



Medicare Critical Access Hospital Version

KEY CONCEPTS OUTLINE

Module 4: Medicare Claims Submission Fundamentals and Billing Issues

I. The UB-04 Form/837 I Electronic Format

A. The UB-04/837I format is used by Medicare for “provider” claims.

1. Handout 8 is a copy of the UB-04 claim form and examples of common claims billed by CAHs.

B. CMS has instructed providers to obtain code descriptions from the National Uniform Billing Committee (NUBC) or from the local MAC. <Medicare Claims Processing Manual Transmittal 1973>

1. The *Official UB-04 Data Specifications Manual* contains the official code descriptions for fields on the UB-04, as well as the meeting minutes of the NUBC committee. It can be obtained by subscribing to the current version of the manual on the NUBC website at www.nubc.org.

- a. The *Official UB-04 Data Specifications Manual* is released on July 1st of every year.

The Medicare Claims Processing Manual, Chapter 25 formerly contained the instructions and code descriptions for the fields on the UB-04.

2. CMS continues to communicate specific code implementation direction via change requests (i.e., transmittals). <Medicare Claims Processing Manual Transmittal 1973>

II. Key UB-04 Fields Applicable to CAHs

A. Billing Provider Name, Address and Telephone Number (FL 01)

1. Identifies the street address or physical location where the service was rendered, including the 9-digit zip code. <See Workgroup for Electronic Data Interchange (WEDI) Frequently Asked Questions, 5010 837 Billing Provider

Address, April 28, 2011; *Medicare Claims Processing Manual*, Chapter 1 § 170.1.1; NUBC August 7-8, 2007 Meeting Minutes, Issue 8, page 962>

- a. The 9-digit zip code reported in this field is used to determine the applicable payment locality where used (e.g. the Medicare Physician Fee Schedule). <*Medicare Claims Processing Manual*, Chapter 1 § 170.1.1>
- b. CMS developed "Systemic Validation Edits for OPPS Providers with Multiple Service Locations" to RTP a claim if the service address does not match an address on the 855A enrollment form submitted by the hospital, however, a CMS representative has indicated the edits are not active. <*Medicare One Time Notice Transmittal 1704*; NUBC Committee Meeting Minutes, April 4-5, 2017>
 - i. CMS has conducted 3 rounds of testing the service address edits and has postponed implementation until further notice due to the Covid-19 pandemic. <*MLN Matters SE19007*>
 - ii. Services reported with Condition Code A7 (hospital service provided in a mobile facility or portable unit) bypass the service address matching edits. <*Medicare One Time Notification Transmittal 2394*>

2. Services Rendered at More Than One Location

- a. If any service on the claim was rendered at the main provider address, only the main provider address is reported in UB04 FL01 (paper claim) and the 837I billing provider loop 2010AA (electronic claim). The provider-based department (PBD) address is not reported in the 837I service facility address loop 2310E (electronic claim). <*MLN Matters SE18002, SE18023*>
- b. If no services on the claim were rendered at the main provider address, but any service was rendered at another campus address of a multi-campus hospital, the campus address is reported in UB04 FL01 (paper claim) and the 837I service facility address loop 2310E (electronic claim). The PBD address is not reported. <*MLN Matters SE18002, SE18023*>
- c. If all services were provided at one PBD location, the PBD address is reported in UB04 FL01 (paper claim) and the 837I service facility address loop 2310E (electronic claim). <*MLN Matters SE18002, SE18023*>
- d. If services are provided at more than one PBD location, the address of the PBD that provided the first registered encounter reported on the claim is reported in UB04 FL01 (paper claim) and the 837I service facility address loop 2310E (electronic claim). <*MLN Matters SE18002, SE18023*>

B. Bill Type (FL 04)

1. The most common bill types used by CAHs include:
 - a. Inpatient Part A – 011X;
 - b. Inpatient Part B – 012X;
 - c. Non-patient diagnostic laboratory – 014X;
 - d. Swing bed in a CAH – 018X; and
 - e. Outpatient Critical Access Hospital – 085X.
2. The last digit of the bill type, often represented by the variable X in CMS policies, is filled in with a frequency code (e.g., 1 for “admit through discharge” or 7 for an “adjustment claim”).

C. Statement Covers Period (From-Through) (FL 06)

1. Indicates the dates of service included on the claim, with the “from” date being the earliest date of service on the claim. <MLN Matters Article SE1117>

D. Admission/Start of Care Date (FL 12)

1. Required on inpatient claims to indicate the admission date of the patient.
 - a. The date of inpatient admission is the date of the written doctor’s order for inpatient care. <42 C.F.R. 412.3, Medicare Claims Processing Manual, Chapter 3 § 40.2.2 K>
 - i. If the patient dies or is discharged prior to being assigned and/or occupying a room, the patient is considered an inpatient on the date of the admission order and the hospital may charge for room and board. <Medicare Claims Processing Manual, Chapter 3 § 40.2.2 K>

Example: A patient is seen in the ED on Monday evening. The physician writes an inpatient admission order at 10:00 p.m. on Monday. The patient remains in the ED until 2:30 a.m. on Tuesday, at which time the patient is transported to an inpatient bed. The date of admission is Monday.

2. The admission date need not match the statement “from” date in FL 6 and may be after the “from” date, if appropriate. <MLN Matters Article SE1117>

E. Patient Discharge Status (FL 17)

1. Indicates the patient status (i.e., discharged, transferred, etc.) as of the “through” date of the billing period.

Tip: CMS published Special Edition MLN Matters Article SE1411 to clarify the use of Patient Discharge Status codes.

- a. Patient status code 66 indicates a patient was discharged or transferred to a CAH for inpatient care.
 - i. A patient who is in the emergency department or observation and is admitted to a CAH, should use patient status code 66 on the outpatient claim.
- b. Patient status code 61 indicates a patient was discharged to a SNF level of care in a CAH’s approved swing bed.

F. Condition Codes (FLs 18-28)

1. Used to communicate various types of claim/beneficiary specific information to the MAC.
 - a. A CAH must report an informational only claim (Condition Code 04) to their MAC for Part C (Medicare Advantage Plan) days for the purposes of calculating the electronic health record (EHR) incentive payments for inpatient services. < *Medicare Claims Processing Manual*, Chapter 3, § 200.2 >

G. Occurrence Codes (FLs 31-34)

1. Used to communicate the occurrence of an event (and the date of the event) to the MAC (e.g., Occurrence Code 32 is used to indicate the date a patient was given an ABN).

H. Occurrence Span Codes (FLs 35-36)

1. Used to communicate the beginning and ending dates for an event (e.g., Occurrence Span Code 72 is used to indicate contiguous outpatient services that precede a short inpatient admission (0-1 days)).

I. Value Codes (FLs 39-41)

1. Used to communicate a dollar amount, unit amount or other similar information required for some types of claims (e.g., Value Code 48 is used to indicate the most recent hemoglobin reading to verify coverage of Epoetin).

J. Revenue Codes (FL 42)

1. Indicates the revenue center for each charge included on the bill.
 - a. Used to capture charges by revenue center for cost/charge-based payment purposes and for cost report reconciliation.
2. If CMS has not provided explicit instructions, hospitals should “report their charges under the revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report.” <Medicare Claims Processing Manual, Chapter 4 § 20.5>
 - a. A crosswalk of revenue code to cost center is posted on the CMS website.

Link: Revenue Code to Cost Center Crosswalk under Medicare-Related Sites – Hospital

3. Hospitals should choose the most precise revenue code or subcode when applicable rather than the “0” (General) or “9” (Other) categories. <Medicare Claims Processing Manual Transmittal 1599, 1. Revenue Code Reporting>
4. Revenue codes are validated (i.e., checked for effective date, deactivation,) based on the claims processing receipt date rather than the claim from and through date or line item date of service. <IOCE Specifications, Section 4.3>

Case Study 1

NOTE: Selected pages from a prior version of Medicare Claims Processing Manual Chapter 25 are included in the materials behind the outline for reference in class only and should not be used for billing and coding purposes.

Facts: A patient comes to the emergency room and has a minor procedure using sterile supplies. Using the Medicare Claims Processing Manual excerpts that follow the outline:

- What revenue code(s) would the emergency department visit, minor procedure and sterile supplies be reported under?

Modified Facts: A patient comes to a provider-based clinic and has a minor procedure using sterile supplies. Using the Medicare Claims Processing Manual excerpts that follow the outline:

- What revenue code would the clinic visit, minor procedure and sterile supplies be reported under?

