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Intermediary Manual

Part 3 - Claims Process

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CHANGE REQUEST 1840

If the provisions of the final rule implementing the law are the same as the provisions of the proposed rule published on August 2, 2001, these instructions will remain as they appear below. If the final rule differs from the proposed rule, CMS will issue new instructions.

<u>HEADER SECTION NUMBERS</u>	<u>PAGES TO INSERT</u>	<u>PAGES TO DELETE</u>
Table of Contents -- Chapter VII	6-5 - 6-6 (2 pp.)	6-5 - 6-6 (2 pp.)
3660.10 - 3660.10 (Cont.)	6-344.1 - 6.344.6 (7 pp.)	6-344.1 - 6.344.6 (6 pp.)
3660.18 - 3663 (Cont.)	6-344.6M - 6-334.6W (11 pp.)	6-344.6M - 6-344.6S (7 pp.)

NEW/REVISED MATERIAL--EFFECTIVE DATE: January 1, 2002
IMPLEMENTATION DATE: January 1, 2002

Section 3660.10, Mammography Screening, is being updated based on §104 of the Benefits Improvement and Protection Act (BIPA) of 2000 which amends §1848(j)(3) of the Act to include screening mammography as a service for which payment is made under the Medicare Physician Fee Schedule (MPFS). The payment limitation for screening mammographies no longer applies for claims with dates of service on or after January 1, 2002.

A new code 76085, "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, screening mammography (List separately in addition to code for primary procedure)" for computer aided detection (CAD), has been created as an add-on code to be billed in conjunction with a regular screening mammography (code 76092).

This section also changes billing procedures for Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) as a result of the new payment method for screening mammographies and payment for Computer-Aided Detection (CADs).

In addition, for claims with dates of service on or after January 1, 2002, Medicare will pay for both a screening and diagnostic mammogram when a radiologist's interpretation of a screening mammography results in additional films.

Section 3660.19, Diagnostic Mammography, has been added to provide coverage and payment criteria for diagnostic mammograms. In addition, a new code G0236, "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography" for computer aided detection (CAD), which has been created as an add-on code to be billed in conjunction with a regular diagnostic mammogram (codes 76090 or 76091).

This section changes billing procedures for RHCs and FQHCs as a result of payment for CADs.

Section 3660.20, Diagnostic and Screening Mammograms Performed with New Technologies, has been added to reflect payment and billing requirements for new digital mammography equipment for both screening and diagnostic mammograms based on §104 of BIPA.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

CHAPTER VII
BILL REVIEW

	<u>Section</u>
Adjustments of Episode Payment--Partial Episode Payment (PEP)	3639.28
Adjustments of Episode Payment--Significant Change in Condition (SCIC).....	3639.29
Adjustments of Episode Payment--Outlier Payments.....	3639.30
Adjustments of Episode Payment--Exclusivity and Multiplicity of Adjustments.....	3639.31
Exhibit: Seven Scenarios for Home Health Prospective Payment Adjustment.....	3639.32
Exhibit: General Guidance on Line Item Billing Under HH PPS.....	3639.33
Exhibit: Acronym Table.	3639.34
Home Health Prospective Payment System (HH PPS) Consolidated Billing and Primary HHAs.....	3639.35
New Common Working File (CWF) Requirements for the Home Health Prospective Payment System (HH PPS)	3640
Creation of the Health Insurance Query System for Home Health Agencies (HIQH) and Hospices in the Common Working File--Replacement of HIQA.....	3640.1
HIQH Inquiry and Response	3640.2
Timeliness and Limitations of HIQH Responses	3640.3
Inquiries to Regional Home Health Intermediaries (RHHIs) Based on HIQH Responses.....	3640.4
National Home Health Prospective Payment Episode History File	3640.5
Opening and Length of HH PPS Episodes	3640.6
Closing, Adjusting and Prioritizing HH PPS Episodes Based on RAP and HHA Claim Activity	3640.7
Other Editing and Changes for HH PPS Episodes.....	3640.8
Priority Among Other Claim Types and HH PPS Consolidating Billing for Episodes.....	3640.9
Medicare Secondary Payment (MSP) and the HH PPS Episode File	3640.10
Exhibit: Chart Summarizing Effects of RAP/Claim Actions on the HH PPS Episode File	3640.11
Rural Health Clinics - General.....	3642
Federally Qualified Health Centers	3643
Dialysis for ESRD - General.....	3644
Special Consideration When Processing ESRD Bills Under Method I.....	3644.1
Review of ESRD Bills Under Method I.....	3644.2
Special Consideration When Processing ESRD Bills Under Method II.....	3644.3
Processing the HCFA-382, ESRD Beneficiary Selection.....	3644.4
Coding for Adequacy of Hemodialysis.....	3644.5
Review of Hospice Bills	3648
Clarifications of Reimbursement for Transfers That Result in Same Day Hospice Discharge and Admission	3648.1
Comprehensive Outpatient Rehabilitation Facilities (CORFS).....	3650
Bill Review For Partial Hospitalization Services Provided In Community Mental Health Centers (CMHCs).....	3651
Billing for Abortion Services	3652
Prospective Payment for Outpatient Rehabilitation Services and the Financial Limitation	3653

Physician Services

Coordination With Health Maintenance Organizations.....	3654
Provider Billing for Services Provided to HMO Beneficiaries	3654.1
Patient Is a Member of HMO for Only Part of Billing Period.....	3654.2
Computer Programs Supplied by HCFA.....	3656
Medicare Code Editor (MCE)	3656.1
DRG Grouper Program.....	3656.2
PPS Pricer Program	3656.3

