CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12423	**Date: December 20, 2023**
	Change Request 13222

Transmittal 12125 issued July 13, 2023, is being rescinded and replaced by Transmittal 12423, dated December 20, 2023, to remove sensitive language, add provider education business requirements and to revise Publication (Pub) 100-04 IOM chapters 2, 4, 12, 20, 25, 29 and 30. All other information remains the same.

NOTE: This Transmittal is no longer sensitive and is being re-communicated December 20, 2023. This instruction may now be posted to the Internet.

SUBJECT: Enforcing Billing Requirements for Intensive Outpatient Program (IOP) Services with New Condition Code 92

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to implement the new condition code 92 for Intensive Outpatient Program (IOP) services and enforce billing requirements.

EFFECTIVE DATE: January 1, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2024

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	2/05/Definition of Provider and Supplier
R	4 - Table of Contents
R	4/10.1/Background
R	4/10.7.1/Outlier Adjustments
R	4/10.9/Updates
R	4/30.1/Coinsurance Election
R	4/120.1/Bill Types Subject to OPPS
R	4/170 - Hospital and CMHC Reporting Requirements for Services Performed on the Same Day
N	4/261/Intensive Outpatient Program Services
N	4/261.1/Special Intensive Outpatient Program Billing Requirements for Hospitals, Community Mental Health Centers, and Critical Access Hospitals
N	4/261.1.1/Bill Review for Intensive Outpatient Program Services Received in Community Mental Health Centers (CMHC)
N	4/261.2/Professional Services Related to Intensive Outpatient Program
N	4/261.3/Outpatient Mental Health Treatment Limitation for Intensive Outpatient Program Services
N	4/261.4/Reporting Service Units for Intensive Outpatient Program
N	4/261.5/Line Item Date of Service Reporting for Intensive Outpatient Program
N	4/261.6/Payment for Intensive Outpatient Program Services
R	4/270/Billing for Hospital Outpatient Services Furnished by Clinical Social Workers (CSW) Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs)
R	4/270.1/Fee Schedule to be Used for Payment for CSW Services
R	12/190.5/Originating Site Facility Fee Payment Methodology
R	12/210.1/Application of the Limitation
R	20/01/Foreword
R	25/75.5/Form Locators 43-65
R	29/110/Glossary
R	30/500/Glossary

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 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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 12423	Date: December 20, 2023	Change Request: 13222

Transmittal 12125 issued July 13, 2023, is being rescinded and replaced by Transmittal 12423, dated December 20, 2023, to remove sensitive language, add provider education business requirements and to revise Publication (Pub) 100-04 IOM chapters 2, 4, 12, 20, 25, 29 and 30. All other information remains the same.

NOTE: This Transmittal is no longer sensitive and is being re-communicated December 20, 2023. This instruction may now be posted to the Internet.

SUBJECT: Enforcing Billing Requirements for Intensive Outpatient Program (IOP) Services with New Condition Code 92

EFFECTIVE DATE: January 1, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2024

I. GENERAL INFORMATION

A. Background: The National Uniform Billing committee has approved for usage a new condition code "92" to identify claims where services were provided under an Intensive Outpatient Program (IOP) services care plan. All services for IOP provided and billed by a hospital or Community Mental Health Center (CMHC) must be submitted with condition code "92". IOP services will receive per diem payments under the Outpatient Prospective Payment System (OPPS) when billed by an OPPS provider.

B. Policy: Section 4124 of the Consolidated Appropriations Act of 2023 establishes Medicare coverage and payment for IOP services for individuals with mental health needs when furnished by hospital outpatient departments, Critical Access Hospital (CAH) outpatient departments, and CMHCs. The law establishes this new benefit for services furnished on or after January 1, 2024.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13222 - 04.1	Contractors shall add the new condition code "92" to the global solution screen.	X								
13222 - 04.1.1	HIGLAS shall accept the new condition code "92"									HIGLAS
13222 - 04.2	Contractors shall ensure that IOP claims with a condition code "92" paid with the OPPS payment methodology have an OPPS/Non-OPPS Flag of "1" assigned to the claim.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	Note: Intensive Outpatient Program (IOP) services that are paid with the OPPS payment methodology are identified as OPPS hospitals on a bill type 013x with a condition code of 92 or CMHCs on a bill type 076x with a condition code of 92. **Note**: Critical Access Hospitals (CAHs) on a bill type 085x with a condition code of 92 continue to pay under 101% of reasonable costs. Non-OPPS hospitals on a bill type 013x with a condition code 92 are paid under their current methodologies.									
13222 - 04.3	Contractors shall ensure that OPPS IOP claims with a condition code "92" paid with an OPPS/Non-OPPS Flag of "1" are routed correctly to the IOCE and OPPS Pricer.					X				IOCE, OPPS Pricer
13222 - 04.4	Contractors shall ensure that IOP claims with a condition code "92" are processed and follow a similar workflow as Partial Hospitalization Program (PHP) claims, including: • Composite Ambulatory Payment Classifications (APC) Processing • Minimum services provided daily (Edit 30) • Weekly services with more than 9 hours of IOP services per week									IOCE

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	• IOP claims submitting a claim with a code first diagnosis in the principal diagnosis position without a mental health diagnosis in the first secondary diagnosis position (Edits 28 & 109). • For Type of Bill (TOB) 076x, IOP providers are subject to outlier payment caps. • For TOB 076x, Mental health services that are not approved for IOP are submitted on an IOP claim (excluding hospital 13x with cc 92) (Edit 80) • For TOB 076x, Remote Mental Health (RMH) services are not permitted (edit 55)									
13222 - 04.5	Contractors shall ensure that IOP claims TOB 076x with condition code "92" are included in charges for logic that caps outliers for CMHC providers (TOB 076x).					X				
13222 - 04.6	Contractors shall bypass duplicate editing with repetitive services when a claim with condition code "92" is billed and overlaps a repetitive service claim without condition code 92. Note: This applies to TOB 013x and 085x.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13222 - 04.7	Contractors shall create a new edit to ensure that IOP claims (TOB 013x, 076x, and 085x) with condition code "92", do not overlap PHP claims with condition code "41". Additionally, the new edit should include, a CMHC provider (TOB 076x) cannot bill an IOP claim with condition code "92" and a separate PHP claim with or without condition code "41" for overlapping periods of time. This edit shall be set to Return to Provider (RTP).					X				
13222 - 04.8	Contractors shall create a new edit to ensure that IOP claims with condition code "92", do not also contain condition code "41". This edit shall be set to RTP.					X				
13222 - 04.9	Contractors shall accept condition code "41" on TOB 076x claims.					X				
13222 - 04.10	Contractors shall ensure that TOB 076x claims with condition code "41" are processed as partial hospitalization claims.					X				
13222 - 04.11	Contractors shall enforce consistency editing for interim claims billing for IOP services submitted by hospitals on a bill type 013x with a condition code of "92", Critical Access Hospitals (CAHs) on a bill type 085x with a condition code of "92", or Community Mental Health Centers on a bill type 076x with a condition code of "92" for the same beneficiary and provider.					X				
13222 - 04.11.1	Contractors shall validate that an incoming claim for IOP services with a bill type of					X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	0131 and condition code "92", 0851 and a condition code "92", or 0761 and a condition code 92 does not have a history IOP services claim with a line item date of service within 7 days prior to the from date for the incoming claim for the same beneficiary and provider. If a history IOP 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.									
13222 - 04.11.2	Contractors shall validate that an incoming claim for IOP services with a bill type of 0132 and condition code "92", 0852 and a condition code "92", or 0762 and a condition code 92 does not have a history IOP services claim with a line item date of service within 7 days prior to the from date for the incoming claim for the same beneficiary and provider. The patient status should be 30 for IOP services billed on an 0XX2 If a history IOP 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				
13222 - 04.11.3	Contractors shall validate that an incoming claim for IOP services with a bill type of 0133 and condition code "92", 0853 and a condition code "92", or 0763 and a condition code "92" has a prior history claim with a line item date of					X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	service within 7 days of the from date and a corresponding claim with a bill type of 0132, 0133, 0137 or contractor adjustment claim and condition code "92"; 0852, 0853, 0857 or contractor adjustment claim and a condition code "92"; or 0762, 0763, 0767 or contractor adjustment and condition code "92" claim in history for the same beneficiary and provider. The patient status should be 30 for IOP services billed on an 0XX3. If there is no history IOP 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.									
13222 - 04.11.4	Contractors shall validate that an incoming claim for IOP services with a bill type of 0134 and condition code "92", 0854 and a condition code "92", or 0764 and a condition code "92" 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 0132, 0133, 0137 or contractor adjustment claim and condition code "92"; 0852, 0853, 0857 or contractor adjustment claim and a condition code "92"; or 0762, 0763, 0767 or contractor adjustment and a condition code "92" claim in history for the same beneficiary and provider. If there is no history IOP services claim that contains a line item date of service within					X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	7 days prior to the from date for the incoming claim, Medicare systems shall Return To Provider the incoming claim.									
13222 - 04.12	Contractors shall enforce sequential billing requirements for IOP claims.					X				
13222 - 04.12.1	Contractors shall validate that an incoming claim for IOP services with a bill type of 0131 and condition code "92", 0851 and a condition code "92", or 0761 and a condition code "92" does not have a history IOP services claim with a line item date of service within 7 days after the through date for the incoming claim for the same beneficiary and provider. If a history IOP 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				
13222 - 04.12.2	Contractors shall validate that an incoming claim for IOP services with a bill type of 0132 and condition code "92", 0852 and a condition code "92", or 0762 and a condition code "92" 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 0131 or 0132 and condition code "92", 0851 or 0852 and a condition code "92", or 0761 or 0762 and a condition code "92" on the history claim for the same beneficiary and provider. The patient status should be 30 for					X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	IOP services billed on an 0XX2. If a history claim with a bill type of 0131 or 0132 and condition code "92", 0851 or 0852 and a condition code "92", or 0761 or 0762 and a condition code "92" 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.									
13222 - 04.12.3	Contractors shall validate that an incoming claim for IOP services with a bill type of 0133 and condition code "92", 0853 and a condition code "92", or 0763 and a condition code "92" 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 0131 or 0132 and condition code "92", 0851 or 0852 and a condition code "92", or 0761 or 0762 and a condition code "92" on the history claim for the same beneficiary and provider. The patient status should be 30 for IOP services billed on an 0XX3. If a history claim with a bill type of 0131 or 0132 and condition code "92", 0851 or 0852 and a condition code "92", or 0761 or 0762 and a condition code "92" 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				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13222 - 04.12.4	Contractors shall validate that an incoming claim for IOP services with a bill type of 0134 and condition code "92", 0854 and a condition code "92", or 0764 and a condition code "92" 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 0131, 0132 or 0133 and condition code "92"; 0851, 0852 or 0853 and a condition code "92"; or 0761, 0762 or 0763 and a condition code "92" on the history claim for the same beneficiary and provider. If a history claim with a bill type of 0131, 0132 or 0133 and condition code "92"; 0851, 0852 or 0853 and a condition code "92"; or 0761, 0762 or 0763 and a condition code "92" 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				
13222 - 04.13	Contractors shall educate IOP 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	CEDI
		A	B	HHH		
13222 - 04.14	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X				

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:

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

V. CONTACTS

Pre-Implementation Contact(s): Fred Rooke, fred.rooke@cms.hhs.gov (for Hospital and CMHC billing questions), Nicolas Brock, nicolas.brock@cms.hhs.gov (for Hospital and CMHC policy questions)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

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 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.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 2 - Admission and Registration Requirements

Table of Contents
(Rev. 12423; Issued: 12-20-23)

05 - Definition of Provider and Supplier
(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

This chapter uses the definition of provider and supplier found in 42 CFR 400.202. These are:

> **Provider** means a hospital, a CAH, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech-language pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization *or intensive outpatient* services.
>
> **Supplier** means a physician or other practitioner, or an entity other than a provider that furnishes health care services under Medicare.

Note that while rural health clinics, Federally qualified health centers, and renal dialysis facilities are suppliers under the regulation, they submit most claims to A/B MACs (A).

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

Table of Contents
(Rev. 12423; Issued: 12-20-23)

Transmittals for Chapter 4

10.1 - Background

(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

Section 1833(t) of the Social Security Act (the Act) as amended by §4533 of the Balanced Budget Act (BBA) of 1997, authorizes CMS to implement a Medicare PPS for:

- Hospital outpatient services, including partial hospitalization *and intensive outpatient* services;
- Certain Part B services furnished to hospital inpatients who have no Part A coverage;
- Partial hospitalization *and intensive outpatient* services furnished by CMHCs;
- Hepatitis B vaccines and their administration, splints, cast, and antigens provided by HHAs that provide medical and other health services;
- Hepatitis B vaccines and their administration provided by CORFs; and
- Splints, casts, and antigens provided to hospice patients for treatment of nonterminal illness.

The Balanced Budget Refinement Act of 1999 (BBRA) contains a number of major provisions that affect the development of the OPPS. These are:

- Establish payments under OPPS in a budget neutral manner based on estimates of amounts payable in 1999 from the Part B Trust Fund and as beneficiary coinsurance under the system in effect prior to OPPS (Although the base rates were calculated using the 1999 amounts, these amounts are increased by the hospital inpatient market basket, minus one percent, to arrive at the amounts payable in the year 2000. See §10.3 for Benefits and Improvement Protection Act (BIPA) changes in market basket updates.);
- Extend the 5.8 percent reduction in operating costs and 10 percent reduction in capital costs (which had been due to sunset on December 31, 1999) through the first date the OPPS is implemented;

- Require annual updating of the OPPS payment weights, rates, payment adjustments and groups;

- Require annual consultation with an expert provider advisory panel in review and updating of payment groups;

- Establish budget neutral outlier adjustments based on the charges, adjusted to costs, for all OPPS services included on the submitted outpatient bill for services furnished before January 1, 2002, and thereafter based on the individual services billed;

- Provide transitional pass-through payment for the additional costs of new and current medical devices, drugs, and biologicals for at least two years but not more than three years;

- Provide payment under OPPS for implantable devices including durable medical equipment (DME), prosthetics and those used in diagnostic testing;

- Establish transitional payments to limit provider's losses under OPPS; the additional payments are for 3 1/2 years for CMHCs and most hospitals, and permanent for the 10 cancer hospitals; and

- Limit beneficiary coinsurance for an individual service paid under OPPS to the inpatient hospital deductible.

