CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2862	**Date: January 24, 2014**
	Change Request 8522

SUBJECT: Medicare Claims Processing Manual, Pub. 100-04, Chapter 4 Update for ICD-10 and ASC X12

I. SUMMARY OF CHANGES: This CR contains language-only changes for updating ICD-10 and ASC X12 language in Pub 100-04, Chapter 4.

EFFECTIVE DATE: October 1, 2014
IMPLEMENTATION DATE: October 1, 2014

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	4/20.6.1/ Where to Report Modifiers on the Hospital Part B Claim
R	4/120/ General Rules for Reporting Outpatient Hospital Services
R	4/231.10/ Billing for Autologous Stem Cell Transplants
R	4/250.2/ Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115 percent Fee Schedule Payment for Professional Services
R	4/250.2.1/ Billing and Payment in a Physician Scarcity Area (PSA)
R	4/250.12.2/ Identifying Primary Care Services Eligible for the PCIP
R	4/260.1.1/ Bill Review for Partial Hospitalization Services Received in Community Mental Health Centers (CMHC)
R	4/260.5/ Line Item Date of Service Reporting for Partial Hospitalization

III. FUNDING:
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
Manual Instruction
**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2862	Date: January 24, 2014	Change Request: 8522

SUBJECT: Medicare Claims Processing Manual, Pub. 100-04, Chapter 4 Update for ICD-10 and ASC X12

EFFECTIVE DATE: October 1, 2014
IMPLEMENTATION DATE: October 1, 2014

I. GENERAL INFORMATION

A. Background: This CR contains language-only changes for updating ICD-10 and ASC X12 language in Pub 100-04, Chapter 4.

B. Policy: This CR contains language-only changes for updating ICD-10 and ASC X12 language in Pub 100-04, Chapter 4. All policies and procedures in this instruction have been previously communicated.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8522.1	MACs that process Part B hospital claims, including inpatient hospital Part B and OPPS claims, shall be aware of changes in the attached instructions in Pub 100-04, Chapter 4.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	Not applicable

Section B: All other recommendations and supporting information: Not Applicable

V. CONTACTS

Pre-Implementation Contact(s): Not applicable, 999-999-9999

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do 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 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

Table of Contents
(Rev.2862, Issued: 01-24-14)

20.6.1 - Where to Report Modifiers on the *Hospital Part B Claim*
(Rev. 2862, Issued: 01-24-14, Effective: 10-01-14, Implementation: 10-01-14)

Modifiers are reported on the hardcopy *Form CMS-1450 with the HCPCS code. See Chapter 25 of this manual for related instructions.* There is space for four modifiers on the hardcopy.

See the ASC X12 837 Institutional Claim Implementation Guide for instructions for reporting HCPCS modifiers when using the ASC X12 837 institutional claim format.

The dash that is often seen preceding a modifier should never be reported.

When it is appropriate to use a modifier, the most specific modifier should be used first. That is, when modifiers E1 through E4, FA through F9, LC, LD, RC, and TA through T9 apply, they should be used before modifiers LT, RT, or -59.

120 - General Rules for Reporting Outpatient Hospital Services
(Rev. 2862, Issued: 01-24-14, Effective: 10-01-14, Implementation: 10-01-14)

Hospitals use the *electronic ASC X12* 837 institutional claim transaction format or the hardcopy Form CMS-1450 to bill for covered outpatient services (type of bill 13X or 83X, and 85X). *The ASC X12 837 is required unless the hospital meets certain exception criteria. These criteria are described in Chapter 24, §§90-90.5.4 of this manual.*
See:

- Medicare Benefit Policy Manual, Chapter 6, for definition of an outpatient;
- Medicare Claims Processing Manual, Chapter 3, “Inpatient Part A Hospital Billing,” for outpatient services treated as inpatient services; and
- *Medicare Claims Processing Manual Chapter 24, §§90-90.5.4 for when paper billing is permissible.*
- Medicare Claims Processing Manual, Chapter 25, for general instructions for completing *the hospital claim data set*.

The HCPCS code is used to describe services where payment is under the Hospital OPPS or where payment is under a fee schedule or other outpatient payment methodology. Line item dates of service are reported for every line where a HCPCS code is required under OPPS. For providers paid via OPPS, FIs return to provider (RTP) bills where a line item date of service is not entered for each HCPCS code reported, or if the line item dates of service reported are outside of the statement-covers period. This includes those claims where the “from and through” dates are equal.

NOTE: Effective for dates of service on or after January 1, 2008, the FI no longer processes claims on TOB 83X for ASCs. All IHS ASC providers must submit their claims to the designated carrier.

231.10 - Billing for Autologous Stem Cell Transplants

(Rev. 2862, Issued: 01-24-14, Effective: 10-01-14, Implementation: 10-01-14)

The hospital bills and shows all charges for autologous stem cell harvesting, processing, and transplant procedures based on the status of the patient (i.e., inpatient or outpatient) when the services are furnished. It shows charges for the actual transplant, described by the appropriate ICD procedure or CPT codes in Revenue Center 0362 (Operating Room Services; Organ Transplant, Other than Kidney, or another appropriate cost center.

