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Guidance on Coding and Billing Date of Service on Professional Claims

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Note: This article was revised on February 1, 2019, to correct a statement in the Home Health Certification and Recertification Section to read, "the physician completes and signs the plan of care." All other information is unchanged.

PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for physicians, non-physician practitioners, and others submitting claims on a CMS-1500 form or the X12 837 Professional Claim to Medicare Administrative Contractors (MACs) for reimbursement for Medicare Part B services.

PROVIDER ACTION NEEDED

STOP – Impact to you:

Physicians and non-physician practitioners need to identify the correct date of service for the services they provide to a Medicare patient.

CAUTION – What you need to know:

This MLN Matters Article is intended for physicians, providers, and suppliers billing MACs for services provided to Medicare beneficiaries.

GO – What you need to do:

Providers need to determine the Medicare rules and regulations concerning the date of service and submit claims appropriately. Be sure your billing and coding staffs are aware of this information.

BACKGROUND

The information below will not provide all the billing instructions for the individual services. The

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article does not present any new or revised Medicare policy. Instead, the article reiterates current Medicare policy. This information concentrates on the date(s) of service to submit when billing for these services. If you are providing these services, please take advantage of the information available on the CMS website in addition to your MACs. The Medicare Benefit Policy Manual, Chapter 15, Section 20 shows that expenses are considered to have been incurred on the date the beneficiary received the item or service, regardless of when it was paid for or ordered. You may review this manual section at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.

Radiology Services

Typically, radiology services have two separate components: a professional and technical component. These services will have a PC/TC indicator of "1" on the Medicare Physician Fee Schedule (MPFS) Relative Value File. The technical component is billed on the date the patient had the test performed. When billing a global service, the provider can submit the professional component with a date of service reflecting when the review and interpretation is completed or can submit the date of service as the date the technical component was performed. This will allow ease of processing for both Medicare and the supplemental payers. If the provider did not perform a global service and instead performed only one component, the date of service for the technical component would the date the patient received the service and the date of service for the professional component would be the date the review and interpretation is completed.

The Medicare Physician Fee Schedule Relative Value File is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html.

Surgical and Anatomical Pathology

Surgical and anatomical pathology services may have two components: a professional and a technical component. These services will have a PC/TC indicator of "1" on the MPFS Relative Value File. The technical component is billed on the date the specimen was collected. This would be the surgery date. When billing a global service, the provider can submit the professional component with a date of service reflecting when the review and interpretation is completed or can submit the date of service as the date the technical component was performed. This will allow ease of processing for both Medicare and the supplemental payers. If the provider did not perform a global service and instead performed only one component, the date of service for the technical component would the date the patient received the service and the date of service for the professional component would be the date the review and interpretation is completed.

When the collection spans two calendar dates, use the date the specimen collection ended. There are exceptions for stored specimens as follows:

Stored specimens

In the case of a test/service performed on a stored specimen, if a specimen was stored for less than or equal to 30 calendar days from the date it was collected, the DOS of the test/service

must be the date the test/service was performed only if:

- The test/service is ordered by the patient's physician at least 14 days following the date of the patient's discharge from the hospital
- The specimen was collected while the patient was undergoing a hospital surgical procedure
- It would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted
- The results of the test/service do not guide treatment provided during the hospital stay; and
- The test/service was reasonable and medically necessary for treatment of an illness.

If the specimen was stored for more than 30 calendar days before testing, the specimen is considered to have been archived and the DOS of the test/service must be the date the specimen was obtained from storage.

For more information, see the Medicare Claims Processing Manual, Chapter 16, Section 40.8, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c16.pdf.

Care Plan Oversight (CPO)

CPO is physician supervision of a patient receiving complex and/or multidisciplinary care as part of Medicare covered services provided by a participating home health agency or Medicare approved hospice. Providers must provide physician supervision of a patient involving 30 or more minutes of the physician's time per month to report CPO services. The claim for CPO must not include any other services and is only billed after the end of the month in which CPO was provided. The date of service submitted on the claim can be the last date of the month or the date in which at least 30 minutes of time is completed.