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), which was signed into law on December 21, 2000, made a number of revisions to the Outpatient Prospective Payment System (OPPS). These are:

- Accelerated reductions of beneficiary copayments;

- Increase in market basket update for 2001;

- Transitional corridor provision for transitional outpatient payments (TOPs) for providers that did not file 1996 cost reports; and

- Special transitional corridor treatment for children's hospitals.

The Secretary has the authority under §1883(t) of the Act to determine which services are included (with the exception of ambulance services for which a separate fee schedule is applicable starting April 1, 2002). Medicare will continue to pay for clinical diagnostic laboratory services, orthotics, prosthetics (except as noted above), and for take-home surgical dressings on their respective fee schedules. Medicare will also continue to pay for chronic dialysis using the composite rate (certain CRNA services, PPV, and influenza vaccines and their administration, orphan drugs, and ESRD drugs and supplies are not included in the composite rate), for screening mammographies based on the current payment limitation, which changes to payment under the Medicare Physician Fee Schedule (MPFS), effective January 1, 2002, and for outpatient rehabilitation services (physical therapy including speech language pathology and occupational therapy) under the MPFS. Acute dialysis, e.g., for poisoning, will be paid under OPPS. The 10 cancer centers exempt from inpatient PPS are included in this system, but are eligible for hold harmless payment under the Transitional Corridor provision.

The Outpatient Prospective Payment System (OPPS) applies to all hospital outpatient departments except for hospitals that provide Part B only services to their inpatients; Critical Access Hospitals (CAHs); Indian Health Service hospitals; hospitals located in American Samoa, Guam, and Saipan; hospitals located in the Virgin Islands; and effective January 1, 2017 non-excepted off-campus provider-based departments of a hospital. The OPPS also applies to partial hospitalization *and intensive outpatient* services furnished by Community Mental Health Centers (CMHCs).

Certain hospitals in Maryland that are paid under Maryland waiver provisions are also excluded from payment under OPPS but not from reporting Healthcare Common Procedure Coding System (HCPCS) and line item dates of service.

10.7.1 - Outlier Adjustments

(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

The OPPS incorporates an outlier adjustment to ensure that outpatient services with variable and potentially significant costs do not pose excessive financial risk to providers. Section 419.43(f) of the Code of Federal Regulations excludes drugs, biologicals and items and services paid at charges adjusted to cost from outlier payments. The OPPS determines eligibility for outliers using either a "multiple" threshold, which is the product of a multiplier and the APC payment rate, or a combination of a multiple and fixed-dollar threshold. A service or group of services becomes eligible for outlier payments when the cost of the service or group of services estimated using the hospital's most recent overall cost-to-charge ratio (CCR) separately exceeds each relevant threshold. For community mental health centers (CMHCs), CMS determines whether billed partial hospitalization *or intensive outpatient* services are eligible for outlier payments using a multiple threshold specific to CMHCs. The outlier payment is a percentage of the difference between the cost estimate and the multiple threshold. The CMS OPPS Web site at www.cms.hhs.gov/HospitalOutpatientPPS/ under "Annual Policy Files" includes a table depicting the specific hospital and CMHC outlier thresholds and the payment percentages in place for each year of the OPPS.

Beginning in CY 2000, CMS determined outlier payments on a claim basis. CMS determined a claim's eligibility to receive outlier payments using a multiple threshold. A claim was eligible for outlier payments when the total estimate of charges reduced to cost for the entire claim exceeded a multiple of the total claim APC payment amount. As provided in Section 1833(t)(5)(D), CMS used each hospital's overall CCR rather than a CCR for each department within the hospital. CMS continues to use an overall hospital CCR specific to ancillary cost centers to estimate costs from charges for outlier payments.

In CY 2002, CMS adopted a policy of calculating outlier payments based on each individual OPPS (line-item) service. CMS continued using a multiple threshold, modified to be a multiple of each service's APC payment rather than the total claim APC payment amount, and an overall hospital CCR to estimate costs from charges. For CY 2004, CMS established separate multiple outlier thresholds for hospitals and CMHCs.

Beginning in CY 2005, for hospitals only, CMS implemented the use of a fixed-dollar threshold to better target outlier payments to complex and costly services that pose hospitals with significant financial risk. The current hospital outlier policy is calculated on a service basis using both fixed-dollar and multiple thresholds to determine outlier eligibility.

The current outlier payment is determined by:

- Calculating the cost related to an OPPS line-item service, including a pro rata portion of the total cost of packaged services on the claim and adding payment for any

device with pass- through status to payment for the associated procedure, by multiplying the total charges for OPPS services by each hospital's overall CCR (see §10.11.8 of this chapter); and

- Determining whether the total cost for a service exceeds 1.75 times the OPPS payment and separately exceeds the fixed-dollar threshold determined each year; and

- If total cost for the service exceeds both thresholds, the outlier payment is 50 percent of the amount by which the cost exceeds 1.75 times the OPPS payment.

The total cost of all packaged items and services, including the cost of uncoded revenue code lines with a revenue code status indicator of "N", that appear on a claim is allocated across all separately paid OPPS services that appear on the same claim. The proportional amount of total packaged cost allocated to each separately paid OPPS service is based on the percent of the APC payment rate for that service out of the total APC payment for all separately paid OPPS services on the claim.

To illustrate, assume the total cost of all packaged services and revenue codes on the claim is $100, and the three APC payment amounts paid for OPPS services on the claim are $200, $300, and $500 (total APC payments of $1000). The first OPPS service or line-item is allocated $20 or 20 percent of the total cost of packaged services, because the APC payment for that service/line-item represents 20 percent ($200/$1000) of total APC payments on the claim. The second OPPS service is allocated $30 or 30 percent of the total cost of packaged services, and the third OPPS service is allocated $50 or 50 percent of the total cost of packaged services.

If a claim has more than one surgical service line with a status indicator (SI) of S or T and any lines with an SI of S or T have less than $1.01 as charges, charges for all S and/or T lines are summed and the charges are then divided across S and/or T lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation.

If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, CMS estimates a single cost for the composite APC from the summarized charges. Total packaged cost is allocated to the composite line item in proportion to other separately paid services on the claim.

In accordance with Section 1833(t)(5)(A)(i) of the Act, if a claim includes a device receiving pass-through payment, the payment for the pass-through device is added to the payment for the associated procedure, less any offset, in determining the associated procedure's eligibility for outlier payment, and the outlier payment amount. The estimated cost of the device, which is equal to payment, also is added to the estimated cost of the procedure to ensure that cost and payment both contain the procedure and device costs when determining the procedure's eligibility for an outlier payment.

CMHC Outlier Payment Cap

Beginning for services provided on or after January 1, 2017, outlier payments made to CMHCs are subject to a cap, applied at the individual CMHC level, so that each CMHC's total outlier payments for the calendar year do not exceed 8 percent of that CMHC's total per diem payments for the calendar year. Total per diem payments are total Medicare per diem payments plus the total beneficiary share of those per diem payments.

Future updates will be issued in a Recurring Update Notification.

10.9 - Updates

(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

Section 1833(t) of the Social Security Act (the Act) as amended by §4533 of the Balanced Budget Act (BBA) of 1997, authorizes CMS to implement a Medicare prospective payment system for hospital outpatient services, including partial hospitalization *and intensive outpatient* services; Certain Part B services furnished to hospital inpatients who have no Part A coverage; Partial hospitalization *and intensive outpatient* services furnished by CMHCs; Hepatitis B vaccines and their administration, splints, cast, and antigens provided by HHAs that provide medical and other health services; Hepatitis B vaccines and their administration provided by CORFs; and Splints, casts, and antigens provided to hospice patients for treatment of non-terminal illness.

By statute, CMS is required to review and revise the APC groups, relative payment rates, wage adjustments, outlier payments and other adjustments required under the OPPS on an annual basis. These annual updates are made final through the publication of proposed and final rules in the Federal Register. The annual update Federal Register rules can be accessed on the OPPS Web site at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/

In addition to the annual update at the beginning of each calendar year, we also update the OPPS on a quarterly basis to account for mid-year changes such as adding new passthrough drugs and/or devices, adding new treatments and procedures to the new technology APCs, removing procedures from the inpatient list, and recognizing new HCPCS codes that may be added during the year. The quarterly updates are issued as Recurring Update Notifications. The quarterly Recurring Update Notifications can be found in Pub. 100-21, Recurring Update Notification, which can be accessed at the following Web site: http://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html

30.1 - Coinsurance Election

(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

The transition to the standard Medicare coinsurance rate (20 percent of the APC payment rate) will be gradual. For those APC groups for which coinsurance is currently a relatively high proportion of the total payment, the process will be correspondingly lengthy. The law offers hospitals the option of electing to reduce coinsurance amounts and advertise their reduced rates for all OPPS services. They may elect to receive a coinsurance payment from Medicare beneficiaries that is less than the wage adjusted coinsurance amount per APC. That amount will apply to all services within that APC. This coinsurance reduction must be offered to all Medicare beneficiaries.

Hospitals should review the list of APCs and their respective coinsurance amounts that is published in the **Federal Register** for the applicable year as a final rule. After adjusting those coinsurance amounts for the wage index applicable to their MSA, hospitals must notify their A/B MACs (A) if they wish to charge their Medicare beneficiaries a lesser amount. The election remains in effect until the following calendar year. The first election must be filed by July 1, 2000, for the period August 1, 2000, through December 31, 2000. Future calendar year elections must be made by December 1st of the year preceding the calendar year for which the election is being made.

Because the final rule on OPPS payment rates for 2002 was not published until March 1, 2002, providers were unable to make election decisions for 2002 by December 1 preceding the year the payment rates became effective, the typical deadline for making such elections. The deadline for providers to make elections to reduce beneficiary copayments for 2002 was extended until April 1, 2002. The elections are effective for services furnished on or after April 1, 2002.

The lesser amount elected:

- May not be less than 20 percent of the wage adjusted APC payment amount;
- May not be greater than the inpatient hospital deductible for that calendar year ($812 for 2002); and
- Will not be wage adjusted by the A/B MAC (A) or CMS.

Once an election to reduce coinsurance is made, it cannot be rescinded or changed until the next calendar year. National unadjusted and minimum unadjusted coinsurance amounts will be posted each year in the addenda of the OPPS final rule (enter CMS1005FC) on CMS' Web site (http://cms.hhs.gov/).

This coinsurance election does not apply to partial hospitalization *or intensive outpatient* services furnished by *CMHCs*, vaccines provided by a CORF, vaccines, splints, casts, and

antigens provided by HHAs, or splints, casts, and antigens provided to a hospice patient for the treatment of a non-terminal illness. It also does not apply to screening colonoscopies, screening sigmoidoscopies, or screening barium enemas, or to services not paid under OPPS.

Hospitals must utilize the following format for notification to the A/B MAC (A):

Provider number	1122334455		
Provider name	XYZ Hospital	Effective from	8/1/2000 - 12/31/2000
Provider contact	Joe Smith	Phone #	123-456-7890
Contact e-mail	Jsmith@XYZ.ORG	Fax #	123-456-7891

XYZ Hospital elects to reduce coinsurance to the amount shown for the following APCs:

APC____ Coinsurance___.__ APC____ Coinsurance___.__
APC____ Coinsurance___.__ APC____ Coinsurance___.__
APC____ Coinsurance___.__ APC____ Coinsurance___.__
APC____ Coinsurance___.__ APC____ Coinsurance___.__
APC____ Coinsurance___.__ APC____ Coinsurance___.__
APC____ Coinsurance___.__ APC____ Coinsurance___.__
APC____ Coinsurance___.__ APC____ Coinsurance___.__
APC____ Coinsurance___.__ APC____ Coinsurance___.__
APC____ Coinsurance___.__ APC____ Coinsurance___.__
APC____ Coinsurance___.__ APC____ Coinsurance___.__

Return to:

Provider Audit & Reimbursement Dept.
Attn: John Doe
A/B MAC (A) Address

The A/B MAC (A) must validate that the reduced coinsurance amount elected by the hospital is not less than 20 percent of the wage adjusted APC amount nor more than the inpatient deductible for the year of the election, and must send an acknowledgment to the hospital that the election has been received, within 15 calendar days of receipt.

120.1 - Bill Types Subject to OPPS

(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

The following bill types are subject to OPPS:

- All outpatient hospital Part B bills (bill types 12X, 13X with condition code 41 *or 92;* 14X and 13X without condition code 41 *or 92*) with the exception of bills from hospitals in Maryland, Indian Health Service, CAHs, hospitals located in Saipan, American Samoa, the Virgin Islands and Guam; and hospitals that provide Part B only services to their inpatients. Effective 4/1/06 the 14X type of bill is for nonpatient laboratory specimens and is no longer applicable for partial hospitalization billing.

- CMHC bills (bill type 76X *with condition code 41 or 92*);

- CORF claims for hepatitis B vaccines (bill type 75X);

- HHA claims for antigens, hepatitis B vaccines, splints and casts (bill type 34X); and

- For splints, casts and antigens when provided to hospice patients for treatment of a non-terminal illness by other than a hospital outpatient department. This requires reporting of condition code 07.

As a result, A/B MACs (A) shall instruct CORFs, HHAs, and other providers to report HCPCS for these services, in order to assure payment under this system. Payment will continue to be made for vaccines provide to hospice patients by the Medicare A/B MAC (B). The appropriate HCPCS codes are as follows:

Categories of Services Requiring HCPCS Codes

Category	HCPCS Codes
Antigens	95144-95149, 95165, 95170, 95180, and 95199
Vaccines	90657-90659, 90732, 90744, 90746, 90747, 90748, G0008, G0009, and G0010
Splints	29105-29131, 29505-29515
Casts	29000-29085, 29305, 29325-29445, 29450, 29700-29750, 29799

NOTE: A/B MACs (HHH) shall advise their HHAs to report the above HCPCS codes with the exception of vaccines under Revenue Code 0550 (Skilled Nursing). The only time revenue code 0550 may be reported is when the HHA is billing for antigens, splints, or casts. See Chapter 18 for the reporting of vaccines by HCPCS codes.

170 - Hospital and CMHC Reporting Requirements for Services Performed on the Same Day

(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

When reporting a 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 3-day payment window are an exception to this OPPS policy).

When a hospital provides electroconvulsive therapy (ECT) on the same day as partial hospitalization *or intensive outpatient* services, both the ECT and partial hospitalization *or intensive outpatient* services should be reported on the same hospital claim. In this instance, the claim should contain condition code 41 *for partial hospitalization services or condition code 92 for intensive outpatient services*. As noted above, report charges for all services and supplies associated with the ECT service that were furnished on the same date(s) on the same claim.

