Medicare
Intermediary Manual
Part 3 - Claims Process

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

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CHANGE REQUEST 1265

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3604 - 3604 (Cont.)	6-25 - 6-26 (2 pp.)	6-25 - 6-26 (2 pp.)
3604 (Cont.) - 3604 (Cont.)	6-56.1 - 6-56.2 (2 pp.)	6-56.1 – 6-56.2 (2 pp.)
3626.2 - 3626.3	6-153 - 6-154 (2 pp.)	6-153 - 6-154 (2 pp.)
3627.4 - 3627.8	6-156.3 - 6-156.4 (2 pp.)	6-156.3 - 6-156.4 (2 pp.)
3661- 3661 (Cont.)	6-344.6O - 6-344.6P (2 pp.)	6-344.6O - 6-344.6P (2 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE:* June 05, 2000
***IMPLEMENTATION DATE:* June 05, 2000**

Effective and implementation dates are a result of the delay in the April release.

Section 3604, Review of Form HCFA-1450 for Inpatient and Outpatient Bills, changes the effective date for line item expansion and line item date of service reporting.

Section 3626.2, Outpatient Services, changes the effective date of editing for line item dates of service.

Section 3661, Hospital Outpatient Partial Hospitalization Services, changes the effective date of editing for line item dates of service.

NEW/REVISED MATERIAL--*EFFECTIVE DATE*: September 25, 2000
***IMPLEMENTATION* DATE: September 25, 2000**

Section 3626.2, Outpatient Services, removes the requirement that Critical Access Hospitals (CAHs), indian health service hospitals and hospitals located in American Samoa, Guam, and Saipan from line item date of service reporting.

Section 3627.2, Addition, Deletion and Change of Local Codes, revised to reflect that requests for local codes will not be accepted for services paid under the hospital outpatient prospective payment system.

Section 3627.8, Reporting Hospital Outpatient Services Using HCFA Common Procedure Coding System (HCPCS), includes the following revisions:

- Removes the requirement that CAHs have to HCPCS code for all services they provide;
- Includes all-inclusive rate hospitals to the list of hospitals that are required to HCPCS code; and,
- Expands list of references for reporting HCPCS and modifiers.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previous published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

HCFA-Pub. 13-3

HCFA-1450

3604. REVIEW OF FORM HCFA-1450 FOR INPATIENT AND OUTPATIENT BILLS

This form, also known as the UB-92, serves the needs of many payers. Some data elements may not be needed by a particular payer. All items on the HCFA-1450 are described, but detailed information is given only for items required for Medicare claims. The National Uniform Billing Committee (NUBC) maintains a complete list of allowable data elements and codes. You must be able to capture all NUBC-approved input data for audit trail purposes and be able to pass all data to other payers with whom you have a coordination of benefits agreement. Items listed as "Not Required" need not be reviewed although providers may complete them when billing multiple payers. All Medicare claims you process must be billed on the HCFA-1450 billing form or billed using related electronic billing record formats.

If required data is omitted, obtain it from the provider or other sources and maintain it on your history record. It is not necessary to search paper files to annotate missing data unless you do not have an electronic history record. You need not obtain data not needed to process the bill.

Data elements in the HCFA uniform electronic billing specifications are consistent with the HCFA-1450 data set to the extent that one processing system can handle both. Definitions are identical. In some situations, the electronic record contains more characters than the corresponding item on the form because of constraints on the form size not applicable to the electronic record. Also, for a few data elements not used by Medicare, conversion may be needed from an alpha code to a numeric, but these do not affect Medicare processing. The revenue coding system for both the HCFA-1450 and the electronic specifications are identical.

Effective June 05, 2000, HCFA extended the claim size to 450 lines. For the hard copy UB-92 or HCFA-1450, this simply means you will accept claims of up to 9 pages. For the electronic format, the new requirements are described in Addendum A.

Form Locator (FL) 1. (Untitled) - Provider Name, Address, and Telephone Number
Required. The minimum entry is the provider's name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine digit ZIP codes are acceptable. Use the information to reconcile provider number discrepancies. Phone and/or FAX numbers are desirable.

