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Information for Medicare Fee-For-Service Health Care Professionals

Related Change Request (CR) #: 4047

MLN Matters Number: MM4047

Related CR Release Date: November 25, 2005

Related CR Transmittal #: 763

Effective Date: N/A

Implementation Date: N/A

Update to Repetitive Billing Instructions in Medicare Claims Processing Manual

Note: This article was updated on February 16, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 4047, which updates repetitive billing instructions in the *Medicare Claims Processing Manual* (Pub. 100-04). It is intended to be informational only to convey the clarifications made in CR4047.

Background

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.

CR3633 can be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R407CP.pdf> on the CMS website. A MLN Matters article (MM3633) is also available at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3633.pdf> on the CMS website.

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).

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Note: These instructions (which were taken from CR4047) also apply to hospice services billed under Part A, and they do not apply to home health services.

By consolidating repetitive services into a single monthly claim, CMS processing costs will be reduced for:

- Relatively small claims; and
- Instances where bills are held for monthly review.

Services are defined as repetitive services if they are repeated over a span of time and billed with the following revenue codes:

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

One bill for repetitive services will be submitted 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 OPSS.

The 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.

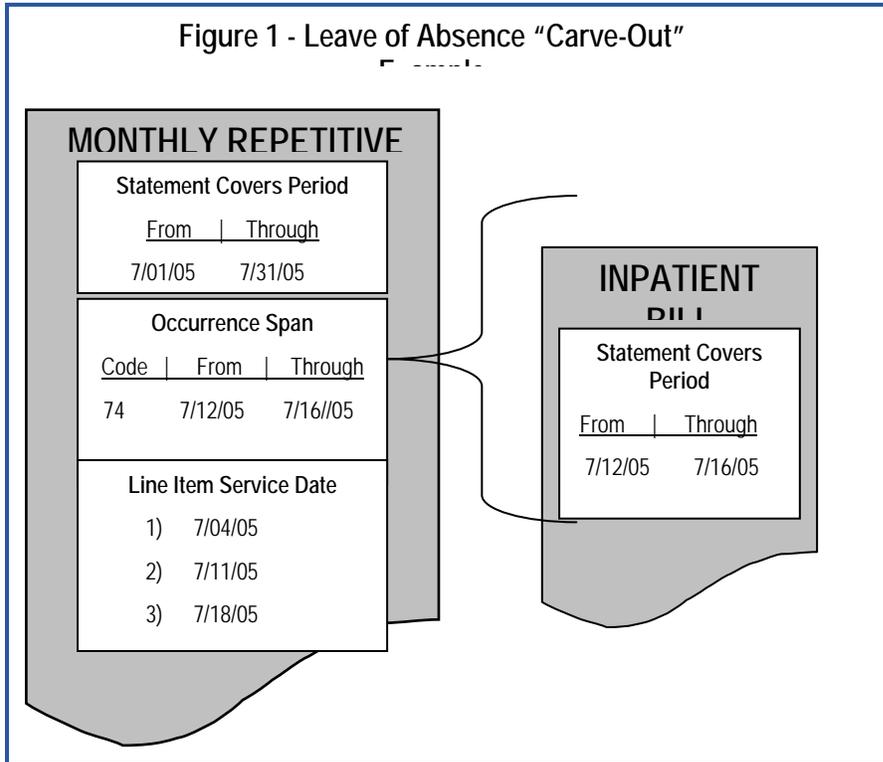
This permits submission of a single bill for the repetitive services for the month and simplifies FI review of these bills.

Note: This is in addition to the bill for the inpatient stay or outpatient surgery.

This is shown in Figure 1 below.

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Any items and/or services in support of the repetitive service will 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 needed specifically in the performance of the repetitive service. Examples may include disposable supplies, drugs, or equipment used to furnish the repetitive service.

To facilitate Ambulatory Payment Classification (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 on a separate OPPS claim:

- The non-repetitive OPPS services; and
- Any packaged and/or services related to the non-repetitive OPPS service.