When a hospital provides non-partial hospitalization mental health services to a partial hospitalization patient, all partial hospitalization services and non-partial hospitalization mental health services should be reported on the same hospital claim with condition code 41.

Likewise, when a hospital provides non-intensive outpatient program mental health services to an intensive outpatient program patient, all intensive outpatient services and non-intensive outpatient mental health services should be reported on the same hospital claim with condition code 92.

NOTE: For a list of revenue codes that are considered repetitive services, see Chapter 1, §50.2.2.

EXAMPLE 1

If a patient receives a laboratory service on May 1st and has an emergency room (ER) visit on the same day, one bill may be submitted since the laboratory service is paid under the clinical diagnostic laboratory fee schedule and not subject to OPPS. In this situation, the laboratory service was not related to the ER visit or done in conjunction with the ER visit.

EXAMPLE 2

If the patient receives physical therapy on July 7th, 29th, and 30th, and receives services in the ER on July 28th, the provider shall submit separate claims since the isolated individual service (ER visit) did not occur on the same day as the repetitive service (physical therapy).

EXAMPLE 3

If a patient has an ER visit (OPPS service) on May 15th and also receives a physical therapy visit (repetitive, non-OPPS service) on the same day (as well as other physical therapy visits provided May 1st through May 31st) the services shall be billed on separate claims. The provider would bill the ER service on one claim and the therapy services on the monthly repetitive claim. Please note, as stated above, the procedures for billing repetitive services remains in effect under OPPS. Therefore, in this example, it would not be appropriate to submit one therapy claim for services provided May 1st through May 15th, a second claim for the ER visit provided on May 15th, and a third claim for therapy visits provided on May 16th through May 31st. Providers shall not split repetitive services in mid-month when another outpatient service occurs.

EXAMPLE 4

If a patient receives chemotherapy, or radiation therapy, clinical laboratory services, a CT scan*,* and an outpatient consultation on the same date of service, the hospital may report all services on the same claim or may submit multiple claims. Chemotherapy, while commonly administered in multiple encounters across a span of time, is not a repetitive service as defined in Chapter 1, Section 50.2.2. The clinical laboratory services may be reported either on the single consolidated claim or on a separate claim that reports the services furnished on the same date as the laboratory services.

EXAMPLE 5

If a partial hospitalization patient receives remote non-partial hospitalization mental health services, the hospital should report all partial hospitalization services and non-partial hospitalization remote mental health services on the same claim. For each date of service with partial hospitalization services (see section 260.1 of this chapter)*, at least one of which is a partial hospitalization primary service*, all partial hospitalization services will be packaged under the *appropriate* hospital-based partial hospitalization APC*, 5863 or 5864*. When APC *5863 or 5864* is assigned, all remote non-partial hospitalization mental health services on the same date of service will be packaged under APC 8010 with no additional payment. For any dates of service with *no* partial hospitalization *primary service*, each remote non-partial hospitalization mental health service will be paid at the corresponding APC payment rate or packaged under the daily mental health composite APC 8010.

260.1 - Special Partial Hospitalization Billing Requirements for Hospitals, Community Mental Health Centers, and Critical Access Hospitals

(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

Medicare Part B coverage is available for hospital outpatient partial hospitalization services.

A. Billing Requirement

Section 1861 (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act defines the services under the partial hospitalization benefit in a hospital.

Section 1866(e)(2) of the Act (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm)recognizes CMHCs as "providers of services" but only for furnishing partial hospitalization *or intensive outpatient* services. See §261.1.1 of this chapter for CMHC partial hospitalization bill review directions.

Hospitals and CAHs report condition code 41 in FLs 18-28 (or electronic equivalent) to indicate the claim is for partial hospitalization services. They must also report a revenue code and the charge for each individual covered service furnished. In addition, hospital outpatient departments are required to report HCPCS codes. CAHs are not required to report HCPCS code for this benefit.

Under component billing, hospitals are required to report a revenue code and the charge for each individual covered service furnished under a partial hospitalization program. In addition, hospital outpatient departments are required to report HCPCS codes. Component billing assures that only those partial hospitalization services covered under §1861(ff) of the Act are paid by the Medicare program.

Effective January 1, 2017, non-excepted off-campus provider-based departments of a hospital are required to report a "PN" modifier on each claim line for non-excepted items and services. The use of modifier "PN" will trigger a payment rate under the Medicare Physician Fee Schedule. We expect the PN modifier to be reported with each nonexcepted item and service including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services.

Excepted off-campus provider-based departments of a hospital must continue to report existing modifier "PO" (Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments) for all excepted items and services furnished. Use of the off-campus PBD modifier became mandatory beginning January 1, 2016.

All hospitals are required to report condition code 41 in FLs 18-28 to indicate the claim is for partial hospitalization services. Hospitals use bill type 13X and CAHs use bill type 85X. The following special procedures apply.

Bills must contain an acceptable revenue code. They are as follows:

Revenue Code	Description
0250	Drugs and Biologicals
043X	Occupational Therapy
0900	Behavioral Health Treatment/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	Behavioral Health/Testing
0942	Education/Training

Hospitals other than CAHs are also required to report appropriate HCPCS codes as follows:

Revenue Code	Description	HCPCS Code

043X	Occupational Therapy	*G0129 (*PHP/IOP*)
0900	Behavioral Health Treatment/Services	****90791 or ***** 90792*, 97153, 97154, 97155, 97156, 97157, 97158*
0904	Activity Therapy	**G0176 (*PHP/IOP*)
0914	Individual Psychotherapy	90785, 90832, 90833, 90834, 90836, 90837, 90838, *90839, 90840,* 90845, 90880*, 90899*
0915	Group Therapy	G0410*,* G0411*, 90853*
0916	Family Psychotherapy	90846*,* 90847*, 90849*
0918	Behavioral Health/Testing	*96112,* 96116, 96130, 96131, 96132, 96133, 96136, 96137, 96138*,* 96139, 96146, *96156, 96158, 96161, 96164, 96167, 97151, 97152* *G0023, G0024, G0140, G0146,* ***G0177*, G0451, 96202, 96203, 97550, 97551,*
0942	Education/Training	*97552*

The A/B MAC (A) will edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. The A/B MAC (A) will not edit for matching the revenue code to HCPCS.

*The definition of code G0129 is as follows:

> Occupational therapy services requiring skills of a qualified occupational therapist, furnished as a component of a partial hospitalization *or intensive outpatient* 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 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 *intensive outpatient programs or* partial hospitalization programs.

Code G0177 may be used in *intensive outpatient programs,* partial hospitalization programs*,* and outpatient mental health settings.

Revenue code *0*250 does not require HCPCS coding. However, Medicare does not cover drugs that can be self-administered.

Edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. Do not edit for the matching of revenue code to HCPCS.

B. <u>Professional Services</u>

The professional services listed below when provided in all hospital outpatient departments are separately covered and paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other than physician assistants (PA) bill the Medicare A/B MAC (B) directly for the professional services furnished to hospital outpatient partial hospitalization patients. The hospital can also serve as a billing agent for these professionals by billing the A/B MAC (B) on their behalf under their billing number for their professional services. The professional services of a PA can be billed to the A/B MAC (B) only by the PA's 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 hospital, the physician and not the hospital would be responsible for billing the A/B MAC (B) on Form CMS-1500 for the services of the PA. The following direct 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;

- Physician assistant (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*, marriage and family therapists, mental health counselors,* and occupational therapists), are bundled when furnished to hospital patients, including partial hospitalization patients. The hospital must bill the contractor for such nonphysician practitioner services as partial hospitalization services. Make payment for the services to the hospital.

C. 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 A/B MAC (A) by a CMHC or hospital outpatient department as partial hospitalization services.

D. Reporting of Service Units

Hospitals report the number of times the service or procedure, as defined by the HCPCS code, was performed. CAHs report the number of times the revenue code visit was performed.

NOTE: Service units are not required to be reported for drugs and biologicals (Revenue Code *0*250).

E. Line Item Date of Service Reporting

Hospitals other than CAHs are required to report line item dates of service per revenue code line for partial hospitalization claims. 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 FL 45 "Service Date" (MMDDYY). See §260.5 for a detailed explanation.

F. Payment

Starting in CY *2024* and subsequent years, the payment structure for partial hospitalization services provided in hospital outpatient departments and CMHCs has been *set to* four *(4) separate* APCs: *Community Mental Health Center PHP APCs 5853 (Level 1 Partial Hospitalization Program (up to 3 services)) and 5854 (Level 2 Partial Hospitalization Program (4 or more services)) and Hospital-based PHP APCs 5863 (Level 1 Partial Hospitalization Program (up to 3 services)) and 5864 (Level 2 Partial Hospitalization Program (4 or more services)).* The following chart displays the CMHC and hospital-based PHP APCs:

Hospital-Based and Community Mental Health Center PHP APCs

CY *2024* APC	Group Title
5853	Partial Hospitalization (3 or *fewer* services per day) for CMHCs
5854	*Partial Hospitalization (4 or more services per day) for CMHCs*

5863	Partial Hospitalization (3 or *fewer* services per day) for hospital-based PHPs
5864	*Partial Hospitalization (4 or more services per day) for hospital-based PHPs*

Apply Part B deductible, if any, and coinsurance.

G. Data for CWF and PS&R

Include revenue codes, HCPCS/CPT codes, units, and covered charges in the financial data section (fields 65a - 65j), as appropriate. Report the billed charges in field 65h, "Charges," of the CWF record.

Include in the financial data portion of the PS&R UNIBILL, revenue codes, HCPCS/CPT codes, units, and charges, as appropriate.

Future updates will be issued in a Recurring Update Notification.

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

(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

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) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act recognizes CMHCs as "providers of services" but only for furnishing partial hospitalization *or intensive outpatient* 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. *CMHCs are required to report condition code 41 in FLs 18-28 to indicate the claim is for partial hospitalization program services.* The A/B MACs (A) follow bill review instructions in chapter 25 of this manual, except for those listed below.

The acceptable revenue codes are as follows:

Revenue 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	Behavioral Health/Testing
0942	Education/Training

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

Revenue Codes	**Description**	**HCPCS Code**
043X	Occupational Therapy	*G0129 (*PHP/IOP*)
0900	Behavioral Health Treatments/Services	****90791 or *****90792*, 97153, 97154, 97155, 97156, 97157, 97158*
0904	Activity Therapy	**G0176 (*PHP/IOP*)
0914	Individual Psychotherapy	90785, 90832, 90833, 90834, 90836, 90837, 90838, *90839, 90840,* 90845, 90865, 90880*, 90899*
0915	Group Psychotherapy	G0410*,* G0411*, 90853*
0916	Family Psychotherapy	90846*,* or 90847*, 90849*
0918	Behavioral Health/Testing	*96112,* 96116, 96130, 96131, 96132, 96133, 96136, 96137, 96138*,* 96139, 96146*96156, 96158, 96161, 96164, 96167, 97151, 97152*
0942	Education/Training	*G0023, G0024, G0140, G0146,* ***G0177*, G0451, 96202, 96203, 97550, 97551, 97552*

The A/B MAC(s) (A) 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.

Definitions *of* each of the asterisked HCPCS codes *follow*:

*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 *or intensive outpatient* 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 intensive outpatient or* partial hospitalization programs.

Code G0177 may be used in partial hospitalization programs*, intensive outpatient programs,* 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. See the ASC X12 837 institutional claim guide for how to report HCPCS electronically. 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 A/B MACs (A) are to advise their CMHCs of these requirements. CMHCs should complete the remaining items on the claim in accordance with the ASC X12 837 Institutional Claim implementation guide and the Form CMS-1450 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 A/B MAC (B) directly for the professional services furnished to CMHC partial hospitalization patients. The ASC X12 837 professional claim format or the paper form 1500 is used. The CMHC can also serve as a billing agent for these professionals by billing the A/B MAC (B) on their behalf for their professional services. The professional services of a PA can be billed to the A/B MAC (B) 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 A/B MAC (B) 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) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act;

- Nurse practitioner and clinical nurse specialist services, as defined in §1861(s)(2)(K)(ii) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act; and,

- Clinical psychologist services, as defined in §1861(ii) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) 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 A/B MAC (A) for such nonphysician practitioner services as partial hospitalization services. The A/B MAC (A) 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 A/B MAC (A) 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 performed by a physician for a total of 3 hours during one day (HCPCS code 96130, first hour; HCPCS code 96131 for 2 additional hours). The CMHC reports revenue code 0918, HCPCS code 96130, and 1 unit; and a second line on the claim showing revenue code 918, HCPCS code 96131, and 2 units.

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	*G0410*	*20240505*	1	$80
0915	*G0410*	*20240529*	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 A/B MACs (A) 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) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act provides the statutory authority governing payment for partial hospitalization services provided by a CMHC. A/B MAC(s) (A) 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 A/B MACs (A) 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 were 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 two CMHC APCS for providing partial hospitalization services were: APC 5851 (Level 1 Partial Hospitalization (3 services)) and APC 5852 (Level 2 Partial Hospitalization (4 or more services)). Effective January 1, 2017, APCs 5851 and 5852 *were combined* into one new APC 5853 (Partial Hospitalization (3 or more services) for CMHCs).

Effective January 1, 2024, there are two APC payment rates for CMHC PHPs: APC 5853 (Level 1 Partial Hospitalization (3 or fewer services per day)) and APC 5854 (Level 2 Partial Hospitalization (4 or more services per day)).

Community Mental Health Center PHP APC

APC	Group Title
5853	Partial Hospitalization (3 or *fewer* services per day) for CMHCs
5854	*Partial Hospitalization (4 or more services per day) 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 A/B MACs (A) 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.

260.2 - Professional Services Related to Partial Hospitalization

(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

A3-3661

The professional services listed below when provided in a hospital or CAH outpatient department are separately covered and paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other than physician assistants (PA)) bill the Medicare A/B MAC (B) directly for the professional services furnished to hospital outpatient partial hospitalization patients. The hospitals or CAHs can also serve as a billing agent for these professionals by billing the A/B MAC (B) on their behalf under their billing number for their professional services. Only a PA's employer can bill the A/B MAC (B) for professional services of a PA.

The following direct 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;
- Physician assistant (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*, marriage and family therapists, mental health counselors* and occupational therapists), are bundled when furnished to hospital or CAH patients, including partial hospitalization patients. The hospital or CAH must bill their A/B MAC (A) for such nonphysician practitioner services as partial hospitalization services. Payment is made to the provider for these services.

