Medicare
Intermediary Manual
Part 3 - Claims Process

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

Transmittal 1825 **Date: FEBRUARY 23, 2001**

CHANGE REQUEST 1572

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3660.18 - 3663	6-344.6M - 6-344.6S (7 pp.)	6-344.6M - 6-344.6S (7 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: July 1, 2001*
IMPLEMENTATION DATE: July 1, 2001

Section 3661, Hospital Outpatient Partial Hospitalization Services, allows Critical Access Hospitals (CAHs) to bill under the hospital outpatient partial hospitalization program. Make payment on a reasonable cost basis.

Only hospitals and CAHs are eligible for payment under the hospital outpatient partial hospitalization program.

Standard systems must assure that payment under the hospital outpatient partial hospitalization program is not made to any other provider type. In addition, until the necessary system changes are implemented, periodically turn off edits that allow only claims with bill types 13X or 14X to process for this benefit in order to work off any backlog of pending claims from CAHs (bill type 85X).

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.

3660.18 Extracorporeal Immunoadsorption (ECI) Using Protein A Columns.--Extracorporeal immunoadsorption using Protein A columns has been developed for the purpose of selectively removing circulating immune complexes (CIC) and immunoglobulins (IgG) from patients in whom these substances are associated with their diseases. The technique involves pumping the patient's anticoagulated venous blood through a cell separator from which 1-3 liters of plasma are collected and perfused over adsorbent columns, after which the plasma rejoins the separated, unprocessed cells and is retransfused to the patient.

For claims with dates of service on or after May 6, 1991 through December 31, 2000, the use of Protein A columns is covered by Medicare only for the treatment of patients with idiopathic thrombocytopenia purpura (ITP) failing other treatments.

For claims with dates of service on or after January 1, 2001, Medicare covers the use of Protein A columns for the treatment of ITP. In addition, Medicare covers the use of Protein A columns for the treatment of rheumatoid arthritis (RA) under the following conditions:

1. Patient has severe RA. Patient disease is active, having > 5 swollen joints, > 20 tender joints, and morning stiffness > 60 minutes.

2. Patient has failed an adequate course of a minimum of 3 Disease Modifying Anti-Rheumatic Drugs (DMARDs). Failure does not include intolerance.

Other uses of these columns are currently considered to be investigational and/or experimental and, therefore, not reasonable and necessary under the Medicare law. (See §1862(a)(1)(A) of the Act.) (Refer to §35-90 of the Coverage Issues Manual.)

In hospital outpatient departments, payment is made under Part B on a reasonable cost basis for claims with dates of service prior to August 1, 2000. Payment for claims with dates of service on or after August 1, 2000, is made under the outpatient prospective payment system. Payment is made on a reasonable cost basis in critical access hospitals (CAHs). Deductible and coinsurance apply.

Follow the general bill review instructions in §3604. Hospitals bill you on Form HCFA-1450 or electronic equivalent.

A. Applicable Bill Types.--The appropriate bill types are 12X, 13X, 83X, and 85X.

Hospitals utilizing the UB-92 flat file use record type 40 to report bill type. Record type (Field No. 1), sequence number (Field No. 2), patient control number (Field No. 3), and type of bill (Field No. 4) are required.

Hospitals utilizing the hard copy UB-92 (Form HCFA-1450), report the applicable bill type in Form Locator (FL) 4 “Type of Bill”.

Hospitals utilizing the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, report the applicable bill type in 2-130-CLM01, CLM05-01, and CLM05-03.

B. Revenue Code Reporting--Hospitals report revenue code 940. Hospitals utilizing the UB-92 flat file use record type 61, Revenue Code (Field No. 5). Hospitals utilizing the hard copy UB-92 report the revenue code in FL 42 “Revenue Code.” Hospitals utilizing the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, report the applicable revenue code in 2-395-SV201.

C. HCPCS Code Reporting--For claims with dates of service on or after May 6, 1991, hospitals report HCPCS code Q0068 (extracorporeal plasmapheresis, immunoadsorption with staphylococcal protein A columns). For claims with dates of service on or after January 1, 2000, extracorporeal affinity column adsoption and plasma reinfusion). Hospitals utilizing the UB-92 flat file, use record type 61, HCPCS code (Field No. 6) to report HCPCS/CPT code. Hospitals utilizing the hard copy UB-92, report the HCPCS/CPT code in FL 44 "HCPCS/Rates." Hospitals utilizing the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, report the HCPCS/CPT in 2-395-SV202-02.

