CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 270 **Date: AUGUST 3, 2004**

CHANGE REQUEST 3382

NOTE: This transmittal replaces Transmittal 239, dated July 23, 2004. The statement in the Summary of Changes referring to 25 to 35 days was deleted. All other information remains the same.

I. SUMMARY OF CHANGES: This instruction requires fiscal intermediaries (FIs) to accept monthly bills from Skilled Nursing Facilities (SNFs) and Tax Equity and Fiscal Responsibility Act (TEFRA) hospitals. It also coordinates proper billing when an individual OPPS service is performed on the same day as an OPPS repetitive service.

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 to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED)

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	1/50/2.3/Submitting Bills In Sequence for a Continuous Inpatient Stay or Course of Treatment
R	4/170/Hospital and CMHC Reporting Requirements for Services Performed on the Same Day

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 270	Date: August 3, 2004	Change Request 3382

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SUBJECT: Update to the Frequency of Billing

I. GENERAL INFORMATION

A. Background:

CMS set limits on the frequency for which particular services may be billed to Medicare. To lower the volume of submitted bills and to facilitate medical review, these frequency limitations required monthly bill submission of repetitive Part B services.

On October 1, 2003, CMS implemented new edits. These edits forced monthly bill submission for long-term care hospitals (LTCHs), skilled nursing facilities (SNFs) and inpatient hospitals not subject to the inpatient prospective payment system (IPPS). In addition, these edits also allowed monthly bill submission for periodic interim payment (PIP) providers and inpatient rehabilitation facilities (IRFs).

B. Policy:

CMS encourages SNFs, IRFs, and Tax Equity and Fiscal Responsibility Act (TEFRA) hospitals to bill monthly. Also, individual OPPS services that are provided on the same day as an OPPS repetitive service are to be billed on a separate OPPS claim containing the individual service and all packaged and/or related services.

C. Provider Education: "A provider education article related to this instruction will be available at http://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 one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin."

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility

3382.1	Fiscal intermediaries shall comply with frequency of billing requirements as outlined in the Claims Processing Manual (Pub. 100-04), Chapter 1, Section 50.2.1.	FISS, FIs
3382.2	Fiscal intermediaries shall accept inpatient bills from TEFRA hospitals and SNFs: • Upon discharge of the beneficiary; • When the beneficiary's benefits are exhausted; • When the beneficiary's need for care changes; or • Monthly.	FISS, FIs
3382.3	Fiscal intermediaries shall comply with frequency of billing requirements for outpatient services as outlined in the Claims Processing Manual (Pub. 100-04), Chapter 1, Section 50.2.2.	FISS, FIs
3382.4	Fiscal intermediaries shall comply with frequency of billing requirements for outpatient services as outlined in the Claims Processing Manual (Pub. 100-04), Chapter 1, Section 50.2.3.	FISS, FIs
3382.5	Fiscal intermediaries shall comply with frequency of billing requirements for outpatient services as outlined in the Claims Processing Manual (Pub. 100-04), Chapter 4, Section 170.	FISS, FIs

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 jbryson2@cms.hhs.gov or 410-786-2986 **Post-Implementation Contact(s):** Regional Office	**These instructions shall be implemented within your current operating budget.**

50.2.1 - Inpatient Billing From Hospitals and SNFs

(Rev. 270, Issued 08-03-04, Effective: 01-01-05/Implementation: 01-03-05)

Inpatient services in TEFRA hospitals (i.e., psychiatric hospitals or units, 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), and long term care hospitals (LTCHs) 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.

The LTCHs will also submit a bill when the beneficiary's benefits exhaust. This permits them to bill a secondary insurer when Medicare ceases to make payment.

An initial inpatient acute care PPS hospital, IRF, 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. 270, Issued 08-03-04, 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. Examples of repetitive Part B services with applicable revenue codes include:

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. 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 on a separate claim from the monthly repetitive services claim.* 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

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.

50.2.3 - Submitting Bills In Sequence for a Continuous Inpatient Stay or Course of Treatment

(Rev. 270, Issued 08-03-04, Effective: 01-01-05/Implementation: 01-03-05)

A3-3603.1

When a patient remains an inpatient of a SNF, TEFRA hospital or unit, swing-bed, or hospice for over 30 days, these providers may submit a bill *monthly* (See §50.2.1 *for frequency of billing requirements*.) Claims for the beneficiary are to be submitted in service date sequence. The shared system must edit to prevent acceptance of a continuing stay claim or course of treatment claim until the prior bill has been processed. If the prior bill is not in history, the incoming bill will be rejected to the provider with the appropriate error message.

When an out-of-sequence claim for a continuous stay or outpatient course of treatment is received, FIs will search the claims history for the prior bill. They do not suspend the out-of-sequence bill for manual review, but perform a history search system for an adjudicated claim. If the prior bill is not in the finalized claims history, they reject the incoming bill with an error

message requesting the prior bill be submitted first, if not already submitted, and the rejected bill only be resubmitted after the provider receives notice of the adjudication of the prior bill. A typical error message follows:

Bills for a continuous stay or admission or for a continuous course of treatment must be submitted in the same sequence in which the services are furnished. If you have not already done so, please submit the prior bill. Then, resubmit this bill after you receive the remittance advice for the prior bill.

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

(Rev. 270, Issued 08-03-04, Effective: 01-01-05/Implementation: 01-03-05)

A-01-91
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) *or containing repetitive Part B services*. If an individual OPPS service is provided on the same day as an OPPS repetitive service, the individual OPPS service must be billed *separately, with all related services, 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, two separate bills *shall* 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 IV antibiotics 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 services (IV antibiotic infusion). In this situation, it does not matter whether the services are reimbursed under OPPS or not.

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.

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.