The CPT codes describing autologous stem cell harvesting procedures may be billed and are separately payable under the Outpatient Prospective Payment System (OPPS) when provided in the hospital outpatient setting of care. Autologous harvesting procedures are distinct from the acquisition services described in Pub. 100-04, Chapter 3, §90.3.3 and §231.11 of this chapter for allogeneic stem cell transplants, which include services provided when stem cells are obtained from a donor and not from the patient undergoing the stem cell transplant.

The CPT codes describing autologous stem cell processing procedures also may be billed and are separately payable under the OPPS when provided to hospital outpatients.

The CPT codes describing autologous stem cell harvesting procedures may be billed and are separately payable under the Outpatient Prospective Payment System (OPPS) when provided in the hospital outpatient setting of care. Autologous harvesting procedures are distinct from the acquisition services described in Pub. 100-04, Chapter 3, §90.3.3 and §231.11 of this chapter for allogeneic stem cell transplants, which include services provided when stem cells are obtained from a donor and not from the patient undergoing the stem cell transplant.

The CPT codes describing autologous stem cell processing procedures also may be billed and are separately payable under the OPPS when provided to hospital outpatients.

250.2 - Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115 percent Fee Schedule Payment for Professional Services

(Rev. 2862, Issued: 01-24-14, Effective: 10-01-14, Implementation: 10-01-14)

The BIPA legislation on payment for professional services at 115 percent of what would otherwise be paid under the fee schedule is effective for services furnished on or after July 1, 2001. A CAH may elect to be paid for outpatient services in any cost reporting period under this method by filing a written election with the intermediary on an annual basis at least 30 days before start of the Cost Reporting period to which the election applies. An election of this payment method, once made for a cost reporting period, remains in effect for all of that period for the CAH.

Effective for cost reporting periods beginning on or after October 1, 2010 if a CAH elected the optional method for its most recent cost reporting period beginning before October 1, 2010 or chooses to elect the optional method on or after October 1, 2010, that election remains in place until it is terminated, an annual election is no longer required. If a CAH elects the optional method on or after October 1, 2010, it must submit its request in writing to its fiscal intermediary or A/B MAC at least 30 days before the start of the first cost reporting period for which the election is effective. That election will not terminate unless the CAH submits a termination request to its fiscal intermediary or A/B MAC at least 30 days before the start of its next cost reporting period.

The Medicare Prescription Drugs, Improvement, and Modernization Act (MMA) of 2003, changed the requirement that each practitioner rendering a service at a CAH that has elected the optional method,

reassign their billing rights to that CAH. This provision allows each practitioner to choose whether to reassign billing rights to the CAH or file claims for professional services through their carrier. The reassignment will remain in effect for that entire cost reporting period.

The individual practitioner must certify, using the Form CMS-855R, if he/she wishes to reassign their billing rights. The CAH must then forward a copy of Form CMS-855R to the intermediary or A/B MAC, and the appropriate carrier or A/B MAC, must have the practitioner sign an attestation that clearly states that the practitioner will not bill the carrier or A/B MAC for any services rendered at the CAH once the reassignment has been given to the CAH. This "attestation" will remain at the CAH.

For CAHs that elected the optional method before November 1, 2003, the provision is effective beginning on or after July 1, 2001. For CAHs electing the optional method on or after November 1, 2003, the provision is effective for cost reporting periods beginning on or after July 1, 2004. Under this election, a CAH will receive payment from their intermediary or A/B MAC for professional services furnished in that CAH's outpatient department. Professional services are those furnished by all licensed professionals who otherwise would be entitled to bill the carrier or A/B MAC under Part B.

Payment to the CAH for each outpatient visit (reassigned billing) will be the sum of the following:

- For facility services, not including physician or other practitioner services, payment will be based on 101 percent of the reasonable costs of the services. *L*ist the facility service(s) rendered to outpatients using the appropriate revenue code. The FI or A/B MAC will pay 101 percent of the reasonable costs for the outpatient services less applicable Part B deductible and coinsurance amounts, plus:

- *Show* the professional services *separately*, along with the appropriate HCPCS code (physician or other practitioner) in one of the following revenue codes - 096X, 097X, or 098X.

The FI or A/B MAC uses the Medicare Physician Fee Schedule (MPFS) amounts to pay for all the physician/nonphysician practitioner services rendered in a CAH that elected the optional method. Payment is based on the lesser of the actual charge or the facility-specific MPFS amount less deductible and coinsurance times 1.15; and

AK - Service rendered in a CAH by a non-participating physician

For a non-participating physician service, a CAH must place modifier AK on the claim. Payment is based on the lesser of the actual charge or a reduced fee schedule amount of 95 percent. Payment is calculated as follows:

- [(facility-specific MPFS amount times the non-participating physician reduction (0.95) minus (deductible and coinsurance] times 1.15.

