CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 763

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: NOVEMBER 25, 2005

Change Request 4047

NOTE:Transmittal 763 is being recommunicated to restore information in Chapter 1, Section 50.2.2 regarding Maryland hospitals that are under the jurisdiction of the Health Services Cost Review Commission that was inadvertently deleted. All other information remains the same.

NOTE: *Transmittal 711, dated October 14, 2005, is rescinded and replaced with Transmittal 763, dated November 25, 2005. The change was to the manual instruction only. All other information remains the same.*

SUBJECT: Update to Repetitive Billing -- Manualization

I. SUMMARY OF CHANGES: This CR updates The Medicare Claims Processing Manual's billing instructions for repetitive and recurring services."

NEW/REVISED MATERIAL
EFFECTIVE DATE: N/A
IMPLEMENTATION DATE: N/A

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	1/50.2.2/Frequency of Billing to FIs for Outpatient Services
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 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 763	Date: November 25, 2005	Change Request 4047

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I. GENERAL INFORMATION

A. Background: On December 17, 2004, CMS issued Transmittal 407 (CR 3633 – Hospital Billing for Repetitive Services) with an effective date of January 1, 2005. Soon after the release of CR 3633, CMS was notified of possible difficulties that may arise from instructions described in CR 3633. CMS chose to re-evaluate the policy of repetitive billing and provide clarification in The Medicare Claims Processing Manual.

B. Policy:

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	
4047.1	Contractors shall be in compliance with the instructions in Pub. 100-04, The Medicare Claims Processing Manual, Chapter 1, Section 50.2.2. Note: No editing is to be done at this time. CMS will notify contractors and maintainers in a separate change request should editing be required.	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4047.2	Contractors shall be in compliance with the instructions in Pub. 100-04, The Medicare Claims Processing Manual, Chapter 4, Section 170. Note: No editing is to be done at this time. CMS will notify contractors and maintainers in a separate change request should editing be required.	X								

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4047.3	A 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 shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. 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.	X								

IV. 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

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: N/A **Implementation Date:** N/A **Pre-Implementation Contact(s):** Billing: Joe Bryson at joseph.bryson@cms.hhs.gov or (410-786-2986) Policy: Joan Sanow at joan.sanow@cms.hhs.gov or (410-786-9739) **Post-Implementation Contact(s):** Regional Office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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

50.2.2 - Frequency of Billing to FIs for Outpatient Services

(Rev. 763, Issued: 11-25-05, Effective/Implementation Dates: N/A)

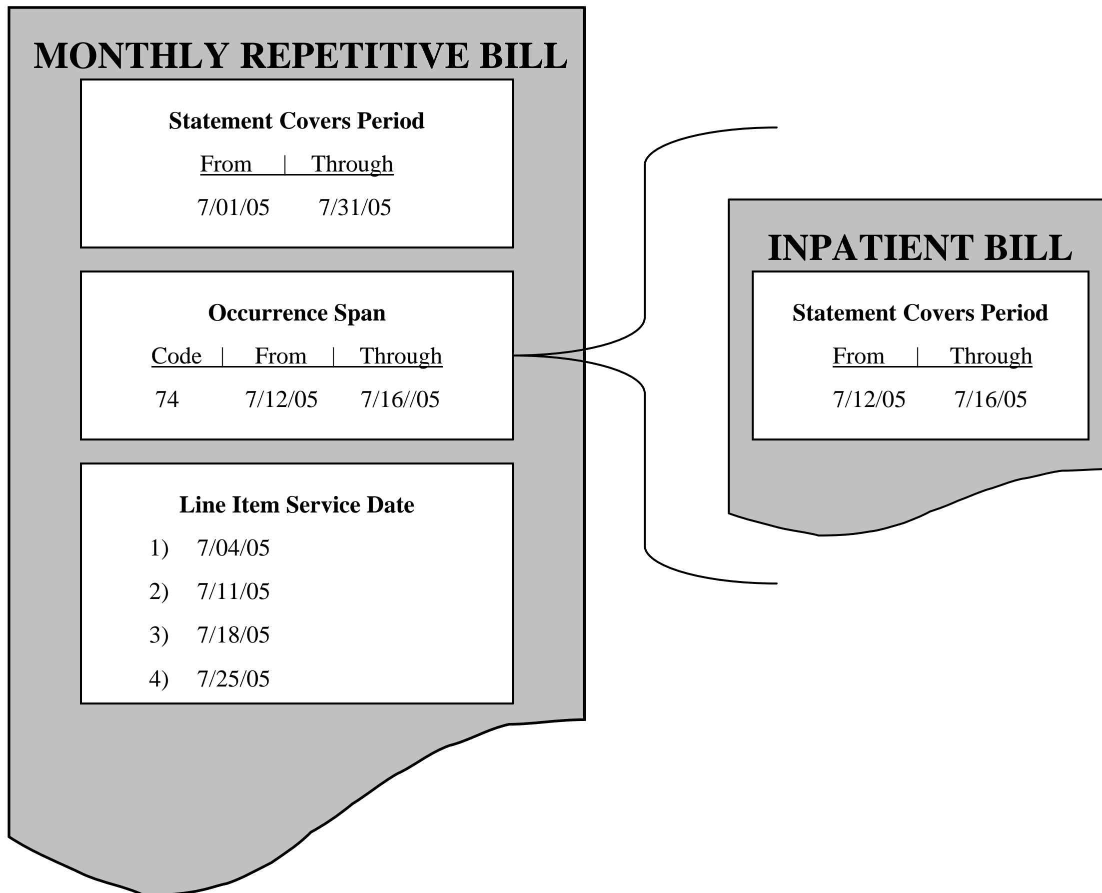
Repetitive Part B services *furnished* to a single individual *by* providers that bill FIs shall be billed monthly (or at the conclusion of treatment). The instructions *in this subsection* also apply to hospice services billed under Part A, *though they do not apply to home health services. Consolidating repetitive services into a single monthly claim* reduces CMS processing costs for relatively small claims and in instances where bills are held for monthly review. *Services repeated over a span of time and billed with the following revenue codes are defined as repetitive services:*