Only the actual employer of the PA can bill for these services. The employer of a PA may be such entities or individuals such 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 hospital or CAH, the physician and not the hospital or CAH is responsible for billing the A/B MAC (B) on the Form CMS-1500 for the services of the PA.

260.5 - Line Item Date of Service Reporting for Partial Hospitalization

(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

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	*G0410*	*20240505*	1	$80.00
0915	*G0410*	*20240529*	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 A/B MAC (A) 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.

260.6 - Payment for Partial Hospitalization Services

(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

For hospital outpatient departments, the A/B MAC (A) makes payments on a reasonable cost basis until August 1, 2000 for partial hospitalization services. The Part B deductible and coinsurance apply. During the year, the A/B MAC (A) will make payment at an interim rate based on a percentage of the billed charges. At the end of the year, the hospital will be paid at the reasonable cost incurred in furnishing partial hospitalization services, based upon the Medicare cost report filed with the A/B MAC (A).

Beginning with services provided on or after August 1, 2000, payment is made under the hospital outpatient prospective payment system for partial hospitalization services.

For CAHs, payment is made on a *101%* reasonable cost basis regardless of the date of service.

In CY *2024*, payment for non-excepted off-campus hospital-based PHPs will be made under the MPFS, paying the CMHC per diem rate for APC 5853, for providing *up to* 3 PHP services per day *and APC 5854, for providing 4 or more PHP services per day*.

The Part B deductible, if any, and coinsurance apply.

261 - Intensive Outpatient Program Services

(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

Medicare Part B coverage is available for Intensive Outpatient Program (IOP) services on or after January 1, 2024 provided by hospitals, CAHs, CMHCs, RHCs, FQHCs, and Opioid Treatment Programs (OTPs). See chapter 9 in this manual for billing instructions for provider-based and independent RHC/FQHC services. See chapter 39 in this manual for billing instructions for OTPs.

261.1 - Special Intensive Outpatient Program Billing Requirements for Hospitals, Community Mental Health Centers, and Critical Access Hospitals

(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

Medicare Part B coverage is available for hospital outpatient intensive outpatient program services.

A. Billing Requirement

Section 1861 (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act defines the services under the intensive outpatient program benefit in a hospital.

Section 1866(e)(2) of the Act (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) recognizes CMHCs as "providers of services" but only for furnishing intensive outpatient program and partial hospitalization services. See §261.1.1 of this chapter for CMHC intensive outpatient program bill review directions.

Hospitals and CAHs report condition code "92" in FLs 18-28 (or electronic equivalent) to indicate the claim is for intensive outpatient program services. They must also report a revenue code and the charge for each individual covered service furnished. In addition, hospital outpatient departments are required to report HCPCS codes. CAHs are not required to report HCPCS code for this benefit.

Under component billing, hospitals are required to report a revenue code and the charge for each individual covered service furnished under an intensive outpatient program. In addition, hospital outpatient departments are required to report HCPCS codes. Component

billing assures that only those intensive outpatient program services covered under §1861(ff) of the Act are paid by the Medicare program.

Effective January 1, 2024, for intensive outpatient program services, non-excepted off-campus provider-based departments of a hospital are required to report a "PN" modifier on each claim line for non-excepted items and services. The use of modifier "PN" will trigger a payment rate under the Medicare Physician Fee Schedule. We expect the PN modifier to be reported with each non-excepted item and service including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services.

Effective January 1, 2024, for intensive outpatient program services, excepted off-campus provider-based departments of a hospital must continue to report existing modifier "PO" (Services, procedures, and/or surgeries provided at off-campus provider-based outpatient departments) for all excepted items and services furnished.

All hospitals are required to report condition code "92" in FLs 18-28 to indicate the claim is for intensive outpatient program services. Hospitals use bill type 013X and CAHs use bill type 085X. The following special procedures apply.

Bills must contain an acceptable revenue code. They are as follows:

Revenue Code	***Description***
0250	*Drugs and Biologicals*
043X	*Occupational Therapy*
0900	*Behavioral Health Treatment/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	*Behavioral Health/Testing*
0942	*Education/Training*

Hospitals other than CAHs are also required to report appropriate HCPCS codes as follows:

Revenue Code	***Description***	***HCPCS Code***
043X	*Occupational Therapy*	**G0129 (PHP/IOP)*

Revenue Code	***Description***	***HCPCS Code***
0900	*Behavioral Health Treatment/Services*	*****90791 or ***** 90792, 97153, 97154, 97155, 97156, 97157, 97158*
0904	*Activity Therapy*	***G0176 (PHP/IOP)*
0914	*Individual Psychotherapy*	*90785, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90865, 90880, 90899*
0915	*Group Therapy*	*G0410, G0411, 90853*
0916	*Family Psychotherapy*	*90846, 90847, 90849*
0918	*Behavioral Health/Testing*	*96112, 96116, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146, 96156, 96158, 96161, 96164, 96167, 97151, 97152*
0942	*Education/Training*	*G0023, G0024, G0140, G0146, ***G0177, G0451, 96202, 96203, 97550, 97551, 97552*

The A/B MAC (A) will edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. The A/B MAC (A) will not edit for matching the revenue code to HCPCS.

**The definition of code G0129 is as follows:*

Occupational therapy services requiring skills of a qualified occupational therapist, furnished as a component of a partial hospitalization or intensive outpatient 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 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 nonphysician.

******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 intensive outpatient programs or partial hospitalization programs.

Code G0177 may be used in intensive outpatient programs, partial hospitalization programs, and outpatient mental health settings.

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

Edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. Do not edit for the matching of revenue code to HCPCS.

B. Professional Services

The professional services listed below when provided in all hospital outpatient departments are separately covered and paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other than physician assistants (PA)) bill the Medicare A/B MAC (B) directly for the professional services furnished to hospital outpatient intensive outpatient program patients. The hospital can also serve as a billing agent for these professionals by billing the A/B MAC (B) on their behalf under their billing number for their professional services. The professional services of a PA can be billed to the A/B MAC (B) only by the PA's 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 hospital, the physician and not the hospital would be responsible for billing the A/B MAC (B) on Form CMS-1500 for the services of the PA. The following direct professional services are unbundled and not paid as intensive outpatient program services.

- *Physician services that meet the criteria of 42 CFR 415.102, for payment on a fee schedule basis;*

- *Physician assistant (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, marriage and family therapists, mental health counselors, and occupational therapists) are bundled when furnished to hospital patients, including intensive outpatient program patients. The hospital must bill the contractor for such nonphysician practitioner services as partial hospitalization services. Make payment for the services to the hospital.

C. 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 intensive outpatient program patients. However, the outpatient mental health treatment limitation does not apply to such mental health treatment services billed to the A/B MAC (A) by a CMHC or hospital outpatient department as intensive outpatient program services.

D. Reporting of Service Units

Hospitals report the number of times the service or procedure, as defined by the HCPCS code, was performed. CAHs report the number of times the revenue code visit was performed.

***NOTE**: Service units are not required to be reported for drugs and biologicals (Revenue Code 0250).*

E. Line Item Date of Service Reporting

Hospitals other than CAHs are required to report line item dates of service per revenue code line for intensive outpatient program claims. 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 FL 45 "Service Date" (MMDDYY). See §260.5 for a detailed explanation.

F. Payment

Starting in CY 2024 and subsequent years, the payment structure for intensive outpatient program services provided in hospital outpatient departments and CMHCs has been set to four (4) separate APCs. Community Mental Health Center IOP APCs 5851 (Level 1 Intensive Outpatient Program (up to 3 services)) and 5852 (Level 2 Intensive Outpatient Program (4 or more services)) and Hospital-based IOP APCs 5861 (Level 1 Intensive Outpatient Program (up to 3 services)) and 5862 (Level 2 Intensive Outpatient Program (4 or more services)). The following chart displays the CMHC and hospital-based IOP APCs:

Hospital-Based and Community Mental Health Center IOP APCs

CY 2024 APC	***Group Title***
5851	*Intensive Outpatient Program (up to 3 services per day) for CMHC IOPs*
5852	*Intensive Outpatient Program (4 or more services per day) for CMHC IOPs*
5861	*Intensive Outpatient Program (up to 3 services per day) for hospital-based IOPs*
5862	*Intensive Outpatient Program (4 or more services per day) for hospital-based IOPs*

Apply Part B deductible, if any, and coinsurance.

G. Data for CWF and PS&R

Include revenue codes, HCPCS/CPT codes, units, and covered charges in the financial data section (fields 65a–65j), as appropriate. Report the billed charges in field 65h, "Charges," of the CWF record.

Include in the financial data portion of the PS&R UNIBILL, revenue codes, HCPCS/CPT codes, units, and charges, as appropriate.

Future updates will be issued in a Recurring Update Notification.

261.1.1 - Bill Review for Intensive Outpatient Program Services Provided in Community Mental Health Centers (CMHC)

(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

A. General

Medicare Part B coverage for intensive outpatient program services provided by CMHCs is available for services provided on or after January 1, 2024.

B. Special Requirements

Section 1866(e)(2) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act recognizes CMHCs as "providers of services" but only for furnishing intensive outpatient program and partial hospitalization services. Applicable provider ranges are 1400–1499, 4600–4799, and 4900–4999.

C. Billing Requirements

CMHCs bill for intensive outpatient program services under bill type 076X. All CMHCs are required to report condition code 92 in FLs 18-28 to indicate the claim is for intensive outpatient program services. The following special procedures apply.
The A/B MACs (A) follow bill review instructions in chapter 25 of this manual, except for those listed below.

The acceptable revenue codes are as follows:

Revenue 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	*Behavioral Health/Testing*
0942	*Education/Training*

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

Revenue Codes	***Description***	***HCPCS Code***
043X	*Occupational Therapy*	**G0129 (PHP/IOP)*
0900	*Behavioral Health Treatments/Services*	*****90791 or *****90792, 97153, 97154, 97155, 97156, 97157, 97158*
0904	*Activity Therapy*	***G0176 (PHP/IOP)*

Revenue Codes	***Description***	***HCPCS Code***
0914	*Individual Psychotherapy*	*90785, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90865, 90880, 90899*
0915	*Group Psychotherapy*	*G0410, G0411, 90853*
0916	*Family Psychotherapy*	*90846, 90847, 90849*
0918	*Behavioral Health/Testing*	*96112, 96116, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146, 96156, 96158, 96161, 96164, 96167, 97151, 97152*
0942	*Education/Training*	*G0023, G0024, G0140, G0146, ***G0177, G0451, 96202, 96203, 97550, 97551, 97552*

The A/B MAC(s) (A) 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.

Definitions of each of the asterisked HCPCS codes follow:

**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 or intensive outpatient 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 nonphysician.

******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 intensive outpatient program and partial hospitalization programs.

Code G0177 may be used in intensive outpatient programs, partial hospitalization programs, 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. See the ASC X12 837 institutional claim guide for how to report HCPCS electronically. 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 A/B MACs (A) are to advise their CMHCs of these requirements. CMHCs should complete the remaining items on the claim in accordance with the ASC X12 837 Institutional Claim implementation guide and the Form CMS-1450 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 A/B MAC (B) directly for the professional services furnished to CMHC intensive outpatient program patients. The ASC X12 837 professional claim format or the paper form 1500 is used. The CMHC can also serve as a billing agent for these professionals by billing the A/B MAC (B) on their behalf for their professional services. The professional services of a PA can be billed to the A/B MAC (B) only by the PA's 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 A/B MAC (B) 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) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act;*
- *Nurse practitioner and clinical nurse specialist services, as defined in §1861(s)(2)(K)(ii) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act; and,*

- *Clinical psychologist services, as defined in §1861(ii) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) 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 A/B MAC (A) for such nonphysician practitioner services as intensive outpatient program services. The A/B MAC (A) 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 intensive outpatient program patients. However, the outpatient mental health treatment limitation **does not** apply to such mental health treatment services billed to the A/B MAC (A) as intensive outpatient program 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 intensive outpatient program services identified by revenue code in subsection C.

***EXAMPLE:** A beneficiary received psychological testing performed by a physician for a total of 3 hours during one day (HCPCS code 96130, first hour; HCPCS code 96131 for 2 additional hours). The CMHC reports revenue code 0905, HCPCS code 96130, and 1 unit; and a second line on the claim showing revenue code 0905, HCPCS code 96131, and 2 units.*

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 intensive outpatient 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	*G0410*	*20240505*	*1*	*$80*
0915	*G0410*	*20240529*	*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 A/B MACs (A) 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) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act provides the statutory authority governing payment for intensive outpatient program services provided by a CMHC. A/B MAC(s) (A) make payment under OPPS. The Part B deductible and coinsurance applied.

Payment principles applicable to intensive outpatient program services furnished in CMHCs are contained in §2400 of the Medicare Provider Reimbursement Manual.

The A/B MACs (A) make payment on a per diem basis under the hospital outpatient prospective payment system for intensive outpatient program services. CMHCs must continue to maintain documentation to support medical necessity of each service provided, including the beginning and ending time.

Effective January 1, 2024, there are four separate APC payment rates for IOP: 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 IOP data).

The two CMHC APCS for providing intensive outpatient program services are: APC 5851 (Level 1 intensive outpatient program (up to 3 services)) and APC 5852 (Level 2 intensive

outpatient program (4 or more services)).

Community Mental Health Center IOP APC

APC	*Group Title*
5851	*Intensive Outpatient Program (3 or more services per day) for CMHCs*
5852	*Intensive Outpatient Program (4 or more services per day) for CMHCs*

NOTE: *Occupational therapy services provided to Intensive Outpatient Program for CMHCs' 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 A/B MACs (A) follow medical review guidelines in Pub. 100-08, Medicare Program Integrity Manual.

I. Coordination with CWF

See chapter 27 of this manual.

261.2 - Professional Services Related to Intensive Outpatient Program

(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

The professional services listed below when provided in a hospital or CAH outpatient department are separately covered and paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other than physician assistants (PA)) bill the Medicare A/B MAC (B) directly for the professional services furnished to hospital outpatient partial hospitalization patients. The hospitals or CAHs can also serve as a billing agent for these professionals by billing the A/B MAC (B) on their behalf under their billing number for their professional services. Only a PA's employer can bill the A/B MAC (B) for professional services of a PA.