CHAPTER VII
BILL REVIEW

	<u>Section</u>
PPS Pricer Program	3656.3
Ambulatory Surgical Center (ASC) Pricer Program.....	3656.4
Outpatient Code Editor (OCE).....	3656.5
Radiology Pricer Program	3656.6
Home Health Prospective Payment System (HH PPS) Pricer Program	3656.7
Special Billing Situations	3660
Ambulance Services	3660.1
All-Inclusive Rate Providers	3660.4
Hospitals That Do Not Charge	3660.5
Billing for Parenteral and Enteral Nutrition (PEN).....	3660.6
Pneumococcal Pneumonia, Influenza Virus and Hepatitis B Vaccines	3660.7
Immunosuppressive Drugs Furnished to Transplant Patients.....	3660.8
Payment for CRNA or AA Services.....	3660.9
Mammography Screening	3660.10
Self-Administered Drugs and Biologicals.....	3660.11
Self-Administered Drug Administered in an Emergency Situation.....	3660.12
Oral Cancer Drugs	3660.13
Self-Administered Anti-emetic Drugs	3660.14
Oral Anti-Nausea Drugs as Full Therapeutic Replacements for Intravenous Dosage Forms as Part of a Cancer Chemotherapeutic Regimen	3660.15
Mammography Quality Standards Act (MQSA)	3660.16
Colorectal Screening	3660.17
Extracorporeal Immunoabsorption (ECI) Using Protein A Columns	3660.18
Diagnostic Mammography.....	3660.19
Diagnostic and Screening Mammograms Performed with New Technologies.....	3660.20
Hospital Outpatient Partial Hospitalization Services	3661
Billing for Hospital Outpatient Services Furnished by Clinical Social Workers (CSWs).....	3662
Outpatient Observation Services.....	3663
Adjustment Bills.....	3664
Tolerance Guides for Submitting Adjustment Bills.....	3664.1
Physician Services	3668
Billing for Physicians Services	3668.1
Combined Billing by All-Inclusive Rate and Teaching Hospitals.....	3668.2

Cost Reimbursement Providers

Residents and Interns Not Under Approved Teaching Programs	3669
Detection of Duplicate Claims	3670
Coordination with Carriers	3672
Part A Denials	3672.1
Nonphysician Services Furnished to Hospital Inpatients Are Billed to Carrier	3672.2
Corrective Action When Nonphysician Services Are Furnished to Hospital Inpatients	3672.3
Recovery of Overpayment When Nonphysician Services Furnished to Hospital Inpatient Paid by Carrier.....	3672.4
Format and Content of A/B Data Match Record Furnished by Carrier	3672.5
Format for Fee Schedule, Prevailing Charge and Conversion Factor Data.....	3672.6
Coordination with the PRO	3674
Limitation of Liability Provision	3674.1
General Responsibilities of Hospitals, PROs, and Intermediaries	3674.2
PRO Preadmission/Preprocedure Review	3674.3
PRO Prepayment Review System (PRS).....	3674.4
PRO Reporting on Medical Review	3674.5

3660.10 Mammography Screening.--Section 4163 of the Omnibus Budget Reconciliation Act of 1990 added §1834(c) of the Act to provide for Part B coverage of mammography screening performed on or after January 1, 1991. The term "screening mammography" means a radiologic procedure provided to an asymptomatic woman for the purpose of early detection of breast cancer and includes a physician's interpretation of the results of the procedure. Unlike diagnostic mammographies, there do not need to be signs, symptoms, or history of breast disease in order for the exam to be covered.

There is no requirement that the screening mammography examination be prescribed by a physician for an eligible beneficiary to be covered. Payment may be made for a screening mammography furnished to a woman at her direct request.

Prior to October 1, 1994, providers that perform screening mammographies must request and be recommended for certification by the State certification agency and approved by HCFA before payment is made. Effective October 1, 1994, providers that perform mammography services (diagnostic and screening) must be issued a certificate from the Food and Drug Administration (FDA) before payment is made. (See §3660.16 for more detailed instructions.) A provider that arranges for another entity to perform a screening mammography for one of its patients must assure, prior to October 1, 1994, that the entity is certified to perform the screening, or on or after October 1, 1994, must assure that the entity has been issued a certificate by FDA. If the entity that performed the screening mammography is not certified, deny the claim utilizing the denial language in subsection G.

Section 4101 of the Balanced Budget Act (BBA) of 1997 provides for annual screening mammographies for women over 39 and waives the Part B deductible. Coverage applies as follows:

- o No payment may be made for a screening mammography performed on a woman under 35 years of age;
- o Pay for only one screening mammography performed on a woman between her 35th and 40th birthday (ages 35 thru 39); or
- o For a woman over 39, pay for a screening mammography performed after 11 full months have passed following the month in which the last screening mammography was performed.

A. Determining 11 Month Period.--To determine the 11 month period, start your count beginning with the month after the month in which a previous screening mammography was performed.

EXAMPLE: The beneficiary received a screening mammography in January 1991. Start your count beginning with February 1991. The beneficiary is eligible to receive another screening mammography in January 1992 (the month after 11 full months have elapsed).

B. Payment.--There is no Part B deductible. However, coinsurance is applicable. Following are three categories of billing for **screening** mammography services:

- o Professional component of mammography services (that is, for the physician's interpretation of the results of the examination),
- o Technical component (all other services), or

o Both professional and technical components (global). However, global billing is not permitted for services furnished in provider outpatient department, except for CAHs electing the optional method of payment for mammography services furnished on or after January 1, 2002.

Claims with dates of service prior to January 1, 2002, are subject to a payment limitation. When the technical and professional components of the screening mammography are billed separately, the payment limit is adjusted to reflect either the professional or technical component only. That is, the limitation (\$62.10 in calendar year 1996, \$63.34 in calendar year 1997, \$64.73 in calendar year 1998, \$66.22 in calendar year 1999, \$67.81 in calendar year 2000 and \$69.23 in calendar year 2001) applicable to global billing for screening is allocated between the professional and technical components as set forth by regulations. For example, in calendar year 2000, 32 percent of the \$67.81 limit, or \$21.69, is used in determining payment for the professional component and 68 percent of the \$67.81 limit, or \$46.12 is used in determining payment for the technical component.

Payment for the technical component equals 80 percent of the least of the:

- o Actual charge for the technical component of the service;
- o Amount determined for the technical component of a bilateral diagnostic mammogram (HCPCS code 76091) for the service under the radiology fee schedule in 1991; or for services furnished on or after January 1, 1992, under the Medicare physicians' fee schedule (MPFS); or
- o Technical portion of the screening mammography limit. This is an amount determined by multiplying the screening mammography limit (\$59.63 in calendar year 1994 by 63 percent, \$60.88 in calendar year 1995, \$62.10 in calendar year 1996, \$63.34 in calendar year 1997, \$64.73 in calendar year 1998, \$66.22 in calendar year 1999, \$67.81 in calendar year 2000, and \$69.23 in calendar year 2001) by 68 percent.

See subsection C below for payment examples.