GF - Services rendered by a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA)

GF - Services rendered in a CAH by a nurse practitioner (NP), clinical nurse specialist (CNS), certified registered nurse (CRN) or physician assistant (PA). (The "GF" modifier is not to be used for CRNA services. If a claim is received and it has the "GF" modifier for certified registered nurse anesthetist (CRNA) services, the claim is returned to the provider.) Also, while this national "GF" modifier includes CRNs, there is no benefit under Medicare law that authorizes payment to CRNs for their services. Accordingly, if a claim is received and it has the "GF" modifier for CRN services, no Medicare payment should be made.

Services billed with the “GF” modifier are paid based on the lesser of the actual charge or a reduced fee schedule amount of 85 percent. Payment is calculated **as follows:**

- [(facility-specific MPFS amount times the nonphysician practitioner services reduction (0.85) minus (deductible and coinsurance)] times 1.15.

SB - Services rendered in a CAH by a certified nurse-midwife

For dates of service prior to January 1, 2011, certified nurse-midwife services billed with the “SB” modifier are paid based on the lesser of the actual charge or a reduced fee schedule amount of 65 percent. Payment is calculated **as follows:**

- [(facility-specific MPFS amount times the certified nurse-midwife reduction (0.65) minus (deductible and coinsurance)] times 1.15.

- For dates of service on or after January 1, 2011, Medicare covers the services of a certified nurse-midwife. The “SB” modifier is used to bill for the services and payment is based on the lesser of the actual charge or 100 percent of the MPFS. MPFS Payment is calculated **as follows**:

- [(facility-specific MPFS amount) minus (deductible and coinsurance)] times 1.15.

AH - Services rendered in a CAH by a clinical psychologist

Payment for the services of a clinical psychologist is based on the lesser of the actual charge or 100 percent of the MPFS. Payment is calculated as follows:

- [(facility-specific MPFS amount) minus (deductible and coinsurance)] times 1.15.

AE - Services rendered in a CAH by a nutrition professional/registered dietitian.

Services billed with the “AE” modifier are paid based on the lesser of the actual charge or a reduced fee schedule amount of 85 percent. Payment is calculated **as follows:**

- [(facility-specific MPFS amount times the registered dietitian reduction (0.85) minus (deductible and coinsurance)] times 1.15.

Outpatient services, including ASC type services, rendered in an all-inclusive rate provider should be billed using the 85X type of bill (TOB). Non-patient laboratory specimens are billed on TOB 14X.

MPFS rates contained in the HHH abstract file are used for payment of all physician/professional services rendered in a CAH that has elected the optional method. If a HCPCS code has a facility rate and a non-facility rate, the facility rate is paid. See Chapter 23 of Pub. 100-04, section 50.1 for the record layout for the HHH abstract file.

Physician Fee Schedule Payment Policy Indicator File

The information on the Physician Fee Schedule Payment Policy Indicator file is used to identify endoscopic base codes, payment policy indicators, global surgery indicators, diagnostic imaging family indicators, or the preoperative, intraoperative and postoperative percentages that are needed to determine if payment adjustment rules apply to a specific CPT code and the associated pricing modifier(s). See Chapter 12 of Pub.

100-04 for more information on payment policy indicators and payment adjustment rules. See Chapter 23 of Pub. 100-04, section 50.6 for the record layout of the Payment Policy Indicator file.

Health Professional Shortage Area (HPSA) Incentive Payments for Physicians

Section 1833 (m) of the Social Security Act, provides incentive payments for physicians who furnish services in areas designated as HPSAs under section 332(a)(1)(A) of the Public Health Service (PHS) Act. This statute recognizes geographic-based, primary medical care and mental health HPSAs, are areas for receiving a 10 percent bonus payment. The Health Resources and Services Administration (HRSA), within the Department of Health & Human Services, is responsible for designating shortage areas.

Physicians, including psychiatrists, who provide covered professional services in a primary medical care HPSA, are entitled to an incentive payment. In addition, psychiatrists furnishing services in mental health HPSAs are eligible to receive bonus payments. The bonus is payable for psychiatric services furnished in either a primary care HPSA, or a mental health HPSA. Dental HPSAs remain ineligible for the bonus payment.

Physicians providing services in either rural or urban HPSAs are eligible for a 10 percent incentive payment. It is not enough for the physician merely to have his/her office or primary service location in a HPSA, nor must the beneficiary reside in a HPSA, although, frequently, this will be the case. The key to eligibility is where the service is actually provided (place of service). For example, a physician providing a service in his/her office, the patient's home, or in a hospital, qualifies for the incentive payment as long as the specific location of the service provision is within an area designed as a HPSA. On the other hand, a physician may have an office in a HPSA, but go outside the office (and the designated HPSA area) to provide the service. In this case, the physician would not be eligible for the incentive payment.