The following direct professional services are unbundled and not paid as intensive outpatient program services:

- *Physician services that meet the criteria of 42 CFR 415.102, for payment on a fee schedule basis;*
- *Physician assistant (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, marriage and family therapists, mental health counselors, and occupational therapists), are bundled when furnished to hospital or CAH patients, including intensive outpatient program patients. The hospital or CAH must bill their A/B MAC (A) for such nonphysician practitioner services as intensive outpatient program services. Payment is made to the provider for these services.

Only the actual employer of the PA can bill for these services. The employer of a PA may be such entities or individuals such 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 hospital or CAH, the physician and not the hospital or CAH is responsible for billing the A/B MAC (B) on the Form CMS-1500 for the services of the PA.

261.3 - Outpatient Mental Health Treatment Limitation for Intensive Outpatient Program Services

(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

The outpatient mental health treatment limitation applies to services to intensive outpatient program patients to treat mental, psychoneurotic, and personality disorders when furnished by physicians, clinical psychologists, NPs, CAHs, and PAs. It does not apply to such mental

health treatment services billed to the A/B MAC (A) by a CMHC, hospital, or CAH as intensive outpatient program services.

261.4 - Reporting Service Units for Intensive Outpatient Program
(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

Hospitals report the number of times the service or procedure, as defined by the HCPCS code, was performed. CAHs report the number of times the revenue code visit was performed.

***EXAMPLE:** A beneficiary received psychological testing (HCPCS code 96100 which is defined in one-hour intervals) for a total of three hours during one day. The hospital reports revenue code 0905 in FL 42, HCPCS code 96100 in FL 44, and three units in FL 46. The CAH would report revenue code 0918, leave HCPCS blanks, and report 1 unit in FL 46.*

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

The A/B MAC (A) must return to the provider claims other than CAH claims that do not contain service units for each HCPCS code.

NOTE: *Service units do not need to be reported for drugs and biologicals (Revenue Code 0250).*

Hospitals must retain documentation to support the medical necessity of each service provided, including beginning and ending time.

261.5 - Line Item Date of Service Reporting for Intensive Outpatient Program
(New)

Hospitals other than CAHs are required to report line item dates of service per revenue code line for intensive outpatient program 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	*G0410*	*20240505*	*1*	*$80.00*
0915	*G0410*	*20240529*	*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 A/B MAC (A) 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.

261.6 - Payment for Intensive Outpatient Program Services

(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

Beginning with services provided on or after January 1, 2024, the A/B MAC (A) makes payment for hospital outpatient departments under the hospital outpatient prospective payment system for intensive outpatient program services. The Part B deductible and coinsurance apply.

For CAHs, payment is made on a 101% reasonable cost basis.

In CY 2024, payment for non-excepted off-campus hospital-based IOPs will be made under the MPFS, paying the CMHC per diem rate for APC 5851, for providing up to 3 IOP services per day and APC 5852, for providing 4 or more IOP services per day.

The Part B deductible, if any, and coinsurance apply.

270 - Billing for Hospital Outpatient Services Furnished by Clinical Social Workers (CSW), *Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs)*

(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

Payment may be made for covered diagnostic and therapeutic services furnished by CSWs*, MFTs, and MHCs* in a hospital outpatient setting. CSW*, MFT, and MHC* services furnished under a partial hospitalization program are included in the partial hospitalization rate. *CSW, MFT, and MHC services furnished under an intensive outpatient program are included in the intensive outpatient rate.* Other CSW*, MFT, and MHC* services must be billed to the A/B MAC (B) on Form CMS-1500 or the electronic equivalent.

See chapters 13 and 15, of the Medicare Benefit Policy Manual, for a discussion of the coverage requirements for *CSWs, MFTs, and MHCs*.

270.1 - Fee Schedule to be Used for Payment for CSW Services

(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

The fee schedule for CSW services is set at 75 percent of the fee schedule for comparable services furnished by clinical psychologists, except for services under a CAH partial hospitalization *or intensive outpatient* program. These are paid on a reasonable cost basis.

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190.5 - Originating Site Facility Fee Payment Methodology

(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

1. Originating site defined

The term originating site means the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. For asynchronous, store and forward telecommunications technologies, an originating site is only a Federal telemedicine demonstration program conducted in Alaska or Hawaii.

2. Facility fee for originating site

The originating site facility fee is a separately billable Part B payment. The contractor pays it outside of other payment methodologies. This fee is subject to post payment verification.

For telehealth services furnished from October 1, 2001, through December 31, 2002, the originating site facility fee was the lesser of $20 or the actual charge. For services furnished on or after January 1 of each subsequent year, the originating site facility fee is updated by the Medicare Economic Index. The updated fee is included in the Medicare Physician Fee Schedule (MPFS) Final Rule, which is published by November 1 prior to the start of the calendar year for which it is effective. The updated fee for each calendar year is also issued annually in a Recurring Update Notification instruction for January of each year.

3. Payment amount:

The originating site facility fee is a separately billable Part B payment. The payment amount to the originating site is the lesser of 80 percent of the actual charge or 80 percent of the originating site facility fee, except CAHs. The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.

The originating site facility fee payment methodology for each type of facility is clarified below.

Hospital outpatient department. When the originating site is a hospital outpatient department, payment for the originating site facility fee must be made as described above and not under the OPPS. Payment is not based on the OPPS payment methodology.

Hospital inpatient. For hospital inpatients, payment for the originating site facility fee must be made outside the diagnostic related group (DRG) payment, since this is a Part B benefit, similar to other services paid separately from the DRG payment, (e.g., hemophilia blood clotting factor).

Critical access hospitals. When the originating site is a critical access hospital, make payment separately from the cost-based reimbursement methodology. For CAH's, the payment amount is 80 percent of the originating site facility fee.

Federally qualified health centers (FQHCs) and rural health clinics (RHCs). The originating site facility fee for telehealth services is not an FQHC or RHC service. When an FQHC or RHC serves as the originating site, the originating site facility fee must be paid separately from the center or clinic all-inclusive rate.

Physicians' and practitioners' offices. When the originating site is a physician's or practitioner's office, the payment amount, in accordance with the law, is the lesser of 80 percent of the actual charge or 80 percent of the originating site facility fee, regardless of geographic location. The A/B MAC (B) shall not apply the geographic practice cost index (GPCI) to the originating site facility fee. This fee is statutorily set and is not subject to the geographic payment adjustments authorized under the MPFS.

Hospital-based or critical access-hospital based renal dialysis center (or their satellites). When a hospital-based or critical access hospital-based renal dialysis center (or their satellites) serves as the originating site, the originating site facility fee is covered in addition to any composite rate or MCP amount.

Skilled nursing facility (SNF). The originating site facility fee is outside the SNF prospective payment system bundle and, as such, is not subject to SNF consolidated billing. The originating site facility fee is a separately billable Part B payment.

Community Mental Health Center (CMHC). The originating site facility fee is not a partial hospitalization *or intensive outpatient* service. The originating site facility fee does not count towards the number of services used to determine payment for partial hospitalization *or intensive outpatient* services. The originating site facility fee is not bundled in the per diem payment for partial hospitalization *or intensive outpatient programs*. The originating site facility fee is a separately billable Part B payment.

To receive the originating facility site fee, the provider submits claims with HCPCS code "Q3014, telehealth originating site facility fee"; short description "telehealth facility fee." The type of service for the telehealth originating site facility fee is "9, other items and services." For A/B MAC (B) processed claims, the "office"

place of service (code 11) is the only payable setting for code Q3014. There is no participation payment differential for code Q3014. Deductible and coinsurance rules apply to Q3014. By submitting Q3014 HCPCS code, the originating site authenticates they are located in either a rural HPSA or non-MSA county.

This benefit may be billed on bill types 12X, 13X, 22X, 23X, 71X, 72X, 73X, 76X, and 85X. Unless otherwise applicable, report the originating site facility fee under revenue code 078X and include HCPCS code "Q3014, telehealth originating site facility fee."

Hospitals and critical access hospitals bill their A/B/MAC (A) for the originating site facility fee. Telehealth bills originating in inpatient hospitals must be submitted on a 12X TOB using the date of discharge as the line item date of service.

Independent and provider-based RHCs and FQHCs bill the appropriate A/B/MAC (A) using the RHC or FQHC bill type and billing number. HCPCS code Q3014 is the only non-RHC/FQHC service that is billed using the clinic/center bill type and provider number. All RHCs and FQHCs must use revenue code 078X when billing for the originating site facility fee. For all other non-RHC/FQHC services, provider based RHCs and FQHCs must bill using the base provider's bill type and billing number. Independent RHCs and FQHCs must bill the A/B MAC (B) for all other non-RHC/FQHC services. If an RHC/FQHC visit occurs on the same day as a telehealth service, the RHC/FQHC serving as an originating site must bill for HCPCS code Q3014 telehealth originating site facility fee on a separate revenue line from the RHC/FQHC visit using revenue code 078X. *Note that for patients in an intensive outpatient program, Q3014 is not considered an intensive outpatient service.*

Hospital-based or CAH-based renal dialysis centers (including satellites) bill their A/B/MAC (A) for the originating site facility fee. Telehealth bills originating in renal dialysis centers must be submitted on a 72X TOB. All hospital-based or CAH-based renal dialysis centers (including satellites) must use revenue code 078X when billing for the originating site facility fee. The renal dialysis center serving as an originating site must bill for HCPCS code Q3014, telehealth originating site facility fee, on a separate revenue line from any other services provided to the beneficiary.

Skilled nursing facilities (SNFs) bill their A/B/MAC (A) for the originating site facility fee. Telehealth bills originating in SNFs must be submitted on TOB 22X or 23X. For SNF inpatients in a covered Part A stay, the originating site facility fee must be submitted on a 22X TOB. All SNFs must use revenue code 078X when billing for the originating site facility fee. The SNF serving as an

originating site must bill for HCPCS code Q3014, telehealth originating site facility fee, on a separate revenue line from any other services provided to the beneficiary.

Community mental health centers (CMHCs) bill their A/B/MAC (A) for the originating site facility fee. Telehealth bills originating in CMHCs must be submitted on a 76X TOB. All CMHCs must use revenue code 078X when billing for the originating site facility fee. The CMHC serving as an originating site must bill for HCPCS code Q3014, telehealth originating site facility fee, on a separate revenue line from any other services provided to the beneficiary. Note that Q3014 does not count towards the number of services used to determine per diem payments for partial hospitalization *or intensive outpatient* services.

The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.

210.1 - Application of the Limitation

(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

A. Status of Patient

The limitation is applicable to expenses incurred in connection with the treatment of an individual who is not an inpatient of a hospital. Thus, the limitation applies to mental health services furnished to a person in a physician's office, in the patient's home, in a skilled nursing facility, as an outpatient, and so forth. The term "hospital" in this context means an institution, which is primarily engaged in providing to inpatients, by or under the supervision of a physician(s):

- Diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled, or sick persons;
- Rehabilitation services for injured, disabled, or sick persons; or
- Psychiatric services for the diagnosis and treatment of mentally ill patients.

B. Disorders Subject to the Limitation

The term "mental, psychoneurotic, and personality disorders" is defined as the specific psychiatric diagnoses described in the International Classification of Diseases, 9th Revision (ICD-9), under the code range 290-319.

When the treatment services rendered are both for a psychiatric diagnosis as defined in the ICD-9 and one or more nonpsychiatric conditions, separate the expenses for the psychiatric aspects of treatment from the expenses for the nonpsychiatric aspects of treatment. However, in any case in which the psychiatric treatment component is not readily distinguishable from the nonpsychiatric treatment component, all of the expenses are allocated to whichever component constitutes the primary diagnosis.

1. Diagnosis Clearly Meets Definition - If the primary diagnosis reported for a particular service is the same as or equivalent to a condition described in the ICD9 under the code range 290-319 that represents mental, psychoneurotic and personality disorders, the expense for the service is subject to the limitation except as described in subsection D.

2. Diagnosis Does Not Clearly Meet Definition - When it is not clear whether the primary diagnosis reported meets the definition of mental, psychoneurotic, and personality disorders, it may be necessary to contact the practitioner to clarify the diagnosis. In deciding whether contact is necessary in a given case, give consideration to such factors as

the type of services rendered, the diagnosis, and the individual's previous utilization history.

C. Services Subject to the Limitation

A/B MACs (B) must apply the limitation to claims for professional services that represent mental health treatment furnished to individuals who are not hospital inpatients by physicians, clinical psychologists, clinical social workers, nurse practitioners, clinical nurse specialists and physician assistants. Items and supplies furnished by physicians or other mental health practitioners in connection with treatment are also subject to the limitation.

Generally, A/B MACs (B) must apply the limitation only to treatment services. However, diagnostic psychological and neuropsychological testing services performed to evaluate a patient's progress during treatment are considered part of treatment and are subject to the limitation.

D. Services Not Subject to the Limitation

1. Diagnosis of Alzheimer's Disease or Related Disorder - When the primary diagnosis reported for a particular service is Alzheimer's Disease or an Alzheimer's related disorder, A/B MACs (B) must look to the nature of the service that has been rendered in determining whether it is subject to the limitation. Alzheimer's disease is coded 331.0 in the "International Classification of Diseases, 9th Revision", which is outside the code range 290-319 that represents mental, psychoneurotic and personality disorders. Additionally, Alzheimer's related disorders are identified by A/B MACs (B) under ICD-9 codes that are within the 290-319 code range (290.XX or others as A/B MACs (B) determine appropriate) or outside the 290-319 code range as determined appropriate by A/B MACs (B). When the primary treatment rendered to a patient with a diagnosis of Alzheimer's disease or a related disorder is psychotherapy, it is subject to the limitation. However, typically, treatment provided to a patient with a diagnosis of Alzheimer's Disease or a related disorder represents medical management of the patient's condition (such as described under CPT code 90862 or any successor code) and is not subject to the limitation. CPT code 90862 describes pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy.

2. Brief Office Visits for Monitoring or Changing Drug Prescriptions - Brief office visits for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic and personality disorders are not subject to the limitation. These visits are reported using HCPCS code M0064 or any successor code (brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of

mental, psychoneurotic, and personality disorders). Claims where the diagnosis reported is a mental, psychoneurotic, or personality disorder (other than a diagnosis specified in subsection A) are subject to the limitation except for the procedure identified by HCPCS code M0064 or any successor code.

