CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2578	**Date: November 1, 2012**
	Change Request 8048

SUBJECT: Enforcing Interim Billing for Partial Hospitalization Services

I. SUMMARY OF CHANGES: In the CY 2013 Physician Fee Schedule final rule, CMS created a new G-code that will be used to report physician or qualifying nonphysician practitioner care management services for a patient following a discharge from partial hospitalization.

Crucial to this implementation, is correct interim billing of Partial Hospitalization Services.

EFFECTIVE DATE: January 1, 2013
IMPLEMENTATION DATE: April 1, 2013

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/revised 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	1/50.2.3/Submitting Bills In Sequence for a Continuous Inpatient Stay or Course of Treatment

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with 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 obliged 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

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2578	Date: November 1, 2012	Change Request: 8048

SUBJECT: Enforcing Interim Billing for Partial Hospitalization Services

EFFECTIVE DATE: January 1, 2013
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I. GENERAL INFORMATION

A. Background: In the CY 2013 Physician Fee Schedule final rule, CMS created a new G-code that will be used to report physician or qualifying nonphysician practitioner care management services for a patient following a discharge from partial hospitalization.

Crucial to this implementation, is correct interim billing of Partial Hospitalization Services.

B. Policy: Based on current Medicare billing policy, Mediare requires that outpatient providers submit claims for a continuing course of treatment for the beneficiary in service date sequence. The shared system must edit to prevent acceptance of a continuing course of treatment claim until the prior bill has been processed. If the prior bill is not in history, the incoming bill will be returned to the provider with the appropriate error message.

When an out-of-sequence claim for an outpatient course of treatment is received, FIs will search the claims history for the prior bill. They do not suspend the out-of-sequence bill for manual review, but perform a history search for an adjudicated claim. For bills other than hospice bills, if the prior bill is not in the finalized claims history, they return to the provider the incoming bill with an error message requesting the prior bill be submitted first, if not already submitted. The returned bill may only be resubmitted after the provider receives notice of the adjudication of the prior bill.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8048.1	Medicare systems shall enforced consistency editing for interim claims billing for Partial Hospital Program services submitted by hospitals on a bill type 13x with a condition code of 41, Critical Access Hospitals (CAHs) on a bill type 85x with a condition code of 41, or Community Mental Health Centers on a bill type							X				

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	76x.											
8048.1.1	Medicare systems shall validate that an incoming claim for partial hospitalization program services with a bill type of 131 and condition code 41, 851 and a condition code 41, or 761 does not have a history partial hospitalization program services claim with a line item date of service within 7 days prior to the from date for the incoming claim. If a history partial hospitalization program services claim contains a line item date of service within 7 days prior to the from date for the incoming claim, Medicare systems shall Return To Provider the incoming claim.							X				
8048.1.2	Medicare systems shall validate that an incoming claim for partial hospitalization program services with a bill type of 132 and condition code 41, 852 and a condition code 41, or 762 does not have a history partial hospitalization program services claim with a line item date of service within 7 days prior to the from date for the incoming claim. If a history partial hospitalization program services claim contains a line item date of service within 7 days prior to the from date for the incoming claim, Medicare systems shall Return To Provider the incoming claim.							X				
8048.1.3	Medicare systems shall validate that an incoming claim for partial hospitalization program services with a bill type of 133 and condition code 41, 853 and a condition code 41, or 763 has a prior history claim with a line item date of service within 7 days of the from date and a corresponding claim with a bill type of 132, 133, 137 or contractor adjustment claim and condition code 41; 852, 853, 857 or contractor adjustment claim and a 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							X				

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	within 7 days prior to the from date for the incoming claim, Medicare systems shall Return To Provider the incoming claim.											
8048.1.4	Medicare systems shall validate that an incoming claim for partial hospitalization program services with a bill type of 134 and condition code 41, 854 and a condition code 41, or 764 has a prior history claim with a line item date of service within 7 days of the from date and a corresponding claim with a bill type of 132, 133, 137 or contractor adjustment claim and condition code 41; 852, 853, 857 or contractor adjustment claim and a 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 shall Return To Provider the incoming claim.							X				
8048.2	Medicare systems shall enforce sequential billing requirements for Partial Hospitalization Program claims.							X				
8048.2.1	Medicare systems shall validate that an incoming claim for partial hospitalization program services with a bill type of 131 and condition code 41, 851 and a condition code 41, or 761 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 claim. If a history partial hospitalization program services claim 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.							X				
8048.2.2	Medicare systems shall validate that an incoming claim for partial hospitalization program services with a bill type of 132 and condition code 41, 852 and a condition							X				