For claims with dates of service on or after January 1, 2002, §104 of the Benefits Improvement and Protection Act (BIPA) 2000, provides for payment of screening mammographies under the Medicare Physician Fee Schedule (MPFS) for such services furnished in hospitals, skilled nursing facilities (SNFs), and in CAHs not electing the optional method of payment for outpatient services. The payment for code 76092 is equal to the lower of the actual charge or locality specific technical component payment amount under the MPFS. Program payment for the service is 80 percent of the lower amount and coinsurance is 20 percent. This is a final payment.

In addition, a new HCPCS code 76085, "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, screening mammography (List separately in addition to code for primary procedure)" for computer aided detection (CAD), has been established as an add-on code that can be billed only in conjunction with the primary service screening mammography code 76092. Payment will be made under the MPFS. There is no Part B deductible. However, coinsurance is applicable.

When a screening CAD (76085) is billed in conjunction with a screening mammography (76092) and the screening mammography (76092) fails the age and frequency edits in CWF both services will be rejected by CWF.

Return to provider claims containing code 76085 that do not also contain HCPCS code 76092 with an explanation that payment for code 76085 cannot be made when billed alone.

You were furnished with a mammography benefit pricing file via Program Memorandum (PM) A-104, CR 1811, dated August 23, 2001. Use this file to pay claims containing the above codes.

For CAHs, see §3610.22 for those that have elected the optional method of payment for outpatient services. Pay these CAHs for screening mammographies furnished on or after January 1, 2002 at 115 percent of the lesser of:

- o Eighty percent of the actual charges of the CAH for the screening mammography, including both the radiologic procedure and the physician's interpretation, or
- o Eighty percent of the global payment amount under the MPFS for the screening mammography.

C. Determining Payment Amount For Technical Component for Claims with Dates of Service Prior to January 1, 2002.--This provides for the payment calculation of the technical portion of a screening mammography. For services in 2000, pay the lower of:

- o Billed charges for HCPCS code 76092;
- o \$46.12 limit; or
- o The physicians' fee schedule amount for the technical component of HCPCS code 76091.

NOTE: For services in 1991, use the fee schedule amount for the technical component of HCPCS code 76092 (since there is no price for HCPCS code 76092, use the technical RVS (3.79) for HCPCS code 76091 and the conversion factor to determine the fee schedule amount).

The screening mammography payment is a final payment, not a payment limit, as are other radiology services, and is not subject to the radiology blend. Therefore, determine the payment in your system before remittance.

EXAMPLE: \$90.00 Provider charges;
\$75.00 Physicians' fee schedule amount; and
\$46.12 Technical portion of the screening mammography limit (68% of \$67.81).

Payment is 80 percent of the lower of:

- \$90.00 Provider charges;
- \$75.00 Physicians' fee schedule amount for the technical component; or
- \$46.12 Technical portion of the screening mammography limit.

To calculate the payment, select the lower of:

- \$90.00 Provider charges;
- \$75.00 Physicians' fee schedule amount for the technical component; or
- \$46.12 Technical portion of the screening mammography limit.

Pay 80 percent of the remainder. Do not apply the provider's interim rate. This is a final payment to the provider.

In this case:

$$\$46.12 \times 80\% = \$36.90 \text{ payment to the provider.}$$

To determine the patient's liability, multiply the actual charge by 20 percent. The result is the patient's liability.

In this case:

$$\$90.00 \times 20\% = \$18.00 \text{ (coinsurance).}$$

NOTE: This payment limitation does not apply to claims with dates of service on or after January 1, 2002.

D. Billing Requirements.--Providers bill for the technical component portion of the screening mammography on Form HCFA-1450 under bill type 14X, 22X, 23X, or 85X, using revenue code 403 and HCPCS code 76092, except for CAHs who have elected the optional method of reimbursement who bill the carrier on the HCFA-1500 for the global amount. See subsection B for payment requirements. Separate bills are required for claims with dates of service prior to January 1, 2002. Providers include on the bill only charges for the mammography screening. Separate bills are not required for claims with dates of service on or after January 1, 2002. (See below for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).)

For claims with dates of service prior to January 1, 2002, provider-based RHCs and FQHCs bill the intermediary for the technical component and their carrier for the professional component of the screening mammography. Provider-based RHCs and FQHCs utilize bill type 14X, 22X, 23X or 85X as appropriate when billing the intermediary for this service. Independent RHCs and free-standing FQHCs bill their carrier for both the technical and professional components. Payment is made based on the limitation.

For claims with dates of service on or after January 1, 2002, the professional component of a screening mammography furnished within an RHC/FQHC by a physician or non-physician is considered an RHC/FQHC service. RHCs and FQHCs bill you under bill type 71X or 73X for the professional component along with revenue code 403 and HCPCS code 76085 or 76092. Payment will be made under the all-inclusive rate. Specific revenue coding and HCPCS coding is required for this service in order for CWF to perform age and frequency editing.

Payment should not be for a screening mammography unless the claim contains a related visit code. Therefore, install an edit in your system to assure payment is not made for revenue code 403 unless the claim also contains a visit revenue code (521).

The technical component of a screening mammography is outside the scope of the RHC/FQHC benefit. The provider of the technical service bills their carrier on Form HCFA-1500.

The technical component of a screening mammography for provider-based RHCs/FQHCs is typically furnished by the provider. The provider of that service bills you under bill type 14X, 22X, 23X or 85X as appropriate using their outpatient provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services). The appropriate revenue code is 403 and the appropriate HCPCS codes are 76085 and 76092.

On every screening claim with dates of service October 1, 1997 thru December 31, 1997, where the patient is not a high risk individual, the provider enters in FL 67, "Principal Diagnosis Code," the following code:

- o V76.12 "Other screening mammography."

If the screening is for a high risk individual, the provider enters in FL 67, "Principal Diagnoses Code," the following code:

- o V76.11 "Screening mammogram for high risk patient."

In addition, for high risk individuals, providers also report one of the following applicable codes in FL 68, "Other Diagnoses Codes":

- o V10.3 "Personal history - Malignant neoplasm female breast;"
- o V16.3 "Family history - Malignant neoplasm breast;" or
- o V15.89 "Other specified personal history representing hazards to health."

The following chart indicates the ICD-9 diagnosis codes providers report for each high risk category:

<u>High Risk Category</u>	<u>Appropriate Diagnosis Code</u>
A personal history of breast cancer	V10.3
A mother, sister, or daughter who has breast cancer	V16.3
Not given birth prior to age 30	V15.89
A personal history of biopsy-proven benign breast disease	V15.89

On every screening claim with dates of service on or after January 1, 1998, providers enter in FL 67, "Principal Diagnosis Code," the following code:

- o V76.12 "Other screening mammography."