3. Diagnostic Services - A/B MACs (B) do not apply the limitation to psychiatric diagnostic evaluations and diagnostic psychological and neuropsychological tests performed to establish or confirm the patient's diagnosis. Diagnostic services include psychiatric diagnostic evaluations billed under CPT codes 90801 or 90802 (or any successor codes) and, psychological and neuropsychological tests billed under CPT code range 96101-96118 (or any successor code range).

   An initial visit to a practitioner for professional services often combines diagnostic evaluation and the start of therapy. Such a visit is neither solely diagnostic nor solely therapeutic. Therefore, A/B MACs (B) must deem the initial visit to be diagnostic so that the limitation does not apply. Separating diagnostic and therapeutic components of a visit is not administratively feasible, unless the practitioner already has separately identified them on the bill. Determining the entire visit to be therapeutic is not justifiable since some diagnostic work must be done before even a tentative diagnosis can be made and certainly before therapy can be instituted. Moreover, the patient should not be disadvantaged because therapeutic as well as diagnostic services were provided in the initial visit. In the rare cases where a practitioner's diagnostic services take more than one visit, A/B MACs (B) must not apply the limitation to the additional visits. However, it is expected such cases are few. Therefore, when a practitioner bills for more than one visit for professional diagnostic services, A/B MACs (B) may find it necessary to request documentation to justify the reason for more than one diagnostic visit.

4. Partial Hospitalization Services Not Directly Provided by a Physician or a Practitioner - The limitation does not apply to partial hospitalization services that are not directly provided by a physician, clinical psychologist, nurse practitioner, clinical nurse specialist, or a physician assistant. Partial hospitalization services are billed by hospital outpatient departments and community mental health centers (CMHCs) to A/B MACs (A). However, services furnished by physicians, clinical psychologists, nurse practitioners, clinical nurse specialists, and physician assistants to partial hospitalization patients are billed separately from the partial hospitalization program of services. Accordingly, these professional's mental health services to partial hospitalization patients are paid under the physician fee schedule by A/B MACs (B) and may be subject to the limitation. (See chapter 4, section 260.1C).
5. *Intensive Outpatient Services Not Directly Provided by a Physician or a Practitioner - The limitation does not apply to intensive outpatient services that are not directly provided by a physician, clinical psychologist, nurse practitioner, clinical nurse specialist, or a*

physician assistant. Intensive outpatient services are billed by hospital outpatient departments, community mental health centers (CMHCs), RHCs, FQHCs, and OTPs to A/B MACs (A). However, services furnished by physicians, clinical psychologists, nurse practitioners, clinical nurse specialists, and physician assistants to intensive outpatient patients are billed separately from the intensive outpatient program of services. Accordingly, these professional's mental health services to intensive outpatient patients are paid under the physician fee schedule by A/B MACs (B) and may be subject to the limitation. (See chapter 4, section 261.1C).

E. Computation of Limitation

A/B MACs (B) determine the Medicare approved payment amount for services subject to the limitation. They:

- Multiply the approved amount by the limitation percentage amount;

- Subtract any unsatisfied deductible; and,

- Multiply the remainder by 0.8 to obtain the amount of Medicare payment. The beneficiary is responsible for the difference between the amount paid by Medicare and the full Medicare approved amount.

The following examples illustrate the application of the limitation in various circumstances as it is gradually reduced under section 102 of the Medicare Improvements for Patients and Providers Act (MIPPA). Please note that although the calendar year 2009 Part B deductible of $135 is used under these examples, the actual deductible amount for calendar year 2010 and future years is unknown and will be subject to change.

Example #1: In 2010, a clinical psychologist submits a claim for $200 for outpatient treatment of a patient's mental disorder. The Medicare-approved amount is $180. Since clinical psychologists must accept assignment, the patient is not liable for the $20 in excess charges. The patient previously satisfied the $135 annual Part B deductible. The limitation reduces the amount of incurred expenses to 68 ¾ percent of the approved amount. Medicare pays 80 percent of the remaining incurred expenses. The Medicare payment and patient liability are computed as follows:

1. Actual charges…….…….$200.00
2. Medicare-approved amount…….…….……$180.00
3. Medicare incurred expenses (0.6875 x line 2)……..…..……...$123.75
4. Unmet deductible……..…$0.00
5. Remainder after subtracting deductible (line 3 minus line 4)……...$123.75
6. Medicare payment (0.80 x line 5)…….$99.00

7. Patient liability (line 2 minus line 6)…….$81.00

Example #2: In 2012, a clinical social worker submits a claim for $135 for outpatient treatment of a patient's mental disorder. The Medicare-approved amount is $120. Since clinical social workers must accept assignment, the patient is not liable for the $15 in excess charges. The limitation reduces the amount of incurred expenses to 75 percent of the approved amount. The patient previously satisfied $70 of the $135 annual Part B deductible, leaving $65 unmet. The Medicare payment and patient liability are computed as follows:

1. Actual charges…….….$135.00
2. Medicare-approved amount…….....$120.00
3. Medicare incurred expenses (0.75 x line 2)……..…….$90.00
4. Unmet deductible……..…….$65.00
5. Remainder after subtracting deductible (line 3 minus line 4)……....$25.00
6. Medicare payment (0.80 x line 5)……...$20.00
7. Patient liability (line 2 minus line 6)…….....$100.00

Example #3: In calendar year 2013, a physician who does not accept assignment submits a claim for $780 for services in connection with the treatment of a mental disorder that did not require inpatient hospitalization. The Medicare-approved amount is $750. Because the physician does not accept assignment, the patient is liable for the $30 in excess charges. The patient has not satisfied any of the $135 Part B annual deductible. The Medicare payment and patient liability are computed as follows:

1. Actual charges…….…….$780.00
2. Medicare-approved amount……..$750.00
3. Medicare incurred expenses (0.8125 x line 2)……..$609.38
4. Unmet deductible……..$135.00
5. Remainder after subtracting deductible (line 3 minus line 4)……...$474.38
6. Medicare payment (0.80 x line 5)…….$379.50
7. Patient liability (line 1 minus line 6)……$400.50

Example #4: A patient's Part B expenses during calendar year 2014 are for a physician's services in connection with the treatment of a mental disorder that initially required inpatient hospitalization, with subsequent physician services furnished on an outpatient basis. The patient has not satisfied any of the $135 Part B deductible. The physician accepts assignment and submits a claim for $780. The Medicare-approved amount is $750. Since the limitation will be completely phased out as of January 1, 2014, the entire $750 Medicare-approved amount is recognized as the total incurred expenses because such expenses are no longer reduced. Also, there is no longer any distinction between mental health services the patient receives as an inpatient or outpatient. The Medicare payment and patient liability are computed as follows:

1. Actual charges……..$780.00
2. Medicare-approved amount……..$750.00
3. Medicare incurred expenses (1.00 x line 2)……..$750.00
4. Unmet deductible……..$135.00
5. Remainder after subtracting deductible (line 3 minus line 4)……...$615.00
6. Medicare payment (0.80 x line 5)…….$492.00

Beneficiary liability (line 2 minus line 6)…….$258.00

Medicare Claims Processing Manual
Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

Table of Contents
(Rev. 12423, Issued: 12-20-23)

01 - Foreword

(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

This chapter provides general instructions on billing and claims processing for durable medical equipment (DME), prosthetics and orthotics (P&O), parenteral and enteral nutrition (PEN), and supplies. Coverage requirements are in the Medicare Benefit Policy Manual and the National Coverage Determinations Manual.

These instructions are applicable to services billed to the A/B MAC (A), (B), and (HHH), and DME MAC unless otherwise noted.

The DME, prosthetic/orthotic devices (except customized devices in a SNF), supplies and oxygen used during a Part A covered stay for hospital and skilled nursing facility (SNF) inpatients are included in the inpatient prospective payment system (PPS) and are not separately billable.

In this chapter the terms provider and supplier are used as defined in 42 CFR 400.42 CFR 400.202 (Follow the link, choose the applicable year, select Title 42, then open Chapter IV. You then must choose which part to open. To get to §400.202 you select the first choice and download the pdf version.).

- Provider means a hospital, a CAH, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech-language pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization *or intensive outpatient* services.

  Of these provider types only hospitals, CAHs, SNFs, and HHAs would be able to bill for DMEPOS; and for hospitals, CAHs, and SNFs usually only for outpatients. Any exceptions to this rule are discussed in this chapter.

- Supplier means a physician or other practitioner, or an entity other than a provider that furnishes health care services under Medicare.

  A DMEPOS supplier must meet certain requirements and enroll as described in Chapter 10 of the Program Integrity Manual. A provider that enrolls as a supplier is considered a supplier for DMEPOS billing. However, separate payment remains restricted to those items that are not considered included in a PPS rate.

Unless specified otherwise the instructions in this chapter apply to both providers and suppliers, and to the A/B MACs (A), (B), (HHH), and DME MACs that process their claims.

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Chapter 25 - Completing and Processing the Form CMS-1450 Data Set

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75.5 - Form Locators 43-65

(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

FL 43 - Revenue Description/IDE Number/Medicaid Drug Rebate

Not Required. The provider enters a narrative description or standard abbreviation for each revenue code shown in FL 42 on the adjacent line in FL 43. The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes. "Other" code categories are locally defined and individually described on each bill.

The investigational device exemption (IDE) or procedure identifies a specific device used only for billing under the specific revenue code 0624. The IDE will appear on the paper format of Form CMS-1450 as follows: FDA IDE # A123456 (17 spaces).

HHAs identify the specific piece of durable medical equipment (DME) or non-routine supplies for which they are billing in this area on the line adjacent to the related revenue code. This description must be shown in Healthcare Common Procedure Coding System (HCPCS) coding.

When required to submit drug rebate data for Medicaid rebates, submit N4 followed by the 11-digit National Drug Code (NDC) in positions 01-13 (e.g., N499999999999). Report the NDC quantity qualifier followed by the quantity beginning in position 14. The Description Field on Form CMS-1450 is 24 characters in length. An example of the methodology is illustrated below.

N	**4**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**0**	**1**	**U**	**N**	**1**	**2**	**3**	**4**	**.**	**5**	**6**	**7**	

FL 44 - HCPCS/Rates/HIPPS Rate Codes

Required. When coding HCPCS for outpatient services, the provider enters the HCPCS code describing the procedure here. On inpatient hospital bills the accommodation rate is shown here.

HCPCS used for Medicare claims are available from Medicare contractors.

Health Insurance Prospective Payment System (HIPPS) Rate Codes

The HIPPS rate code consists of the three-character resource utilization group (RUG) code that is obtained from the "Grouper" software program followed by a 2-digit assessment indicator (AI) that specifies the type of assessment associated with the RUG code obtained from the Grouper. SNFs must use the version of the Grouper software program identified by CMS for national PPS as described in the Federal Register for that year. The Grouper translates the data in the Long Term Care Resident Instrument into a case mix group and assigns the correct RUG code. The AIs were developed by CMS.

The Grouper will not automatically assign the 2-digit AI, except in the case of a swing bed MDS that is will result in a special payment situation AI (see below). The HIPPS rate codes that appear on the claim must match the assessment that has been transmitted and accepted by the State in which the facility operates. The SNF cannot put a HIPPS rate code on the claim that does not match the assessment.

HIPPS Rate Codes used for Medicare claims are available from Medicare contractors. As of October 1, 2019, SNF PDPM changes are effective (see §§120ff. in Chapter 6 of this manual).

HIPPS Modifiers/Assessment Type Indicators

The assessment indicators (AI) were developed by CMS to identify on the claim, which of the scheduled Medicare assessments or off-cycle assessments is associated with the assessment reference date and the RUG that is included on the claim for payment of Medicare SNF services. In addition, the AIs identify the Effective Date for the beginning of the covered period and aid in ensuring that the number of days billed for each scheduled Medicare assessment or off cycle assessment accurately reflect the changes in the beneficiary's status over time. The indicators were developed by utilizing codes for the reason for assessment contained in section AA8 of the current version of the Resident Assessment Instrument, Minimum Data Set in order to ease the reporting of such information. Follow the CMS manual instructions for appropriate assignment of the assessment codes.

HIPPS Modifiers/Assessment Type Indicators used for Medicare claims are available from Medicare contractors. As of October 1, 2019, SNF PDPM changes are effective (see §§120ff. in Chapter 6 of this manual).

HCPCS Modifiers (Level I and Level II)

Form CMS-1450 accommodates up to four modifiers, two characters each. See AMA publication CPT 20xx (xx= to current year) Current Procedural Terminology Appendix A - HCPCS Modifiers Section: "Modifiers Approved for Ambulatory Surgery Center (ASC) Hospital Outpatient Use". Various CPT (Level I HCPCS) and Level II HCPCS codes

may require the use of modifiers to improve the accuracy of coding. Consequently, reimbursement, coding consistency, editing and proper payment will benefit from the reporting of modifiers. Hospitals should not report a separate HCPCS (five-digit code) instead of the modifier. When appropriate, report a modifier based on the list indicated in the above section of the AMA publication.

HCPCS modifiers used for Medicare claims are available from Medicare contractors.

FL 45 - Service Date

Required Outpatient. CMHCs and hospitals (with the exception of CAHs, Indian Health Service hospitals and hospitals located in American Samoa, Guam and Saipan) report line item dates of service on all bills containing revenue codes, procedure codes or drug codes. This includes claims where the "from" and "through" dates are equal. This change is due to a HIPAA requirement.

There must be a single line item date of service (LIDOS) for every iteration of every revenue code on all outpatient bills (TOBs 013X, 014X, 023X, 024X, 032X, 033X, 034X, 071X, 072X, 073X, 074X, 075X, 076X, 077X (effective April 1, 2010), 081X, 082X, 083X, and 085X and on inpatient Part B bills (TOBs 012x and 022x). If a particular service is rendered 5 times during the billing period, the revenue code and HCPCS code must be entered 5 times, once for each service date.

FL 46 - Units of Service

Required. Generally, the entries in this column quantify services by revenue code category, e.g., number of days in a particular type of accommodation, pints of blood. However, when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was performed.

The provider enters up to seven numeric digits. It shows charges for noncovered services as noncovered, or omits them. **NOTE:** Hospital outpatient departments report the number of visits/sessions when billing under the partial hospitalization program *or the intensive outpatient program*.

