Medicare Hospital Manual

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

Transmittal 770 **Date: FEBRUARY 23, 2001**

REFER TO CHANGE REQUEST 1572

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Sec. 452 - 455 (Cont.)	4-499 - 4-500.2b (6 pp.)	4-499 - 4-500.2a (5 pp.)

Section 452, Billing for Hospital Outpatient Partial Hospitalizaiton Services, allows Critical Access Hositals (CAHs) to bill under the partial hospitalization program. Payment is made on a reasonable cost basis.

Until the necessary system changes are implemented, your intermediary will 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).

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

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.

452. BILLING FOR HOSPITAL OUTPATIENT PARTIAL HOSPITALIZATION SERVICES

Medicare Part B coverage is available for hospital outpatient partial hospitalization services. (See §230.5.D.1 for a description of services covered under this benefit.)

A. Billing Requirements.--Sections 1861ff. of the Act define the services covered under the partial hospitalization benefit in a hospital or Critical Access Hospital (CAH) outpatient setting.

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 HCPCS code for this benefit. This reporting assures that only those partial hospitalization services covered under §§1861ff. of the Act are paid by the Medicare program.

Hosptial outpatient departments bill for partial hospitalization services on Form HCFA-1450 (or electronic equivalent) under bill type 13X and CAHs under bill type 85X. Follow billing procedures in §460 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 of Form HCFA-1450 to indicate the claim is for partial hospitalization services.

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

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

918	Psychiatric Testing	96100, 96115, or 96117
942	Education Training	***G0177

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

*The definition of code G0129 is as follows:

"Occupational therapy requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization 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, (PAs)), bill the Medicare Part B carrier directly for the professional services furnished to your partial hospitalization patients. Hospitals and CAHs can also serve as billing agents for these professionals by billing the Part B carrier on their behalf 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 paid as partial hospitalization services.

o Physician services that meet the criteria of 42 CFR 415.102, for payment on a fee schedule basis;

o PA services, as defined in §1861(s)(2)(K)(i) of the Act;

o Nurse practitioner and clinical nurse specialist services, as defined in §1861(s)(2)(K)(ii) of the Act; and

o 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. You must bill your intermediary for such nonphysician practitioner services as partial hospitalization services. Payment is made to you for these services.

PA services can be billed only 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 your hospital or CAH, the physician and not you is responsible for billing the carrier on the HCFA-1500 for the services of the PA.

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 your intermediary as partial hospitalization services.

D. Reporting of Service Units.--Visits should no longer be reported as units by hospital outpatient departments. Instead, hospitals 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 the following 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 provider 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 time frame (either minutes, hours or days), do not bill for sessions of less than 45 minutes.

Your intermediary will 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 Form-1450), report as follows:

FL 42	FL44	FL45	FL46	FL47
915	90849	05-05-98	1	$ 80.00
915	90849	05-29-98	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~

Your intermediary will RTP hospital claims if a line item date of service is not entered for each HCPCS code reported, or if the line item dates of service reported fall 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, your intermediary makes payment to you on a reasonable cost basis until August 1, 2000 for partial hospitalization services. The Part B deductible and coinsurance apply. During the year, your intermediary will make payment at an interim rate based on a percentage of your billed charges. At the end of the year, you will be paid the reasonable costs incurred in furnishing partial hospitalization services, based upon the Medicare cost report you file with your intermediary. 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, payment is made 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 beginning and ending time.

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

The Part B deductible, if any, and coinsurance apply.

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

Payment may be made for covered diagnostic and therapeutic services furnished by CSWs in a hospital outpatient setting.

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 services limitation in §1833(c) 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.

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 you bill the carrier for the services on Form HCFA-1500 (or electronic equivalent). These services are not billed to your intermediary.

2. Partial Hospitalization Services--CSW services furnished under the partial hospitalization program are also bundled for hospital and CAHs. However, bill your intermediary for these services. Payment is made on a reasonable cost basis.

(See §452 for an explanation.)

454. MAMMOGRAPHY QUALITY STANDARDS ACT (MQSA)

A. Background.--The MQSA requires the Secretary to ensure that all facilities that provide mammography services meet national quality standards. Effective October 1, 1994, all facilities providing screening and diagnostic mammography services (except VA facilities) must have a certificate issued by the FDA to continue to operate. On September 30, 1994, HCFA stopped conducting surveys of screening mammography facilities. The responsibility for collecting certificate fees and surveying mammography facilities (screening and diagnostic) was transferred to the FDA, Center for Devices and Radiological Health.

B. General.--Your intermediary will pay diagnostic and screening mammography services for claims submitted by you only if you have been issued an MQSA certificate by FDA. Your intermediary is responsible for determining that you have a certificate prior to payment. In addition, it is responsible for ensuring that payment is not made in situations where your certificate has expired, or it has been suspended or revoked or you have been issued a written notification by the FDA stating that you must cease conducting mammography examinations because you are not in compliance with certain critical FDA certification requirements.

C. Under Arrangements.--When you obtain mammography services for your patients under arrangements with another facility, you must ensure that the facility performing the services has been issued a MQSA certificate from the FDA.

D. Denied Services.--When your intermediary determines the facility that performed the mammography service has not been issued a certificate by FDA, or the certificate is suspended or revoked, your claim will be denied utilizing the denial language in §451.G, related to certified facilities.

455. OUTPATIENT OBSERVATION SERVICES

A. 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. Services exceeding 48 hours will be denied. (See §230.6.)

If you believe that exceptional circumstances in a particular case justify approval of additional time in outpatient observation status, you may request an exception to the denial of services from your intermediary. See §230.6D for procedures for requesting an exception.

Bill for outpatient observation services using the following revenue code.

Revenue Code	Description
762	Observation Services

For observation services, report the number of hours in the units field. Begin counting when the patient is placed in the observation bed, and round to the nearest hour. If necessary, verify the time in the nurses' notes. For example, a patient who was placed in an observation bed at 3:03 p.m. according to the nurse's 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 §230.6E for non-covered services

If you have provided hours of observation for non-covered services, and have given proper notice to the beneficiary, show only covered observation services. If you have provided more than 48 hours of observation, but think that the additional hours qualify for coverage, show all hours of service you provided in the units field. The intermediary will 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.