Medicare Hospital Manual

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

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Refer to CHANGE REQUEST 2589

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
402 – 402 (Cont.)	4-29 - 4-31 (3 pp.)	4-29 – 4-31 (3 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE:* October 1, 2003
IMPLEMENTATION DATE: October 1, 2003

Section 402, Frequency of Billing, has been amended to include more information specific to the frequency of bill acceptance and will assist providers in billing other insurers more timely. Common Working File (CWF) edits regarding outpatient services and inpatient hospital stays are being modified.

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.

402. FREQUENCY OF BILLING

Your intermediary will inform you about the frequency with which it can accept billing records and the frequency with which you may bill on individual cases.

In its requirements, your intermediary considers your systems operation, intermediary systems requirements, and Medicare program and administrative requirements.

Inpatient Billing.— Inpatient services in TEFRA hospitals (i.e., psychiatric hospitals or units, cancer and children's hospitals) will be billed:

- Upon discharge of the beneficiary;
- When the beneficiary' benefits are exhausted;
- When the beneficiary's need for care changes; or
- After 30 days and every 30 days thereafter.

You will submit a bill when a beneficiary ceases to need skilled care in a SNF or swingbed (occurrence code 22), or a beneficiary ceases to need hospital level care (occurrence code 22).

Each hospital PPS interim bill must include all diagnoses, procedures and services from admission to the through date. Repeat charges included on the prior bill on the subsequent interim adjustment bill.

Your initial PPS interim claims must have a patient status of 30 (still patient). Submit all interim hospital PPS bills with the following designation:

-- 112 (interim bill – first claim) for hospitals

When you submit a bill subsequent to the first, submit it in the adjustment format as one of the following:

- A 117 bill with a patient status of 30 (still patient); or
- A 117 discharge bill with a patient status of:

-- 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 ICF;
-- 05 -Discharged/transferred to another type of institution (including distinct parts), or referred for outpatient services to another institution;
-- 06 - Discharged/transferred to home under care of organized home health service organization;
-- 08 - Discharged to home under care of a home IV therapy provider; or
-- 20 - Expired (or did not recover – Religious Non-medical Healthcare Institution patient)
-- 43 -Discharged/transferred to a federal hospital
-- 50 -Hospice – home
-- 51 -Hospice – medical facility
-- 61 -Discharged/transferred within institution to swing bed
-- 62 -Discharged to another IRF or IRF unit (1/1/02)
-- 63 -Discharge to a long term care hospital (1/1/02)
-- 64 -Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare

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

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

These instructions apply to all providers, including those receiving Periodic Interim Payments (PIP). Continue submitting no pay bills until discharge.

Outpatient Billing.--Bill repetitive Part B services to a single individual monthly (or at the conclusion of treatment). These instructions also apply to Home Health Agency and hospice services billed under Part A. This avoids Medicare processing costs in holding such bills for monthly review and reduces bill processing costs for relatively small claims. Examples of repetitive Part B services and HHA and hospice services billed under Part A with applicable revenue codes include:

Service	Revenue Code
- DME Rental	290-299
- Therapeutic Radiology	330-339
- Therapeutic Nuclear Medicine	342
- Respiratory Therapy	410-419
- Physical Therapy	420-429
- Occupational Therapy	430-439
- Speech Pathology	440-449
- Home Health Visits	550-599
- Hospice Services	650-659
- Kidney Dialysis Treatments	820-859
- Cardiac Rehabilitation Services	482, 943
- Psychological Services	(910-919 in a psychiatric facility)

Where there is an inpatient stay, outpatient surgery, or other outpatient services subject to OPPS, during a period of repetitive outpatient services, you may submit one bill for the entire month if you use an occurrence span code 74 to encompass the inpatient stay, day of outpatient surgery, or outpatient hospital services subject to OPPS. The Common Working File (CWF) must read occurrence span code 74 and recognize that an inpatient beneficiary is on leave of absence from the repetitive services subject to OPPS outpatient services. This permits you to submit a single bill for the month, and simplifies the review of these bills. This is in addition to the bill for the inpatient stay or outpatient surgery.

Bill other one-time Part B services upon completion of the service.

Bills for outpatient hospital services subject OPPS must contain, on a single bill, all services provided on the same day of surgery 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 a repetitive service, the individual OPPS service must be billed on the OPPS monthly repetitive claim. Indian Health Service Hospitals, as well as those 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 must 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 hospitals services furnished on a day other than the day of surgery must not be included on the outpatient surgical bill.) These services normally include:

- Nursing services, services of technical personnel, and other related services;
- The patient's use of the hospital's facilities;
- Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances, and equipment;
- Diagnostic or therapeutic items and services (except lab services);
- Blood, blood plasma, platelets, etc.; and
- Materials for anesthesia.

See Addendum C for list of applicable revenue codes.