If the CAH electing the Optional Method (Method II) is located within a primary medical care HPSA, and/or mental health HPSA, the physicians providing (outpatient) professional services in the CAH are eligible for HPSA physician incentive payments. Therefore, payments to such a CAH for professional services of physicians in the outpatient department will be 115 percent **times** the amount payable under fee schedule **times** 110 percent. An approved Optional Method CAH that is located in a HPSA County should notify you of its HPSA designation **in writing**. Once you receive the information, place an indicator on the provider file showing the effective date of the CAH's HPSA status. The CMS will furnish quarterly lists of mental health HPSAs to intermediaries.

The HPSA incentive payment is 10 percent of the amount actually paid, not the approved amount. Do not include the incentive payment in each claim. Create a utility file so that you can run your paid claims file for a quarterly log. From this log you will send a quarterly report to the CAHs for each physician payment, one month following the end of each quarter. The sum of the "10% of line Reimbursement" column should equal the payment sent along with the report to the CAH. If any of the claims included on the report are adjusted, be sure the adjustment also goes to the report. If an adjustment request is received after the end of the quarter, any related adjustment by the FI will be included on next quarter's report. The CAHs must be sure to keep adequate records to permit distribution of the HPSA bonus payment when received. If an area is designated as both a mental health HPSA and a primary medical care HPSA, only one 10 percent bonus payment shall be made for a single service.

250.2.1 - Billing and Payment in a Physician Scarcity Area (PSA)

(Rev. 2862, Issued: 01-24-14, Effective: 10-01-14, Implementation: 10-01-14)

Section 413a of the MMA 2003 requires that a new 5 percent bonus payment be established for physicians in designated physician scarcity areas. The payment should be made on a quarterly basis and placed on the quarterly report that is now being produced for the HPSA bonus payments.

Section 1861(r)(1), of the Act, defines physicians as doctors of medicine or osteopathy. Therefore, dentists, chiropractors, podiatrists, and optometrists are not eligible for the physician scarcity bonus as either primary

care or specialty physicians. Only the primary care designations of general practice, family practice, internal medicine, and obstetrics/gynecology, will be paid the bonus for the ZIP codes designated as primary care scarcity areas. All physician provider specialties are eligible for the specialty physician scarcity bonus except the following: oral surgery (dentist only); chiropractic; optometry; and podiatry. The bonus is payable for dates of service January 1, 2005, through December 31, 2007. The Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 amended §1833(u)(1) of the Social Security Act and has extended payment of that bonus through June 30, 2008.

One of the following modifier(s) must accompany the HCPCS code to indicate type of physician:

AG – Primary Physician
AF – Specialty Physician

Modifiers AG and AF are not required for dates of service on or after January 1, 2005. Modifier AR, physician providing services in a physician scarcity area, may be required for claims with dates of service on or after January 1, 2005 to receive the PSA bonus. Refer to §250.2.2 of this chapter for more information on when modifier AR is required.

There may be situations when a CAH is not located in a bonus area but its outpatient department is in a designated bonus area, or vice versa. If a CAH has an off-site outpatient department/clinic the off-site department's complete address, including the ZIP code, must be placed on the claim as the service facility. The FISS must look at the service facility ZIP code to determine if a bonus payment is due.

For electronic claims, the service facility address should be in the 2310E loop of the *ASC X12 837 institutional claim format*. On the hard copy *Form CMS-1450* the address should be placed in "Remarks"; however, the ZIP code placement will be determined by the FI.

250.12.2 - Identifying Primary Care Services Eligible for the PCIP

(Rev. 2862, Issued: 01-24-14, Effective: 10-01-14, Implementation: 10-01-14)

CAHs paid under the optional method billing on TOB 85X for professional primary care services (revenue code 96X, 97X or 98X) furnished by primary care physicians and nonphysician practitioners who have reassigned their billing rights to the CAH are eligible for PCIP payments.

The National Provider Identifier (NPIs) of primary care practitioners eligible for PCIP payment in a given calendar year (CY) are posted on Medicare contractor web sites in the Primary Care Incentive Payment Program Eligibility File by January 31 of the applicable incentive payment CY. Eligible practitioners for PCIP payment in a given calendar year who were newly enrolled in Medicare in the year immediately preceding the PCIP payment year will be identified later in the payment year and posted on their Medicare contractor's website at that point in time. CAHs paid under the optional method should contact their contractor with any questions regarding the eligibility of physician and nonphysician practitioners for PCIP payments.

Primary care practitioners furnishing primary care services will be identified on CAH claims by the NPI of the rendering practitioner as follows:

- Line level 'Rendering Provider' field when populated or,
- Claim level 'Rendering Provider' field where a line level 'Rendering Provider' field is blank or,
- Claim level 'Attending Provider' field if the claim level 'Rendering Provider' field is blank.

In order for a primary care service to be eligible for PCIP payment, the CAH paid under the optional method must be billing for the professional services of physicians under their NPIs or of physician assistants,

clinical nurse specialists, or nurse practitioners under their own NPIs because they are not furnishing services incident to physicians' services.

Multiple primary care services rendered by different physicians may be present on a single claim. Providers shall ensure they identify each physician on the claim form per the *ASC X12 837 Institutional Claim Implementation Guide*.