FL 2. (Untitled)
Not Required. This is one of the four fields which have not been assigned for national use. Use of the field, if any, is assigned by the SUBC and is uniform within a State.

FL 3. Patient Control Number
Required. The patient's unique alphanumeric number assigned by the provider to facilitate retrieval of individual financial records and posting of payment.

FL 4. Type of Bill
Required. This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as "frequency" code.

Code Structure (only codes used to bill Medicare are shown).

1st Digit - Type of Facility
1 - Hospital
2 - Skilled Nursing
3 - Home Health
4 - Religious Non- Medical (Hospital)
5 - Religious Non-Medical (Extended Care)
6 - Intermediate Care
7 - Clinic or Hospital Based Renal Dialysis Facility (requires special information in second digit below).
8 - Special Facility or hospital ASC surgery (requires special information in second digit below).
9 - Reserved for National Assignment

2nd Digit - Classification (Except Clinics and Special Facilities)
1 - Inpatient (Part A)
2 - Hospital Based or Inpatient (Part B) (includes HHA visits under a Part B plan of treatment).
3 - Outpatient (includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment).
4 - Other (Part B) (includes HHA medical and other health services not under a plan of treatment, SNF diagnostic clinical laboratory services to "nonpatients", and referred diagnostic services).
5 - Intermediate Care - Level I
6 - Intermediate Care - Level II
7 - Subacute Inpatient (Revenue Code 19X required)
8 - Swing bed (used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement.)
9 - Reserved for National Assignment

2nd Digit - Classification (Clinics Only)
1 - Rural Health Clinic (RHC)
2 - Hospital Based or Independent Renal Dialysis Facility
3 - Free-Standing Provider-Based Federally Qualified Health Centers (FQHC)
4 - Other Rehabilitation Facility (ORF)
5 - Comprehensive Outpatient Rehabilitation Facility (CORF)
6 - Community Mental Health Center (CMHC)
7-8 Reserved for National Assignment
9 - OTHER

2nd Digit - Classification (Special Facilities Only)
1 - Hospice (Nonhospital Based)
2 - Hospice (Hospital Based)
3 - Ambulatory Surgical Center Services to Hospital Outpatients
4 - Free Standing Birthing Center
5 - Critical Access Hospital
6-8 Reserved for National Assignment
9 - OTHER

3rd Digit - Frequency	Definition
A - Hospice Admission Notice	This code is used when the hospice is submitting the HCFA-1450 as an admission notice.
B - Hospice Termination/ Revocation Notice	This code is used when the hospice is submitting the HCFA-1450 as a notice of termination/revocation for a previously posted hospice election.

98X Professional Fees

Subcategory Standard	Abbreviation
1 - Emergency Room	PRO FEE/ER
2 - Outpatient Services	PRO FEE/OUTPT
3 - Clinic	PRO FEE/CLINIC
4 - Medical Social Services	PRO FEE/SOC SVC
5 - EKG	PRO FEE/EKG
6 - EEG	PRO FEE/EEG
7 - Hospital Visit	PRO FEE/HOS VIS
8 - Consultation	PRO FEE/CONSULT
9 - Private Duty Nurse	FEE/PVT NURSE

99X Patient Convenience Items

Charges for items that are generally considered by the third party payers as strictly convenience items and are not covered.

Rationale: Permits identification of particular services as necessary.

Subcategory Standard	Abbreviation
0 - General Classification	PT CONVENIENCE
1 - Cafeteria/Guest Tray	CAFETERIA
2 - Private Linen Service	LINEN
3 - Telephone/Telegraph	TELEPHONE
4 - TV/Radio	TV/RADIO
5 - Nonpatient Room Rentals	NONPT ROOM RENT
6 - Late Discharge Charge	LATE DISCHARGE
7 - Admission Kits	ADMIT KITS
8 - Beauty Shop/Barber	BARBER/BEAUTY
9 - Other Patient Convenience Items	PT CONVENCE/OTH

FL 43. Revenue Description
Not Required. A narrative description or standard abbreviation for each revenue code in FL 42 is shown on the adjacent line in FL 43. The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes. "Other" code categories descriptions are locally defined and individually described on each bill.