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	code 41, or 762 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 type of 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 a bill type of 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.											
8048.2.3	Medicare systems shall validate that an incoming claim for partial hospitalization program services with a bill type of 133 and condition code 41, 853 and a 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 a bill type of 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 a bill type of 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.							X				
8048.2.4	Medicare systems shall validate that an incoming claim for partial hospitalization program services with a bill type of 134 and condition code 41, 854 and a 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 type of 131, 132 or 133 and condition code 41; 851, 852 or 853 and a condition code 41; or 761, 762 or 763 on the history claim. If a history claim with a bill type of 131, 132 or 133 and condition code 41; 851, 852 or 853 and a condition							X				

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	code 41; or 761, 762 or 763 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.											
8048.3	Medicare contractors shall educate partial hospitalization providers on how to appropriate bill interim claims including proper usage of the following: • Sequential Billing • Type of Bill Frequency • Discharge Status Codes	X			X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8048.4	MLN Article : 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. Contractors shall post this article, or a direct link to this article, on their Web sites 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 the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider	X			X			

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
	community in billing and administering the Medicare program correctly.							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	None.

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Jason Kerr, jason.kerr@cms.hhs.gov , Sarah Shirey-Losso, sarah.shirey-losso@cms.hhs.gov , Jana Lindquist, 410-786-9374 or Jana.Petze@cms.hhs.gov , Fred Rooke, fred.rooke@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
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Section B: For Medicare Administrative Contractors (MACs):
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Medicare Claims Processing Manual
Chapter 1 - General Billing Requirements

50.2.3 - Submitting Bills In Sequence for a Continuous Inpatient Stay or Course of Treatment

(Rev.2578, Issued: 11-01-12, Effective: 01-01-13, Implementation: 04-01-13)

When a patient remains an inpatient of a SNF, TEFRA hospital or unit, swing-bed, or hospice beyond the end of a calendar month, providers must submit a bill for each calendar month. (See §50.2.1 for frequency of billing for inpatient services.) Claims for the beneficiary are to be submitted in service date sequence. The shared system must edit to prevent acceptance of a continuing stay claim or course of treatment claim until the prior bill has been processed. If the prior bill is not in history, the incoming bill will be returned to the provider with the appropriate error message.

When an out-of-sequence claim for a continuous stay or outpatient course of treatment is received, FIs will search the claims history for the prior bill. They do not suspend the out-of-sequence bill for manual review, but perform a history search for an adjudicated claim. For bills other than hospice bills, if the prior bill is not in the finalized claims history, they return to the provider the incoming bill with an error message requesting the prior bill be submitted first, if not already submitted. The returned bill may only be resubmitted after the provider receives notice of the adjudication of the prior bill. A typical error message would be as follows:

> Bills for a continuous stay or admission or for a continuous course of treatment must be submitted in the same sequence in which the services are furnished. If you have not already done so, please submit the prior bill. Then, resubmit this bill after you receive the remittance advice for the prior bill.

For a partial hospitalization program claim to determine out-of-sequence claim submission for the outpatient course of treatment, providers must utilize the correct frequency digit in the type of bill as follows:

> 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). The final Patient Discharge Status code (FL 17) will be entered.
>
> If the “from” and “through” dates (FL6) 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). The Patient Discharge Status code (FL 17) will be a “30”.
>
> If the “from” and “through” dates (FL6) 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). The Patient Discharge Status code (FL 17) will be a "30".

If the "from" and "through" dates (FL6) 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). The final Patient Discharge Status code (FL 17) will be entered.

Leave of Absence "Carve-Out" process from 50.2.2 applies. Providers 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.

For a hospice claim that is out of sequence, the FI searches their claims history. If the FI finds the prior claim has been received but has not been finalized (for instance, it has been suspended for additional development), they do not cause the out of sequence claim to be returned to the provider. Instead, they hold the out of sequence claim until the prior claim has been finalized and then process the out of sequence claim. If the prior hospice claim has not been received, the out of sequence hospice claim is returned to the provider with an error message as described above. FIs shall perform editing to ensure hospice claims are processed in sequence after any necessary medical review of the claims has been completed.

Since hospice claims received out of sequence do not pass all required edits, they do not meet the definition of "clean" claims defined in §80.2 below. As a result, they are not subject to the mandated claims processing timeliness standard and are not subject to interest payments. FIs will enter condition code 64 on the out of sequence claims they are holding when awaiting the processing of the prior claims to indicate that they are not "clean" claims.