NOTE: Providers code the ICD-9 diagnosis codes to the appropriate fourth or fifth digit. Omit decimal points for data entry purposes. In addition, due to the BBA of 1997, there is no need for providers to continue to report the high risk diagnosis codes effective January 1, 1998.

E. Actions Required.--Consider the following when determining whether payment may be made:

- o Presence of revenue code 403;
- o Presence of HCPCS code 76092;
- o Date of last screening mammography; and
- o Age of beneficiary.

Expand your system to edit to accept revenue code 403 for bill types 14X, 22X, 23X, 71X, 73X or 85X. CWF records are annotated with the date of the first (technical or global) screening

mammography claim received. The record is updated based on the next covered (technical or global) claim received. Assume the claim is the first received for the beneficiary where your records do not contain a date of last screening, and process accordingly. In addition, use of the 14X bill type will require you to change your system, if you have not already done so, to allow other than clinical diagnostic laboratory services for nonpatients.

F. Data for CWF and PS&R.--Include revenue code, HCPCS code, units, and covered charges in the financial data section (fields 65a- 65j). Report the payment amount for revenue code 403 in field 65g, "Rate," and the billed charges in field 65h, "Charges", of the CWF record. In addition, report special override code 1 in field 65j, "Special Action", of the CWF record to avoid application of the Part B deductible.

Include in the financial data portion of the PS&R UNIBILL, revenue code, HCPCS code, units, charges, and rate (fee schedule amount).

The PS&R system will include screening mammographies on a separate report from cost-based payments. See your PS&R guidelines for specific information.

G. Special Billing Instructions When a Radiologist Interpretation Results in Additional Films (Claims with Dates of Service October 1, 1998 through December 31, 2001).--Radiologists who interpret screening mammographies are allowed to order and interpret additional films based on the results of the screening mammogram while a beneficiary is still at the facility for the screening exam. Where a radiologist's interpretation results in additional films, the mammography is no longer considered a screening exam for application of age and frequency standards or for payment purposes. When this occurs, the claim should be billed and paid as a diagnostic mammography instead of a screening mammography. However, since the original intent for the exam was for a screening, for statistical purposes, the claim is considered a screening.

The claim must be prepared reflecting the diagnostic revenue code (401) along with HCPCS code 76090, 76091, G0204, G0206 or G0236 as appropriate, and modifier GH "diagnostic mammogram converted from screening mammogram on same day". Statistics will be collected based on the presence of modifier GH. A separate claim is not required. Modify your system to accept modifier GH. Regular billing instructions remain in place for screening mammographies that do not fit this situation. (See subsection D for appropriate bill types and §3660.19 for payment methods.)

H. Special Billing Instructions When a Radiologist Interpretation Results in Additional Films (Claims with Dates of Service on or after January 1, 2002.)--Radiologists who interpret screening mammographies are allowed to order and interpret additional films based on the results of the screening mammogram while a beneficiary is still at the facility for the screening exam. When a radiologist's interpretation results in additional films, Medicare will now pay for both the screening and diagnostic mammogram.

The diagnostic claim must be prepared reflecting the diagnostic revenue code (401) along with HCPCS code 76090, 76091, G0204, G0206 or G0236 and modifier GG "Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day." Modify your system to accept modifier GG. Reporting of **this** modifier is needed for data collection purposes. Regular billing instructions remain in place for screening mammographies that do not fit this situation. See subsection D for appropriate bill types, §3660.19 for detailed information regarding HCPCS code G0236, and §3660.20 for detailed information regarding HCPCS codes G0204 and G0206.

I. Medicare Summary Notice (MSN) and Explanation of Your Medicare Benefits (EOMB) Messages.--Intermediaries that have not yet converted to MSN should utilize the following EOMB messages. Intermediaries who have converted to MSN should utilize the following MSN messages.
6-344.5A

If the claim is denied because the beneficiary is under 35 years of age, state on the EOMB or MSN the following message:

"Screening mammography is not covered for women under 35 years of age."
AEl examen de mamografía para mujeres menores de 35 años no está cubierto. @
(MSN message number 18-3 or EOMB message number 18.18)

If the claim is denied for a woman 35-39 because she has previously received this examination, state on the EOMB or MSN the following message:

"A screening mammography is covered only once for women age 35-39."
"AUn examen de mamografía es cubierto una sola vez para mujeres entre las edades de 35-39 años."
(MSN message number 18-6 or EOMB message number 18.19)

If the claim is denied because the period of time between screenings for the woman based on age has not passed, state on the EOMB or MSN the following message:

"This service is being denied because it has not been 12 months since your last examination of this kind."
"Este servicio fue denegado debido a que no han transcurrido 12 meses desde su último examen de esta clase."
(MSN message number 18-4 or EOMB message number 18.20)

If the claim is denied because the provider that performed the screening is not certified, state on the EOMB or MSN the following message:

"This service cannot be paid when provided in this location/facility."
"Este servicio no se puede pagar cuando es administrado en esta facilidad/localidad."
(MSN message number 16-2 or EOMB message number 16.4)

In addition to the above denial messages, you have the option of using the following message on the MSN or EOMB:

"Screening mammograms are covered annually for women 40 years of age and older."
"Un examen de mamografía es cubierto una vez al año para mujeres de 40 años de edad o más."
(MSN message number 18-12 or EOMB message number 18.21)

J. Remittance Advice Messages.--If the claim is denied because the beneficiary is under 35 years of age, you use existing American National Standard Institute (ANSI) X-12-835 claim adjustment reason code/message 6, "The procedure code is inconsistent with the patient's age" along with line level remark code M37, "Service is not covered when the beneficiary is under age 35."

If the claim is denied for a woman 35-39 because she has previously received this examination, use existing ANSI X-12-835 claim adjustment reason code/message 119, "Benefit maximum for this time period has been reached" along with line level remark code M89, "Not covered more than once under age 40."

If the claim is denied for a woman age 40 and above because she has previously received this examination within the past 12 months, use existing ANSI X-12-835 claim adjustment reason code/message 119, "Benefit maximum for this time period has been reached" along with line level remark code M90, "Not covered more than once in a 12-month period."