The investigational device exemption (IDE) or procedure identifies a specific device used only for billing under the specific revenue code 624. The IDE will appear on the paper format of Form HCFA-1450 as follows: FDA IDE # A123456 (17 spaces).

HHAs identify the specific piece of DME or nonroutine supplies for which they are billing in this area on the line adjacent to the related revenue code. This description must be shown in HCPCS coding. (Also, see FL 84, Remarks.)

FL 44. HCPCS/Rates
Required. When coding HCPCS for outpatient services (i.e., outpatient surgery bills, clinical diagnostic laboratory bills for outpatients or nonpatients, radiology, other diagnostic services, orthotic/prosthetic devices, take home surgical dressings, therapies (identified in AB 98-63), preventive services, drugs identified in §3631.C.3, and other services described in §3627.8 and § 3627.9), the provider enters the HCPCS code describing the procedure here.

On inpatient hospital or SNF bills, the accommodation rate or HIPPS code is shown here.

FL 45. Service Date
Required. Effective June 5, 2000, CMHCs and hospitals (with the exception of CAHs, indian health service hospitals and hospitals located in American Samoa, Guam and Saipan) report line item dates of service wherever a HCPCS code is required for services paid under the outpatient prospective payment system (OPPS). This includes claims where the from and through dates are equal.

FL 46. Service Units
Required. Generally, the entries in this column quantify services by revenue category, e.g., number of days in a particular type of accommodation, pints of blood. However, when HCPCS codes are required for hospital outpatient services, the units are equal to the number of times the procedure/service being reported was performed. (See §3627.8.) Providers have been instructed to provide the number of covered days, visits, treatments, procedures, tests, etc., as applicable, for the following:

Accommodations - 100s - 150s, 200s, 210s (days)
Blood - 380s (pints)
DME - 290s (rental months)
Emergency room - 450, 452, and 459 (HCPCS code definition for visit or procedure)
Clinic - 510s and 520s (HCPCS code definition for visit or procedure)
Dialysis treatments - 800s (sessions or days)
Orthotic/prosthetic devices - 274 (items)
Outpatient therapy visits - 410, 420, 430, 440, 480, 910, and 943 (Units are equal to the number of times the procedure/service being reported was performed.)
Outpatient clinical diagnostic laboratory tests - 30X - 31X (tests)
Radiology - 32x, 34x, 35x, 40x, 61x, and 333 (HCPCS code definition of tests or services)
Oxygen - 600s (rental months, feet or pounds)
Hemophilia blood clotting factors - 636

Up to seven numeric digits may be entered. Charges for non-covered services are shown as noncovered or are omitted.

FL 47. Total Charges
Required. The total charges for the billing period are summed by revenue code (FL 42) or in the case of diagnostic laboratory tests for outpatient or nonpatients by HCPCS procedure code and entered on the adjacent line in FL 47. The last revenue code entered in FL 42 is "0001" which represents the grand total of all covered and non-covered charges billed. FL 47 totals on the adjacent line. Each line allows up to nine numeric digits (0000000.00).

HCFA policy is for providers to bill Medicare on the same basis that they bill other payers. This policy provides consistency of bill data with the cost report so that bill data may be used to substantiate the cost report.

Medicare and non-Medicare charges for the same department must be reported consistently on the cost report. This means that the professional component is included on, or excluded from, the cost report for Medicare and non-Medicare charges. Where billing for the professional component is not consistent for all payers, i.e., where some payers require net billing and others require gross, the provider must adjust either net charges up to gross or gross charges down to net for cost report preparation. In such cases, adjust your provider statistical and reimbursement reports (PS&R) that you derive from the bill.

For outpatient Part B billing, only charges believe to be covered are submitted in FL 47. Non-covered charges are omitted on the bill.

3626. HOSPITAL BILLING FOR INPATIENT PART B AND OUTPATIENT SERVICES

3626.1 Inpatient Part B Services.--Participating hospitals use Form HCFA-l450 to bill for the following services furnished directly or under arrangements to inpatients whose benefit days are exhausted or who are otherwise not entitled to have payment made under Part A. (See §3ll0.)

