Program Memorandum Intermediaries

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

Transmittal A-02-087 **Date: SEPTEMBER 12, 2002**

CHANGE REQUEST 1768

SUBJECT: Clarification of Provider Billing Requirements Under the Outpatient Prospective Payment System (OPPS)

This Program Memorandum (PM) replaces PM A-01-91 issued July 31, 2001. Material addressing observation and screening mammography services has been deleted in this PM since it is now outdated. Current instructions regarding observation services under OPPS are contained in PM A-02-026, dated March 28, 2002 and current instructions regarding screening mammography services are contained in § 3660.10.D of the Medicare Intermediary Manual.

The purpose of this PM is to clarify previous instructions issued on billing requirements and questions and answers numbers 103 to 105 on the Internet regarding bill submittal requirements under OPPS. It also clarifies the billing of observation services.

Same Day Rule

Hospitals and community mental health centers (CMHCs) are required to report all OPPS services that are provided on the same day on the same claim with the exception of claims containing condition codes 20, 21 or G0 (zero). 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. (See below and §3603.B of the Part A Medicare Intermediary Manual and §402 of the Medicare Hospital Manual for a listing of outpatient repetitive services that are required to be billed monthly). The policy for repetitive services continues under OPPS for all providers. If a non-OPPS repetitive service is provided on the same day as an OPPS service, separate claims may be submitted. In addition, if a 13X and 14X type of bill (TOB) contains OPPS services that were performed on the same day for the same beneficiary, the services must be reported on the same claim. Providers must submit one claim in the situation utilizing the 13X TOB.

The following revenue codes are considered to be repetitive services and must be billed monthly or at the conclusion of treatment. Note that all repetitive services with the exception of physical, occupational and speech therapy are subject to OPPS.

Type of Service	Revenue Code(s)
Therapeutic Radiology	330-339
Therapeutic Nuclear Medicine	342
Respiratory Therapy	410-419
Physical Therapy	420-429
Occupational Therapy	430-439
Speech Pathology	440-449
Cardiac Rehabilitation Services	482, 943
Psychological Services	910-919

EXAMPLE I

If a patient receives a laboratory service on May 1st and has an emergency room (ER) visit on the same day, two separate bills 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 II

If a patient was seen in the emergency room (ER) and the same patient received non-partial hospitalization psychological services on the same day as well as several other days in the month, the provider should report the ER visit on the monthly repetitive claim along with the psychological services, since both services are paid under OPPS.

EXAMPLE III

If a patient has an ER visit on the same day as a chemotherapy visit, the provider should report both of these services on the monthly chemotherapy repetitive claim since both services are paid under OPPS.

EXAMPLE IV

If the patient receives chemotherapy on July 7th, 29th, and 30th and receives services in the ER on July 28th, the provider may submit separate claims since the isolated individual service (ER visit) did not occur on the same day as the repetitive services (chemotherapy services). In this situation, it does not matter whether the services are reimbursed under OPPS or not.

EXAMPLE V

If a patient has an ER visit (OPPS service) on May 15th and also received a physical therapy visit (non-OPPS service) on the same day (as well as other physical therapy visits provided May 1st through May 31st) the services may be billed on separate claims. The provider would bill the ER service on one claim and the therapy services on the monthly repetitive claim. Note, as stated above, the procedures for billing of repetitive services remain 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 should not split repetitive services in mid-month when another outpatient service occurs.

As previously indicated, return claims submitted for the same date of service to the provider (except exact duplicates or those containing condition codes 20, 21, or G0) with a notification that an adjustment bill should be submitted. Claims containing condition code G0 should not automatically be rejected as a duplicate claim. When returning claims that do not meet the above requirement, the basis of the returned claim must be determined at the line level and not solely on the "From" and "Thru" dates on the claim.

Do not reject or return claims to providers that have been billed appropriately in accordance with these instructions. Claims that are unable to process for payment due to duplicate payment edits in the Standard System or your internal claims processing system must be manually reviewed to determine if they were submitted appropriately. These claims are not considered part of the medical review workload.

The *effective date* for this PM is August 1, 2000.

The *implementation date* for this PM is October 1, 2001.

These instructions should be implemented within your current operating budget.

This PM may be discarded after October 1, 2003.

If you have any questions, contact your regional office.