psychiatric facilities (IPFs)* may interim bill in at least 60-day intervals. Subsequent bills must be in the adjustment bill format. Each bill must include all applicable diagnoses and procedures.

An initial inpatient acute care PPS hospital, IRF, *IPF* and a LTCH interim claims must have a patient status code of 30 (still patient). When processing interim PPS hospital bills, providers use the bill designation of 112 (interim bill - first claim). Upon receipt of a subsequent bill, the FI must cancel the prior bill and replace it with one of the following bill designations:

- For subsequent interim bills, bill type 117 with a patient status of 30 (still patient); or
- For subsequent discharge bills, bill type 117 with a patient status of one of the following:
    - 01 - Discharged to home or self care;
    - 02 - Discharged/transferred to another short-term general hospital;
    - 03 - Discharged/transferred to SNF;
    - 04 - Discharged/transferred to an ICF;
    - 05 - Discharged/transferred to another type of institution (including distinct part), or referred for outpatient services to another institution;

- 06 - Discharged/transferred to home under care of an organized home health service organization;
- 07 – Left against medical advice;
- 08 - Discharged/transferred to home under care of a home IV drug therapy provider;
- 20 - Expired (or did not recover - Religious Non-Medical Healthcare Institution patient);
- 43 - Discharged/transferred to a Federal hospital (effective for discharges on and after October 1, 2003);
- 50 - Hospice - home
- 51 - Hospice - medical facility
- 61 - Discharged/transferred within this institution to a hospital-based Medicare approved swing bed.
- 62 - Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital
- 63 - Discharged/transferred to long term care hospitals
- 64 - Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
- 65 - Discharged/transferred to a psychiatric hospital or psychiatric part unit of a hospital (effective April 1, 2004)
- 71 - Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (deleted October 1, 2003)
- 72 - Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (deleted October 1, 2003)

All inpatient providers must submit bills when any of the following occur, regardless of the date of the prior bill (if any):

- Benefits are exhausted;
- The beneficiary ceases to need a hospital level of care (all hospitals);
- The beneficiary falls below a skilled level of care (SNFs and hospital swing beds; or
- The beneficiary is discharged.

These instructions for hospitals and SNFs apply to all providers, including those receiving Periodic Interim Payments (PIP). Providers should continue to submit no-pay bills until discharge.

50.2.2 - Frequency of Billing for Outpatient Services to FIs

(Rev. 407, Issued: 12-17-04, Effective: 01-01-05, Implementation: 01-03-05)

Repetitive Part B services to a single individual from providers that bill FIs shall be billed monthly (or at the conclusion of treatment). These instructions also apply to hospice services billed under Part A. This reduces CMS processing costs for relatively small claims and in instances where bills are held for monthly review. *Repetitive Part B services are defined as services billed under the following (and only the following) revenue codes:*

Type of Service	**Revenue Code(s)**
DME Rental	0290 – 0299
Radiation Therapy	0333
Respiratory Therapy	0410 – 0419
Physical Therapy	0420 – 0429
Occupational Therapy	0430 – 0439
Speech Pathology	0440 – 0449
Home Health Visits	0550 – 0559
Kidney Dialysis Treatments	0820 – 0859
Cardiac Rehabilitation Services	0482, 0943
Psychological Services	0900, 0901, 0911 - 0919 (in a psychiatric facility)

This does not apply to Home Health Services. See Chapter 10 for requirements for HHAs.

Where there is an inpatient stay, or outpatient surgery, or outpatient hospital services subject to OPPS, during a period of repetitive outpatient services, one bill shall be submitted for the entire month if the provider uses an occurrence span code 74 to encompass the in-patient stay, day of outpatient surgery, or outpatient hospital services subject to OPPS. CWF and shared systems must read occurrence span 74 and recognize that the beneficiary cannot receive outpatient services while an inpatient, and consequently is on leave of absence from repetitive services. This permits submitting a single bill for the month and simplifies FI review of these bills. This is in addition to the bill for the inpatient stay or outpatient surgery.

Other one-time Part B services may be billed upon completion of the service.

Bills for outpatient hospital services subject to OPPS shall contain on a single bill all services provided on same day except claims containing condition codes 20, 21, or G0 (zero) or kidney dialysis services, which are billed on a 72X bill type. *Beginning January 1, 2005, repetitive service bills may include services paid under the clinical laboratory fee schedule. However, to allow for APC recalibration, repetitive bills may no longer include other non-repetitive services*

(even if both the non-repetitive service and the repetitive service are paid under OPPS). If an individual OPPS service is provided on the same day as an OPPS repetitive service, the individual OPPS service is to be billed on a separate OPPS claim containing the individual service and all packaged and/or related services. For example, if a chemotherapy drug is administered on a day a repetitive service is also rendered, then the chemotherapy drug, its administration, its related supplies, etcetera, are reported on a separate claim from the monthly repetitive services claim. *Similarly, if for example, a radiation therapy treatment (which is a repetitive service because it is reported under a revenue code on the repetitive service list) is administered on the same day that an outpatient consultation and a CT scan is performed, the hospital will report the radiation therapy service on the claim with the other radiation therapy services provided in the applicable month. The visit for the consultation and the CT scan will be reported on a separate claim.*

Chemotherapy administration is not a repetitive service. However it is common for it to be administered in multiple encounters in a month. Where there are multiple encounters for chemotherapy or other non-repetitive services in a month, they may all be reported on the same claim or may be billed separately.