260.1.1 - Bill Review for Partial Hospitalization Services Provided in Community Mental Health Centers (CMHC)

(Rev. 2862, Issued: 01-24-14, Effective: 10-01-14, Implementation: 10-01-14)

A. General

Medicare Part B coverage for partial hospitalization services provided by CMHCs is available effective for services provided on or after October 1, 1991.

B. Special Requirements

Section 1866(e)(2) of the Act recognizes CMHCs as "providers of services" but only for furnishing partial hospitalization services. Applicable provider ranges are 1400-1499, 4600-4799, and 4900-4999.

C. Billing Requirements

The CMHCs bill for partial hospitalization services under bill type 76X. The FIs follow bill review instructions in chapter 25 of this manual, except for those listed below.

The acceptable revenue codes are as follows:

Code	Description
0250	Drugs and Biologicals
043X	Occupational Therapy
0900	Behavioral Health Treatments/Services
0904	Activity Therapy
0910	Psychiatric/Psychological Services (Dates of Service prior to October 16, 2003)
0914	Individual Therapy
0915	Group Therapy
0916	Family Therapy
0918	Testing
0942	Education Training

The CMHCs are also required to report appropriate HCPCS codes as follows:

Revenue Codes	Description	HCPCS Code
043X	Occupational Therapy (Partial Hospitalization)	*G0129
0900	Behavioral Health Treatments/Services	****90791 or***** 90792
0904	Activity Therapy (Partial Hospitalization)	**G0176
0914	Individual Psychotherapy	90785, 90832, 90833, 90834, 90836, 90837, 90838, 90845, 90865, or 90880
0915	Group Psychotherapy	G0410 or G0411
0916	Family Psychotherapy	90846 or 90847

Revenue Codes	Description	HCPCS Code
0918	Psychiatric Testing	96101, 96102, 96103, 96116, 96118, 96119, or 96120
0942	Education Training	***G0177

The FIs edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. They do not edit for the matching of revenue codes to HCPCS.

*The definition of code G0129 is as follows:

Occupational therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, - per session (45 minutes or more).

**The definition of code G0176 is as follows:

Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more).

***The definition of code G0177 is as follows:

Training and educational services related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more).

****The definition of code 90791 is as follows:

Psychiatric diagnostic evaluation (no medical services) completed by a non-physician.

*****The definition of code 90792 is as follows:

Psychiatric diagnostic evaluation (with medical services) completed by a physician.

Codes G0129 and G0176 are used only for partial hospitalization programs.

Code G0177 may be used in both partial hospitalization program and outpatient mental health settings.

Revenue code 0250 does not require HCPCS coding. However, drugs that can be self-administered are not covered by Medicare.

HCPCS includes CPT-4 codes. CMHCs report HCPCS codes on Form CMS-1450 in FL44, "HCPCS/Rates." HCPCS code reporting is effective for claims with dates of service on or after April 1, 2000.

The FIs are to advise their CMHCs of these requirements. CMHCs should complete the remaining items on Form CMS-1450 in accordance with the bill completion instructions in Chapter 25 of this manual.

The professional services listed below are separately covered and are paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other than physician assistants (PAs)) bill the Medicare Part B carrier directly for the professional services furnished to CMHC partial hospitalization patients. The CMHC can also serve as a billing agent for these professionals by billing the Part B carrier on their behalf for their professional services. The professional services of a PA can be billed to the carrier only by the PAs employer. The employer of a PA may be such entities or individuals as a physician, medical group, professional corporation, hospital, SNF, or nursing facility. For example, if a physician is the employer of the PA and the PA renders services in the CMHC, the physician and not the CMHC would be responsible for billing the carrier on Form CMS-1500 for the services of the PA.

The following professional services are unbundled and not paid as partial hospitalization services:

- Physician services that meet the criteria of 42 CFR 415.102, for payment on a fee schedule basis;
- PA services, as defined in §1861(s)(2)(K)(i) of the Act;
- Nurse practitioner and clinical nurse specialist services, as defined in §1861(s)(2)(K)(ii) of the Act; and,
- Clinical psychologist services, as defined in §1861(ii) of the Act.

The services of other practitioners (including clinical social workers and occupational therapists) are bundled when furnished to CMHC patients. The CMHC must bill the FI for such nonphysician practitioner services as partial hospitalization services. The FI makes payment for the services to the CMHC.

D. Outpatient Mental Health Treatment Limitation

The outpatient mental health treatment limitation **may apply** to services to treat mental, psychoneurotic, and personality disorders when furnished by physicians, clinical psychologists, NPs, CNSs, and PAs to partial hospitalization patients. However, the outpatient mental health treatment limitation **does not** apply to such mental health treatment services billed to the FI as partial hospitalization services.

E. Reporting of Service Units

Visits should no longer be reported as units. Instead, CMHCs report in the field, "Service Units," the number of times the service or procedure, as defined by the HCPCS code, was performed when billing for partial hospitalization services identified by revenue code in subsection C.