K. HCPCS Codes/Rates (FL 44)

1. On inpatient claims, can be used to report the accommodation rate.
2. On outpatient claims, used to report HCPCS codes (i.e., CPT and HCPCS Level II codes).
 - a. Handout 9 is a diagram of coding systems for reference.
 - b. Reporting HCPCS codes is generally required for hospitals paid under the OPFS.
 - i. A CAH is only required to report HCPCS codes for Part B services not paid to them on a reasonable cost basis (e.g., screening mammography and bone mass measurements) and when reimbursed under Method II for professional fees. < *Medicare Claims Processing Manual*, Chapter 4, § 20.1>
 - ii. However, some revenue codes require reporting HCPCS codes for outpatient services (e.g., surgery, radiology, laboratory, and preventive services).
 - c. Modifiers are two-digit codes, consisting of letters and numbers, that are reported after HCPCS codes to provide more information about the code. < *Medicare Claims Processing Manual*, Chapter 4 § 20.6>
 - i. Modifiers may bypass code edits, trigger payment modifications, or be informational.
 - ii. Modifiers should only be appended to HCPCS codes if the clinical circumstances justify the use of the modifier and must be used if the payment or informational conditions for use of the modifier have been met. < *NCCI Policy Manual*, Chapter 1 (E)>
 - iii. Modifiers that impact payment should be appended first, followed by descriptive or informational modifiers. < *Billing 340B Modifiers under the Hospital Outpatient Prospective Payment System (OPPS)*, Frequently Asked Questions, Q14>
 - a) If conflicting modifiers are reported together on the same HCPCS code line, edit 102 of the Integrated Outpatient Code Editor (IOCE) will return the claim to the provider. < See Handout 11 *IOCE Specifications*, Section 6.2, Edit 102>
 - b) The list of modifier pairs that trigger edit 102 are available in the IOCE Quarterly Data File, Data Table Reports folder,

"MAP_MODIFIER_CONFLICT" available on the IOCE homepage.
The current list is included in the materials behind the outline.

- iv. MACs are required to accept and process up to five modifiers.
< *Medicare Claims Processing Manual*, Chapter 23 § 20.3>

L. Principal Diagnosis Code (FL 67)

1. For inpatient claims, used to report the "principal" diagnosis.
 - a. The principal diagnosis is "the condition established after study to be chiefly responsible for [the] admission." < *Official ICD-10-CM Guidelines For Coding and Reporting*, Section II>
2. For outpatient claims, used to report the "first-listed" diagnosis.
 - a. The first-listed diagnosis is the "diagnosis, condition, problem, or other reason for [the] encounter/visit shown in the medical record to be chiefly responsible for the services provided." < *Official ICD-10-CM Guidelines for Coding and Reporting*, IV(G)>
 - i. The "principal diagnosis" concept does not apply to outpatient services. < *Official ICD-10-CM Guidelines For Coding and Reporting*, Section IV(A)>

M. Other Diagnosis Codes (FLs 67A-Q)

1. Used to report additional diagnosis codes applicable to a visit or admission.
2. Medicare claims processing systems accept 24 additional diagnosis codes in addition to the principal diagnosis. < *Integrated Outpatient Code Editor Specifications*, Section 3.1.1; *Medicare Claims Processing Manual*, Chapter 3 § 20.2.1 C>

N. Present on Admission (POA) Indicator (FLs 67, 67A-Q, and 72 supplemental locator)

1. The POA is used to indicate whether a condition was present upon inpatient admission. < *Official ICD-10-CM Guidelines for Coding and Reporting*, Appendix I Present on Admission Reporting Guidelines, "General Reporting Requirements">
2. Reporting of the POA indicator is required for inpatient claims submitted by hospitals paid under the Inpatient Prospective Payment System (IPPS) and Maryland Hospitals exempt from IPPS. < *Medicare Claims Processing Manual Transmittal 1240*; 78 Fed. Reg. 50524-25>

- a. Critical Access Hospitals, Long Term Care Hospitals, Inpatient Rehabilitation Facilities, Inpatient Psychiatric Facilities, cancer hospitals, and children's hospitals are exempt from POA reporting requirements. *<One Time Notification Transmittal 354>*
 - i. When reported by a CAH for internal or state reporting requirements, the POA indicator is assigned based on whether the condition was present when the inpatient order was written. *<Official ICD-10-CM Guidelines, Appendix I, "Assigning the POA Indicator"; Medicare Claims Processing Manual Transmittal 1240>*
 - ii. Conditions that develop in the emergency department, observation, outpatient surgery or other outpatient setting prior to an inpatient admission order are considered present on admission. *<Official ICD-10-CM Guidelines, Appendix I, "Assigning the POA Indicator"; Medicare Claims Processing Manual Transmittal 1240>*
 - iii. The POA indicator may be assigned based on the documentation of any physician or "qualified healthcare practitioner" legally accountable for establishing the patient's diagnosis, regardless if the provider is the admitting physician. *<Official ICD-10-CM Guidelines, Appendix I, "Assigning the POA Indicator", Medicare Claims Processing Manual Transmittal 1240>*

O. Admitting Diagnosis (FL 69)

1. For inpatient claims, the "condition identified by the physician at the time of the patient's admission requiring hospitalization" must be reported in this field for all claims subject to review by the Quality Improvement Organization (QIO).

P. Patient's Reason for Visit (FLs 70a-c)

1. For outpatient claims, the patient's reason for the visit must be reported for claims with type of bill 013X (hospital outpatient) and 085X (critical access hospital outpatient) if:
 - a. The Priority (Type) of Admission or Visit is 1 (emergency), 2 (urgent), or 5 (trauma); and
 - b. Revenue codes 045X (emergency department), 0516 (urgent care clinic), or 0762 (observation hours) are reported.

2. Although signs and symptoms that are integral or related to the definitive diagnosis are not reported as additional diagnosis codes, they may be reported in FLS70a-c. <MLN Matters Article 3437; Coding Clinic for ICD-9-CM, Third Quarter 2003>

Tip: The Reason for Visit may be reported on any claim type at the discretion of the provider if the information substantiates the medical necessity of the services rendered.

Case Study 2

Facts: A patient presents to the emergency department with chest pain (R07.9). Following testing, including an EKG and cardiac enzymes, the patient is diagnosed with a recurrence of Gastroesophageal Reflux Disease (GERD) (K21.0).

- To support the medical necessity of all services that were provided, what diagnosis or diagnoses codes should be reported on the claim?
- Other than the first listed diagnosis code, what additional field(s) would be required for an ER visit?

Q. Principal Procedure (FL 74) and Other Procedures (FLs 74A-E)

1. Required only for inpatient claims to report ICD-10-PCS procedure codes.
 - a. The principal procedure is "the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of a complication".
 - b. Medicare inpatient claims processing systems process 24 procedures in addition to the principal procedure, for a total of 25 procedure codes. <Medicare Claims Processing Manual, Chapter 3 § 20.2.1>

III. Time Limitations on Filing Claims

- A. Medicare fee for service claims must be filed within one calendar year of the date of service. <One Time Notification Transmittal 697>
 1. For institutional claims, the "through" date on the claim will be used to determine the date of service for claims filing timeliness. <One Time Notification Transmittal 734; Medicare Claims Processing Manual, Chapter 1 § 70.1>

2. There are four situations in which the provider can receive an exception to the time limit for filing claims. <Medicare Claims Processing Manual, Chapter 1 § 70.7>
 - a. Error or misrepresentation by an employee, contractor or agent of CMS performing Medicare functions and acting within their scope of authority. <Medicare Claims Processing Manual, Chapter 1 § 70.7.1>
 - b. Retroactive entitlement to Medicare after the time of service. <Medicare Claims Processing Manual, Chapter 1 § 70.7.2>
 - c. Retroactive entitlement to Medicare after the time of service where a state Medicaid agency recouped Medicaid payment for the service more than six months after the date of service. <Medicare Claims Processing Manual, Chapter 1 § 70.7.3>
 - d. Retroactive disenrollment from a Medicare Advantage Plan or Program of All-Inclusive Care for the Elderly (PACE) provider organization after the time of service where the plan or organization recouped their payment more than six months after the date of service. <Medicare Claims Processing Manual, Chapter 1 § 70.7.4>

IV. Outpatient Repetitive Services

A. What is a "Repetitive Service"

1. CMS defines repetitive services based on the revenue codes used to bill for the services. <See Medicare Claims Processing Manual, Chapter 1 § 50.2.2>
 - a. The revenue codes that define repetitive services are listed in the Medicare Claims Processing Manual, Chapter 1 § 50.2.2, included in the materials behind the outline.

B. Billing for Repetitive Services

1. Separate monthly claim
 - a. Repetitive services must be billed monthly on a separate claim. <See Medicare Claims Processing Manual, Chapter 1 § 50.2.2; Medicare Claims Processing Manual, Chapter 4 § 170>
2. Services "in support" of repetitive services

- a. Any items or services needed in the performance of the repetitive service should be reported on the same claim as the repetitive service, regardless of the revenue code those items or services are billed under. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.2.2>

Examples of supporting items or services include disposable supplies, drugs or equipment used to furnish the repetitive service

- 3. Other services provided during the same month as repetitive services
 - a. Other services, except those provided in support of the repetitive services, may not be billed on the same claim as the repetitive services. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.2.2>
 - i. Occurrence Span Code (OSC) 74
 - a) When an inpatient stay or non-repetitive outpatient hospital services paid under OPPOS occurs during the same month as repetitive services, OSC 74 and the dates encompassing the inpatient stay or outpatient service must be reported on the repetitive service bill. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.2.2>
 - b) Presumably, reporting OSC 74 also applies to a CAH to prevent triggering duplicate claim edits that have been implemented by Medicare claims processing systems.