For more information, see the Medicare Claims Processing Manual, Chapter 12, Section 180.1.A, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf And the Medicare Benefit Policy Manual, Chapter 15, Section 30.G at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.

Home Health Certification and Recertification

The date of service for the Certification is the date the physician completes and signs the plan of care. The date of the Recertification is the date the physician completes the review.

For more information, see the Medicare Claims Processing Manual, Chapter 12, Section 180.1.B, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf.

Physician End-Stage Renal Disease (ESRD) Services

A physician may provide monthly or daily oversight of a patient on dialysis with ESRD. The date

of service for a patient beginning dialysis is the date of their first dialysis through the last date of the calendar month. For continuing patients, the date of service is the first through the last date of the calendar month. For transient patients or less than a full month service, these can be billed on a per diem basis. The date of service is the date of responsibility for the patient by the billing physician. This would also include when a patient's dies during the calendar month. When submitting a date of service span for the monthly capitation procedure codes, the day/units should be coded as "1".

For more information, see the Medicare Claims Processing Manual, Chapter 8, Section 140, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c08.pdf.

Transitional Care Management (TCM)

TCM services are 30-day services provided when a patient is discharged from an appropriate facility and requires moderate or high-complexity medical decision making. The date of service is the date the practitioner completes the required face-to-face visit. Keep in mind, there are additional services to be provided during the 30-day period.

TCM Guidance including Questions and Answers and Fact Sheets are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management.html.

Clinical Laboratory Services

Generally, the date of service for clinical laboratory services is the date the specimen was collected. If the specimen is collected over a period that spans two calendar dates, the date of service is the date the collection ended. There are three exceptions to the general date of service rule for clinical laboratory tests:

1. Date of service for tests/services performed on stored specimens

   In the case of a test/service performed on a stored specimen, if the specimen was stored less than or equal to 30 calendar days from the date it was collected, the date of service of the test/service must be the date the test/service was performed only if:
   - The test/service was ordered by the patient's physician at least 14 days following the date of the patient's discharge from the hospital;
   - The specimen was collected while the patient was undergoing a hospital surgical procedure;
   - It would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted;
   - The results of the test/service do not guide treatment provided during the hospital stay; and
   - The test/service was reasonable and necessary for the treatment of an illness.

If the specimen was stored for more than 30 calendar days before testing, the specimen is considered to have been archived and the date of service of the test/service must be the date the specimen was obtained from storage.

2. Date of service for chemotherapy sensitivity tests/services performed on live tissue

In the case of a chemotherapy sensitivity test/service performed on live tissue, the date of service of the test/service must be the date the test/service was performed only if:

- The decision as to the specific chemotherapy agent to test is made at least 14 days after discharge;
- The specimen was collected while the patient was undergoing a hospital surgical procedure;
- It would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted;
- The results of the test/service do not guide treatment provided during the hospital stay; and
- The test/service was reasonable and medically necessary for treatment of an illness.

3. Date of service for advanced diagnostic laboratory tests (ADLTs) and molecular pathology tests

In the case of a molecular pathology test or a test designated by CMS as an ADLT under paragraph (1) of the definition of advanced diagnostic laboratory test in 42 CFR 414.502, the date of service must be the date the test was performed only if:

- The test was performed following a hospital outpatient's discharge from the hospital outpatient department;
- The specimen was collected from a hospital outpatient during an encounter;
- It was medically appropriate to collect the sample from the hospital outpatient during the hospital outpatient encounter;
- The results of the test do not guide treatment provided during the hospital outpatient encounter; and
- The test was reasonable and necessary for the treatment of an illness.

ADLTs and molecular pathology tests subject to the third exception to the general laboratory date of service rule are available on the Medicare Clinical Laboratory Fee Schedule web page under the Laboratory Date of Service Policy tab at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html.

Additional information is available in the Medicare Claims Processing Manual, Chapter 16, Section 40.8, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c16.pdf.

