



Related MLN Matters Article #: MM4047

Date Posted: December 2, 2005

Related CR #: 4047

Update to Repetitive Billing Instructions in Medicare Claims Processing Manual

Key Words

MM4047, CR4047, MM3633, CR3633, update, repetitive, billing, instructions, claim

Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs) for repetitive Part B, including Inpatient Hospital Part B and Outpatient Prospective Payment System (OPPS) services and repetitive hospice Part A services

Key Points

- The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 3633 (Transmittal 407, "Hospital Billing for Repetitive Services," dated December 17, 2004) with an effective date of January 1, 2005.
- Soon after the release of CR3633, CMS became aware of difficulties that may arise from instructions contained in CR3633. Therefore, CMS re-evaluated the policy of repetitive billing and provided clarifications in CR4047.

General Billing Requirements

Frequency of Billing to Fiscal Intermediaries (FIs) for Outpatient Services

- Repetitive Part B services furnished to a single individual by providers who bill FIs should be billed monthly (or at the conclusion of treatment). This also applies to hospice services billed under Part A, but they do not apply to home health services.
- Services are defined as repetitive services if they are repeated over a span of time and billed with the Revenue Codes listed in the Table on page 2 of MLN Matters Article MM4047.
- Affected providers will submit one bill for repetitive services for the entire month (during a period of repetitive outpatient services) for cases in which there is:
 - An inpatient stay; or
 - Outpatient surgery; or
 - Outpatient hospital services subject to OPPS.

- In addition to the bill for the inpatient stay or outpatient surgery, the affected provider will use an occurrence span code 74 (Leave of Absence) on the repetitive bill to encompass the:
 - Inpatient stay;
 - Day of outpatient surgery; or
 - Outpatient hospital services subject to OPSS.
- Any items and/or services in support of the repetitive service (those needed specifically in the performance of the repetitive service) will be reported by the affected provider on the same claim even if the revenue code(s) reported with those supported services are not on the repetitive revenue code list.
- To facilitate Ambulatory Payment Classification (APC) recalibration, affected providers should 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 OPSS).
- If a non-repetitive OPSS service is provided on the same date as a repetitive service, the affected provider should report on a separate OPSS claim:
 - The non-repetitive OPSS services; and
 - Any packaged and/or services related to the non-repetitive OPSS service.
- 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.
- Since 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 be billed:
 - On the same claim; or
 - Separately (by date of service).

Part B Hospital (Including Inpatient Hospital Part B and OPSS)

Hospital and Community Mental Health Center (CMHC) Reporting Requirements for Services Performed on the Same Day

- When reporting a Healthcare Common Procedure Coding System (HCPCS) code for a separately payable, non-repetitive hospital OPSS service, affected providers should report charges for all services and supplies associated with that service that were furnished on the same date. (Services subject to the three-day payment window are an exception to this OPSS policy.)
- When a hospital provides electroconvulsive therapy (ECT) on the same day as partial hospitalization services, both the ECT and partial hospitalization services should be reported on the same hospital claim.

- In this instance, the claim should contain condition code 41. The hospital should report charges for all services and supplies associated with the ECT service that was furnished on the same date(s) on the same claim.

Important Links

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4047.pdf>

For complete details, affected providers should see the official instruction issued to their intermediary regarding this change. That instruction may be viewed by going to

<http://www.cms.hhs.gov/transmittals/downloads/R763CP.pdf> on the CMS website.