Case Study 3

Facts: A patient received cardiac rehab services on May 1, 5, 7 and 9. The patient was then admitted as an inpatient to the hospital on May 11-15 following a motor vehicle accident. The patient returned to cardiac rehab on May 19 and received cardiac rehab services on May 19, 21, 23, 26, 28 and 30.

- How should the cardiac rehab services be billed?

V. Outpatient Non-repetitive and Recurring Services

A. Non-Repetitive Services on Different Dates

- 1. Multiple non-repetitive services provided on different dates in the same month may be billed on the same claim or separate claims. CMS sometimes

refers to these services as “recurring services”. <Medicare Claims Processing Manual, Chapter 1 § 50.2.2>

B. Non-Repetitive Services on the Same Date

1. All services and supplies provided on the same day as a separately payable, non-repetitive outpatient service must be reported on the same claim. This will generally result in a single claim for all non-repetitive services provided on the same date of service. <Medicare Claims Processing Manual, Chapter 4 § 170>

a. Exception for multiple medical visits:

- i. A CAH may report multiple medical visits provided on the same date in the same revenue center on the same or separate claims. <Medicare Claims Processing Manual, Chapter 4 § 180.4>

CMS has provided the following examples of distinct and independent visits:

- A visit to the ER in the morning for a broken arm and in the evening for chest pain
- Two visits to the ER on the same day (one for broken arm and one for chest pain)

- ii. A CAH is not required to report condition code G0 to correctly process claims with multiple medical visits on the same date of service that are “distinct and constitute independent visits”, even if they occurred in the same revenue center. <IOCE Specifications, Section 5 – Processing Conditions that Apply to OPSPS Claims Only>
- iii. Modifier -27

- a) Modifier -27 - “Multiple Outpatient Hospital E/M Encounters on the Same Date”, is reported for “separate and distinct” medical visits provided on the same date. <Program Memorandum A-01-80>

Modifier -27 is an NCCI modifier that may be used to override edits for two visit codes reported on the same claim when the definition of “separate and distinct” is met.

VI. Billing Outpatient Services Separately from an Inpatient Admission

- A. CAHs are exempt from the 1- and 3-day preadmission payment window bundling provisions for outpatient services provided prior to an inpatient admission at a CAH. <See Medicare Claims Processing Manual, Chapter 3 §§ 30.1.1, 40.3>

1. Outpatient services provided by the CAH must be billed on a separate claim (TOB 085X) from the inpatient services (i.e., TOB 011X or TOB 012X).
 2. However, if a CAH is wholly owned or operated by a hospital paid under IPPS and is admitted to that IPPS hospital, either on the same day or within 3 days immediately prior to the admission, the outpatient services performed at the CAH may be subject to the payment window.
- B. Under cost-based reimbursement methodology, all CAH outpatient services provided on the same date as the CAH inpatient admission must be billed on a separate claim using the appropriate outpatient type of bill. <42 C.F.R. 413.70>
1. The Common Working File (CWF) and the shared system will bypass the CAH provider number when applying edits that compare outpatient and inpatient claims to apply the bundling provisions. <See *Medicare Claims Processing Manual*, Chapter 3 §§ 30.1.1, 40.3>
 2. The outpatient claim will be paid separately from the inpatient claim.

Case Study 4

Facts: A Medicare patient presents to the CAH's emergency department with severe abdominal pain and a high fever. The ER physician determines the patient has a ruptured appendix and the patient is taken into emergency surgery. During the recovery phase, the surgeon writes an order for inpatient admission for a 3-day course of IV antibiotics, hydration, and pain medication.

- Would it be permissible to roll all the outpatient charges into the inpatient claim and bill the entire stay on TOB 0111?

VII. Billing Outpatient Non-Covered Items or Services

- A. Handout 10 is an overview of billing for outpatient non-covered services that are discussed in this section.
- B. An Effective ABN was Issued
 1. Bill to the MAC with Occurrence Code 32
 - a. When an ABN is provided, the claim for the items or services related to the ABN must be filed with an occurrence code 32. <*Medicare Claims Processing Manual*, Chapter 1 § 60.4.1>

- i. The occurrence date should be the date that the ABN was given to the beneficiary.
- 2. Bill as covered charges
 - a. Items or services for which an ABN was given should be billed as "covered charges." <Medicare Claims Processing Manual, Chapter 1 § 60.4.1>
- 3. Other covered or non-covered services billed on the same claim
 - a. If other covered or non-covered items or services are billed on the same claim, modifier –GA should be used to identify those items or services for which an ABN was given. <Medicare Claims Processing Manual, Chapter 1 § 60.4.1>
- 4. Collecting payment from the beneficiary after denial by the MAC
 - a. Where the MAC denies payment for services, for which an effective ABN was provided, payment for the services is collected from the Medicare beneficiary.
 - b. Medicare charge limits do not apply to services for which an effective ABN was given. <Medicare Claims Processing Manual, Chapter 30 § 50.12>
- C. An ABN was Required but Not Issued
 - 1. May bill on a "Fully Non-Covered Claim"
 - a. A "fully non-covered claim" is billed without indicators of liability or only provider liability indicators and is used to bill entirely non-covered services for which the hospital is liable. "Fully non-covered claims" are allowed but not required for hospital liable services. <Medicare Claims Processing Manual, Chapter 1 § 60.1.3.1>
 - b. Indicators of liability on "Fully Non-Covered Claims"
 - i. No indicators of liability at the claim or line level (i.e., no condition code 21 which is a claim level indicator of beneficiary liability), or
 - ii. All indicators of liability at the claim or line level must indicate that the hospital, and not the beneficiary, is liable (i.e., no modifier –GY which is a line level indicator of beneficiary liability). <Medicare Claims Processing Manual, Chapter 1 § 60.1.3.1>
 - 2. Bill as non-covered charges

- a. Charges should be billed as non-covered. < *Medicare Claims Processing Manual*, Chapter 1 § 60.1.3.1>
- 3. Other covered or non-covered services billed on the same claim
 - a. Modifier -GZ indicates a line item expected to be denied as not reasonable and necessary and no ABN was given. Modifier -GZ triggers automatic denial and hospital liability. < *Medicare Claims Processing Manual*, Chapter 1 § 60.1.3.1 and 60.4.2, Table 8; *Medicare Program Integrity Manual*, Chapter 3 § 3.3.1.1 (G)>

D. At Request of the Beneficiary (Demand Bill)

- 1. Bill to the MAC with Condition Code 20
 - a. Where the hospital expects a service to be non-covered due to a categorical or technical denial, but the beneficiary requests that the claim be submitted to Medicare for a determination anyway, the claim should be submitted with condition code 20. This has traditionally been referred to as a "demand bill." < *Medicare Claims Processing Manual*, Chapter 1 § 60.3.1>
 - i. The beneficiary has the right to have any service provided to them billed to Medicare for an official payment decision that they may appeal if they choose. < *Medicare Claims Processing Manual*, Chapter 1 § 60.3.1>

Caution: The UB04 Manual states that condition code is limited to home health and inpatient SNF claims. On February 19, 2010, CMS issued Medicare Claims Processing Manual Transmittal 1921 stating that condition code 20 may be used on any claim, when appropriate.

- 2. Bill as non-covered charges
 - a. The charges for which coverage is "in dispute" must be submitted as non-covered charges. < *Medicare Claims Processing Manual*, Chapter 1 § 60.3.1>
- 3. Other covered services billed on same claim
 - a. Covered services may, but are not required, to appear on the same claim as non-covered services billed with condition code 20. < *Medicare Claims Processing Manual*, Chapter 1 § 60.3.2>
- 4. Other non-covered services billed on a separate claim

- a. Other non-covered services (i.e., billed with occurrence code 32 or condition code 21) must be submitted on a separate claim from demand bill services. Claims with condition code 20 are exempt from same day billing rules. <Medicare Claims Processing Manual, Chapter 1 § 60.3.2>
- 5. Voluntary ABN issued (Limitation on Liability does not apply)
 - a. Modifier –GX may be used to identify items subject to categorical or technical denial for which an ABN was given anyway (i.e., voluntary ABN). <Medicare Claims Processing Manual Transmittal 1921 B>
 - i. Modifier –GX may be reported with other liability modifiers, including modifier –GY. <Medicare Claims Processing Manual Transmittal 1921>
- E. Billing for Denial Notices for Secondary Payers (No-pay Bill)
 - 1. Bill to the MAC with Condition Code 21
 - a. Where services are clearly non-covered (i.e., categorical or technical denials) but a claim is being submitted to Medicare for purposes of obtaining a denial notice that can be forwarded to secondary payers, the claim should be submitted with condition code 21. These types of claims are sometimes referred to as “no-pay bills.” <Medicare Claims Processing Manual, Chapter 1 § 60.1.3>
 - 2. Bill as non-covered Charges
 - a. All charges on no-pay bills must be submitted as non-covered charges. <Medicare Claims Processing Manual, Chapter 1 § 60.1.3>
 - 3. Other covered and non-covered services billed on same claim
 - a. Non-covered services being billed for a denial must be submitted with modifier –GY, rather than condition code 21, when they appear on the same claim as covered and other non-covered services. <Medicare Claims Processing Manual, Chapter 1 § 60.1.2 (B)>
 - i. Modifier –GY indicates a line item that is statutorily excluded or does not meet the definition of any Medicare benefit (i.e., categorical and technical denial). Modifier –GY triggers beneficiary liability. <Medicare Claims Processing Manual, Chapter 1 § 60.4.2, Table 8>

CASE STUDIES WITH ANALYSIS

Case Study 1

NOTE: *Selected pages from a prior version of Medicare Claims Processing Manual Chapter 25 are included in the materials behind the outline for reference in class only and should not be used for billing and coding purposes.*

Facts: A patient comes to the emergency room and has a minor procedure using sterile supplies. Using the Medicare Claims Processing Manual excerpts that follow the outline:

- What revenue code(s) would the emergency department visit, minor procedure and sterile supplies be reported under?

