Medicare

Outpatient Physical Therapy

Comprehensive Outpatient Rehabilitation Facility and Community Mental Health Center

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

Transmittal 13 **Date: AUGUST 4, 2000**

REFER TO CHANGE REQUEST 980

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
414 (Cont.) - 414 (Cont.)	4-32.1 - 4-32.2 (2 pp.)	4-32.1 - 4-32.2 (2 pp.)

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

Section 414, Billing Instructions 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 7, 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 This date has been superceded by June 5, 2000, due to the delay of the April release.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 provides the effective date for implementation of the hospital outpatient prospective payment system.

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.**

However, the outpatient mental health treatment limitation does not apply to such mental health treatment services billed to your intermediary as partial hospitalization services.

E. Reporting of Service Units.--Visits should no longer be reported as units. Instead, 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 the partial hospitalization services identified by revenue codes 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. Report 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), do not bill for sessions of less than 45 minutes.

Your intermediary will return to you 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.--Effective with claims with dates of service on or after June 5, 2000, you are required to report line item 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~

Your intermediary will return to you 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 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 you. Beginning with services provided on or after August 1, 2000 your intermediary will make payment on a per diem basis under the hospital outpatient prospective payment system. The Part B deductible and coinsurance apply. Beginning with services provided on or after the implementation of OPPS, payment will be made on a per diem basis under the hospital outpatient prospective payment system for partial hospitalization services. You must continue to maintain documentation to support medical necessity of each service provided, including the beginning and ending time.