EXAMPLE: A beneficiary received psychological testing (HCPCS code 96100, which is defined in 1 hour intervals) for a total of 3 hours during one day. The CMHC reports revenue code 0918, HCPCS code 96100, and "3".

When reporting service units for HCPCS codes where the definition of the procedure does not include any reference to time (either minutes, hours or days), CMHCs should not bill for sessions of less than 45 minutes.

The CMHC need not report service units for drugs and biologicals (Revenue Code 0250)

NOTE: Information regarding the *Form CMS-1450* form locators that correspond with these fields is found in Chapter 25 of this manual. *See the ASC X12 837 Institutional Claim Implementation Guide for related guidelines for the electronic claim.*

F. Line Item Date of Service Reporting

Dates of service per revenue code line for partial hospitalization claims that span two or more dates. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in "Service Date". See examples below of reporting line item dates of service. These examples are for group therapy services provided twice during a billing period.

For claims, report as follows:

Revenue Code	HCPCS	Dates of Service	Units	Total Charges
0915	G0176	20090505	1	$80
0915	G0176	20090529	2	$160

NOTE: Information regarding the *Form CMS-1450* form locators that correspond with these fields is found in Chapter 25 of this manual. *See the ASC X12 837 Institutional Claim Implementation Guide for related guidelines for the electronic claim.*

The FIs return to provider claims that span two or more dates if a line item date of service is not entered for each HCPCS code reported or if the line item dates of service reported are outside of the statement covers period. Line item date of service reporting is effective for claims with dates of service on or after June 5, 2000.

G. Payment

Section 1833(a)(2)(B) of the Act provides the statutory authority governing payment for partial hospitalization services provided by a CMHC. FIs made payment on a reasonable cost basis until OPPS was implemented. The Part B deductible and coinsurance applied.

Payment principles applicable to partial hospitalization services furnished in CMHCs are contained in §2400 of the Medicare Provider Reimbursement Manual.

The FIs make payment on a per diem basis under the hospital outpatient prospective payment system for partial hospitalization services. CMHCs must continue to maintain documentation to support medical necessity of each service provided, including the beginning and ending time.

Effective January 1, 2011, there are four separate APC payment rates for PHP: two for CMHCs (for Level I and Level II services based on only CMHC data) and two for hospital-based PHPs (for Level I and Level II services based on only hospital-based PHP data). The following chart displays the CMHC APCs:

Community Mental Health Center PHP APCs

APC	Group Title
0172	Level I Partial Hospitalization (3 services) for CMHCs
0173	Level II Partial Hospitalization (4 or more services) for CMHCs

NOTE: Occupational therapy services provided to partial hospitalization patients are not subject to the prospective payment system for outpatient rehabilitation services, and therefore the financial limitation required under §4541 of the Balanced Budget Act (BBA) does not apply.

H. Medical Review

The FIs follow medical review guidelines in Pub. 100-08, Medicare Program Integrity Manual.

I. Coordination With CWF

See chapter 27 of this manual. All edits for bill type 74X apply, except provider number ranges 4600-4799 are acceptable only for services provided on or after October 1, 1991.

Attachment A – Tables for the Policy Section

Table 1 – New CY 2013 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2013 HCPCS Code	CY 2013 Long Descriptor	CY 2013 SI	CY 2013 APC
C9294	Injection, taliglucerase alfa, 10 units	G	9294
C9295	Injection, carfilzomib, 1 mg	G	9295
C9296	Injection, ziv-aflibercept, 1 mg	G	9296
J1744	Injection, icatibant, 1 mg	K	1443
J2212	Injection, methylnaltrexone, 0.1 mg	K	1445
J7315	Mitomycin, ophthalmic, 0.2 mg	N	
Q4134	Hmatrix, per square centimeter	E	
Q4135	Mediskin, per square centimeter	E	
Q4136	Ez-derm, per square centimeter	E	
Q9969	Tc-99m from non highly-enriched uranium source, full cost recovery add-on, per study dose	K	1442

