

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services



News Flash –

NEW product from the Medicare Learning Network® (MLN)

- [“Recovery Auditors Findings Resulting from Medical Necessity Reviews of Renal and Urinary Tract Disorders,”](#) Podcast, ICN 906985, Downloadable only.

MLN Matters® Number: MM8048

Related Change Request (CR) #: CR 8048

Related CR Release Date: November 1, 2012

Effective Date: January 1, 2013

Related CR Transmittal #: R2578CP

Implementation Date: April 1, 2013

## Enforcing Interim Billing for Partial Hospitalization Services

### Provider Types Affected

This MLN Matters® Article is intended for hospitals, Critical Access Hospitals (CAHs), and Community Mental Health Centers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and A/B Medicare Administrative Contractors (A/B MACs)) for providing Partial Hospitalization Program services to Medicare beneficiaries.

### Provider Action Needed

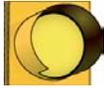


#### **STOP – Impact to You**

Effective April 1, 2013, Medicare systems will enforce consistency editing for interim claims billing for Partial Hospital Program services, which may impact the processing of claims for these services.

#### Disclaimer

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### CAUTION – What You Need to Know

Change Request (CR) 8048, from which this article is taken, announces that in order to achieve the goal of implementing a new G-code that will be used to report physician or qualifying nonphysician practitioner care management services for a patient who is discharged from partial hospitalization, (effective April 1, 2013) Medicare systems will enforce consistency editing for Partial Hospital Program services interim claims received from hospitals, CAHs, and Community Mental Health Clinics.

Basically, these edits are intended to ensure that outpatient providers submit claims for a continuing course of treatment for a beneficiary in service date sequence. Bills submitted out of sequence will be returned to the provider.



### GO – What You Need to Do

You should ensure that your billing staffs are aware of these instructions.

## Background

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Medicare billing processes require outpatient providers to submit claims for a beneficiary's continuing course of treatment in the same sequence in which the services are furnished. When an out-of-sequence claim for an outpatient course of treatment is received, Medicare will not suspend the out-of-sequence bill for manual review, but rather will search its claims history for the prior adjudicated bill.

For other than hospice bills, if the prior bill is not in the finalized claims history, Medicare will return the incoming bill to the provider with an error message requesting that the prior bill be submitted first (if not already submitted). You may, then, resubmit the out of sequence bill after you receive the remittance advice for the prior bill.

In the Calendar Year (CY) 2013 Physician Fee Schedule final rule, the Centers for Medicare & Medicaid Services (CMS) has created a new G-code that will be used to report physician or qualifying nonphysician practitioner care management services for a patient who is discharged from partial hospitalization.

Further, CMS has identified that correct interim billing of Partial Hospitalization Services is crucial to this G-code implementation. In order, therefore, to achieve this goal, Medicare systems will enforce consistency editing for interim claims billing for Partial Hospital Program services that are received from:

- A hospital on a bill type 13x (Hospital, Outpatient, Void/Cancel of a Prior Abbreviated Encounter Submission) and condition code 41;
- A Critical Access Hospital (CAH) on a bill type 85x (Special Facility, Critical Access Hospital, Void/Cancel of a Prior Abbreviated Encounter Submission) and condition code 41; or
- A Community Mental Health Center on a bill type 76x (Clinic, Community Mental Health Center, Void/Cancel of a Prior Abbreviated Encounter Submission).

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### Initial Partial Hospitalization Program Services Claim (or Claim for All Services in the Course of Treatment)

Medicare systems will validate that an initial incoming claim for partial hospitalization program services received from:

- A hospital on bill types 131 (Hospital, Outpatient, Admit thru Discharge Claim) and condition code 41, or 132, (Hospital, Outpatient, Interim – First Claim) and condition code 41;
- A Critical Access Hospital (CAH) on bill types 851 (Special Facility, Critical Access Hospital, Admit thru Discharge Claim) and condition code 41, or 852, (Special Facility, Critical Access Hospital, Interim - First Claim) and condition code 41; or
- A Community Mental Health Center on bill types 761 (Clinic, Community Mental Health Center, Admit through Discharge Claim) or 762 (Clinic, Community Mental Health Center, Interim - First Claim);

does not have a prior history partial hospitalization program services claim with a line item date of service within 7 days prior to the “from” date of the incoming claim.

If a prior history partial hospitalization program services claim does contain a line item date of service within 7 days prior to the “from” date of the incoming claim, Medicare systems will Return To Provider the incoming claim.

Medicare systems will also validate that an incoming claim for first-time partial hospitalization program services with bill types 131 or 132 and condition code 41, 851, or 852 and condition code 41, or 761, or 762 does not have a history partial hospitalization program services claim with a line item date of service within 7 days after the “through” date for the incoming.

If a history claim with bill types 131 or 132 and condition code 41, 851, or 852 and a condition code 41, or 761, or 762 does contain a line item date of service within 7 days after the “through” date for the incoming claim, Medicare systems shall Return To Provider the incoming claim.