If the claim is denied because the provider that performed the screening is not certified, use existing ANSI X-12-835 claim adjustment reason code/message B7, "This provider was not certified for this procedure/service on this date of service."

3660.18 Extracorporeal Immunoabsorption (ECI) Using Protein A Columns.--Extracorporeal immunoabsorption using Protein A columns has been developed for the purpose of selectively removing circulating immune complexes (CIC) and immunoglobulins (IgG) from patients in whom these substances are associated with their diseases. The technique involves pumping the patient's anticoagulated venous blood through a cell separator from which 1-3 liters of plasma are collected and perfused over adsorbent columns, after which the plasma rejoins the separated, unprocessed cells and is retransfused to the patient.

For claims with dates of service on or after May 6, 1991 through December 31, 2000, the use of Protein A columns is covered by Medicare only for the treatment of patients with idiopathic thrombocytopenia purpura (ITP) failing other treatments.

For claims with dates of service on or after January 1, 2001, Medicare covers the use of Protein A columns for the treatment of ITP. In addition, Medicare covers the use of Protein A columns for the treatment of rheumatoid arthritis (RA) under the following conditions:

1. Patient has severe RA. Patient disease is active, having > 5 swollen joints, > 20 tender joints, and morning stiffness > 60 minutes.
2. Patient has failed an adequate course of a minimum of 3 Disease Modifying Anti-Rheumatic Drugs (DMARDs). Failure does not include intolerance.

Other uses of these columns are currently considered to be investigational and/or experimental and, therefore, not reasonable and necessary under the Medicare law. (See §1862(a)(1)(A) of the Act.) (Refer to §35-90 of the Coverage Issues Manual.)

In hospital outpatient departments, payment is made under Part B on a reasonable cost basis for claims with dates of service prior to August 1, 2000. Payment for claims with dates of service on or after August 1, 2000, is made under the outpatient prospective payment system. Payment is made on a reasonable cost basis in critical access hospitals (CAHs). Deductible and coinsurance apply.

Follow the general bill review instructions in §3604. Hospitals bill you on Form HCFA-1450 or electronic equivalent.

- A. Applicable Bill Types.--The appropriate bill types are 12X, 13X, 83X, and 85X.

Hospitals utilizing the UB-92 flat file use record type 40 to report bill type. Record type (Field No. 1), sequence number (Field No. 2), patient control number (Field No. 3), and type of bill (Field No. 4) are required.

Hospitals utilizing the hard copy UB-92 (Form HCFA-1450), report the applicable bill type in Form Locator (FL) 4 "Type of Bill".

Hospitals utilizing the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, report the applicable bill type in 2-130-CLM01, CLM05-01, and CLM05-03.

B. Revenue Code Reporting.--Hospitals report revenue code 940. Hospitals utilizing the UB-92 flat file use record type 61, Revenue Code (Field No. 5). Hospitals utilizing the hard copy UB-92 report the revenue code in FL 42 "Revenue Code." Hospitals utilizing the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, report the applicable revenue code in 2-395-SV201.

C. HCPCS Code Reporting.--For claims with dates of service on or after May 6, 1991, hospitals report HCPCS code Q0068 (extracorporeal plasmapheresis, immunoabsorption with staphylococcal protein A columns). For claims with dates of service on or after January 1, 2000, extracorporeal affinity column adsorption and plasma reinfusion). Hospitals utilizing the UB-92 flat file, use record type 61, HCPCS code (Field No. 6) to report HCPCS/CPT code. Hospitals utilizing the hard copy UB-92, report the HCPCS/CPT code in FL 44 "HCPCS/Rates." Hospitals utilizing the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, report the HCPCS/CPT in 2-395-SV202-02.

D. ICD-9-CM Reporting.--For claims with dates of service on or after May 6, 1991, hospitals report ICD-9 code 287.3 (Primary thrombocytopenia). For claims with dates of service on or after January 1, 2001, hospitals report 287.3 (primary thrombocytopenia), 714.0 (rheumatoid arthritis), 714.1 (Felty's syndrome), 714.2 (other rheumatoid arthritis with visceral or systemic involvement), 714.30, 714.31, 714.32, or 714.33 (types of juvenile rheumatoid arthritis). Hospitals utilizing the UB-92 flat file, use record type 70, Principal Diagnosis Code/Other Diagnoses Code (Field No. 4-12) to report the ICD-9 code. Hospitals utilizing the hard copy UB-92, report the ICD-9 code in FLs 67 -75 (Principal Diagnosis Code/Other Diagnoses Codes). Hospitals utilizing the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, report the ICD-9 in 2-225.A-HI02-02 through HI10-02.

E. Edits.--For claims with dates of service on or after January 1, 2001, deny claims reflecting any diagnosis code (ICD-9) other than 287.3, 714.0, 714.1, 714.2, 714.30, 714.31, 714.32, or 714.33 when reported with CPT code 36521.

F. MSN/EOMB Messages.--If the claim is denied use the following message:

21.22/16.58 Medicare does not pay for this service because it is considered investigational and/or experimental in these circumstances.

G. Remittance Advice Messages.--If the claim is denied, you use existing American National Standard Institute (ANSI) X-12-835 claim adjustment reason code/message B22, "This claim/service is denied/reduced based on the diagnosis."

3660.19 Diagnostic Mammography.--A radiological mammogram is a covered diagnostic test under the following conditions:

- o A patient has distinct signs and symptoms for which a mammogram is indicated;
- o A patient has a history of breast cancer; or
- o A patient is asymptomatic, but on the basis of the patient's history and other factors the physician considers significant, the physician's judgment is that a mammogram is appropriate.

Payment for diagnostic mammograms are made under OPPS for hospital outpatient departments, on a reasonable cost basis for CAHs, under the MPFS for SNFs, and under the all inclusive rate for the professional component furnished in an RHC or FQHC.

RHCs and FQHCs bill you under bill type 71X or 73X for the professional component along with revenue code 401 and HCPCS codes 76090 or 76091.

Payment should not be made for a diagnostic mammography unless the claim contains a related visit code. Therefore, install an edit in your system to assure payment is not made for revenue code 401 unless the claim also contains a visit revenue code (521).

The technical component of a diagnostic mammography is outside the scope of the RHC/FQHC benefit. The provider of that technical service bills their carrier on Form HCFA-1500.