- o Diagnostic X-ray tests, diagnostic laboratory, and other diagnostic tests.
- o X-ray, radium, and radioactive isotope therapy, including materials and services of technicians. (See §3146.)
- o Surgical dressings, splints, casts, and other devices used for the reduction of fractures and dislocations. (See §3110.3.)
- o Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue) or replace all or part of the functions of a permanently inoperative or malfunctioning internal body organ, including replacement or repair of such devices. (See §3110.5.)
- o Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes, including adjustments, repairs, and replacements required because of breakage, wear, loss, or change in the patient's physical condition. (See §3110.5.)
- o Outpatient physical therapy services furnished inpatients. (See §3147ff.)
- o Outpatient speech pathology services furnished inpatients. (See §§3147ff.)
- o Outpatient occupational therapy services furnished inpatients. (See §§3147ff.)
- o Screening mammography services.
- o Screening pap smears and pelvic exams.
- o Influenza, pneumococcal pneumonia, and hepatitis B vaccines. (See §3157.)
- o Colorectal screening. (See §3660.17.)
- o Bone mass measurements.
- o Diabetes self-management.
- o Prostate screening.

Part B coverage for services furnished by a participating hospital to its inpatients is limited to the above items and services.

3626.2 Outpatient Services.--Section 3604 contains general instructions for review of Form HCFA-l450. Hospitals use this form to bill for covered outpatient services (type of bill 13X or 14X, 83X and 85X). (See §3112.1 for definition of an outpatient and §3610.3 for outpatient services treated as inpatient services.)

Line item dates of service are reported for every line where a HCPCS code is required for services paid under OPPS on all hospital outpatient (with the exception of CAHs, indian health service hospitals, and hospitals located in American Samoa, Guam and Saipan) and CMHC bills. This includes those claims where the from and thru dates are equal. Effective for services on or after June 05, 2000, return to provider (RTP) bills where a line item date of service is not entered for each HCPCS code reported for services paid under OPPS, or if the line item dates of service reported are outside of the statement-covers period.

3626.3 Calculating the Part B Payment.--Under Part B, the patient is responsible for a cash deductible for covered services as well as 20 percent coinsurance and a blood deductible for blood furnished in a calendar year for services other than those paid under the outpatient prospective payment system (OPPS). After the deductibles are met, the patient pays only 20 percent (coinsurance) of the reasonable charges (e.g., billed charges) for covered services.

Determine deductible status based on your internal records. CWF applies the applicable deductible based upon its files and, if necessary, automatically adjusts the claim. This information is returned to you for correct processing.

To determine interim payments on outpatient claims submitted by hospitals, CAHs, SNFs, and CORFs, apply the provider's interim rate to billed charges and deduct any applicable Medicare Part B deductible and coinsurance. This is the amount Medicare will pay on an interim basis prior to any deductions for Gramm-Rudman-Hollings, or any add-ons for interest due to late payment of clean claims (see §3600.6 for an explanation of Gramm-Rudman-Hollings reduction and §3600.1.A5 for interest payments.)

EXAMPLE:	$400	Provider's billed charges
	X90%	Provider's interim rate
	$360	
	$-75	Part B deductible to be met
	$285	
	$-65	Applicable coinsurance*
	$220	Reimbursement to provider

*To determine the applicable coinsurance amount, exclude any charges for clinical diagnostic lab services, influenza vaccine, and pneumococcal pneumonia vaccine, and deduct any unmet Part B deductible from the billed charges. Multiply the remainder by 20%. The result is the applicable coinsurance on the claim. In this example: $400 (charges) - $75 (deductible) = $325 x 20% = $65 (coinsurance).

NOTE: The above addresses interim payments only. It does not address payments for outpatient claims containing services subject to fee schedules. (See §3628 for determining payment for clinical diagnostic lab services and §3629C for DME, orthotic/prosthetic devices, and take home surgical dressings and PM AB-98-63 for outpatient rehabilitation services.) It also does not apply to screening mammography services which are subject to a special payment limit. (See §3660.10.)