Analysis: The emergency department visit and minor procedure would be reported in the Emergency Room revenue code 0450 and the sterile supplies would be reported in the Medical/Surgical Supplies revenue code, subcategory Sterile Supply, 0272.

Modified Facts: A patient comes to a provider-based clinic and has a minor procedure using sterile supplies. Using the Medicare Claims Processing Manual excerpts that follow the outline:

- What revenue code would the clinic visit, minor procedure and sterile supplies be reported under?

Analysis: The clinic visit and minor procedure would be reported in the Clinic revenue code 0510 and the sterile supplies would be reported in the Medical/Surgical Supplies revenue code, subcategory Sterile Supply 0272.

Case Study 2

Facts: A patient presents to the emergency department with chest pain (R07.9). Following testing, including an EKG and cardiac enzymes, the patient is diagnosed with a recurrence of Gastroesophageal Reflux Disease (GERD) (K21.0).

- To support the medical necessity of all services that were provided, what diagnosis or diagnoses codes should be reported on the claim?
- Other than the first listed diagnosis code, what additional field(s) would be required for an ER visit?

Analysis: The GERD (K21.0) should be reported in FL 67 Principal/First Listed Diagnosis Code. The chest pain (R07.9) must also be reported in FL 70 Patient Reason for Visit because this was an emergency visit and a Patient Reason for Visit must be reported on emergency department visits. The chest pain further provides the justification for the cardiac related tests, even though the final diagnosis for the patient was GERD.

Case Study 3

Facts: A patient received cardiac rehab services on May 1, 5, 7 and 9. The patient was then admitted as an inpatient to the hospital on May 11-15 following a motor vehicle accident. The patient returned to cardiac rehab on May 19 and received cardiac rehab services on May 19, 21, 23, 26, 28 and 30.

- How should the cardiac rehab services be billed?

Analysis: Cardiac rehabilitation is categorized as a repetitive service and must be billed on a separate monthly claim. When an inpatient stay occurs during the same month as a repetitive service, OSC 74 and the dates of the inpatient stay should be reported on the repetitive service outpatient claim to prevent a duplicate claim edit.

Version 02/27/2023
Check for Updates

Case Study 4

Facts: A Medicare patient presents to the CAH's emergency department with severe abdominal pain and a high fever. The ER physician determines the patient has a ruptured appendix and the patient is taken into emergency surgery. During the recovery phase, the surgeon writes an order for inpatient admission for a 3-day course of IV antibiotics, hydration, and pain medication.

- Would it be permissible to roll all the outpatient charges into the inpatient claim and bill the entire stay on TOB 0111?

Analysis: No. A CAH must report all outpatient charges on one claim using TOB 0851 and all inpatient charges on TOB 0111. CAHs are exempt from the 1- and 3-day preadmission payment window bundling provisions for outpatient services provided prior to an inpatient admission at a CAH. Under cost-based reimbursement methodology, all outpatient services provided on the same date as the inpatient admission must be billed on a separate claim using the appropriate outpatient type of bill. The inpatient admission did not begin until after the surgery when the order was written.

Note: these sections have been updated by CMS to remove code descriptions. ^{4 - 21}
Selected pages from the last version with code descriptions are included for
reference during class only. Current code descriptions may be obtained from NUBC.

Medicare Claims Processing Manual

Chapter 25 - Completing and Processing the Form CMS-1450 Data Set

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(Rev. 1932, 03-17-10)
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80 - Reserved

Code	Title	Definition
Y3	Part B Coinsurance	This is the amount of Part B coinsurance applied by the intermediary to this claim. For demonstration claims this will be a fixed copayment unique to each hospital and DRG (or DRG/procedure group).
Y4	Conventional Provider Payment Amount for Non-Demonstration Claims	This is the amount Medicare would have reimbursed the provider for Part A services if there had been no demonstration. This should include the prospective DRG payment (both capital as well as operational) as well as any outlier payment, which would be applicable. It does not include any pass through amounts such as that for direct medical education nor interim payments for operating IME and DSH.
Y5-ZZ		Reserved for assignment by the NUBC

75.4 - Form Locator 42

(Rev. 1915; Issued: 02-05-10; Effective Date/Implementation Date: 04-14-10)



FL 42 - Revenue Code

Required. The provider enters the appropriate revenue codes from the following list to identify specific accommodation and/or ancillary charges. It must enter the appropriate numeric revenue code on the adjacent line in FL 42 to explain each charge in FL 47. Additionally, there is no fixed “Total” line in the charge area. The provider must enter revenue code 0001 instead in FL 42. Thus, the adjacent charges entry in FL 47 is the sum of charges billed. This is the same line on which non-covered charges, in FL 48, if any, are summed. To assist in bill review, the provider must list revenue codes in ascending numeric sequence and not repeat on the same bill to the extent possible. To limit the number of line items on each bill, it should sum revenue codes at the “zero” level to the extent possible.

The biller must provide detail level coding for the following revenue code series:

0290s - Rental/purchase of DME

0304 - Renal dialysis/laboratory

0330s - Radiology therapeutic

0367 - Kidney transplant

025X Pharmacy (Also see 063X, an extension of 025X)

Code indicates charges for medication produced, manufactured, packaged, controlled, assayed, dispensed, and distributed under the direction of a licensed pharmacist.

Rationale: Additional breakdowns are provided for items that individual hospitals may wish to identify because of internal or third party payer requirements. Sub code 4 is for hospitals that do not bill drugs used for other diagnostic services as part of the charge for the diagnostic service. Sub code 5 is for hospitals that do not bill drugs used for radiology under radiology revenue codes as part of the radiology procedure charge.

Subcategory	Standard Abbreviations
0 – General Classification	PHARMACY
1 – Generic Drugs	DRUGS/GENERIC
2 - Non-generic Drugs	DRUGS/NONGENERIC
3 - Take Home Drugs	DRUGS/TAKEHOME
4 - Drugs Incident to Other Diagnostic Services	DRUGS/INCIDENT ODX
5 - Drugs Incident to Radiology	DRUGS/INCIDENT RAD
6 - Experimental Drugs	DRUGS/EXPERIMT
7 - Nonprescription	DRUGS/NONPSCRPT
8 - IV Solutions	IV SOLUTIONS
9 - Other DRUGS/OTHER	DRUGS/OTHER

026X IV Therapy

Code indicates the administration of intravenous solution by specially trained personnel to individuals requiring such treatment.

Rationale: For outpatient home intravenous drug therapy equipment, which is part of the basic per diem fee schedule, providers must identify the actual cost for each type of pump for updating of the per diem rate.

Subcategory	Standard Abbreviations
0 – General Classification	IV THERAPY

1 – Infusion Pump	IV THER/INFSN PUMP
2 - IV Therapy/Pharmacy Services	IV THER/PHARM/SVC
3 - IV Therapy/Drug/Supply/Delivery	IV THER/DRUG/SUPPLY DELV
4 - IV Therapy/Supplies	IV THER/SUPPLIES
9 - Other IV Therapy	IV THERAPY/OTHER

027X Medical/Surgical Supplies (Also see 062X, an extension of 027X)

Code indicates charges for supply items required for patient care.

Rationale: Additional breakdowns are provided for items that hospitals may wish to identify because of internal or third party payer requirements.

Subcategory	Standard Abbreviations
0 – General Classification	MED-SUR SUPPLIES
1 – Non--sterile Supply	NONSTER SUPPLY
2 - Sterile Supply	STERILE SUPPLY
3 - Take Home Supplies	TAKEHOME SUPPLY
4 - Prosthetic/Orthotic Devices	PROSTH/ORTH DEV
5 - Pace maker	PACE MAKER
6 - Intraocular Lens	INTR OC LENS
7 – Oxygen - Take Home	02/TAKEHOME
8 - Other Implants	SUPPLY/IMPLANTS
9 - Other Supplies/Devices	SUPPLY/OTHER

028X Oncology

Code indicates charges for the treatment of tumors and related diseases.