The technical component of a diagnostic mammography for a provider-based RHC/FQHC, is typically furnished by the provider. The provider of that service bills you under bill type 14X, 22X, 23X or 85X as appropriate using their outpatient provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services.) The appropriate revenue code is 401 and the appropriate HCPCS codes are 76090, 76091 and G0236.

A new HCPCS code G0236, "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography (List separately in addition to code for primary procedure)" for computer-aided detection (CAD), has been established as an add-on code that can be billed only in conjunction with the primary service diagnostic mammography code 76090 or 76091. Payment will be made under OPFS for hospital outpatient departments, on a reasonable cost basis for CAHs, under the MPFS for SNFs, and under the all inclusive rate for for the professional component provided in an RHC or FQHC. The Part B deductible and coinsurance apply.

RHCs and FQHCs must report revenue code 401 and HCPCS code G0236 when performing this service. Payment is made as described above for diagnostic mammographies.

Return to provider claims containing code G0236 that do not also contain HCPCS code 76090 or 76091 with an explanation that payment for code G0236 cannot be made when billed alone.

You were furnished with a mammography benefit pricing file via Program Memorandum (PM) A-01-104, dated August 23, 2001, CR 1811. Use this file to pay claims containing the above codes.

For CAHs, see §3610.22 for those that have elected the optional method of payment for outpatient services. Pay these CAHs for the professional component (PC) of the diagnostic mammographies furnished on or after January 1, 2002 at 115 percent of the lesser of:

- o Eighty percent of the actual charges of the CAH for the physicians interpretation of the diagnostic mammography, or
- o Eighty percent of the PC determined under the MPFS for the diagnostic mammography.

3660.20 Diagnostic and Screening Mammograms Performed with New Technologies.--Section 104 of the Benefits Improvement and Protection Act 2000, (BIPA) entitled Modernization of Screening Mammography Benefit, provides for new payment methodologies for both diagnostic and screening mammograms that utilize advanced new technologies for the period April 1, 2001, through December 31, 2001.

Payment restrictions for digital screening and diagnostic mammography apply to those facilities that meet all FDA certifications as provided under the Mammography Quality Standards Act as described in §3660.16.

A. Payment Requirements for Claims with Dates of Service on or After April 1, 2001 through December 31, 2001.--Providers billing for the technical component of screening and diagnostic mammographies that utilize advanced technologies use one of six new HCPCS codes, G0202 - G0207. See below for how payment for each of the codes will be determined during the period April 1, 2001 through December 31, 2001. Payment for codes G0202 through G0205 are based, in part, on the MPFS payment amounts. The amounts that are based on the MPFS that you will need in calculating the new payments for these codes were furnished to you in a BIPA mammography benefit pricing file for implementation on April 1, 2001.

o HCPCS code G0202, Screening mammography producing direct digital image, bilateral, all views. Payment will be the lesser of the provider's charge or the amount that will be provided for this code in the pricing file. (That amount is 150 percent of the locality specific technical component payment amount under the physician fee schedule for CPT code 76091, the code for bilateral diagnostic mammogram, during 2001.) Deductible does not apply. Coinsurance will equal 20 percent of the lesser of the actual charge or 150 percent of the locality specific payment of CPT code 76091.

o HCPCS code G0203, Screening mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views. Payment will be equal to the lesser of the actual charge for the procedure, the amount that will be provided in the pricing file (which represents 68 percent of the locality specific global payment amount for a bilateral diagnostic mammography (CPT 76091) under the physician fee schedule), or \$57.28 (which represents the amount of the 2001 statutory limit for a screening mammography attributable to the technical component of the service, plus the technical portion of the \$15.00 add-on for 2001 which is provided under the new legislation). Deductible does not apply. Coinsurance is 20 percent of the charge.

o HCPCS code G0204, Diagnostic mammography, direct digital image, bilateral, all views. Payment will be the lesser of the provider's charge or the amount that will be provided for this code in the pricing file. (That amount is 150 percent of the locality specific amount paid under the physician fee schedule for the technical component (TC) of CPT code 76091, the code for a bilateral diagnostic mammogram.) Deductible is applicable. Coinsurance will equal 20 percent of the lesser of the actual charge or 150 percent of the locality specific payment of CPT code 76091.

o HCPCS code G0205, Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views. Payment will be equal to the lesser of the actual charge for the procedure, the amount that will be provided in the pricing file (which represents 68 percent of the locality specific global payment amount for a bilateral diagnostic mammography (CPT 76091) under the physician fee schedule), or \$57.28 (which represents the amount of the 2001 statutory limit for a screening mammography attributable to the technical component of the service, plus the technical portion of the \$15.00 add-on for 2001 which is provided under the new legislation). Deductible applies. Coinsurance is 20 percent of the charge.

o HCPCS code G0206, Diagnostic mammography, direct digital image, unilateral, all views. Payment will be made based on the same amount that is paid to the provider, under the payment method applicable to the specific provider type (i.e., hospital, rural health clinic, etc.) for CPT code 76090, the code for a mammogram, one breast. For example, this service, when furnished as a hospital outpatient service, will be paid the amount under the outpatient prospective payment system (OPPS) for CPT code 76090. Deductible applies. Coinsurance is the national unadjusted coinsurance for the APC wage adjusted for the specific hospital.

o HCPCS code G0207, Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all view. Payment will be based on the same amount that is paid to the provider, under the payment method applicable to the specific provider type (i.e., hospital, rural health clinic, etc.) for CPT code 76090, the code for mammogram, one breast. For example, this service, when furnished as a hospital outpatient service, will be paid the amount payable under the OPFS for CPT code 76090. Deductible applies. Coinsurance is the national unadjusted coinsurance for the APC wage adjusted for the specific hospital.

B. Payment Requirements for Services Furnished on or After January 1, 2002.--Payment will be made as follows:

Code G0202 Payment will be equal to the lower of the actual charge or the locality specific technical component payment amount under the MPFS when performed in a hospital outpatient department, CAH, or SNF. Coinsurance is 20 percent of the lower amount, the Program pays 80 percent.

Deductible does not apply.

Code G0204 Payment will be made under OPFS for hospital outpatient departments. Coinsurance is the national unadjusted coinsurance for the APC wage adjusted for the specific hospital. Payment will be made on a reasonable cost basis for CAHs and coinsurance is based on charges. Payment is made under the MPFS when performed in a SNF and coinsurance is 20 percent of the lower of the actual charge or the MPFS amount.

Deductible applies.