You may publish, edit, and abridge CPT-4 terminology within your claims processing area. You are not allowed to publish, edit, or abridge versions of CPT-4 for distribution outside of your claims processing structure. This would violate copyright laws. You may print the codes and approved narrative descriptions in newsletters that instruct providers in how and when to use certain codes when reporting services on claims forms, e.g., services subject to ASC limitation, out-of-scope services, need for documentation of services, handling of unusual circumstances, reporting new and changed codes. However, HCFA acknowledges that CPT is a trademark of the AMA and your newsletter must show the following statement in close proximity to listed codes and descriptors:

"CPT codes and descriptions only are copyright 1996 AMA. All Rights Reserved. (The date is the date of the most recent publication of CPT.)

You may also print the code and approved narrative description in development requests relating to individual cases.

3627.2 Addition, Deletion, and Change of Local Codes.--Under the outpatient prospective payment system, payment is made based on HCPCS codes. As a result, request for local codes are not accepted for services paid under this system since there is no mechanism for the pricing of local codes. However, requests to add a new local code or modifier for services not subject to the outpatient prospective payment system may continue to be made. Such requests must include the following information:

- Identify the component making the request and its address, i.e., contractor name and number;

- Exact descriptor or terminology to be used;

- Reason the code/modifier assignment is requested e.g., received on claim, request from hospital, new procedure, new product, etc. This provides background that helps HCFA in deciding whether or not a national code may be required;

- Expected coverage, utilization, or payment limits placed upon the service;

- Nearest national HCPCS code/modifier with an explanation why it cannot be used; and

- For modifiers only, a description of how the modifier will be used (e.g., to trigger MR, for informational purposes, to affect payment, how it impacts payment, or for internal processing only). (See §3627.11 for information on reporting of modifiers.)

Send requests for local codes to your RO. The RO will review the request to determine that the required documentation is provided, and whether a current code/modifier exists. If no current code/modifier is found, the RO will forward the submitted documentation and its recommendation for consideration of a local code/modifier assignment to the HCPCS Coordinator, Room C4-02-16 in CO. The request will be placed on the HCFA HCPCS Workgroup agenda for review and a final decision regarding the establishment of a new local code/modifier. The RO will be notified of the decision and, if approved, the new code/modifier will be added to the HCPCS database.

The RO and CO must receive written notification when local codes/modifiers are deleted and when there are changes to administrative data.

3627.3 Use and Acceptance of HCPCS Codes.--HCPCS is updated annually to reflect changes in the practice of medicine and provision of health care. HCFA provides a file containing the updated HCPCS codes to contractors and Medicaid State agencies 90 days in advance of the implementation of the annual update. Update your HCPCS file and map all new or deleted codes to appropriate payment information no later than 3 months after receipt of the update.

3627.4 HCPCS Manuals.--Providers use the CPT-4 manual published by the AMA as a coding source. It is your responsibility to supply providers with HCFA s alpha-numeric code updates and with your local codes.

Inform providers when the annually updated HCPCS becomes available and effective in your claims processing system.

3627.6 Public Relations.--Establish a knowledgeable person as a focal point for provider inquiries. This person must be able to address coding and payment questions.

When codes change, are added or deleted, or when general problems arise, send appropriate bulletins to providers.

Since local changes can occur throughout the year, continue your professional relations work to provide as much information as possible to providers.

3627.7 HCPCS Training.--A large number of changes to HCPCS may necessitate the training of provider personnel. If this is necessary, schedule the sessions in conjunction with the State medical records association or the State hospital association. In issuing the invitations, ensure that the people who complete the bills attend. In the training, emphasize the use of the new manuals and the proper completion of the claim forms.

Be alert to a provider having difficulty with HCPCS. Provide follow up training geared to the individual situation. Review and discuss specific billing problems over the phone or by mail. If a volume of problems develop with a specific provider, schedule a visit to provide the specific training needed. Training is your responsibility.