Subcategory	Standard Abbreviations
0 – General Classification	ONCOLOGY

Services provided by a qualified occupational therapy practitioner for therapeutic interventions to improve, sustain, or restore an individual's level of function in performance of activities of daily living and work, including: therapeutic activities, therapeutic exercises; sensorimotor processing; psychosocial skills training; cognitive retraining; fabrication and application of orthotic devices; and training in the use of orthotic and prosthetic devices; adaptation of environments; and application of physical agent modalities.

Subcategory	Standard Abbreviations
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0 – General Classification	OCCUPATION THER
1 - Visit Charge	OCCUP THERP/VISIT
2 - Hourly Charge	OCCUP THERP/HOUR
3 - Group Rate	OCCUP THERP/GROUP
4 - Evaluation or Re-evaluation	OCCUP THERP/EVAL
9 - Other Occupational Therapy (may include restorative therapy)	OTHER OCCUP THER

044X Speech Therapy

Charges for services provided to persons with impaired functional communications skills.

Subcategory	Standard Abbreviations
--------------------	-------------------------------

0 - General Classification	SPEECH PATHOL
1 - Visit Charge	SPEECH PATH/VISIT
2 - Hourly Charge	SPEECH PATH/HOUR
3 - Group Rate	SPEECH PATH/GROUP
4 - Evaluation or Re-evaluation	SPEECH PATH/EVAL
9 - Other Speech-Language Pathology	OTHER SPEECH PAT

045X Emergency Room

Charges for emergency treatment to those ill and injured persons who require immediate unscheduled medical or surgical care.

Rationale: Permits identification of particular items for payers. Under the provisions of the Emergency Medical Treatment and Active Labor Act (EMTALA), a hospital with an emergency department must provide, upon request and within the capabilities of the hospital, an appropriate medical screening examination and stabilizing treatment to any individual with an emergency medical condition and to any woman in active labor, regardless of the individual's eligibility for Medicare (Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985).

Subcategory	Standard Abbreviations
0 - General Classification	EMERG ROOM
1 - EMTALA Emergency Medical screening services	ER/EMTALA
2 - ER Beyond EMTALA Screening	ER/BEYOND EMTALA
6 - Urgent Care	URGENT CARE
9 - Other Emergency Room	OTHER EMER ROOM

NOTE: Observation or hold beds are not reported under this code. They are reported under revenue code 0762, "Observation Room."

Usage Notes

An "X" in the matrix below indicates an acceptable coding combination.

	0450 ^a	0451 ^b	0452 ^c	0456	0459
0450					
0451			X	X	X
0452		X			
0456		X			X
0459		X		X	

a. General Classification code 0450 should not be used in conjunction with any subcategory. The sum of codes 0451 and 0452 is equivalent to code 0450. Payers that do not require a breakdown should roll up codes 0451 and 0452 into code 0450.

b. Stand alone usage of code 0451 is acceptable when no services beyond an initial screening/assessment are rendered.

1 – Cardiac Cath Lab	CARDIAC CATH LAB
2 - Stress Test	STRESS TEST
3 - Echo cardiology	ECHOCARDIOLOGY
9 - Other Cardiology	OTHER CARDIOL

049X Ambulatory Surgical Care

Charges for ambulatory surgery not covered by any other category.

Subcategory	Standard Abbreviations
0 – General Classification	AMBUL SURG
9 - Other Ambulatory Surgical Care	OTHER AMBL SURG

NOTE: Observation or hold beds are not reported under this code. They are reported under revenue code 0762, “Observation Room.”

050X Outpatient Services

Outpatient charges for services rendered to an outpatient who is admitted as an inpatient before midnight of the day following the date of service. This revenue code is no longer used for Medicare.

Subcategory	Standard Abbreviations
0 – General Classification	OUTPATIENT SVS
9 - Other Outpatient Services	OUTPATIENT/OTHER

051X Clinic

Clinic (non-emergency/scheduled outpatient visit) charges for providing diagnostic, preventive, curative, rehabilitative, and education services to ambulatory patients.

Rationale: Provides a breakdown of some clinics that hospitals or third party payers may require.

Subcategory	Standard Abbreviations
0 – General Classification	CLINIC
1 – Chronic Pain Center	CHRONIC PAIN CL

2 - Dental Clinic	DENTAL CLINIC
3 - Psychiatric Clinic	PSYCH CLINIC
4 - OB-GYN Clinic	OB-GYN CLINIC
5 - Pediatric Clinic	PEDS CLINIC
6 - Urgent Care Clinic	URGENT CLINIC
7 - Family Practice Clinic	FAMILY CLINIC
9 - Other Clinic	OTHER CLINIC

052X Free-Standing Clinic

Rationale: Provides a breakdown of some clinics that hospitals or third party payers may require.

Subcategory

Standard Abbreviations

0 - General Classification	FREESTAND CLINIC
1 - Clinic visit by member to RHC/FQHC	RURAL/CLINIC
2 - Home visit by RHC/FQHC practitioner	RURAL/HOME
3 - Family Practice	FS FAMILY PRACT
4 - Visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF	FS/STD FAMILY CLINIC
5 - Visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility	RHC/FQHC/SNF/ NONCOVERED
6 - Urgent Care Clinic	FR/STD URGENT CLINIC
7 - RHC/FQHC Visiting Nurse Service(s) to a member's home when in a home health shortage area	RHC/FQHC/HOME/ VIS NURSE



5010 837 Billing Provider Address

FREQUENTLY ASKED QUESTIONS

April 28, 2011

This document addresses some Frequently Asked Questions about Billing Provider Address reporting requirements in the ASC X12 Version 005010 (5010) 837 claims transactions.

Background: In January 2009, the Centers for Medicare & Medicaid Services (CMS) issued a final rule requiring the replacement of the HIPAA-named ASC X12 Version 004010A1 (4010A1) transactions with version 005010 (5010). All HIPAA covered entities using the HIPAA-named transactions will be required to send and receive only the 5010 transactions as of the compliance date, January 1, 2012.

Overall, the address portion of the Pay-to loop (2010AB N3 and N4) in the 837 health care claim transactions did not change from version 4010A1 to 5010. The functionality of this loop is to allow the provider to report the address, when it is different from the Billing Provider Address, where they want their payment to be sent. The absence of a Pay-to Address indicates that payment is to be sent to the Billing Provider Address.

Specific questions have been raised about the reporting requirement changes for Billing Provider Address. The WEDI 5010 837 Subworkgroup (SWG) developed this paper in order to answer commonly asked questions about these changes.

The Billing Provider Address is the street address or physical location where the services were rendered. Note that for providers without direct interaction with the patient, the Billing Provider Address is still where the provider is rendering the service, e.g. mail-order pharmacy, where the prescription is filled. The street address includes a street name and number (e.g., 123 Main Street). The physical location may be a description of the location. (e.g., Mile Marker 3 Route 45; Intersection of Route 45 and Route 144). The term "street address" will be used throughout this document for simplicity, which includes physical location.

Note: The following responses apply to and are consistent with the data requirements in the following transactions:

- Health Care Claim: Dental (837), 005010X224A2
- Health Care Claim: Institutional (837), 005010X223A2
- Health Care Claim: Professional (837), 005010X222A1

The following questions are addressed in this document.

- **Can I report a PO Box address in the Billing Provider Address fields?**
- **I'm in a rural location and have a PO Box because there is no mail delivery. Shouldn't my Billing Provider Address be my mailing address?**
- **Do I have to use a 9-digit ZIP code?**
- **I'm in a rural location. How do I know what my "street address" is?**
- **I did not use my street address when I enrolled with my payers. Will this cause a problem?**
- **What is the best way for a provider to validate that they are ready for the 5010 Billing Provider Address changes?**
- **My current physical address does not match my physical address in the NPI database. Will this cause a problem?**

Question: *Can I report a PO Box address in the Billing Provider Address fields?*

Response: No. The Billing Provider Address reported in N3 must be a street address. PO Box, also called Post Office Box, lock box, and lock bin, addresses cannot be reported in the Billing Provider Address segment. If you use a PO Box address as the delivery location for payments, you can continue to use this approach and report the address in the Pay-to Address segment.

Question: *I'm in a rural location and have a PO Box because there is no mail delivery. Shouldn't my Billing Provider Address be my mailing address?*

Response: The Billing Provider Address is the street address where the services were provided, which may or may not be the mailing address. If the mailing address is a PO Box, it is reported in the Pay-to Address segment.

Question: *Do I have to use a 9-digit ZIP code in the Billing Provider Address loop?*

Response: Yes. The ZIP code reported in the Billing Provider 2010AA N3 must be a 9-digit ZIP code. Adding "-0000" to create a 9-digit ZIP code is not accurate. If you do not know your 9-digit ZIP code, contact your local Post Office or go to www.usps.com. Nine-digit ZIP codes are only required for the Billing Provider and Service Facility Location loops.

CMS Transmittal 1920/Change Request 6816 issued on February 19, 2010 addresses what Medicare will use for Medicare-to-secondary payer coordination of benefits (COB) claims when the + 4 ZIP code is unknown. The CMS Transmittal does not apply to all payers.

Question: *I'm in a rural location. How do I know what my "street address" is?*

Response: You can no longer report a PO Box in the Billing Provider loop, so you need to report your street address. Your local Post Office can provide you with your street address or best description of your physical location if you are unsure what to report in the 2010AA loop. See the 837 TR3s for more information.