Indian Health Service Hospitals, Maryland hospitals, as well as hospitals located in Saipan, Guam, American Samoa, and the Virgin Islands are not subject to OPPS. In addition, hospitals that furnish only inpatient Part B services are also exempt from OPPS. Bills for ambulatory surgery in these hospitals shall contain on a single bill all services provided on the same day as the surgery except kidney dialysis services, which are billed on a 72X bill type. Non-OPPS services furnished on a day other than the day of surgery shall not be included on the outpatient surgical bill.

See Chapter 16 for clinical diagnostic lab services paid under the fee schedule when included with outpatient bills for other services.

FIs periodically review bills from providers known to be furnishing repetitive services to determine if they are billing more frequently than proper. Techniques that may be used are:

- Sample review of bills to determine if most are for a monthly period (by using from and thru dates or number of services). This may be done manually or electronically. FIs may rely on informal communications from their medical review staff, and
- Modification of duplicate screens to detect bills that meet duplicate criteria except for billing period, but which fall in the same 30 day period.

FIs should educate providers that bill improperly. FIs shall:

- Return bills with an explanation and request proper billing to providers that continue to bill improperly.
- Not return bills where the treatment plan is completed indicating discontinued services because the beneficiary dies or moves.

170 – Hospital and CMHC Reporting Requirements for Services Performed on the Same Day

(Rev. 407, Issued: 12-17-04, Effective: 01-01-05, Implementation: 01-03-05)

Hospitals and Community Mental Health Centers (CMHCs) are required to report all OPPS services that are provided on the same day on the same claim with the exception of claims containing condition codes 20, 21, or G0 (zero), and claims containing repetitive Part B services. Services that are paid under the clinical laboratory fee schedule may be reported on claims for repetitive services and on claims for non-repetitive services. If non-repetitive OPPS services are provided on the same day as OPPS repetitive services, report the non-repetitive OPPS services with all attendant charges and packaged services, on a claim separately from the OPPS monthly repetitive claim. However, if some of the services are for partial hospitalization, the provider shall place condition code 41 on the claim. For claims containing condition code 41, all services billed on the same day are to be included on the monthly bill for repetitive services. Non-repetitive OPPS services, exclusive of partial hospitalization services, are to be put on a single claim along with any packaged services. Repetitive services are billed monthly on a separate claim.

The policy for repetitive services continues under OPPS for all providers. If a non-OPPS repetitive service is provided on the same day as an OPPS service, separate claims may be submitted. In addition, if a 13X and 14X type of bill (TOB) contains OPPS services that were performed on the same day for the same beneficiary, the services must be reported on the same claim. Providers must submit one claim in the situation utilizing the 13X TOB.

NOTE: For a list of revenue codes that are considered repetitive services, see Chapter 1, §50.2.2.

EXAMPLE 1

If a patient receives a laboratory service on May 1st and has an emergency room (ER) visit on the same day, one bill may be submitted since the laboratory service is paid under the clinical diagnostic laboratory fee schedule and not subject to OPPS. In this situation, the laboratory service was not related to the ER visit or done in conjunction with the ER visit.

EXAMPLE 2

If a patient was seen in the emergency room (ER) and the same patient received non-partial hospitalization psychological services on the same day as well as several other days in the month, the provider shall not report the ER visit on the monthly repetitive claim along with the psychological services, since both services are paid under OPPS.

EXAMPLE 3

If the patient receives *physical therapy* on July 7th, 29th, and 30th, and receives services in the ER on July 28th, the provider shall submit separate claims since the isolated individual service (ER visit) did not occur on the same day as the repetitive service (*physical therapy*).

EXAMPLE 4

If a patient has an ER visit (OPPS service) on May 15th and also received a physical therapy visit (non-OPPS service) on the same day (as well as other physical therapy visits provided May 1st through May 31st) the services shall be billed on separate claims. The provider would bill the ER service on one claim and the therapy services on the monthly repetitive claim. Please note, as stated above, the procedures for billing repetitive services remains in effect under OPPS. Therefore, in this example, it would not be appropriate to submit one therapy claim for services provided May 1st through May 15th, a second claim for the ER visit provided on May 15th, and a third claim for therapy visits provided on May 16th through May 31st. Providers shall not split repetitive services in mid-month when another outpatient service occurs.

EXAMPLE 5

If a patient receives radiation therapy (billed under revenue code 333), an outpatient consultation, clinical laboratory services and a CT scan on the same day, the hospital reports the radiation therapy on the monthly claim with the other repetitive services and reports the outpatient consultation, CT scan on a separate claim from that submitted for the radiation therapy. The clinical laboratory services may be reported on either claim.

EXAMPLE 6

If a patient receives chemotherapy, clinical laboratory services, a CT scan and an outpatient consultation on the same date of service, the hospital may report all services on the same claim or may submit multiple claims. Chemotherapy, while commonly administered in multiple encounters across a span of time, is not a repetitive service as defined in Chapter 1, Section 50.2.2.

Fiscal Intermediary Actions

The FI shall return claims submitted for the same date of service to the provider (except exact duplicates or those containing condition codes 20, 21, or G0 (zero) or those containing condition code 41 indicating partial hospitalization) with a notification that an adjustment bill should be submitted. Claims containing condition code G0 (zero) shall not automatically be rejected as a duplicate claim. When returning claims that do not meet the above requirement, the basis of the returned claim must be determined at the line level and not solely on the “From” and “Thru” dates on the claim.

The FI shall not reject or return claims to providers that have been billed appropriately in accordance with these instructions. Claims that are unable to process for payment due to duplicate payment edits in the Shared System or the contractor’s internal claims processing system must be manually reviewed to determine if they were submitted appropriately. These claims are not considered part of the medical review workload.