FL 47 - Total Charges - Not Applicable for Electronic Billers

Required. This is the FL in which the provider sums the total charges for the billing period for each revenue code (FL 42); or, if the services require, in addition to the revenue center code, a HCPCS procedure code, where the provider sums the total charges for the billing period for each HCPCS code. The last revenue code entered in FL 42 is "0001" which represents the grand total of all charges billed. The amount for this code, as for all others is entered in FL 47. Each line for FL 47 allows up to nine numeric digits (0000000.00). The CMS policy is for providers to bill Medicare on the same basis that

they bill other payers. This policy provides consistency of bill data with the cost report so that bill data may be used to substantiate the cost report. Medicare and non-Medicare charges for the same department must be reported consistently on the cost report. This means that the professional component is included on, or excluded from, the cost report for Medicare and non-Medicare charges. Where billing for the professional components is not consistent for all payers, i.e., where some payers require net billing and others require gross, the provider must adjust either net charges up to gross or gross charges down to net for cost report preparation. In such cases, it must adjust its provider statistical and reimbursement (PS&R) reports that it derives from the bill. Laboratory tests (revenue codes 0300-0319) are billed as net for outpatient or nonpatient bills because payment is based on the lower of charges for the hospital component or the fee schedule. The A/B MAC (A or HHH) determines, in consultation with the provider, whether the provider must bill net or gross for each revenue center other than laboratory. Where "gross" billing is used, the A/B MAC (A or HHH) adjusts interim payment rates to exclude payment for hospital-based physician services. The physician component must be billed to the Part B MAC to obtain payment. All revenue codes requiring HCPCS codes and paid under a fee schedule are billed as net.

FL 48 - Noncovered Charges

Required. The total non-covered charges pertaining to the related revenue code in FL 42 are entered here.

FL 49 - (Untitled)

Not used. Data entered will be ignored.

Note: the "PAGE ____ OF ____" and CREATION DATE on line 23 should be reported on all pages of the UB-04.

FL 50A (Required), B (Situational), and C (Situational) - Payer Identification

If Medicare is the primary payer, the provider must enter "Medicare" on line A. Entering Medicare indicates that the provider has developed for other insurance and determined that Medicare is the primary payer. All additional entries across line A (FLs 51-55) supply information needed by the payer named in FL 50A. If Medicare is the secondary or tertiary payer, the provider identifies the primary payer on line A and enters Medicare information on line B or C as appropriate.

FL 51A (Required), B (Situational), and C (Situational) – Health Plan ID

Report the national health plan identifier when one is established; otherwise report the "number" Medicare has assigned.

FLs 52A, B, and C - Release of Information Certification Indicator

Required. A "Y" code indicates that the provider has on file a signed statement permitting it to release data to other organizations in order to adjudicate the claim. Required when state or federal laws do not supersede the HIPAA Privacy Rule by requiring that a signature be collected. An "I" code indicates Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes. Required when the provider has not collected a signature and state or federal laws do not supersede the HIPAA Privacy Rule by requiring a signature be collected.

NOTE: The back of Form CMS-1450 contains a certification that all necessary release statements are on file.

FL 53A, B, and C - Assignment of Benefits Certification Indicator

Not used. Data entered will be ignored.

FLs 54A, B, and C - Prior Payments

Situational. Required when the indicated payer has paid an amount to the provider towards this bill.

FL 55A, B, and C - Estimated Amount Due From Patient

Not required.

FL 56 – Billing Provider National Provider ID (NPI)

Required on or after May 23, 2008.

FL 57 – Other Provider ID (primary, secondary, and/or tertiary)

Not used. Data entered will be ignored.

FLs 58A, B, and C - Insured's Name

Required. The name of the individual under whose name the insurance benefit is carried.

FL 59A, B, and C - Patient's Relationship to Insured

Required. If the provider is claiming payment under any of the circumstances described under FLs 58 A, B, or C, it must enter the code indicating the relationship of the patient to the identified insured, if this information is readily available.

Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.

FLs 60A (Required), B (Situational), and C (Situational) – Insured's Unique ID (Certificate/Social Security Number/*Medicare beneficiary identifier)*

The unique number assigned by the health plan to the insured.

FL 61A, B, and C - Insurance Group Name

Situational (required if known). Where the provider is claiming payment under the circumstances described in FLs 58A, B, or C and a Worker's Compensation (WC) or an Employer Group Health Plan (EGHP) is involved, it enters the name of the group or plan through which that insurance is provided.

FL 62A, B, and C - Insurance Group Number

Situational (required if known). Where the provider is claiming payment under the circumstances described in FLs 58A, B, or C and a WC or an EGHP is involved, it enters the identification number, control number or code assigned by that health insurance carrier to identify the group under which the insured individual is covered.

FL 63 - Treatment Authorization Code

Situational. Required when an authorization or referral number is assigned by the payer and then the services on this claim AND either the services on this claim were preauthorized or a referral is involved. Whenever Quality Improvement Organization (QIO) review is performed for outpatient preadmission, pre-procedure, or Home IV therapy services, the authorization number is required for all approved admissions or services.

FL 64 – Document Control Number (DCN)

Situational. The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control.

FL 65 - Employer Name (of the Insured)

Situational. Where the provider is claiming payment under the circumstances described in the second paragraph of FLs 58A, B, or C and there is WC involvement or an EGHP, it enters the name of the employer that provides health care coverage for the individual identified on the same line in FL 58.

Medicare Claims Processing Manual

Chapter 29 - Appeals of Claims Decisions

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(Rev. 12423; Issued; 12-20-23)

110 - Glossary

(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

Adjudicator – The entity responsible for making the decision at any level of the Medicare claim decision making process, from initial determination to the final level of appeal, on a specific claim.

Administrative Law Judge (ALJ) – Adjudicator employed by the Department of Health and Human Services (HHS), Office of Medicare Hearings and Appeals (OMHA) that holds hearings and issues decisions related to level 3 of the appeals process.

Affirmation - A term used to denote that a prior claims determination has been upheld by the current claims adjudicator. Although appeals through the OMHA level are de novo, CMS and its contractors often use this term when an adjudicator reaches the same conclusion as that in the prior determination, even though he/she is not bound by the prior determination.

Amount in Controversy (AIC) - The dollar amount required to be in dispute to establish the right to a particular level of appeal. Congress establishes the amount in controversy requirements.

Appeals Council – The Medicare Appeals Council (herein Appeals Council), a division within the Departmental Appeals Board, provides the final level of administrative review of claims for entitlement to Medicare and individual claims for Medicare coverage and payment. (See also Departmental Appeals Board.)

Appellant - The term used to designate the party (i.e., the beneficiary, provider, supplier, or other person showing an interest in the claim determination) or the representative of the party that has filed an appeal. The adjudicator determines if a particular appellant is a proper party or representative of a proper party.

Applicable plan – Applicable plan means liability insurance (including self-insurance), no-fault insurance, or a workers' compensation law or plan.

Appointed representative – The individual appointed by a party to represent the party in a Medicare claim or claim appeal.

Assignee – (1) With respect to the assignment of a claim for items or services, the assignee is the supplier who has furnished items or services to a beneficiary and has accepted a valid assignment of a claim;

OR

(2) With respect to an assignment of appeal rights, an assignee is a provider or supplier who is not already a party to an appeal, who has furnished items or services to a beneficiary, and has accepted a valid assignment of the right to appeal a claim executed by the beneficiary.

Assignment of appeal rights – The transfer by a beneficiary of his or her right to appeal under the claims appeal process to a provider or supplier who is not already a party, and who provided the items or services to the beneficiary.

Assignor – A beneficiary whose provider of service or supplier has taken assignment of a claim, or assignment of an appeal of a claim.

Attorney Adjudicator - A licensed attorney employed by OMHA with knowledge of Medicare coverage and payment laws and guidance, authorized to take the actions provided for in 42 CFR 405 subpart I on requests for ALJ hearing and requests for reviews of QIC dismissals.

Authorized representative – An individual authorized under State or other applicable law to act on behalf of a beneficiary or other party involved in the appeal. The authorized representative will have all of the rights and responsibilities of a beneficiary or party, as applicable, throughout the appeals process.

Beneficiary – Individual who is enrolled to receive benefits under Medicare Part A and/or Part B.

Contractor - An entity that contracts with the Federal government to review and/or adjudicate claims, determinations and/or decisions.

Date of Receipt – A determination, decision or notice is presumed to have been received by the party five days from the date included on the determination or decision, unless there is evidence to the contrary.

NOTE: Throughout Chapter 29, reference to day or days means calendar days unless otherwise specified.

Departmental Appeals Board (DAB) Review - The DAB provides impartial, independent review of disputed decisions in a wide range of Department of Health and Human Services programs under more than 60 statutory provisions. The Medicare Appeals Council (herein Appeals Council), a division within the Departmental Appeals Board, provides the final level of administrative review of claims for entitlement to Medicare and individual claims for Medicare coverage and payment. (See section 340 in this chapter.)

De Novo - Latin phrase meaning "anew" or "afresh," used to denote the manner in which claims are adjudicated in the administrative appeals process. Adjudicators at each level of appeal make a new, independent and thorough evaluation of the claim(s) at issue, and are not bound by the findings and decision made by an adjudicator in a prior determination or decision.

Decisions and Determinations -If a Medicare appeal request does not result in a dismissal, adjudication of the appeal results in either a "determination" or "decision." There is no apparent practical distinction between these two terms although applicable regulations use the terms in distinct contexts.

A decision that is reopened and thereafter revised is called a "revised determination."

Dismissal - An action taken by an adjudicator when an appeal will not be conducted as requested. A request for appeal may be dismissed for any number of reasons, including:

1. Abandonment of the appeal by the appellant;
2. A request is made by the appellant to withdraw the appeal;
3. A determination that an appellant is not a proper party;
4. The amount in controversy requirements have not been met; and
5. The appellant has died and no one else is prejudiced by the claims determination.

Limitation on Liability Determination- Section 1879 of the Social Security Act (the Act) provides financial relief to beneficiaries, providers and suppliers by permitting Medicare payment to be made, or requiring refunds to be made, for certain services and items for which Medicare coverage and payment would otherwise be denied. This section of the Act is referred to as "the limitation on liability provision." Both the underlying coverage determination and the limitation on liability determination may be challenged. For more detailed information see chapter 30 of this manual.

Medicare number and/or Medicare beneficiary identifier (Mbi) - are general terms describing a beneficiary's Medicare identification number. Medicare beneficiary identifier references both the Health

Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes. For the beneficiary population, the term Medicare number is used to describe the Medicare beneficiary identifier (Mbi).

Office of Medicare Hearings and Appeals (OMHA) - The Office of Medicare Hearings and Appeals is responsible for level 3 of the Medicare claims appeal process and certain Medicare entitlement appeals and Part B premium appeals. At level 3 of the appeals process, an appellant may have a hearing before an OMHA ALJ, or review by an attorney adjudicator.

Party - A person and/or entity normally understood to have standing to appeal an initial determination and/or a subsequent administrative appeal determination or decision. (See section 210 in this chapter.)

Provider of services (herein provider) – As used in this section, the definition in 42 CFR 405.902 for provider applies. Provider means a hospital, a critical access hospital (CAH), a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization *or intensive outpatient* services. NOTE: A non-participating provider, that is, an entity eligible to enter into a provider agreement to participate in Medicare but has not entered into such an agreement, is not considered a provider of services and does not have party status for an initial determination or appeal.

Qualified Independent Contractor (QIC) – Entity that contracts with the Secretary in accordance with the Act to perform level 2 appeals, which are called reconsiderations, and expedited reconsiderations.

Remand – An action taken by an adjudicator to vacate a lower level appeal decision, or a portion of the decision, and return the case, or a portion of the case, to that level for a new decision.

Reopening - See IOM 100-04 Chapter 34.

Reversal - Although appeals in the administrative appeals process are de novo proceedings (i.e., a new determination/decision is made at each level), Medicare uses this term where the new determination/decision is more favorable to the appellant than the prior determination/decision, even if some aspects of the prior determination/decision remain the same.

NOTE: The term reversal describes the coverage determination, not the liability determination. For example, an item or service may be determined to be non-covered as not medically reasonable and necessary (under section 1862(a)(1)(A) of the Act), but Medicare may, nevertheless, make payment for the item or service if the party is found not financially liable after applying the limitation on liability provision (section 1879 of the Act). Thus, the coverage determination is affirmed, but Medicare makes payment as required by statute.

Revised Determination or Decision - An initial determination or decision that is reopened and which results in the issuance of a revised determination or decision. A revised determination or decision is considered a separate and distinct determination or decision and may be appealed. For example, a postpayment review of an initial determination that results in a reversal of a previously covered/paid claim (and, potentially, a subsequent overpayment determination) constitutes a reopening and a revised initial determination. The first level of appeal following a revised initial determination is a redetermination.
Spouse - The word "spouse" as used in this chapter, and as used in sections 405.952, 405.972, 405.1052, and 405.1114 of title 42 of the Code of Federal Regulations (CFR) regarding the dismissal of an appeal includes same-sex spouses as well as opposite-sex spouses. The relationship of two individuals of the same

sex will be recognized as a marriage if either (1) the state or territory in which the individuals live recognizes their relationship as a marriage, or (2) the individuals entered into a legally valid marriage under the law of any state, territory, or foreign jurisdiction. Because civil unions and domestic partnerships are not marriages, civil union and domestic partners are not regarded as spouses by CMS.

Supplier –Unless the context otherwise requires, a physician or other practitioner, a facility, or entity (other than a provider of services) that furnishes items or services under Medicare.

Vacate – To set aside a previous action.

200 - CMS Decisions Subject to the Administrative Appeals Process

(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

A. Entitlement Determinations

In accordance with a memorandum of understanding with the Secretary, the Social Security Administration (SSA) makes initial Part A and Part B entitlement determinations and initial determinations on applications for entitlement. Individuals should contact the SSA for administrative appeals involving entitlement (telephone 1-800-772-1213 (TTY 1-800-325-0778 or access the SSA's website at: http://ssa.gov/pgm/medicare.htm). This would include issues that involve the question of whether the beneficiary:

- Has attained age 65 or is entitled to Medicare benefits under the disability or renal disease provisions of the law;
- Is entitled to a monthly retirement, survivor, or disability benefit;
- Is qualified as a railroad beneficiary;
- Met the deemed insured provisions; and
- Met the eligibility requirements for enrollment under the supplementary medical insurance (SMI) program or for hospital insurance (HI) obtained by premium payment.

If a beneficiary is dissatisfied with the SSA's initial determination on entitlement, he or she may request a reconsideration with the SSA. The SSA performs a reconsideration of its initial determination in accordance with 20 CFR part 404, subpart J. Following the reconsideration, the beneficiary may request a hearing before a HHS Administrative Law Judge (ALJ). If the beneficiary obtains a hearing before an ALJ and is dissatisfied with the decision of the ALJ, he or she may request the Appeals Council to review the case. Following the action of the Appeals Council, the beneficiary may be entitled to file suit in Federal district court.