Code G0206 Payment will be made under OPFS for hospital outpatient departments. Coinsurance is the national unadjusted coinsurance for the APC wage adjusted for the specific hospital. Payment will be made on a reasonable cost basis for CAHs and coinsurance is based on charges. Payment is made under the MPFS when performed in a SNF. Coinsurance is 20 percent of the lower of the actual charge or the MPFS amount.

Deductible applies.

You were furnished with a mammography benefit pricing file and record layout via Program Memorandum (PM) A-01-104, dated August 23, 2001, CR 1811. Use this pricing file to pay claims containing the above codes.

For CAHs, see §3610.22 for those that have elected the optional method of payment for outpatient services. For code G0202, see §3660.10B and for codes G0204 and G0206, see §3660.19.

C. Billing Requirements.--Providers bill for the technical portion of screening and diagnostic mammograms on Form HCFA-1450 under bill type 14X, 22X, 23X, or 85X. The professional component is billed to the carrier on Form HCFA-1500 (or electronic equivalent).

Providers bill for digital screening mammographies on Form HCFA-1450, utilizing revenue code 403 and HCPCS G0202 or G0203.

Providers bill for digital diagnostic mammographies on Form HCFA-1450, utilizing revenue code 401 and HCPCS G0204, G0205, G0206 or G0207.

NOTE: Codes G0203, G0205 and G0207 are not billable codes for claims with dates of service on or after January 1, 2002.

3661. HOSPITAL OUTPATIENT PARTIAL HOSPITALIZATION SERVICES

Medicare Part B coverage is available for hospital outpatient partial hospitalization services. (See §3112.7.D for a description of services covered under this benefit.)

A. Billing Requirements.--Section 1861(ff) of the Act defines the services covered under the partial hospitalization benefit in a hospital or critical access hospital (CAH) outpatient setting. However, no separate payment methodology for these services is mandated. Therefore, in order to make proper payment, hospitals and CAHs are required to component bill for any service provided under this benefit.

Under component billing, hospitals and CAHs are required to report a revenue code and the charge for each individual covered service furnished under a partial hospitalization program. In addition, hospital outpatient departments are required to report HCPCS codes. CAHs are not required to report HCPCS codes for this benefit. Billing as individual services assures that only those partial hospitalization services covered under §1861(ff) of the Act are paid by the Medicare program.

Hospital outpatient departments bill you for partial hospitalization services on the Form HCFA-1450 (or electronic equivalent) under bill type 13X or 14X as appropriate. CAH outpatient departments bill under 85X. Follow bill review instructions in §3604 with the following exceptions.

Bills must contain an acceptable revenue code. They are as follows:

<u>Revenue Code</u>	<u>Description</u>
250	Drugs and Biologicals
43x	Occupational Therapy
904	Activity Therapy
910	Psychiatric/Psychological Services
914	Individual Therapy
915	Group Therapy
916	Family Therapy
918	Testing
942	Education Training

Hospitals and CAHs are required to report condition code 41 in FLs 24-30 to indicate the claim is for partial hospitalization services.

Hospitals other than CAHs are also required to report appropriate HCPCS codes as follows:

<u>Revenue Code</u>	<u>Description</u>	<u>HCPCS Code</u>
43X	Occupational Therapy	*G0129
904	Activity Therapy (Partial Hospitalization)	**G0176
910	Psychiatric General Services	90801, 90802, 90875, 90876, 90899, or 97770

914	Individual Psychotherapy	90816, 90818, 90821, 90823, 90826, or 90828
915	Group Psychotherapy	90849, 90853, or 90857
916	Family Psychotherapy	90846, 90847, or 90849
918	Psychiatric Testing	96100, 96115, or 96117
942	Education Training	***G0177

Edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. Do not edit for the matching of revenue code to HCPCS.

*The definition of code G0129 is as follows:

“Occupational therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per day,”

**The definition of code G0176 is as follows:

“Activity therapy, such as music dance, art or play therapies not for recreation, related to the care and treatment of patient’s disabling mental health problems, per session (45 minutes or more).”

***The definition of code G0177 is as follows:

“Training and educational services related to the care and treatment of patient’s disabling mental health problems, per session (45 minutes or more).”

Revenue code 250 does not require HCPCS coding. However, drugs that can be self-administered are not covered by Medicare.

B. Professional Services.--The professional services listed below when provided in a hospital or CAH outpatient department are separately covered and paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other than physician assistants (PA) bill the Medicare Part B carrier directly for the professional services furnished to hospital outpatient partial hospitalization patients. The hospital or CAH can also serve as a billing agent for these professionals by billing the Part B carrier on their behalf under their billing number for their professional services. The professional services of a PA can be billed to the carrier only by the PAs employer. The following direct professional services are unbundled and not paid as partial hospitalization services.

- o Physician services that meet the criteria of 42 CFR 415.102, for payment on a fee schedule basis;

- o Physician assistant (PA) services as defined in §1861(s)(2)(K)(i) of the Act;

- o Nurse practitioner and clinical nurse specialist services, as defined in §1861(s)(2)(K)(ii) of the Act; and

- o Clinical psychologist services as defined in §1861(ii) of the Act.

The services of other practitioners (including clinical social workers and occupational therapists), are bundled when furnished to hospital or CAH patients, including partial hospitalization patients. The hospital must bill you for such nonphysician practitioner services as partial hospitalization services. Make payment for the services to the hospital or CAH.

PA services can only be billed by the actual employer of the PA. The employer of a PA may be such entities or individuals such as a physician, medical group, professional corporation, hospital, SNF, or nursing facility. For example, if a physician is the employer of the PA and the PA renders services in the hospital or CAH, the physician and not the hospital would be responsible for billing the carrier on Form HCFA-1500 for the services of the PA. (See Medicare Carriers Manual (MCM), §16001.)

C. Outpatient Mental Health Treatment Limitation.--The outpatient mental health treatment limitation may apply to services to treat mental, psychoneurotic, and personality disorders when furnished by physicians, clinical psychologists, NPs, CNSs, and PAs to partial hospitalization patients. However, the outpatient mental health treatment limitation does not apply to such mental health treatment services billed to the intermediary by a CMHC, hospital, or CAH outpatient department as partial hospitalization services.

D. Reporting of Service Units.--Visits should no longer be reported as units by hospitals other than CAHs. Instead, hospital outpatient departments are required to report in FL 46, "Service Units," the number of times the service or procedure, as defined by the HCPCS code, was performed when billing for partial hospitalization services identified by revenue codes in subsection C.