D. ICD-9-CM Reporting--For claims with dates of service on or after May 6, 1991, hospitals report ICD-9 code 287.3 (Primary thrombocytopenia). For claims with dates of service on or after January 1, 2001, hospitals report 287.3 (primary thrombocytopenia), 714.0 (rheumatoid arthritis), 714.1 (Felty's syndrome), 714.2 (other rheumatoid arthritis with visceral or systemic involvement), 714.30, 714.31, 714.32, or 714.33 (types of juvenile rheumatoid arthritis). Hospitals utilizing the UB-92 flat file, use record type 70, Principal Diagnosis Code/Other Diagnoses Code (Field No. 4-12) to report the ICD-9 code. Hospitals utilizing the hard copy UB-92, report the ICD-9 code in FLs 67 –75 (Principal Diagnosis Code/Other Diagnoses Codes). Hospitals utilizing the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, report the ICD-9 in 2-225.A- HI02-02 through HI10-02.

E. Edits.--For claims with dates of service on or after January 1, 2001, deny claims reflecting any diagnosis code (ICD-9) other than 287.3, 714.0, 714.1, 714.2, 714.30, 714.31, 714.32, or 714.33 when reported with CPT code 36521.

F. MSN/EOMB Messages.--If the claim is denied use the following message:

21.22/16.58 Medicare does not pay for this service because it is considered investigational and/or experimental in these circumstances.

G. Remittance Advice Messages.--If the claim is denied, you use existing American National Standard Institute (ANSI) X-12-835 claim adjustment reason code/message B22, "This claim/service is denied/reduced based on the diagnosis."

3661. HOSPITAL OUTPATIENT PARTIAL HOSPITALIZATION SERVICES

Medicare Part B coverage is available for hospital outpatient partial hospitalization services. (See §3112.7.D for a description of services covered under this benefit.)

A. Billing Requirements.--Section 1861(ff) of the Act defines the services covered under the partial hospitalization benefit in a hospital or Critical Access Hospital (CAH) outpatient setting. However, no separate payment methodology for these services is mandated. Therefore, in order to make proper payment, hospitals and CAHs are required to component bill for any service provided under this benefit.

Under component billing, hospitals and CAHs are required to report a revenue code and the charge for each individual covered service furnished under a partial hospitalization program. In addition, hospital outpatient departments are required to report HCPCS codes. CAHs are not required to report HCPCS codes for this benefit. Billing as individual services assures that only those partial hospitalization services covered under §1861(ff) of the Act are paid by the Medicare program.

Hospital outpatient departments bill you for partial hospitalization services on the Form HCFA-1450 (or electronic equivalent) under bill type 13X or 14X as appropriate. CAH outpatient departments bill under 85X. Follow bill review instructions in §3604 with the following exceptions.

Bills must contain an acceptable revenue code. They are as follows:

Revenue Code	Description
250	Drugs and Biologicals
43x	Occupational Therapy
904	Activity Therapy
910	Psychiatric/Psychological Services
914	Individual Therapy
915	Group Therapy
916	Family Therapy
918	Testing
942	Education Training

Hospitals and CAHs are required to report condition code 41 in FLs 24-30 to indicate the claim is for partial hospitalization services.

Hospitals other than CAHs are also required to report appropriate HCPCS codes as follows:

Revenue Code	Description	HCPCS Code
43X	Occupational Therapy	*G0129
904	Activity Therapy (Partial Hospitalization)	**G0176
910	Psychiatric General Services	90801, 90802, 90875, 90876, 90899, or 97770
914	Individual Psychotherapy	90816, 90818, 90821, 90823, 90826, or 90828
915	Group Psychotherapy	90849, 90853, or 90857
916	Family Psychotherapy	90846, 90847, or 90849
918	Psychiatric Testing	96100, 96115, or 96117
942	Education Training	***G0177

Edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. Do not edit for the matching of revenue code to HCPCS.

*The definition of code G0129 is as follows:

"Occupational therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per day,"

**The definition of code G0176 is as follows:

"Activity therapy, such as music dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)."

***The definition of code G0177 is as follows:

"Training and educational services related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)."

Revenue code 250 does not require HCPCS coding. However, drugs that can be self-administered are not covered by Medicare.