Question: *I did not use my street address when I enrolled with my payers. Will this cause a problem?*

Response: It might. Many payers use the address on their provider files that you provided at initial enrollment. You may not need to submit any changes to the payer if you want to receive payment exactly as you do today and you will be using the following 5010 provider loops correctly:

2010AA N3 Billing Provider Address-- can only contain street addresses

2010AB Pay-to Address -- use if you want to receive payment at a different address from the Billing Provider Address (This is the location where a PO Box is to be reported.)

If you change your billing address to a street address from a PO Box and do not include the Pay-to Address information, your payer might not be able to identify you, causing your claims to be pended or rejected. You are saying to the payer by excluding the Pay-to Address data in the EDI file that you want to be reimbursed at your Billing Provider Address. If you really are changing where you want payments to be sent, then you must update all payer(s) with the correct address you want payments to be sent to prior to submitting 5010 claims. You should begin this work now.

Payers and providers are encouraged to communicate with one another about any changes they plan to make in preparation for 5010 to the Pay-to Address they use for remittance today.

See the NPI SWG issues briefs related to NPI changes in 5010, specifically *The 005010 Claim Transactions Implementation: Communication Strategies* issue brief for additional information.

Question: *What is the best way for a provider to validate that they are ready for the 5010 Billing Provider Address changes?*

Response: If you will be making changes to your current billing provider address to meet the 5010 requirements, you can do this today in 4010A1 or your current format. Begin by contacting your clearinghouse or payer regarding their approach to validate these changes. At a minimum, it is recommended that you have a limited set of “production” claims in your current format sent through your usual claim submission channels for “end-to-end” processing to validate the changes to the Billing Provider Address. (“Production” claims are “real” claims that are sent through the “real” production systems. They are not test data sent through a test system. “End-to-end” processing means that the transaction goes through the normal channels for processing and the response transaction is returned to the provider in a production environment, i.e., 837 – 835.)

If your claim encounters a problem at the clearinghouse or payer system, then you need to work with that entity to resolve the issue. You will want to re-validate the changes to make sure that all problems have been resolved before submitting the changes in full production. You should begin this work now.

Note: The validation of data changes, described above, is different from the testing of 5010 transactions. Be aware that these changes still need to be tested as part of your overall 5010 testing.

Question: *My current street address does not match my street address in the NPI database. Will this cause a problem?*

Response: It might. Payers might use the NPI database, known as the National Plan & Provider Enumeration System (NPPES) (<https://nppes.cms.hhs.gov/NPPES/Welcome.do>), to validate the provider. Providers are responsible for keeping their information up-to-date in the NPPES. Failing to keep your information up-to-date may cause claims to be pended or rejected until the payer can validate your information. If you know that any of your information has changed since you applied for your NPI, update NPPES now.

Resources

Accredited Standards Committee X12, Insurance Subcommittee, ASC X12N. Type 1 Errata to Health Care Claim: Dental (837), 005010X224A2. Washington Publishing Company, June 2010. <<http://www.wpc-edi.com>>.

Accredited Standards Committee X12, Insurance Subcommittee, ASC X12N. Type 1 Errata to Health Care Claim: Institutional (837), 005010X223A2. Washington Publishing Company, June 2010. <<http://www.wpc-edi.com>>.

Accredited Standards Committee X12, Insurance Subcommittee, ASC X12N. Type 1 Errata to Health Care Claim: Professional (837), 005010X222A1. Washington Publishing Company, June 2010. <<http://www.wpc-edi.com>>.

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Check for Updates

- For subsequent interim bills, bill type 117 with a patient status of 30 (still patient); or
- For subsequent discharge bills, bill type 117 with a patient status other than 30. (See Chapter 25 for a list of valid patient discharge status codes)

All inpatient providers must submit bills when any of the following occur, regardless of the date of the prior bill (if any):

- Benefits are exhausted;
- The beneficiary ceases to need a hospital level of care (all hospitals);
- The beneficiary falls below a skilled level of care (SNFs and hospital swing beds); or
- The beneficiary is discharged.

Effective December 3, 2007, when a beneficiary's Medicare benefits exhaust in an IPF or an LTCH, the hospital is allowed to submit a no pay bill (TOB 110) with a patient status code 30 in 60 day increments until discharge. They no longer have to continually adjust bills until physical discharge or death. The last bill shall contain a discharge patient status code.

These instructions for hospitals and SNFs apply to all providers, including those receiving Periodic Interim Payments (PIP). Providers should continue to submit no-pay bills until discharge.

NOTE: For stays that necessitate the reporting of more than ten OSCs (i.e., more OSCs than the claim formats allow), Long Term Care Hospitals, Inpatient Psychiatric Facilities, and Inpatient Rehabilitation Facilities shall refer to instructions provided in Chapter 32, section 74.3 of this manual.



50.2.2 - Frequency of Billing for Providers Submitting Institutional Claims with Outpatient Services

(Rev. 2092, Issued: 11-12-10, Effective: 04-01-11, Implementation: 04-04-11)

Repetitive Part B services furnished to a single individual by providers that bill institutional claims shall be billed monthly (or at the conclusion of treatment). The instructions in this subsection also apply to hospice services billed under Part A, though they do not apply to home health services. Consolidating repetitive services into a single monthly claim reduces CMS processing costs for relatively small claims and in instances where bills are held for monthly review. Services repeated over a span of time and billed with the following revenue codes are defined as repetitive services:

Type of Service

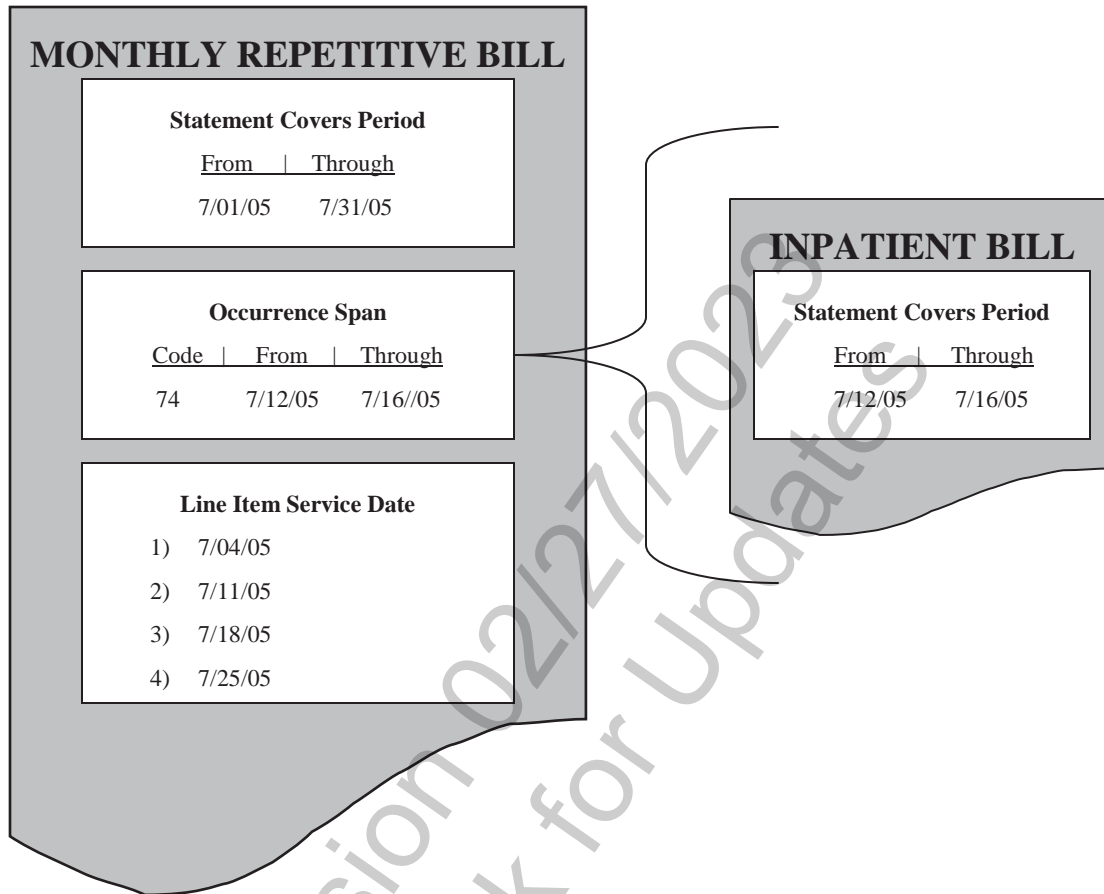
Revenue Code(s)

Type of Service	Revenue Code(s)
DME Rental	0290 – 0299
Respiratory Therapy	0410, 0412, 0419
Physical Therapy	0420 – 0429
Occupational Therapy	0430 – 0439
Speech-Language Pathology	0440 – 0449
Skilled Nursing	0550 – 0559
Kidney Dialysis Treatments	0820 – 0859
Cardiac Rehabilitation Services	0482, 0943
Pulmonary Rehabilitation Services	0948

Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to monthly billing cycles.

