

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2092	Date: November 12, 2010
	Change Request 7163

SUBJECT: Update to the Frequency Billing Requirements

I. SUMMARY OF CHANGES: Update to the Frequency Billing Requirements to include Pulmonary Rehabilitation Services, revenue code 0948 to the list of repetitive Part B services.

EFFECTIVE DATE: April 1, 2011

IMPLEMENTATION DATE: April 4, 2011

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revise information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/Table of Contents
R	1/50.2.2 /Frequency of Billing for Providers Submitting Institutional Claims with Outpatient Services

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2092	Date: November 12, 2010	Change Request: 7163
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SUBJECT: Update to the Frequency Billing Requirements

Effective Date: April 1, 2011

Implementation Date: April 4, 2011

I. GENERAL INFORMATION

A. Background:

CMS sets limits on the frequency of which particular services may be billed to Medicare. In an effort to lower the volume of submitted bills and to facilitate medical review, frequency limitations have been created to require monthly bill submission of repetitive Part B services.

This changes request is adding Pulmonary Rehabilitation Services, revenue code 0948 to the list of repetitive Part B services as outlines in the Claims Processing Manual (Pub. 100-04), Chapter 1, section 50.2.2.

B. Policy:

This instruction does not change existing policy for repetitive billing services.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M M A C	F I I E R	C A R I E R	R H I S S	Shared-System Maintainers				OTH ER
						F I S S	M C S	V M S	C W F		
7163.1	Contractors shall update the appropriate edits to add Pulmonary Rehabilitation (revenue code 0948) to the list of Repetitive Services as outlines in the Claims Processing Manual (Pub. 100-04), Chapter 1, section 50.2.2.						X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I 	C A R R I E R	R H H I	Shared-System Maintainers				OTH ER
						F I S S	M C S	V M S	C W F		
7163.2	<p>A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.</p> <p>Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.</p>	X		X							

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Tracey Mackey (claims processing) 410-786-5736 or Wil Gehne 410-786-6148.

Post-Implementation Contact(s): Appropriate RO

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs)*, *Regional Home Health Intermediaries (RHHIs)*, and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: For *Medicare Administrative Contractors (MACs)*, include the following statement:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

Table of Contents

(Rev.2092, Issued: 11-12-10)

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

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)

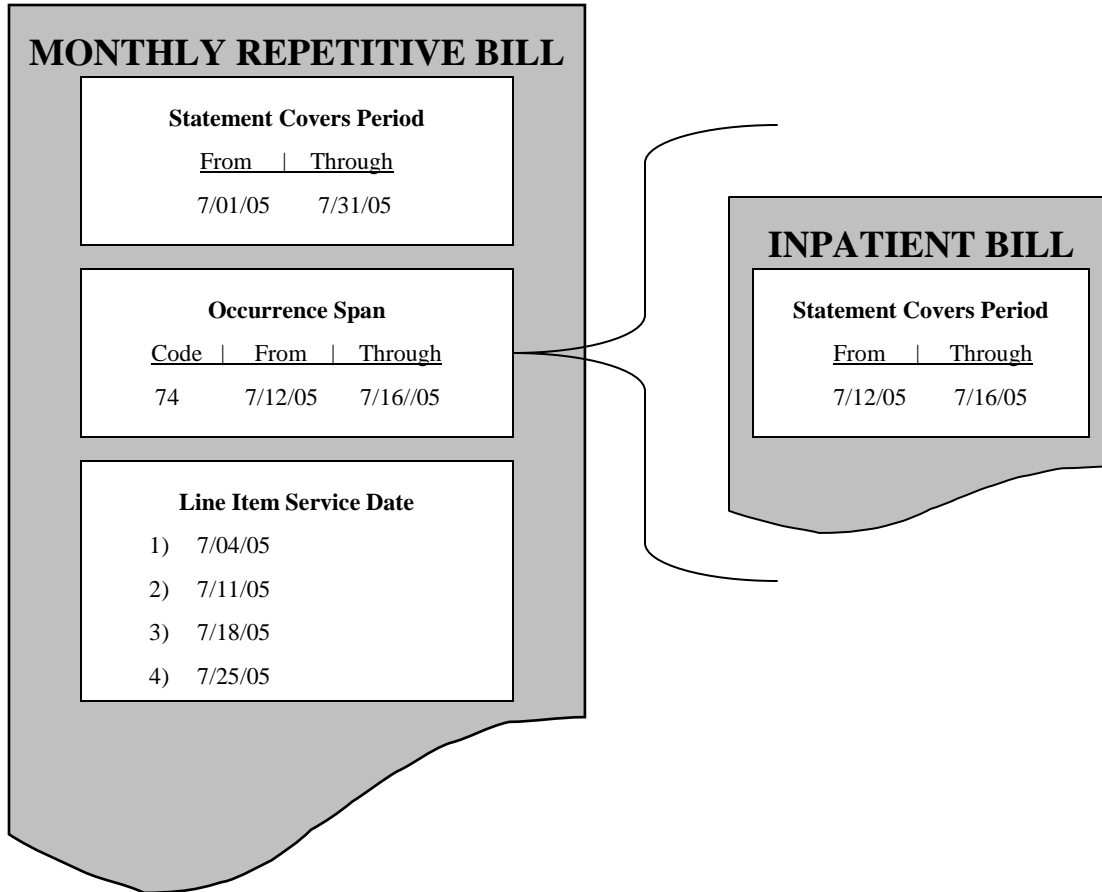
Repetitive Part B services furnished to a single individual by providers that bill *institutional claims* shall be billed monthly (or at the conclusion of treatment). The instructions in this subsection also apply to hospice services billed under Part A, though they do not apply to home health services. 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)
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
<i>Pulmonary Rehabilitation Services</i>	<i>0948</i>