Table 2 – Other CY 2013 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2012 HCPCS/ CPT code	CY 2012 Long Descriptor	CY 2013 HCPCS/ CPT Code	CY 2013 Long Descriptor
C9279	Injection, ibuprofen, 100 mg	J1741	Injection, ibuprofen, 100 mg
C9286	Injection, belatacept, 1 mg	J0485	Injection, belataccept, 1 mg
C9287	Injection, brentuximab vedotin, 1 mg	J9042	Injection, brentuximab vedotin, 1 mg
C9288	Injection, centruroides (scorpion) immune f(ab)2 (equine), 1 vial	J0716	Injection, centruroides immune f(ab)2, up to 120 milligrams
C9289	Injection, asparaginase erwinia chrysanthemi, 1,000 international units (i.u.)	J9019	Injection, asparaginase (Erwinaze), 1,000 IU
C9366	EpiFix, per square centimeter	Q4131	Epifix, per square centimeter
C9368	Grafix core, per square centimeter	Q4132	Grafix core, per square centimeter
C9369	Grafix prime, per square centimeter	Q4133	Grafix prime, per square centimeter
J1051	Injection, medroxyprogesterone acetate, 50 mg	J1050	Injection, medroxyprogesterone acetate, 1 mg
J8561	Everolimus, oral, 0.25 mg	J7527	Everolimus, oral, 0.25 mg
J9020	Injection, asparaginase, 10,000 units	J9020	Injection, Asparaginase, Not Otherwise Specified, 10,000 Units
J9280	Mitomycin, 5 mg	J9280	Injection, mitomycin, 5 mg
Q2045*	Injection, human fibrinogen concentrate, 1 mg	J7178	Injection, human fibrinogen concentrate, 1 mg
Q2046*	Injection, aflibercept, 1 mg	J0178	Injection, aflibercept, 1 mg
Q2047	Injection, peginesatide, 0.1 mg (for esrd on dialysis)	J0890	Injection, peginesatide, 0.1 mg (for esrd on dialysis)
Q2048*	Injection, doxorubicin hydrochloride, liposomal, doxil, 10 mg	J9002	Injection, doxorubicin hydrochloride, liposomal, doxil, 10 mg
Q4119	Matristem wound matrix, per square centimeter	Q4119	Matristem wound matrix, psmx, rs, or psm, per square centimeter
Q4126	Memoderm, per square centimeter	Q4126	Memoderm, dermaspan, tranzgraft or integuply, per square centimeter

CY 2012 HCPCS/ CPT code	CY 2012 Long Descriptor	CY 2013 HCPCS/ CPT Code	CY 2013 Long Descriptor
Q4128	Flexhd or allopatch hd, per square centimeter	Q4128	Flex hd, allopatch hd, or matrix hd, per square centimeter

*HCPCS code J1680 was replaced with HCPCS code Q2045 effective July 1, 2012. HCPCS code Q2045 was subsequently replaced with HCPCS code J7178, effective January 1, 2013.

*HCPCS code C9291 was replaced with HCPCS code Q2046 effective July 1, 2012. HCPCS code Q2046 was subsequently replaced with HCPCS code J0178, effective January 1, 2013.

*HCPCS code J9001 was replaced with HCPCS code Q2048 effective July 1, 2012. HCPCS code Q2048 was subsequently replaced with HCPCS code J9002, effective January 1, 2013.

Table 3 – Updated payment Rates for Certain HCPCS Codes Effective April 1, 2012 through June 30, 2012

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
Q4112	K	1250	Cymetra allograft	$271.12	$54.22

Table 4 – Updated payment Rates for Certain HCPCS Codes Effective July 1, 2012 through September 30, 2012

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
Q4112	K	1250	Cymetra allograft	$323.65	$64.73

Table 5 – Wage Index by CBSA for Non-IPPS Hospitals that are Eligible for the Section 505 Out-Commuting Adjustment

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2013
012011	11500	YES	0.7485
013027	01	YES	0.7224
013032	23460	YES	0.7634
014006	23460	YES	0.7634
014016	01	YES	0.7291
042007	38220	YES	0.8079
042011	04	YES	0.7621
052034	36084	YES	1.6145
052035	42044	YES	1.2313
052039	42044	YES	1.2313
052053	42044	YES	1.2313
053034	42044	YES	1.2313
053301	36084	YES	1.6145
053304	42044	YES	1.2313

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2013
053306	42044	YES	1.2313
053308	42044	YES	1.2313
054074	46700	YES	1.5648
054110	36084	YES	1.6145
054122	34900	YES	1.5752
054135	42044	YES	1.2313
054141	46700	YES	1.5648
054146	36084	YES	1.6145
063033	24540	YES	1.0071
064007	14500	YES	1.0367
074003	25540	YES	1.1830
074007	25540	YES	1.1830
114018	11	YES	0.7737
132001	17660	YES	0.9423
134010	13	YES	0.8746
153040	15	YES	0.8625
154014	15	YES	0.8540
154035	15	YES	0.8422
154047	15	YES	0.8625
183028	21060	YES	0.8199
184012	21060	YES	0.8199
192022	19	YES	0.7895
192026	19	YES	0.8119
192034	19	YES	0.7997
192036	19	YES	0.8078
192040	19	YES	0.8078
192050	19	YES	0.8056
193036	19	YES	0.7997
193044	19	YES	0.8078
193047	19	YES	0.7997
193049	19	YES	0.7997
193055	19	YES	0.7890
193058	19	YES	0.7915
193063	19	YES	0.8078
193067	19	YES	0.7948
193068	19	YES	0.8078
193069	19	YES	0.7915
193073	19	YES	0.7997
193079	19	YES	0.8078
193081	19	YES	0.8056
193088	19	YES	0.8056
193091	19	YES	0.7911
194047	19	YES	0.8119
194075	19	YES	0.7948
194077	19	YES	0.7895