Where there is an inpatient stay, or outpatient surgery, or outpatient hospital services subject to OPPS, during a period of repetitive outpatient services, one bill for repetitive services shall nonetheless be submitted for the entire month as long as the provider uses an occurrence span code 74 on the monthly repetitive bill to encompass the inpatient stay, day of outpatient surgery, or outpatient hospital services subject to OPPS. CWF and shared systems must read occurrence span 74 and recognize the beneficiary cannot receive non-repetitive services while receiving repetitive services, and consequently, is on leave of absence from the repetitive services. This permits submitting a single, monthly bill for repetitive services and simplifies Contractor review of these bills. The following is an illustration explaining this scenario:

Leave of Absence “Carve-Out” Example

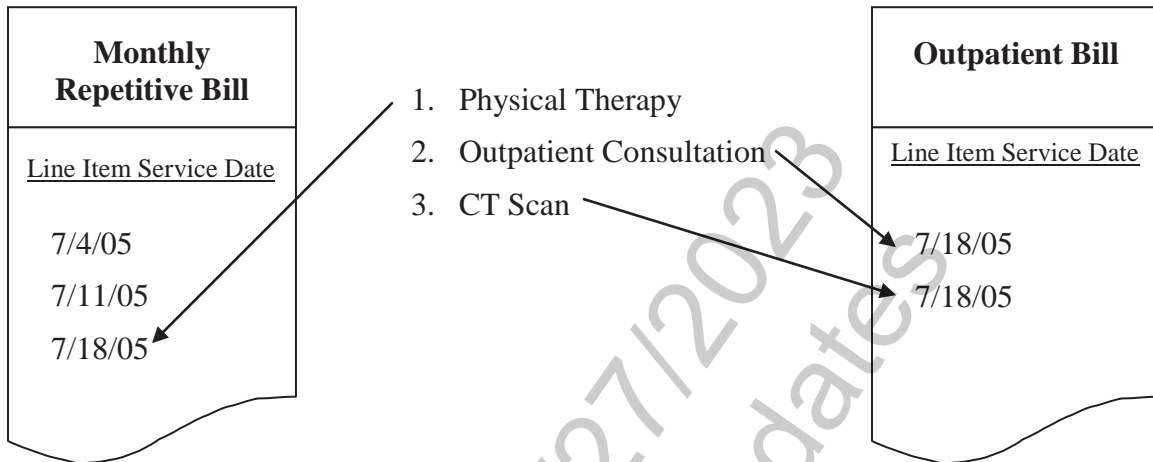


Any items and/or services in support of the repetitive service shall be reported on the same claim even if the revenue code(s) reported with those supported services are not on the repetitive revenue code list (**NOTE:** Supporting items and/or services are those in which are needed specifically in the performance of the repetitive service. Examples may include disposable supplies, drugs or equipment used to furnish the repetitive service).

However, to facilitate APC recalibration, do not report unrelated one-time, non-repetitive services that have the same date of service as a repetitive service (even if both the non-repetitive service and the repetitive service are paid under OPPS). If a non-repetitive OPPS service is provided on the same date as a repetitive service, report the non-repetitive OPPS services, along with any packaged and/or services related to the non-repetitive OPPS service, on a separate OPPS claim. For example, if a chemotherapy drug is administered on a day a repetitive service is also rendered, report the chemotherapy drug, its administration, its related supplies, etcetera, on a separate claim from the monthly repetitive services claim. Similarly, as shown below in the illustration, “Example: Monthly Repetitive Billing Procedure,” a physical therapy treatment (which is a repetitive service because it is reported under a revenue code on the repetitive service

list) is administered on the same day an outpatient consultation and a CT scan are furnished, report the physical therapy service on the claim with the other physical therapy services provided during the applicable month. Report the visit for the consultation and the CT scan on a separate claim.

Example: Monthly Repetitive Billing Procedure



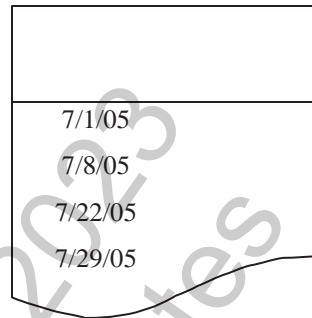
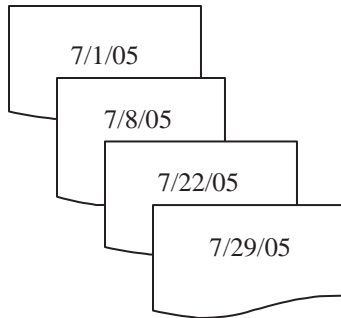
Revenue codes usually reported for chemotherapy and radiation therapy are not on the list of revenue codes that may only be billed monthly. Therefore, hospitals may bill chemotherapy or radiation therapy sessions on separate claims for each date of service. However, because it is common for these services to be furnished in multiple encounters that occur over several weeks or over the course of a month, hospitals have the option of reporting charges for those recurring services on a single bill, as though they were repetitive services. If hospitals elect to report charges for recurring, non-repetitive services (such as chemotherapy or radiation therapy) on a single bill, they must also report all charges for services and supplies associated with the recurring service on the same bill. The services may all be reported on the same claim or billed separately by date of service as illustrated below:

Billing Procedures for Recurring Services Not Defined as Repetitive

1) Submit multiple bills for each date of service (include only the recurring service and its related services):

OR

2) Submit a monthly bill for all line item dates of service (for the entire month's recurring services with all services related to the recurring services):



Indian Health Service Hospitals, Maryland hospitals, as well as hospitals located in Saipan, Guam, American Samoa, and the Virgin Islands are not subject to OPPS. In addition, hospitals that furnish only inpatient Part B services are also exempt from OPPS. Bills for ambulatory surgery in these hospitals shall contain on a single bill all services provided on the same day as the surgery except kidney dialysis services, which are billed on a 72X bill type. Non-ASC services furnished on a day other than the day of surgery shall not be included on the outpatient surgical bill.

See Chapter 16 for clinical diagnostic lab services paid under the fee schedule when included with outpatient bills for other services.

Contractors periodically review bills from providers known to be furnishing repetitive services to determine if they are billing more frequently than proper. Techniques that may be used are:

- Sample review of bills to determine if most are for a monthly period (by using from and thru dates or number of services). This may be done manually or electronically. Contractors may rely on informal communications from their medical review staff, and

Contractors should educate providers that bill improperly. Contractors shall:

- Return bills with an explanation and request proper billing to providers that continue to bill improperly.
- Not return bills where the treatment plan is completed indicating discontinued services because the beneficiary dies or moves.

Medicare Program Memorandum Intermediaries, Transmittal A-00-36

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- o All outpatient hospital Part B bills (bill types 12X, 13X with condition code 41, 13X without condition code 41 or 14X) with the exception of bills from hospitals in Maryland, Indian health service, CAHs, and hospitals located in Saipan, American Samoa, and Guam;
- o CMHC bills (bill type 76X);
- o CORF and HHA bills containing certain HCPCS codes as described in "New HCPCS Coding Requirements for CORFs and HHAs" above (bill types 75X or 34X); and
- o Any bill containing a condition code 07 with certain HCPCS codes as described in "New HCPCS Coding Requirements for CORFs and HHAs" above.

NOTE: For bill type 34X only vaccines and their administration, splints, casts, and antigens will be paid under OPPS. For bill type 75X only vaccines and their administration will be paid under OPPS. For bills containing condition code 07 only splints, casts, and antigens will be paid under OPPS.

Discontinuation of Bill Type 83X for Hospitals Subject to OPPS

Since bill type 83X "Ambulatory Surgical Center Services to Hospital Outpatients" will not be utilized under OPPS, hospitals are required, beginning with claims with dates of service on or after August 1, 2000, to report in Form Locator 6 "Statement Covers Period From Date" the earliest date services were rendered. As a result, pre-operative laboratory services will always have a line item date of service within the from and through dates on the claim. The instructions in §3626.4 of the MIM only apply to claims with dates of service prior to August 1, 2000.

Indian health service hospitals continue to bill for surgeries utilizing bill type 83X.

Discontinuation of Value Code 05 Reporting

With line item date of service reporting, there will be no way to correctly allocate professional component charges reported in value code 05 to specific line items on the claim. As a result, advise your hospitals that currently report professional component charges in value code 05 on outpatient claims to no longer include the professional component amount in their charges and to discontinue reporting the professional component in value code 05.

Provider Reporting Requirements

Advise your providers paid under OPPS not to include July 2000 and August 2000 dates of service on the same claim. Standard systems must edit to assure that a hospital or CMHC claim does not contain dates of service that span July 2000 and August 2000. In addition, advise your hospitals and CMHCs that every effort should be made to report all services performed on the same day on the same claim to assure proper payment under OPPS. Return claims submitted for the same date of service to the provider (except duplicates or those containing condition codes 20, 21 or G0) with a notification that an adjustment bill should be submitted. Claims with condition code G0 should not be automatically rejected as a duplicate claim.

