Medicare
Intermediary Manual
Part 3 - Claims Process

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal 1802 **Date: AUGUST 4, 2000**

CHANGE REQUEST 980

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3651 (Cont.) - 3651 (Cont.)	6-303.2 - 6-303.3 (2 pp.)	6-303.2 - 6-303.3 (2 pp.)

CHANGED PROCEDURES—*EFFECTIVE/IMPLEMENTATION DATE*: For claims with dates of service on or after June 05, 2000.

Section 3651, Bill Review for Partial Hospitalization Services Provided in Community Mental Health Centers (CMHCs), changes the effective date for line item date of service reporting which was shown in Transmittal Number 1784, issued in November 1999 as April 1, 2000. This date has been superceded by June 5, 2000, due to the delay of the April release. It also changes the date for implementation of the hospital outpatient prospective payment system.

These instructions should be implemented within your current operating budget.

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.

PA services can only be billed by the actual employer of the PA. The employer of a PA may be such entities or individuals 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 CMHC, the physician and not the CMHC would be responsible for billing the carrier on Form HCFA-1500 for the services of the PA. (See Medicare Carriers Manual (MCM), §16001.)

D. 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 you as partial hospitalization services.

E. Reporting of Service Units.--Visits should no longer be reported as units. Instead, CMHCs report in Form Locator (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 code in subsection C.

EXAMPLE: A beneficiary received psychological testing (HCPCS code 96100, which is defined in one hour intervals) for a total of 3 hours during one day. The CMHC 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), CMHCs should not bill for sessions of less than 45 minutes.

Return to provider 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)

F. Line Item Date of Service Reporting.--Dates of service per revenue code line for partial hospitalization claims that span two or more dates. 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:

Record Type	Revenue Code	HCPCS	Dates of Service	Units	Total Charges
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:

FL 42	FL 44	FL 45	FL 46	FL 47
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*19990505~
LX*2~
SV2*915*HC:90849*160*UN*2~
DTP*472*D8*19990529~

Return to provider claims that span two or more dates if a line item date of service is not entered for each HCPCS code reported 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 05, 2000.

G. Payment.--Section 1833(a)(2)(B) of the Act provides the statutory authority governing payment for partial hospitalization services provided by a CMHC. Make payment on a reasonable cost basis until OPPS is implemented. The Part B deductible and coinsurance apply.

During the year, make payment at an interim rate based on a percentage of billed charges. Payment principles applicable to partial hospitalization services furnished in CMHCs are contained in §§2400ff of the Provider Reimbursement Manual. Furnish each CMHC with one copy of that manual.

Beginning with services provided on or after August 1, 2000, make payment on a per diem basis under the hospital outpatient prospective payment system for partial hospitalization services. CMHCs must continue to maintain documentation to support medical necessity of each service provided, including the beginning and ending time.

NOTE: Occupational therapy services provided to partial hospitalization patients are not subject to the prospective payment system for outpatient rehabilitation services, and therefore the financial limitation required under §4541 of the Balanced Budget Act (BBA) does not apply.

H. Medical Review.--Follow medical review guidelines in §3920.1k3.

I. Coordination With CWF.--Use the HUOP record format. CWF began accepting provider numbers 4600-4799 for transmissions November 11, 1991, and later. All edits for bill type 74X apply, except provider number ranges 4600-4799 are acceptable only for services provided on or after October 1, 1991.