### Continuing Partial Hospitalization Program Services Claim

Medicare systems will validate that an incoming claim for continuing partial hospitalization program services received from:

- A hospital on bill type 133 (Hospital, Outpatient, Interim – Continuing Claims (Not Valid for PPS Bills)) and condition code 41;
- A CAH on bill type 853 (Special Facility, Critical Access Hospital, Interim - Continuing Claim) and condition code 41; or
- A Community Mental Health Clinic on bill type 763, (Clinic, Community Mental Health Center, Interim-Continuing Claims (Not valid for PPS Bills));

has a prior history claim with a line item date of service within 7 days of the “from” date, and a corresponding claim with bill types 132, 133, 137, (Hospital, Outpatient, Replacement of Prior Claim), or a contractor adjustment claim and condition code 41; 852, 853, 857, (Special Facility, Critical Access Hospital, Replacement of Prior Claim), or a contractor adjustment claim and condition code

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41; or 762, 763, 767, (Clinic, Community Mental Health Center, Replacement of a Prior Claim), or a contractor adjustment claim in history.

If there is no history partial hospitalization program services claim that contains a line item date of service within 7 days prior to the “from” dates for these incoming claims, Medicare systems will Return To Provider the incoming claim.

Medicare systems will also validate that an incoming claim for partial hospitalization program services with bill types 133 and condition code 41, 853, and condition code 41, or 763 does not have a history claim with a line item date of service within 7 days after the “through” date for the incoming claim with bill types 131 or 132 and condition code 41, 851, or 852 and a condition code 41, or 761, or 762 on the history claim.

If a history claim with bill types 131 or 132 and condition code 41, 851, or 852 and a condition code 41, or 761, or 762 contains a line item date of service within 7 days after the “through” date for the incoming claim, Medicare systems shall Return To Provider the incoming claim.

#### Last Claim for Partial Hospitalization Program Services

Medicare systems will validate that an incoming last claim for partial hospitalization program services received from:

- A hospital on bill type 134 and condition code 41;
- A CAH on bill type 854 (Special Facility, Critical Access Hospital, Interim - Last Claim) and condition code 41; or
- A Community Mental Health Center on bill type 764 (Clinic, Community Mental Health Center, Interim-Last Claim (Not valid for PPS Bills));

has a prior history claim with a line item date of service within 7 days of the “from” date, and a corresponding claim with bill types of 132, 133, 137, or contractor adjustment claim and condition code 41; 852, 853, 857, or contractor adjustment claim and condition code 41; or 762, 763, 767, or contractor adjustment claim in history.

If there is no history partial hospitalization program services claim that contains a line item date of service within 7 days prior to the “from” date for the incoming claim, Medicare systems will Return To Provider the incoming claim.

Medicare systems will also validate that an incoming claim for partial hospitalization program services with bill types 134 and condition code 41, 854, and condition code 41, or 764 does not have a history claim with a line item date of service within 7 days after the “through” date for the incoming claim with a bill types 131, 132, or 133 and condition code 41; 851, 852, or 853 and condition code 41; or 761, 762, or 763 on the history claim.

If a history claim with a bill types 131, 132, or 133 and condition code 41; 851, 852, or 853 and condition code 41; or 761, 762, or 763 does contain a line item date of service within 7 days after the through date for the incoming claim, Medicare systems shall Return To Provider the incoming claim.

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### Helpful Guidance

In order to prevent your claims from being returned you should consider the following guidance:

- If the “from” and “through” (FL6) dates on the claim being submitted include the dates for all services of the course of treatment, then the frequency digit in the type of bill will be a “1” [Admit through Discharge Claim] (i.e., 131, 761, or 851); you should enter the final Patient Discharge Status code (FL 17).
- If the “from” and “through” dates on the claim being submitted include the dates for services at the start of the course of treatment (first of a series of bills) and additional services are expected to be submitted on a subsequent bill, then the frequency digit in the type of bill will be a “2” [Interim – First Claim] (i.e., 132, 762, or 852) and the Patient Discharge Status code will be a “30.”
- If the “from” and “through” dates on the claim being submitted include the dates for services at the neither at the start or at the completion of the course of treatment and additional services are expected to be submitted on a subsequent bill, then the frequency digit in the type of bill will be a “3” [Interim – Continuing Claim] (i.e., 133, 763, or 853), and the Patient Discharge Status code will be a “30.”
- If the “from” and “through” dates on the claim being submitted include the dates for services at the completion of the course of treatment (last of a series of bills), and no additional services are expected to be submitted on a subsequent bill, then the frequency digit in the type of bill will be a “4” [Interim – Last Claim] (i.e., 134, 764, or 854), and you should enter the final Patient Discharge Status code.

Please note that the Leave of Absence “Carve-Out” process from the “Medicare Claims Processing Manual,” Chapter 1 (General Billing Requirements), Section 50.2.2 (Frequency of Billing for Providers Submitting Institutional Claims With Outpatient Services) applies. Finally, you may submit Interim Bills daily, weekly, or monthly as long as the claims are submitted with the correct frequency code in the type of bill and sequentially.

### **Additional Information**

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The official instruction, CR8048, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2578CP.pdf> on the CMS website. You will find the “Medicare Claims Processing Manual,” Chapter 1 (General Billing Requirements), Section 50.2.3 - Submitting Bills In Sequence for a Continuous Inpatient Stay or Course of Treatment as an attachment to that CR.

If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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