Type of Service	**Revenue Code(s)**
DME Rental	0290 – 0299
Respiratory Therapy	0410*, 0412, 0419*
Physical Therapy	0420 – 0429
Occupational Therapy	0430 – 0439
Speech Pathology	0440 – 0449
Skilled Nursing	0550 – 0559
Kidney Dialysis Treatments	0820 – 0859
Cardiac Rehabilitation Services	0482, 0943

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

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 *for repetitive services* shall *nonetheless* be submitted for the entire month *as long as the provider uses an occurrence span code 74 on the monthly repetitive bill to encompass the inpatient stay, day of outpatient surgery, or outpatient hospital services subject to OPPS.* CWF and shared systems must read occurrence span 74 and recognize the beneficiary cannot receive *non-repetitive services* while *receiving repetitive services*, and consequently*,* is on leave of absence from *the repetitive* services. This permits submitting a single, *monthly* bill *for repetitive services* and simplifies FI review of these bills. *The following is an illustration explaining this scenario:*

Leave of Absence "Carve-Out" Example

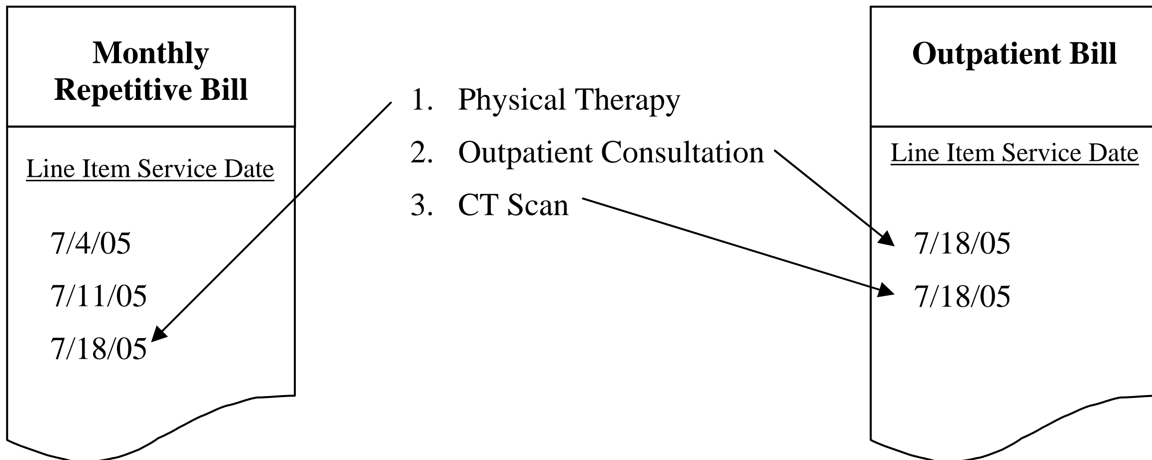


*Any items and/or services in support of the repetitive service shall be reported on the same claim even if the revenue code(s) reported with those supported services are not on the repetitive revenue code list (**NOTE:** Supporting items and/or services are those in which are needed specifically in the performance of the repetitive service. Examples may include disposable supplies, drugs or equipment used to furnish the repetitive service).*

However, *to facilitate* APC recalibration, *do not report unrelated one-time, non-repetitive services that have the same date of service as a* repetitive *service* (even if both the non-repetitive service and the repetitive service are paid under OPPS). If *a non-repetitive* OPPS service is provided on the same date as a repetitive service, report the non-repetitive OPPS services, along with any *packaged and/or services related to the non-repetitive OPPS service,* on a separate OPPS *claim*. For example, if a chemotherapy drug is administered on a day a repetitive service is also rendered, *report* the chemotherapy drug, its administration, its related supplies, etcetera, on a separate claim from the monthly repetitive services claim. Similarly, *as shown below in the illustration, "Example: Monthly Repetitive Billing Procedure,"* a *physical* 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 an outpatient consultation and a CT scan *are furnished*, *report the physical* therapy service on the claim with the other *physical* therapy services provided *during* the applicable month. *Report the* visit for the consultation and the CT scan on a separate claim.

Example: Monthly Repetitive Billing Procedure