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

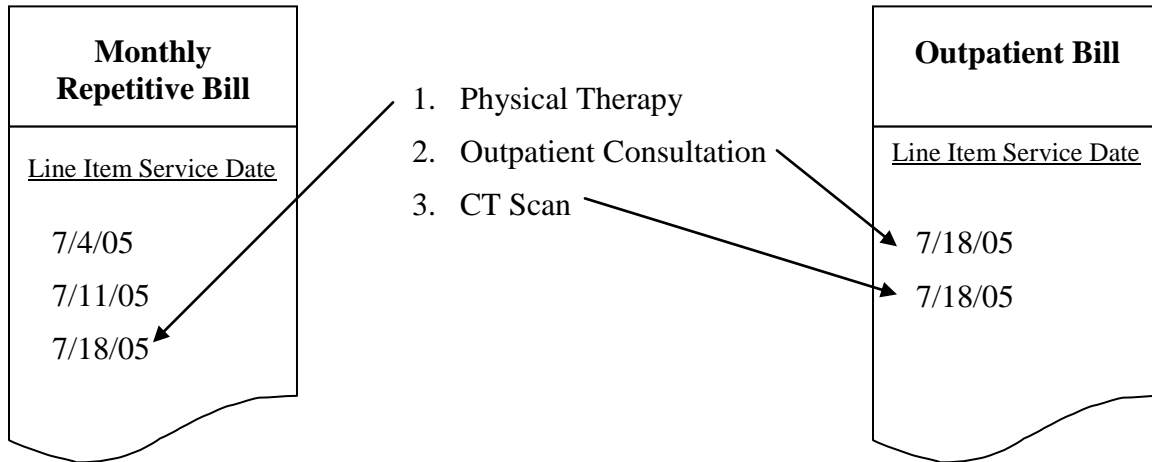


Any items and/or services in support of the repetitive service shall be reported on the same claim even if the revenue code(s) reported with those supported services are not on the repetitive revenue code list (**NOTE:** Supporting items and/or services are those in which are needed specifically in the 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.

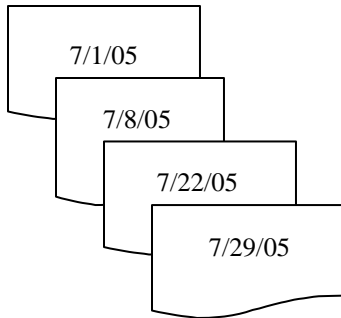
Example: Monthly Repetitive Billing Procedure



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:

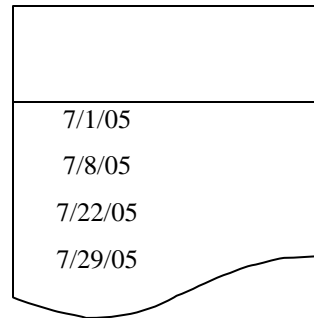
Billing Procedures for Recurring Services Not Defined as Repetitive

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 OPSS. In addition, hospitals that furnish only inpatient Part B services are also exempt from OPSS. 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.