B. Professional Services.--The professional services listed below when provided in a hospital or CAH outpatient department are separately covered and paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other than physician assistants (PA) bill the Medicare Part B carrier directly for the professional services furnished to hospital outpatient partial hospitalization patients. The hospital or CAH can also serve as a billing agent for these professionals by billing the Part B carrier on their behalf under their billing number for their professional services. The professional services of a PA can be billed to the carrier only by the PAs employer. The following direct professional services are unbundled and not paid as partial hospitalization services.

- Physician services that meet the criteria of 42 CFR 415.102, for payment on a fee schedule basis;
- Physician assistant (PA) services as defined in §1861(s)(2)(K)(i) of the Act;
- Nurse practitioner and clinical nurse specialist services, as defined in §1861(s)(2)(K)(ii) of the Act; and
- Clinical psychologist services as defined in §1861(ii) of the Act.

The services of other practitioners (including clinical social workers and occupational therapists), are bundled when furnished to hospital or CAH 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 or CAH.

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 or CAH, 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.)

C. 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 the intermediary by a CMHC, hospital, or CAH outpatient department as partial hospitalization services.

D. .Reporting of Service Units.--Visits should no longer be reported as units by hospitals other than CAHs. Instead, 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).

CAHs report the number of visits in FL 46 "Service Units".

E. Line Item Date of Service Reporting.--Hospitals other than CAHs 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*19980505~
LX*2~
SV2*915*HC:90849*160*UN*2~
DTP*472*D8*19980529~

You must RTP hospital claims where a line item date of service is not entered for each HCPCS code reported by hospitals, 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 5, 2000.

F. Payment.--For hospital outpatient departments, make payment on the reasonable cost basis until August 1, 2000.

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.

For CAHs make payment on a reasonable cost basis, regardless of the date of service.

Apply Part B deductible, if any, and coinsurance.

G. 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.

H. 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.

B. Payment Limitation.--CSW services are subject to the outpatient mental health treatment limitation in §1833 of the Act. Carriers apply the limitation of 62.5 percent to the lesser of the actual charge or fee schedule amount. Diagnostic services are not subject to the limitation. (See MCM, §2152 for more detail regarding the payment limit.)

C. Coinsurance and Deductible.--The annual Part B deductible and the 20 percent coinsurance apply to CSW services.

D. Billing.--

1. Hospital and CAH Outpatient Services--CSWs do not bill directly for these services. Hospital and CAH outpatient services are bundled and hospitals bill the carrier for the services on Form HCFA-1500 (or electronic equivalent). These services are not billed to you.

2. Partial Hospitalization Services--CSW services furnished under the partial hospitalization program are also bundled for hospitals and CAHs. However, the hospital bills you for the services. Make payment on a reasonable cost basis. (See §3661 for an explanation.)

3663. OUTPATIENT OBSERVATION SERVICES

Observation Services.--Observation services are those services furnished on a hospital's premises, including use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission as an inpatient. Such services are covered only when provided by order of a physician or another individual authorized by State licensure law and hospital bylaws to admit patients to the hospital or to order outpatient tests. Observation services usually do not exceed one day. Some patients, however, may require a second day of outpatient observation services. Observation services exceeding 48 hours will be denied. (See §3112.8.)

A hospital which believes that exceptional circumstances in a particular case justify approval of additional time in outpatient observation status may request an exception to the denial of services from you. See §3112.8E for procedures for requesting an exception.

The hospital will bill for observation services using the following revenue code.

Revenue Code	Description
762	Observation Services

For observation services, the hospital should report the number of hours in the units field. They should begin counting when the patient is placed in the observation bed. If necessary, they should verify the time in the nurses' notes. Round to the nearest hour. For example, a patient who was placed in an observation bed at 3:03 p.m. according to the nurses' notes and discharged to home at 9:45 p.m. should have a "7" placed in the units field.

B. Services Not Covered as Observation Services.--See §3112.8E for noncovered services. If the hospital has provided noncovered services, and given proper notification to the beneficiary, it will show only those charges associated with covered services. If the hospital provided more than 48 hours of observation, but thinks that the additional hours qualify for coverage, they will show all hours in the units field. Suspend the claim for documentation of the medical necessity of all observation services. If any such services are denied, the beneficiary cannot be held liable for payment.