B. Initial Determinations

The Medicare contractor makes initial determinations regarding claims for benefits under Medicare Part A and Part B. A finding that a request for payment does not meet the requirements for a Medicare claim shall not be considered an initial determination. An initial determination for purposes of this chapter includes, but is not limited to, determinations with respect to:

(1) Whether the items and/or services furnished are covered under title XVIII of the Act;

(2) In the case of determinations on the basis of section 1879(b) or (c) of the Act, whether the beneficiary, or supplier who accepts assignment under 42 CFR 424.55 knew, or could reasonably have been expected to know at the time the services were furnished, that the services were not covered;

(3) In the case of determinations on the basis of section 1842(l)(1) of the Act, whether the beneficiary or supplier knew, or could reasonably have been expected to know at the time the services were furnished, that the services were not covered;

(4) Whether the deductible has been met;

(5) The computation of the coinsurance amount;

(6) The number of days used for inpatient hospital, psychiatric hospital, or post-hospital extended care;

(7) Periods of hospice care used;

(8) Requirements for certification and plan of treatment for physician services, durable medical equipment, therapies, inpatient hospitalization, skilled nursing care, home health, hospice, partial hospitalization services*, and intensive outpatient services*;

(9) The beginning and ending of a spell of illness, including a determination made under the presumptions established under 42 CFR 409.60(c)(2), and as specified in 42 CFR 409.60(c)(4);

(10) The medical necessity of services, or the reasonableness or appropriateness of placement of an individual at an acute level of patient care made by the Quality Improvement Organization (QIO) on behalf of the contractor in accordance with 42 CFR 476.86(c)(1);

(11) Any other issues having a present or potential effect on the amount of benefits to be paid under Part A or Part B of Medicare, including a determination as to whether there has been an underpayment of benefits paid under Part A or Part B, and if so, the amount thereof;

(12) If a waiver of adjustment or recovery under sections 1870(b) and (c) of the Act is appropriate*:*

(i) when an overpayment of hospital insurance benefits or supplementary medical insurance benefits (including a payment under section 1814(e) of the Act) has been made with respect to an individual, or

(ii) with respect to a Medicare Secondary Payer recovery claim against a beneficiary or against a provider or supplier*;*

(13) Whether a particular claim is not payable by Medicare based upon the application of the Medicare Secondary Payer provisions of section 1862(b) of the Act;

(14) Under the Medicare Secondary Payer provisions of section 1862(b) of the Act that Medicare has a recovery claim against a provider, supplier, or beneficiary for services or items that have already been paid by the Medicare program, except when the Medicare Secondary Payer recovery claim against the provider or supplier is based upon failure to file a proper claim as defined in 42 CFR part 411 because this action is a reopening*;*

(15) A claim not payable to a beneficiary for the services of a physician who has opted-out. NOTE: A physician who has opted-out of Medicare is not considered a party to the initial determination or any subsequent appeal; and

(16) Under the Medicare Secondary Payer provisions of section 1862(b) of the Act that Medicare has a recovery claim if Medicare is pursuing recovery directly from an applicable plan. That is, there is an initial determination with respect to the amount and existence of the recovery claim.

C. Actions That Are Not Initial Determinations

Actions that are not initial determinations and are not appealable under this chapter include, but are not limited to—

(1) Any determination for which CMS has sole responsibility, for example: whether an entity meets the conditions for participation in the program; whether an independent laboratory meets the conditions for coverage of services; or a determination under the Medicare Secondary Payer provisions of section 1862(b) of the Act of the debtor for a particular recovery claim;

(2) The coinsurance amounts prescribed by regulation for outpatient services under the prospective payment system;

(3) Any issue regarding the computation of the payment amount of program reimbursement of general applicability for which CMS or a contractor has sole responsibility under Part B, such as the establishment of a fee schedule set forth in 42 CFR, part 414, subpart B, or an inherent reasonableness adjustment pursuant to 42 CFR 405.502(g) and any issue regarding the cost report settlement process under Part A:

NOTE: For example, section 1848(i)(1) of the Act prohibits administrative and judicial review of the individual components used to compute Medicare physician fee schedule payment amounts. However, a payment amount determination with respect to a particular item or service on a claim is an initial determination that is appealable.

(4) Whether an individual's appeal meets the qualifications for expedited access to judicial review provided in 42 CFR 405.990;

(5) Any determination regarding whether a Medicare overpayment claim should be compromised, or collection action terminated or suspended under the Federal Claims Collection Act of 1966, as amended;

(6) Determinations regarding the transfer or discharge of residents of skilled nursing facilities in accordance with 42 CFR 483.5 (definition of transfer and discharge) and 483.15;

(7) Determinations regarding the readmission screening and annual resident review processes required by 42 CFR part 483, subparts C and E;

(8) Determinations with respect to a waiver of Medicare Secondary Payer recovery under section 1862(b) of the Act;

(9) Determinations with respect to a waiver of interest;

(10) Determinations for a finding regarding the general applicability of the Medicare Secondary Payer provisions (as opposed to the application in a particular case);

(11) Determinations under the Medicare Secondary Payer provisions of section 1862(b) of the Act that Medicare has a recovery against an entity that was or is required or responsible (directly, as an insurer or self-insurer; as a third party administrator; as an employer that sponsors, contributes to or facilitates a group health plan or a large group health plan; or otherwise) to make payment for services or items that were already reimbursed by the Medicare program, except with respect to the amount and existence of a recovery claim under section 1862(b) of the Act where Medicare is pursuing recovery directly from an applicable plan as specified in 42 CFR 405.924(b)(16);

(12) A contractor's, QIC's, ALJ's, OMHA attorney adjudicator's, or Appeals Council's determination or decision to reopen or not to reopen an initial determination, redetermination, reconsideration, hearing decision, or review decision;

(13) Determinations that CMS or its contractors may participate in the proceedings on a request for an ALJ hearing or act as parties in an ALJ hearing or Appeals Council review;

(14) Determinations that a provider or supplier failed to submit a claim timely or failed to submit a timely claim despite being requested to do so by the beneficiary or the beneficiary's subrogee;

(15) Determinations with respect to whether an entity qualifies for an exception to the electronic claims submission requirement under 42 CFR part 424;

(16) Determinations by the Secretary of sustained or high levels of payment errors in accordance with section 1893(f)(3)(B);

(17) A contractor's prior determination related to coverage of physicians' services;

(18) Requests for anticipated payment under the home health prospective payment system under 42 CFR 409.43(c)(ii)(s); and

(19) Claim submissions on forms/formats that are incomplete, invalid, or do not meet the requirements of a Medicare claim and returned or rejected to the provider or supplier.

NOTE: Duplicate items and services are not afforded appeal rights, unless the supplier is appealing whether or not the service was, in fact, a duplicate.

D. Initial Determinations Subject to Reopening

Minor errors or omissions in an initial determination may be corrected only through the contractor's reopening process. Since it is neither cost efficient or necessary for contractors to correct clerical errors through the appeals process, requests for adjustments to claims resulting from clerical errors must be handled and processed as reopenings. In situations where a provider, supplier, or beneficiary requests an appeal and the issue involves a minor error or omission, irrespective of the request for an appeal, contractors shall treat the request as a request for reopening. A contractor must transfer the appeal request to the reopenings unit or other designated unit for processing. See Chapter 34 Section 10.1 Authority to Conduct a Reopening of the Medicare Claims Processing Manual for information specific to conducting a reopening when a redetermination was requested.

Medicare Claims Processing Manual
Chapter 30 - Financial Liability Protections

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(Rev. 12423, Issued:12-20-23)

500 - Glossary

(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

The following terms are defined only for purposes of this Chapter 30 of the Medicare Claims Processing Manual.

Advance notice of non-coverage– 42 CFR 418.408(d)(2) states that if Medicare would be likely to deny payment as not medically reasonable and necessary, before the service was provided, the physician informed the beneficiary, or someone acting on the beneficiary's behalf, in writing that the physician believed Medicare was likely to deny payment for the specific service and that the beneficiary signed a statement agreeing to pay for that service. This statement may appear as the notice of non-coverage (e.g. Advance Beneficiary Notice of Non-coverage (ABN), Form CMS-R-131, Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN), Form CMS10055, Home Health Change of Care Notice (HHCCN), Form CMS-10280), as defined in 42 CFR 411.404.)

Advance Beneficiary Notice of Non-coverage (ABN, Form CMS-R-131) - Issued by healthcare providers and suppliers to Original Medicare (fee for service) beneficiaries in situations where Medicare payment is expected to be denied.

Authorized representative – An individual authorized under State or other applicable law, e.g., a legally appointed representative or guardian of the beneficiary (if, for example, the beneficiary has been legally declared incompetent by a court) to act on behalf of a beneficiary when the beneficiary is temporarily or permanently unable to act for himself or herself. The authorized representative will have all of the rights and responsibility of a beneficiary or party, as applicable. In states which have health care consent statutes providing for health care decision making by surrogates on behalf of patients who lack advance directives and guardians, reliance upon individuals appointed or designated under such statutes to act as authorized representatives is permissible. The **Appointment of Representative**, Form CMS-1696 is available for the convenience of the beneficiary or any other individual to use when appointing a representative.

For purposes of this chapter, when the term beneficiary is used, for legal purposes, and the beneficiary has an authorized representative, the use of either beneficiary or authorized representative are exchangeable of each other, unless otherwise indicated.

Beneficiary – Individual who is enrolled to receive benefits under Medicare Part A and/or Part B.

Detailed Explanation of Non-Coverage (DENC, Form CMS-10124) – Medicare FeeFor-Service (FFS) Expedited Determination Notice given only if a beneficiary requests an expedited determination. The DENC explains the specific reasons for the end of services.

Detailed Notice of Discharge (DND, Form CMS-10066) – Hospital Discharge Appeal Notice given to beneficiaries who choose to appeal a discharge decision from the hospital or their Medicare Advantage plan, if applicable.

Financial Liability Protections (FLP) Provisions – The FLP provisions of the Social Security Act protect beneficiaries, healthcare providers, and suppliers under certain circumstances from unexpected liability for charges associated with claims that Medicare does not pay. The FLP provisions apply after an item or service's coverage determination is made.

Healthcare provider – Healthcare provider means a "provider of services" (or provider) (as defined under Section 1861(u) of the Social Security Act), a hospital, a critical access hospital (CAH), a skilled nursing facility (SNF), a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization *or intensive outpatient* services).

Home Health Change of Care Notice (HHCCN, Form CMS-10280) - Used by Home Health Agencies (HHAs) to notify Original Medicare beneficiaries receiving home health care benefits of plan of care changes. HHAs are required to provide notification to beneficiaries before reducing or terminating an item and/or service.

Hospital-Issued Notices of Non-coverage (HINNs) - Hospitals provide to beneficiaries prior to admission, at admission, or at any point during an inpatient stay if the hospital determines that the care the beneficiary is receiving, or is about to receive, is not covered by Medicare.

Important Message from Medicare (IM, Form CMS-R-193) – Hospital Discharge Appeal Notice delivered to all Medicare beneficiaries (Original Medicare beneficiaries and Medicare Advantage plan enrollees) who are hospital inpatients. The IM informs hospitalized inpatient beneficiaries of their hospital discharge appeal rights.

Limitation on Liability (LOL) Provision– The LOL provisions, §1879(a)-(g) of the Social Security Act, fall under the FLP provisions and provide financial relief and protection to beneficiaries, healthcare providers, and suppliers by permitting Medicare payment to be made, or requiring refunds to be made, for certain items and/or services for which Medicare payment would otherwise be denied.

Limitation on Recoupment – The requirement that (in certain cases) Medicare must cease or delay recovery of an overpayment when a valid first or second level appeal request is received from a provider on an overpayment, in accordance with Section 1893

of the Social Security Act. For more information, see 100-06 Medicare Financial Management Manual, Chapter 3, Overpayments.

Medicare Beneficiary Identifier (MBI) - is a general term describing a beneficiary's Medicare identification number. Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Medicare Contractor - An entity that contracts with the Federal government to review and/or adjudicate claims, determinations and/or decisions.

Medicare Outpatient Observation Notice (MOON, Form CMS-10611) - A standardized notice to inform Medicare beneficiaries (including health plan enrollees) that they are outpatients receiving observation services and are not inpatients of a hospital or CAH.

Notice of Medicare Non-Coverage (NOMNC, Form CMS-10123) - FFS Expedited Determination Notices that informs beneficiaries on how to request an expedited determination from their Quality Improvement Organization (QIO) and gives beneficiaries the opportunity to request an expedited determination from a QIO.

Overpayment Recovery Waiver – An allowance providing that beneficiaries, healthcare providers, and suppliers can keep Medicare overpayments (in certain circumstances) if they are determined to be "without fault" for causing the overpayment, in accordance with Section 1870 of the Social Security Act. For more information, see 100-06 Medicare Financial Management Manual, Chapter 3, Overpayments.

Refund Requirements (RR) for Non-assigned Claims for Physicians Services - Under §9332(c) of OBRA 1986 (P.L. 99-509), which added §1842(l) to the Social Security Act, new liability protections for Medicare beneficiaries affect nonparticipating physicians.

Refund Requirements (RR) for Assigned and Non-assigned Claims for Medical Equipment and Supplies – Under §132 of SSAA-1994 (Social Security Act Amendments of 1994, P.L. 103-432) which adds §1834(a)(18) to the Social Security Act, and under §133 of SSAA-1994 which adds §1834(j)(4) and §1879(h) to the Social Security Act, new liability protections for Medicare beneficiaries affect suppliers of medical equipment and supplies. All suppliers who sell or rent medical equipment and supplies to Medicare beneficiaries are subject to the refund provisions of §§1834(a)(18), 1834(j)(4) and 1879(h) of the Social Security Act.

Skilled Nursing Facility Advance Notice of Non-coverage (SNF ABN, Form CMS-10055) – Issued in order for a Skilled Nursing Facility (SNF) to transfer financial liability to an Original Medicare beneficiary for items or services, paid under the SNF PPS, that Medicare is expected to deny payment (entirely or in part).

Supplier – Unless the context otherwise requires, a physician or other practitioner, a facility, or entity (other than a provider of services) that furnishes health services covered by Medicare.