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2013
194081	19	YES	0.7897
194082	19	YES	0.7948
194083	19	YES	0.7915
194085	19	YES	0.8056
194087	19	YES	0.7895
194091	19	YES	0.8078
194092	19	YES	0.7871
194095	19	YES	0.7997
194097	19	YES	0.8056
212002	25180	YES	0.9536
214001	12580	YES	1.0032
214003	25180	YES	0.9536
222000	15764	YES	1.3439
222003	15764	YES	1.3439
222026	37764	YES	1.3308
222044	37764	YES	1.3308
222047	37764	YES	1.3308
223026	15764	YES	1.3439
223028	37764	YES	1.3308
224007	15764	YES	1.3439
224033	37764	YES	1.3308
224038	15764	YES	1.3439
224039	37764	YES	1.3308
232019	19804	YES	0.9427
232023	47644	YES	0.9628
232025	35660	YES	0.8456
232027	19804	YES	0.9427
232028	12980	YES	0.9754
232030	47644	YES	0.9631
232031	19804	YES	0.9427
232032	19804	YES	0.9427
232035	12980	YES	0.9754
232036	27100	YES	0.8760
232038	19804	YES	0.9427
233025	12980	YES	0.9754
233027	19804	YES	0.9427
233028	47644	YES	0.9631
233300	19804	YES	0.9427
234011	47644	YES	0.9631
234021	47644	YES	0.9628
234023	47644	YES	0.9631
234028	19804	YES	0.9427
234034	19804	YES	0.9427
234035	19804	YES	0.9427
234038	19804	YES	0.9427

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2013
234039	47644	YES	0.9628
234040	19804	YES	0.9427
252011	25	YES	0.7986
264005	26	YES	0.8023
303026	40484	YES	1.2045
304001	40484	YES	1.2045
312018	20764	YES	1.1233
312020	35084	YES	1.1366
313025	35084	YES	1.1427
313300	20764	YES	1.1233
314010	35084	YES	1.1427
314011	20764	YES	1.1233
314016	35084	YES	1.1366
314020	35084	YES	1.1427
334017	39100	YES	1.1742
334049	10580	YES	0.8681
334061	39100	YES	1.1742
342019	34	YES	0.8404
344001	39580	YES	0.9383
344011	39580	YES	0.9383
344014	39580	YES	0.9383
362016	15940	YES	0.8627
362032	15940	YES	0.8627
364031	15940	YES	0.8627
364040	44220	YES	0.9241
364042	36	YES	0.8470
364043	36	YES	0.8529
372017	37	YES	0.7848
372019	37	YES	0.8064
373032	37	YES	0.7848
392031	27780	YES	0.8329
392034	10900	YES	0.9258
393026	39740	YES	0.9246
393050	10900	YES	1.1235
394014	39740	YES	0.9246
394020	30140	YES	0.8589
394052	39740	YES	0.9246
422004	43900	YES	0.9012
423029	11340	YES	0.9070
424011	11340	YES	0.9070
424013	42	YES	0.8359
444008	44	YES	0.7920
444019	17300	YES	0.8360
452018	23104	YES	0.9489
452019	23104	YES	0.9489

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2013
452028	23104	YES	0.9489
452088	23104	YES	0.9489
452099	23104	YES	0.9489
452110	23104	YES	0.9489
453040	23104	YES	0.9489
453041	23104	YES	0.9489
453042	23104	YES	0.9489
453089	45	YES	0.8103
453094	23104	YES	0.9489
453300	23104	YES	0.9489
454009	45	YES	0.8125
454012	23104	YES	0.9489
454101	45	YES	0.8211
454113	23104	YES	0.9489
462005	39340	YES	0.8986
464014	39340	YES	0.8986
493026	49	YES	0.8229
522005	39540	YES	0.9716
524025	22540	YES	0.9509
673035	23104	YES	0.9489
673044	23104	YES	0.9489
673048	23104	YES	0.9489

260.5 - Line Item Date of Service Reporting for Partial Hospitalization

(Rev. 2862, Issued: 01-24-14, Effective: 10-01-14, Implementation: 10-01-14)

Hospitals other than CAHs are required to report line item dates of service per revenue code line for partial hospitalization claims. Where services are provided on more than one day included in the billing period, the date of service must be identified. Each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. See examples below of reporting line item dates of service. These examples are for group therapy services provided twice during a billing period.

For the claims, report as follows:

Revenue Code	HCPCS	Dates of Service	Units	Total Charges
0915	G0176	20090505	1	$80.00
0915	G0176	20090529	2	$160.00

NOTE: Information regarding the *Form CMS-1450* form locators that correspond with these fields is found in Chapter 25 of this manual. *See the ASC X12 837 Institutional Claim Implementation Guide for related guidelines for the electronic claim.*

The FI must return to the hospital (RTP) claims where a line item date of service is not entered for each HCPCS code reported, or if the line item dates of service reported are outside of the statement covers period. Line item date of service reporting is effective for claims with dates of service on or after June 5, 2000.