EXAMPLE: A beneficiary received psychological testing (HCPCS code 96100 which is defined in 1 hour intervals) for a total of 3 hours during 1 day. The hospital reports revenue code 918 in FL 42, HCPCS code 96100 in FL 44, and three units in FL 46.

When reporting service units for HCPCS codes where the definition of the procedure does not include any reference to time (either minutes, hours or days), hospital outpatient departments do not bill for sessions of less than 45 minutes.

You must RTP claims that contain more than one unit for HCPCS codes G0129, Q0082, and G0172 or that do not contain service units for a given HCPCS code.

NOTE: Service units are not required to be reported for drugs and biologicals (Revenue Code 250).

CAHs report the number of visits in FL 46 "Service Units".

E. Line Item Date of Service Reporting.--Hospitals other than CAHs are required to report line item dates of service per revenue code line for partial hospitalization claims. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in FL 45 "Service Date" (MMDDYY). See examples below of reporting line item dates of service. These examples are for group therapy services provided twice during a billing period.

For the UB-92 flat file, report as follows:

<u>Record Type</u>	<u>Revenue Code</u>	<u>HCPCS</u>	<u>Dates of Service</u>	<u>Units</u>	<u>Total Charges</u>
61	915	90849	19980505	1	\$ 80.00
61	915	90849	19980529	2	\$160.00

For the hard copy UB-92 (HCFA-1450), report as follows:

<u>FL42</u>	<u>FL44</u>	<u>FL45</u>	<u>FL46</u>	<u>FL47</u>
915	90849	050598	1	\$ 80.00
915	90849	052998	2	\$160.00

For the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, report as follows:

LX*1~
 SV2*915*HC:90849*80*UN*1~
 DTP*472*D8*19980505~
 LX*2~
 SV2*915*HC:90849*160*UN*2~
 DTP*472*D8*19980529~

You must RTP hospital claims where a line item date of service is not entered for each HCPCS code reported by hospitals, or if the line item dates of service reported are outside of the statement covers period. Line item date of service reporting is effective for claims with dates of service on or after June 5, 2000.

F. Payment.--For hospital outpatient departments, make payment on the reasonable cost basis until August 1, 2000.

During the year, make payment at an interim rate based on a percentage of billed charges. Information applicable to determining interim rates for partial hospitalization services furnished as hospital outpatient services are contained in §§2400ff of the Provider Reimbursement Manual. Beginning with services provided on or after August 1, 2000, make payment under the hospital outpatient prospective payment system for partial hospitalization services. Hospitals must continue to maintain documentation to support medical necessity of each service provided, including beginning and ending time.

For CAHs make payment on a reasonable cost basis, regardless of the date of service.

Apply Part B deductible, if any, and coinsurance.

G. Data for CWF and PS&R.--Include revenue codes, HCPCS/CPT codes, units, and covered charges in the financial data section (fields 65a - 65j), as appropriate. Report the billed charges in field 65h, "Charges," of the CWF record.

Include in the financial data portion of the PS&R UNIBILL, revenue codes, HCPCS/CPT codes, units, and charges, as appropriate.

H. Medical Review.--Follow medical review guidelines in §3920.1.K3.

3662. BILLING FOR HOSPITAL OUTPATIENT SERVICES FURNISHED BY CLINICAL SOCIAL WORKERS (CSWs)

Payment is made for covered diagnostic and therapeutic services furnished by CSWs in a hospital outpatient setting. (See MCM, §5113 for an explanation of how payment is made and §2152 for CSW licensure and educational requirements.)

A. Fee Schedule To Be Used for Payment of CSW Services.--The fee schedule for CSW services is set at 75 percent of the fee schedule for comparable services furnished by clinical psychologists.

B. Payment Limitation.--CSW services are subject to the outpatient mental health treatment limitation in §1833 of the Act. Carriers apply the limitation of 62.5 percent to the lesser of the actual charge or fee schedule amount. Diagnostic services are not subject to the limitation. (See MCM, §2152 for more detail regarding the payment limit.)

C. Coinsurance and Deductible.--The annual Part B deductible and the 20 percent coinsurance apply to CSW services.

D. Billing.--

1. Hospital and CAH Outpatient Services.--CSWs do not bill directly for these services. Hospital and CAH outpatient services are bundled and hospitals bill the carrier for the services on Form HCFA-1500 (or electronic equivalent). These services are not billed to you.

2. Partial Hospitalization Services.--CSW services furnished under the partial hospitalization program are also bundled for hospitals and CAHs. However, the hospital bills you for the services. Make payment on a reasonable cost basis. (See §3661 for an explanation.)

3663. OUTPATIENT OBSERVATION SERVICES

A. Observation Services.--Observation services are those services furnished on a hospital's premises, including use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission as an inpatient. Such services are covered only when provided by order of a physician or another individual authorized by State licensure law and hospital bylaws to admit patients to the hospital or to order outpatient tests. Observation services usually do not exceed one day. Some patients, however, may require a second day of outpatient observation services. Observation services exceeding 48 hours will be denied. (See §3112.8.)

A hospital which believes that exceptional circumstances in a particular case justify approval of additional time in outpatient observation status may request an exception to the denial of services from you. See §3112.8E for procedures for requesting an exception.

The hospital will bill for observation services using the following revenue code.

<u>Revenue Code</u>	<u>Description</u>
762	Observation Services

For observation services, the hospital should report the number of hours in the units field. They should begin counting when the patient is placed in the observation bed. If necessary, they should verify the time in the nurses' notes. Round to the nearest hour. For example, a patient who was placed in an observation bed at 3:03 p.m. according to the nurses' notes and discharged to home at 9:45 p.m. should have a "7" placed in the units field.

B. Services Not Covered as Observation Services.--See §3112.8E for noncovered services. If the hospital has provided noncovered services, and given proper notification to the beneficiary, it will show only those charges associated with covered services. If the hospital provided more than 48 hours of observation, but thinks that the additional hours qualify for coverage, they will show all hours in the units field. Suspend the claim for documentation of the medical necessity of all observation services. If any such services are denied, the beneficiary cannot be held liable for payment.

Include in the financial data portion of the PS&R UNIBILL, revenue codes, HCPCS/CPT codes, units, and charges, as appropriate.