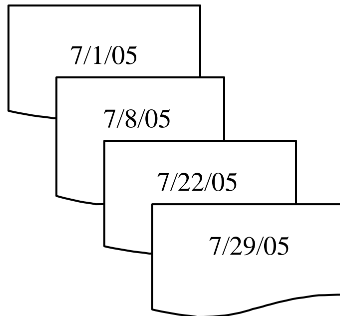
Revenue codes usually reported for chemotherapy and radiation therapy are not on the list of revenue codes that may only be billed monthly. Therefore, hospitals may bill chemotherapy or radiation therapy sessions on separate claims for each date of service. However*, because* it is common for *these services* to be *furnished* in multiple encounters *that occur over several weeks or over the course of a month, hospitals have the option of reporting charges for those recurring services on a single bill, as though they were repetitive services. If hospitals elect to report charges for recurring, non-repetitive services (such as chemotherapy or radiation therapy) on a single bill, they must also report all charges for services and supplies associated with the recurring service on the same bill. The services* may all be reported on the same claim or *billed separately by date of service as illustrated below:*

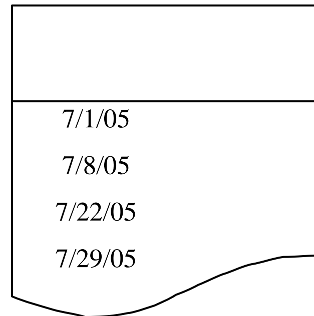
Billing Procedures for Recurring Services Not Defined as Repetitive

1) Submit multiple bills for each date of service (include only the recurring service and its related services):

OR

2) Submit a monthly bill for all line item dates of service (for the entire month's recurring services with all services related to the recurring services):





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-*ASC* 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.

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

(Rev. 763, Issued: 11-25-05, Effective/Implementation Dates: N/A)

When reporting a HCPCS code for a separately payable, non-repetitive hospital OPPS service, report charges for all services and supplies associated with that service, that were furnished on the same date (services subject to the 3-day payment window are an exception to this OPPS policy).

When a hospital provides electroconvulsive therapy (ECT) on the same day as partial hospitalization services, both the ECT and partial hospitalization services should be reported on the same hospital claim. In this instance, the claim should contain condition code 41. As noted above, report charges for all services and supplies associated with the ECT service, which were furnished on the same date(s) on the same claim.

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 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 *3*

If a patient has an ER visit (OPPS service) on May 15th and also *receives* a physical therapy visit (repetitive, 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 *4*

If a patient receives chemotherapy*, or radiation therapy,* 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. The clinical laboratory services may be reported either *on the single consolidated* claim *or on a separate claim that reports the services furnished on the same date as the laboratory services.*