3627.8 Reporting Hospital Outpatient Services Using HCFA Common Procedure Coding System (HCPCS).--

A. General.--Section 9343(g) of the Omnibus Budget Reconciliation Act (OBRA) of 1986 requires hospitals to report claims for outpatient services using HCPCS coding. HCPCS includes CPT-4 codes. In preparation of implementation of a hospital outpatient prospective payment system, hospitals are required to report services, utilizing HCPCS coding in order to assure proper payment. This applies to acute care hospitals, including those paid under alternative payment systems (e.g., Maryland), long-term care hospitals, rehabilitation hospitals, psychiatric hospitals, hospital-based RHCs, and hospital-based FQHCs. These instructions also apply to all-inclusive rate hospitals. If the hospital has your approval to combine- bill the professional component charges, they do not report HCPCS for the professional service revenue code, but must report HCPCS for hospital services. Hospital-based and independent ESRD facilities must also use HCPCS to bill for blood and blood products, and to bill for drugs and clinical diagnostic laboratory services paid outside the composite rate. (See §§3644.E and 3644.F.) In addition, hospitals are required to report HCPCS and modifiers as described in §3661.1.

CAHs are required to report HCPCS only for services not paid on a reasonable cost basis, e.g., screening mammographies and bone mass measurements.

HCPCS codes are required for surgery, radiology, other diagnostic procedures, clinical diagnostic lab, durable medical equipment, orthotic-prosthetic devices, take home surgical dressings, therapies, preventive services, immunosupressive drugs, drugs identified in §3660.11 - §3660.15, and the other services described in §3627.9.

B. Line Item Dates of Service.--Hospitals are required to report line item dates of service (FL 45 on Form HCFA-1450) for every line where a HCPCS code is required for services paid under OPPS on all outpatient bills, including claims where the from and thru dates are equal. (See §3626.2 for edit requirements.)

The services of other practitioners (including clinical social workers and occupational therapists), are bundled when furnished to hospital patients, including partial hospitalization patients. The hospital must bill you for such nonphysician practitioner services as partial hospitalization services. Make payment for the services to the hospital.

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

B. 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, CASs, and PAs to partial hospitalization patients. However, the outpatient mental health treatment limitation does not apply to such mental health treatment services billed to the intermediary by a CMHC or hospital outpatient department as partial hospitalization services.

C. Reporting of Service Units.--Visits should no longer be reported as units. Hospital outpatient departments are required to report in 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 codes in subsection C.

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

You must RTP 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).

D. Line Item Date of Service Reporting.--Hospitals are required to report line item dates of service per revenue code line for partial hospitalization claims. 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:

FL42	FL44	FL45	FL46	FL47
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~

You must RTP claims where 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.

E. Payment.--Make payment on a reasonable cost basis, and apply Part B deductible, if any, and coinsurance. Base coinsurance on the hospital's reasonable and customary charges.

During the year, make payment at an interim rate based on a percentage of billed charges. Information applicable to determining interim rates for partial hospitalization services furnished as hospital outpatient services are contained in §2400ff of the Provider Reimbursement Manual. Beginning with services provided on or after August 1, 2000, make payment under the hospital outpatient prospective payment system for partial hospitalization services. Hospitals must continue to maintain documentation to support medical necessity of each service provided, including beginning and ending time.

F. Data for CWF and PS&R.--Include revenue codes, HCPCS/CPT codes, units, and covered charges in the financial data section (fields 65a - 65j), as appropriate. Report the billed charges in field 65h, "Charges," of the CWF record.

Include in the financial data portion of the PS&R UNIBILL, revenue codes, HCPCS/CPT codes, units, and charges, as appropriate.

G. Medical Review.--Follow medical review guidelines in §3920.1.K3.

3662. BILLING FOR HOSPITAL OUTPATIENT SERVICES FURNISHED BY CLINICAL SOCIAL WORKERS (CSWs)

Payment is made for covered diagnostic and therapeutic services furnished by CSWs in a hospital outpatient setting. (See MCM, §5113 for an explanation of how payment is made and §2152 for CSW licensure and educational requirements.)

A. Fee Schedule To Be Used for Payment of CSW Services.--The fee schedule for CSW services is set at 75 percent of the fee schedule for comparable services furnished by clinical psychologists.