Home Prothrombin Time (PT/INR) Monitoring

There are several procedure codes applicable to this service. The G0248 describes the initial demonstration use of home INR monitoring and instructions for reporting. The date of service is the date the demonstration and instructions for reporting are given in a face-to-face setting with the patient. G0249 describes the provision of test materials and equipment for home INR monitoring. The date of service is the date the test materials and equipment are given to the patient. G0250 describes the physician review, interpretation, and patient management of home INR testing. This service is payable only once every 4 weeks. The date of service is the date of the fourth test interpretation. For 2018, there is also code 93793 describing the physician interpretation and instructions. The appropriate date of service is the date of the review.

For more information, see the Medicare Claims Processing Manual, Chapter 32, Section 60.5, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c32.pdf.

Cardiovascular Monitoring Services

There are many different procedure codes that represent the cardiovascular monitoring services. These can be identified as professional components, technical components, or a combination of the two. Some of these monitoring services may take place at a single point in time, others may take place over 24 or 48 hours, or over a 30-day period. The determination of the date of service is based on the description of the procedure code and the time listed. When the service includes a physician review and/or interpretation and report, the date of service is the date the physician completes that activity. If the service is a technical service, the date of service is the date the monitoring concludes based on the description of the service. For example, if the description of the procedure code includes 30 days of monitoring and a physician interpretation and report, then the date of service will be no earlier than the 30th day of monitoring and will be the date the physician completed the professional component of the service.

For more information, see the Medicare National Coverage Determination Manual, Chapter 1, Section 20.8.1.1, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_part1.pdf.

Psychiatric Testing and Evaluations

In some cases, for various reasons, psychiatric evaluations (90791/90792) and/or psychological and neuropsychological tests (96101/96146) are completed in multiple sessions that occur on different days. In these situations, the date of service that should be reported on the claim is the date of service on which the service (based on CPT code description) concluded.

Documentation should reflect that the service began on one day and concluded on another day (the date of service reported on the claim). If documentation is requested, medical records for both days should be submitted.

Psychiatric Testing when provided over multiple days based on the patient being able to provide information, is billed based on the time involved as described by CPT and the last date of the

test. For more information, see the Medicare Benefit Policy Manual, Chapter 15, Section 80.2, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.

Surgical Services

Medicare's payment for most surgical services is made using the global surgery rules. All services considered to be part of the global package including follow-up visits, are considered to have occurred on the same day as the surgical service and are not submitted separately. Surgeons who perform the surgery and then transfer post-operative care to another practitioner will submit their claims using the date of the surgery as the date of service along with Modifier 54. If the surgeon keeps responsibility for the patient for some of the post-operative care, he/she would submit the date of the surgery, the surgery procedure code with Modifier 55, and the last date of responsibility indicated in Item 19 or the electronic equivalent. The practitioner receiving the transfer of care will submit his/her post-operative services using the surgical procedure code with Modifier 55 with the date of the surgery as his/her date of service. If the practitioner receives the patient on a date other than the discharge date from an inpatient stay, Item 19 or the electronic equivalent will include the date care began. For more information, see the Medicare Claims Processing Manual, Chapter 12, Section 40 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf.

Maternity Benefits

All expenses incurred for surgical and obstetrical care including preoperative/prenatal examinations, testing, and post-operative/postnatal services are part of the maternity package and may be billed under the appropriate surgical code on the date of delivery or termination. Charges the practitioner may impose that are not related to the delivery are incurred on the date furnished.

For more information, see the Medicare Benefit Policy Manual, Chapter 15, Section 20.1, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.

Services Which Transpire Over to Another Calendar Date

This category could include multiple types of services. The service would be started on one day and concluded the following day. The service cannot be submitted to Medicare until completed. Unless otherwise notated, the billing entity can use either the date the service began or the following day when the service concluded.

Note: This document was developed through the A/B Medicare Administrative Contractor (MAC) Provider Outreach & Education (POE) Collaboration Team. This joint effort ensures consistent communication and education throughout the nation on a variety of topics and will assist the provider and physician community with information necessary to submit claims appropriately and receive proper payment in a timely manner.

ADDITIONAL INFORMATION

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
February 1, 2019	This article was revised to correct a statement in the Home Health Certification and Recertification Section to read, "the physician completes and signs the plan of care."
January 24, 2019	CMS reissued the article to clarify information.
October 2, 2017	CMS rescinded the article.
September 19, 2017	Initial article released.