Medicare
Intermediary Manual
Part 3 - Claims Process

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

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HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3603 – 3603.2 (Cont.	6-21 – 6-24.1 (4 pp.)	6-21 – 6-24 (4 pp.)

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

Section 3603, 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 and Skilled Nursing Facility (SNF) stays are being modified.

Provider Education
Place a notice on your Web site, within two weeks of receiving this manual update, informing PIP providers they may bill every 30 or 60 days based on the type of services they are providing. Also, all inpatient providers will submit bills:

- 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; or
- After 60 days and every 60 days thereafter (long-term care hospitals, inpatient rehabilitation facilities, and short-term acute care hospitals under PPS).

If you have a listserv that targets the affected provider communities, you must use it to notify subscribers that information about "Frequency of Billing" is available on your Web site. In addition, this notice must also be published in the next regularly scheduled bulletin.

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.

3603. FREQUENCY OF BILLING

Inform providers about the frequency with which you can accept billing records and the frequency with which they may bill on individual claims.

A. Inpatient Billing.--Inpatient services in TEFRA hospitals (i.e., psychiatric hospitals or units, cancer and children's hospitals) and SNFs 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.

Providers will submit a bill to you when a beneficiary in a SNF ceases to need active care (occurrence code 22), or a beneficiary in one of these hospitals ceases to need hospital level care (occurrence code 22).

Ensure that each bill includes all applicable diagnoses and procedures. However, 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.

Inpatient acute-care PPS hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long Term Care Hospitals (LTCHs) may bill 60 days after an admission, if they choose, and every 60 days thereafter. Subsequent bills must be in the adjustment bill format. Each bill must include all applicable diagnoses and procedures.

Initial inpatient acute care PPS hospital, inpatient rehabilitation facility, and a long term care hospital 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, cancel the prior bill and replace it with one of the following bill designations:

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

  -- 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;

  -- 08 - Discharged/transferred to home under care of a home IV drug therapy provider; or

  -- 20 - Expired (or did not recover – Religious Non-Medical Healthcare Institutions 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

For interim hospital PPS bills, send to CWF a debit only to adjust the prior bill with a bill type designation of 117 and an action code of 3, with the following:

o A 117 bill for hospitals with a patient status code 30 (still patient) and an action code of 1; or

o A 117 discharge bill for hospitals with an action code of 1 and 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 parts) or referred for outpatient services to another institution;

-- 06 - Discharged/transferred to home under care of organized home health service organization;

-- 08 - Discharged/transferred to home under care of a home IV therapy provider; or

-- 20 - Expired (or did not recover – Religious Non-Medical Healthcare Institution patient).

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-- 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):

- 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). Continue submitting no pay bills until discharge.

B. Outpatient Billing.--Repetitive Part B services to a single individual must be billed monthly (or at the conclusion of treatment). (These instructions also apply to home health agency (HHA) and hospice services billed under Part A.) By doing so, bill processing costs are reduced for relatively small claims and in instances where bills are held for monthly review. Examples of repetitive Part B services and HHA and hospice services billed under Part A with applicable revenue codes include:

Type of Service	Revenue Code(s)
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
Kidney Dialysis Treatments	820-859
Cardiac Rehabilitation Services	482, 943
Psychological Services	910-919 (in a psychiatric facility)

Where there is an inpatient stay, or outpatient surgery, or outpatient hospital services subject to OPPS, during a period of repetitive outpatient services, providers may submit one bill for the entire month if they 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 beneficiary cannot receive outpatient services while an inpatient, and consequently, is on a leave of absence from repetitive services. This permits them to submit a single bill for the month and simplifies your 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 to OPPS must contain, on a single bill, all services provided on the 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 must be billed on the OPPS monthly repetitive 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 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.)

See §3628 for clinical diagnostic lab services paid under the fee schedule when included with outpatient bills for other services.

Periodically review bills from providers known to be furnishing repetitive services to determine if they are billing more frequently than proper. Techniques you may use 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. You may rely on informal communications from your medical review staff; and

- Modification of your duplicate screens to detect bills that meet duplicate criteria except for billing period, but which fall in the same 30 day period.

Where providers bill improperly, attempt an educational contact. If this fails, return bills with an explanation and request proper billing.

Be alert to situations where the treatment plan is completed or discontinued because the beneficiary dies or moves.

3603.1 Requirement That Bills Be Submitted in Sequence for a Continuous Inpatient Stay or Course of Treatment.--When a patient remains an inpatient of a SNF, non-PPS hospital, distinct part unit, swing-bed, hospice, or home health agency for over 30 days, the provider is permitted to submit a bill every 30 days. (See §3603 for Frequency of Billing.) Providers are instructed to bill their claims in sequence for each beneficiary they service. Install edits to prevent acceptance of a continuing stay claim or course of treatment claim until you have processed the prior bill. If you have not processed the prior bill, reject the bill to the provider with the appropriate error message.

When an out-of-sequence claim for a continuous stay or course of treatment reaches you, search your history for the prior bill. Do not suspend the out-of-sequence bill for manual review, but search your system for an adjudicated claim. If the prior bill is not in your history, 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.

3603.2 Need to Reprocess Inpatient or Hospice Claims in Sequence.--If a beneficiary, provider, or a secondary insurer notifies you that out-of-sequence processing has raised the liability of the beneficiary or a secondary insurer, verify this through your and CWF's records. If true, cancel the previously processed bills for that spell-of-illness and reprocess all bills in the spell-of-illness or

benefit period in sequence. This may require coordination with another intermediary. The CWF utilization record must be corrected to properly allocate full, coinsurance, and lifetime reserve days, as applicable. The CWF utilization record must also be corrected to reflect the correct hospice periods.

This is an issue only when the beneficiary is an inpatient for more than 30 days (in the same or different facilities) during the spell-of-illness or benefit period. This situation occurs most often when long-term care hospitals are involved. For hospice claims, claims processed out of sequence must be reprocessed to maintain the integrity of hospice election periods. If you are contacted by another intermediary, or any regional office (RO), cancel all affected claims and reprocess in accordance with the instructions from the lead intermediary or RO.

If you are the lead intermediary, i.e., the one contacted by a provider, beneficiary, or other insurer to complain of improper payment as result of out-of-sequence billing, and another intermediary is also involved, coordinate actions with the second intermediary to cancel and reprocess the bills, as necessary. For inpatient stays, once you have verified that the provider, beneficiary, or other insurer was adversely affected, coordinate these actions directly with any other affected intermediary, cancel any bills posted out-of-sequence, and request that the other intermediary also cancel any affected bills. For hospice claims, once you verify that there was an out-of-sequence claim that would impact the hospice election period, coordinate these actions directly with any other affected intermediary, cancel any bills posted out-of- sequence, and request that the other intermediary also cancel any affected bills. Both you and the other intermediary are to reprocess all bills based on the actual sequence of the beneficiary's stays at the various providers or on the actual sequence of hospice services. You control the sequence in which the bills are processed and posted to CWF.

If you experience any difficulty with another intermediary, call your RO and arrange for them to coordinate with any necessary ROs for other affected intermediaries' bills.

This approach is to be used only when the beneficiary, provider, or other insurer has increased liability as a result of out-of-sequence processing or when the hospice election periods are incorrect. It is not to be used if the liability stays the same, e.g., if deductible is applied on the second stay instead of the first, but there is no issue with regard to the effective date of supplementary coverage.