For example, if a chemotherapy drug is administered on a day a repetitive service is also rendered, then report the chemotherapy drug, its administration, its related supplies, and so on, on a separate claim from the monthly repetitive services claim. Similarly, as shown below in Figure 2, "Example: Monthly Repetitive Billing Procedure," the following occurs on the same day:

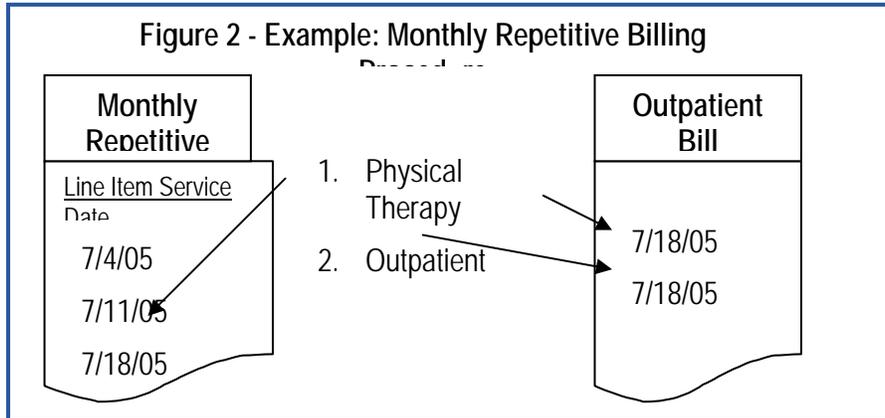
- A physical therapy treatment (which is a repetitive service because it is reported under a revenue code on the repetitive service list) is administered;
- An outpatient consultation is furnished; and

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- A CT scan is furnished.

In this case, report the physical therapy service on the claim with the other physical therapy services provided during the applicable month, and report the visit for the consultation and the CT scan on a separate claim.



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.

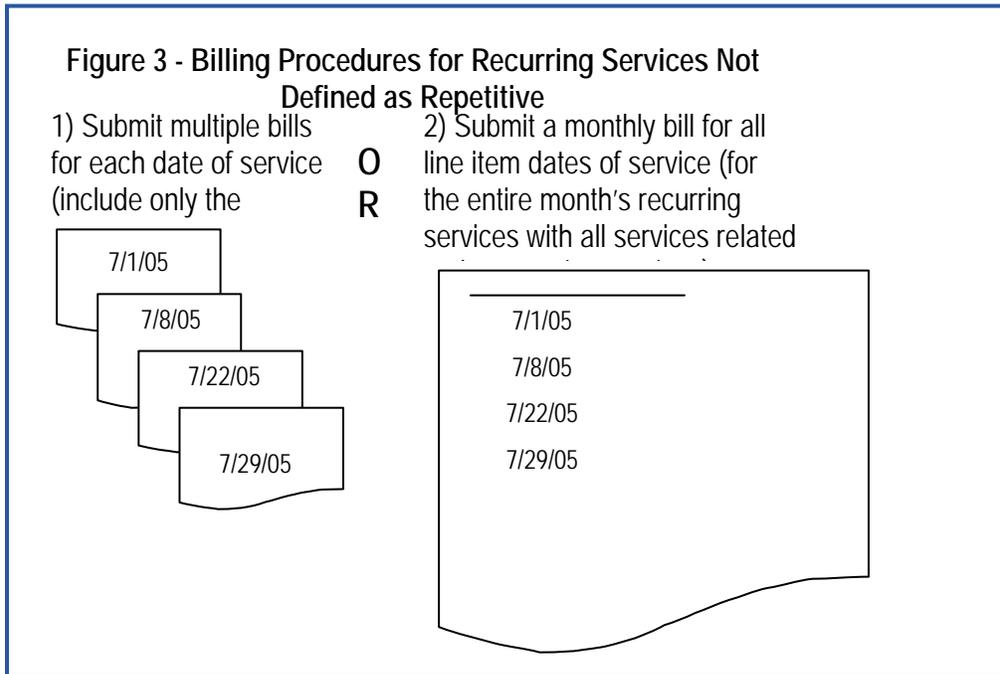
However, because it is common for these services to be furnished in multiple encounters that occur over several weeks or over the course of a month, hospitals have the option of reporting charges for those recurring services on a single bill, as though they were repetitive services. If hospitals elect 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 be billed:

- On the same claim; or
- Separately (by date of service).

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This is shown in Figure 3 below:



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

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 OPPS service, 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 OPPS 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. Report charges for all services and supplies associated with the ECT service that was furnished on the same date(s) on the same claim.

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed by going to <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R763CP.pdf> on the CMS website.

If you have any questions, please contact your intermediary 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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