Procedures for Submitting Late Charges

Hospitals and CMHCs may not submit a late charge bill (Step 5 in the third position of the bill type) for bill types 12X, 13X, 14X, and 76X effective for claims with dates of service on or after August 1, 2000. They must submit an adjustment bill for any services required to be billed with HCPCS codes, units and line item dates of service by reporting a 7 in the third position of the bill type. Separate bills containing only late charges will not be permitted.

The submission of an adjustment bill, instead of a late charge bill, will ensure proper duplicate detection, bundling, correct application of coverage policies and proper editing by OCE and payment under OPPS.

Medicare Claims Processing Manual, Chapter 3, Inpatient Hospital Billing

3. The facility has been granted swing-bed approval by CMS.

A CAH that participated in Medicare as a rural primary care hospital (RPCH) on September 30, 1997, and on that date had in effect an approval from CMS to use its inpatient facilities to provide post-hospital SNF care, may continue in that status under the same terms, conditions, and limitations that were applicable at the time those approvals were granted.

A CAH may establish psychiatric and rehabilitation distinct part units effective for cost reporting periods beginning on or after October 1, 2004. The CAH distinct part units must meet the following requirements:

1. The facility distinct part unit has been certified as a CAH by CMS;
2. The distinct part unit meets the conditions of participation requirements for hospitals;
3. The distinct part unit must also meet the requirements, other than conditions of participation requirements, that would apply if the unit were established in an acute care hospital;
4. Services provided in these distinct part units will be paid under the payment methodology that would apply if the unit was established in an acute care (non-CAH) hospital paid under the hospital inpatient PPS; Inpatient Rehabilitation Facilities in CAHs are paid under the Inpatient Rehabilitation Facility PPS (see Pub 100-04, Chapter 3, Section 140 for billing requirements) and the Inpatient Psychiatric Units in CAHs are paid on a reasonable cost basis until a prospective payment system is created (expected in 2005);
5. Beds in these distinct part units are excluded from the 25 bed count limit for CAHs;
6. The bed limitations for each distinct part unit is 10; and

If a distinct part unit does not meet applicable requirements with respect to a cost reporting period, no payment may be made to the CAH for services furnished in the unit during that period. Payment may resume only after the CAH has demonstrated that the unit meets applicable requirements.




30.1.1 - Payment for Inpatient Services Furnished by a CAH

(Rev. 530, Issued: 04-22-05; Effective: 01-05-04 - HPSA Bonus; 01-03-05 - Physician Scarcity; 07-01-01; Implementation: 07-05-05)

For cost reporting periods beginning after October 1, 1997, payment for inpatient services of a CAH is the reasonable cost of providing the services. Effective for cost reporting periods beginning after January 1, 2004, payment for inpatient services of a CAH is 101

percent of the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except the following principles do not apply:

- The lesser of costs or charges (LCC) rule;
- Ceilings on hospital operating costs;
- The reasonable compensation equivalent (RCE) limits for physician services to hospitals; and
-  The payment window provisions for preadmission services treated as inpatient services under §40.3. (Because CAHs are exempt from the 1- and 3-day window provisions, services rendered by a CAH to a beneficiary who is an outpatient prior to that beneficiary's admission to the CAH as an inpatient, are not bundled on the inpatient bill. Outpatient CAH services must be billed as such and on a separate bill (85x TOB) from inpatient services. CWF and the shared system shall bypass the CAH provider numbers when applying the edits that compare hospital outpatient and inpatient bills to apply the window provisions. Outpatient services rendered on the date of admission to an inpatient setting are still billed and paid separately as outpatient services in a CAH.)

Low Osmolar Contrast Material (LOCM) furnished as part of medically necessary imaging procedures for inpatients is paid for based on bill type 11X (for LOCM furnished during an inpatient stay covered under Part A), or 12X (for LOCM furnished to an inpatient where payment is under Part B because the stay is not covered under Part A). Bills must include revenue code 636 along with one of the following HCPCS codes as appropriate:

- A4644 Supply of low osmolar contrast material (100 – 199 mgs of iodine);
- A4645 Supply of low osmolar contrast material (200 – 299 mgs of iodine); or
- A4646 Supply of low osmolar contrast material (300 – 399 mgs of iodine).

Payment for inpatient CAH services is subject to Part A deductible and coinsurance requirements. Inpatient services should be billed on an 11X type of bill.

30.1.1.1 - Payment for Inpatient Services Furnished by an Indian Health Service (IHS) or Tribal CAH

(Rev. 231, Issued 07-23-04, Effective: 01-01-04, Implementation: 01-03-05)

Reimbursement to IHS or Tribal CAHs for covered inpatient services is based on a facility specific per diem rate that is established on a yearly basis from the most recently filed cost report information.

The provider bills for covered days with days of leave included in FL 8, Noncovered Days. Noncovered charges for leave of absence days (holding a bed) may be omitted from the bill or may be shown under revenue code 018x. Providers will be instructed by their FI on which billing method to use. Occurrence span code 74 is used to report the dates the leave began and ended. Although the Medicare program may not be billed for days of leave, the provider is not permitted to charge a beneficiary for them.

Where a patient on leave of absence from a non-PPS hospital who was shown as "Still Patient" (patient status code 30, FL 22) on an interim bill:

- Has not returned within 60 days, including the day leave began, or
- Has been admitted to another institution at any time during the leave of absence, submit an adjusted bill.

The hospital shows the day the patient left the hospital as the date of discharge. (A beneficiary cannot be an inpatient of two institutions at the same time.)

NOTE: Home health or outpatient services provided during a leave of absence do not affect the leave and no discharge bill is required unless the above events occur.



40.3 - Outpatient Services Treated as Inpatient Services

(Rev. 2539, Issued: 08-31-12, Effective: 10-01-12, Implementation: 10-01-12)

A Outpatient Services Followed by Admission Before Midnight of the Following Day (Effective For Services Furnished Before October 1, 1991)

When a beneficiary receives outpatient hospital services during the day immediately preceding the hospital admission, the outpatient hospital services are treated as inpatient services if the beneficiary has Part A coverage. Hospitals and FIs apply this provision only when the beneficiary is admitted to the hospital before midnight of the day following receipt of outpatient services. The day on which the patient is formally admitted as an inpatient is counted as the first inpatient day.

When this provision applies, services are included in the applicable PPS payment and not billed separately. When this provision applies to hospitals and units excluded from the hospital PPS, services are shown on the bill and included in the Part A payment. See Chapter 1 for FI requirements for detecting duplicate claims in such cases.

B Preadmission Diagnostic Services (Effective for Services Furnished On or After January 1, 1991)

Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), within 3 days prior to and including the date of the beneficiary's admission are

deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage. For example, if a patient is admitted on a Wednesday, outpatient services provided by the hospital on Sunday, Monday, Tuesday, or Wednesday are included in the inpatient Part A payment.

This provision does not apply to ambulance services and maintenance renal dialysis services (see the Medicare Benefit Policy Manual, Chapters 10 and 11, respectively). Additionally, Part A services furnished by skilled nursing facilities, home health agencies, and hospices are excluded from the payment window provisions.

For services provided before October 31, 1994, this provision applies to both hospitals subject to the hospital inpatient prospective payment system (IPPS) as well as those hospitals and units excluded from IPPS.

For services provided on or after October 31, 1994, for hospitals and units excluded from IPPS, this provision applies only to services furnished within one day prior to and including the date of the beneficiary's admission. The hospitals and units that are excluded from IPPS are: psychiatric hospitals and units; inpatient rehabilitation facilities (IRF) and units; long-term care hospitals (LTCH); children's hospitals; and cancer hospitals.



The 3-day (or 1-day) payment window policy does not apply when the admitting hospital is a critical access hospital (CAH). Therefore outpatient diagnostic services rendered to a beneficiary by a CAH, or by an entity that is wholly owned or operated by a CAH, during the payment window, must not be bundled on the claim for the beneficiary's inpatient admission at the CAH. However, outpatient diagnostic services rendered to a beneficiary at a CAH that is wholly owned or operated by a non-CAH hospital, during the payment window, are subject to the 3-day (or 1-day) payment window policy.

The technical portion of any outpatient diagnostic service rendered to a beneficiary at a hospital-owned or hospital-operated physician clinic or practice during the payment window is subject to the 3-day (or 1-day) payment window policy (see MCPM, chapter 12, sections 90.7 and 90.7.1).

The 3-day (or 1-day) payment window policy does not apply to outpatient diagnostic services included in the rural health clinic (RHC) or Federally qualified health center (FQHC) all-inclusive rate (see MCPM, chapter 19, section 20.1).

Outpatient diagnostic services furnished to a beneficiary more than 3 days (for a non-subsection (d) hospital, more than 1 day) preceding the date of the beneficiary's admission to the hospital, by law, are not part of the payment window and must not be bundled on the inpatient bill with other outpatient services that were furnished during the span of the 3-day (or 1-day) payment window, even when all of the outpatient services were furnished during a single, continuous outpatient encounter. Instead, the outpatient diagnostic services that were furnished prior to the span of the payment window may be separately billed to Part B.