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Guidance on Coding and Billing Date of Service on Professional Claims

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PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for physicians, non-physician practitioners, and others submitting claims on a CMS-1500 form or the X12 837 Professional Claim to Medicare Administrative Contractors (MACs) for reimbursement for Medicare Part B services.

PROVIDER ACTION NEEDED

STOP – Impact to you:

Physicians and non-physician practitioners need to identify the correct date of service for the services they provide to a Medicare patient.

CAUTION – What you need to know:

This MLN Matters Article is intended for physicians, providers, and suppliers billing MACs for services provided to Medicare beneficiaries.

GO – What you need to do:

Providers need to determine the Medicare rules and regulations concerning the date of service and submit claims appropriately. Be sure your billing and coding staffs are aware of this information.

BACKGROUND

The information below will not provide all the billing instructions for the individual services. The article does not present any new or revised Medicare policy. Instead, the article reiterates current Medicare policy. This information concentrates on the date(s) of service to submit when billing for these services. If you are providing these services, please take advantage of the

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information available on the CMS website in addition to your MACs. The Medicare Benefit Policy Manual, Chapter 15, Section 20 shows that expenses are considered to have been incurred on the date the beneficiary received the item or service, regardless of when it was paid for or ordered. You may review this manual section at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.

Radiology Services

Typically, radiology services have two separate components, a professional and technical component. These services will have a PC/TC indicator of "1" on the Medicare Physician Fee Schedule Relative Value File. The technical component is billed on the date the patient had the test performed. The professional component is billed on the date the physician provided the interpretation and report of the radiology service. If these are furnished on different dates, they must be billed on different dates using the TC Modifier for the technical component and the 26 Modifier for the professional component.

The Medicare Physician Fee Schedule Relative Value File is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html.

Surgical and Anatomical Pathology

Surgical and anatomical pathology services may have two components: a professional and a technical component. These services will have a PC/TC indicator of "1" on the Medicare Physician Fee Schedule Relative Value File. The technical component is billed on the date the specimen was collected. This would be the surgery date. The professional component is billed on the date of service when the physician provided the interpretation and report of the pathology service. If these occur on different dates, these must be billed on different dates using the TC Modifier for the technical component and the 26 Modifier for the professional component.

When the collection spans two calendar dates, use the date the specimen collected ended.

Stored specimens – If the test is performed on a stored specimen (stored less than or equal to 30 calendar days), the date of service must be the date the test was performed only if:

- The test is ordered by the patient's physician at least 14 days following the date of the patient's discharge from the hospital.
- The specimen was collected while the patient was undergoing a hospital procedure.
- It would be medically inappropriate to have collected the specimen other than during the hospital procedure for which the patient was admitted.
- The results of the test do not guide treatment provided during the hospital stay.
- The test was reasonable and medically necessary for treatment of illness or injury.

If the test is ordered on a specimen stored more than 30 days, the date of service for the technical service is the date the specimen is retrieved from storage. The professional component is billed on the date the physician provided the interpretation and report.

For more information, see the Medicare Claims Processing Manual, Chapter 16, Section 40.8, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c16.pdf.

Care Plan Oversight (CPO)

CPO is physician supervision of a patient receiving complex and/or multidisciplinary care as part of Medicare covered services provided by a participating home health agency or Medicare approved hospice. Providers must provide physician supervision of a patient involving 30 or more minutes of the physician's time per month to report CPO services. The claim for CPO must not include any other services and is only billed after the end of the month in which CPO was provided. The date of service submitted on the claim is the date the provider completed the 30 minutes of supervision.

For more information, see the Medicare Claims Processing Manual, Chapter 12, Section 180.1.A, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf.

Home Health Certification and Recertification

The date of service is the date the physician completes the plan of care. The physician should sign and date at that time allowing for a few days delay when a transcriptionist is involved.

For more information, see the Medicare Claims Processing Manual, Chapter 12, Section 180.1.B, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

Physician End-Stage Renal Disease Services

A physician may provide monthly or daily oversight of a patient on dialysis with End-Stage Renal Disease (ESRD). For physicians billing the monthly capitation payment, the date of service is the first through the last day of the month. For transient or less than a full month service, these can be billed on a per diem basis. The date of service is the date of responsibility for the patient by the billing physician. This would also include when a patient's dies during the calendar month.

For more information, see the Medicare Claims Processing Manual, Chapter 8, Section 140, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c08.pdf.

Transitional Care Management (TCM)

TCM services are a 30-day service provided when a patient is discharged from an appropriate facility and requires moderate or high-complexity medical decision making. The date of service is the date the practitioner completes the required face-to-face visit. Keep in mind, there are additional services to be provided during the 30-day period.

Transitional Care Management Guidance including Questions and Answers and Fact Sheets

are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management.html.

Clinical Lab Services

Generally, the date of service is the date the specimen was collected. If the specimen is collected over a period that spans two calendar dates, the date of service is the date the collection ended. There are two exceptions to the general date of service rule for laboratory tests performed on stored specimens and chemotherapy sensitivity tests performed on live tissue if specific criteria are met.

Additional information is available in the Medicare Claims Processing Manual, Chapter 16, Section 40.8, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c16.pdf.

Home Prothrombin Time (PT/INR) Monitoring

There are three procedure codes applicable to this service. The G0248 describes the initial demonstration use of home INR monitoring and instructions for reporting. The date of service is the date the demonstration and instructions for reporting are given in a face-to-face setting with the patient. G0249 describes the provision of test materials and equipment for home INR monitoring. The date of service is the date the test materials and equipment are given to the patient. G0250 describes the physician review, interpretation, and patient management of home INR testing. The date of service is the date of the fourth test interpretation.

For more information, see the Medicare Claims Processing Manual, Chapter 32, Section 60.5, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c32.pdf.

Cardiovascular Monitoring Services

There are many different procedure codes that represent the cardiovascular monitoring services. These can be identified as professional components, technical components, or a combination of the two. Some of these monitoring services may take place at a single point in time, others may take place over 24 or 48 hours, or over a 30-day period. The determination of the date of service is based on the description of the procedure code and the time listed. When the service includes a physician review and/or interpretation and report, the date of service is the date the physician completes that activity. If the service is a technical service, the date of service is the date the monitoring concludes based on the description of the service. For example, if the description of the procedure code includes 30 days of monitoring and a physician interpretation and report, then the date of service will be no earlier than the 30th day of monitoring and will be the date the physician completed the professional component of the service.

For more information, see the Medicare National Coverage Determination Manual, Chapter 1, Section 20.8.1.1, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_part1.pdf.

Diagnostic Psychological and Neuropsychological Tests

In some cases, for various reasons, psychological and neuropsychological tests (96101/96127) are completed in multiple sessions that occur on different days. In these situations, the date of service that should be reported on the claim is the date of service on which the service (based on CPT code description) concluded. Documentation should reflect that the service began on one day and concluded on another day (the date of service reported on the claim). If documentation is requested, medical records for both days should be submitted.

Psychiatric Testing when provided over multiple days based on the patient being able to provide information, is billed based on the time involved as described by CPT and the last date of the test. For more information, see the Medicare Benefit Policy Manual, Chapter 15, Section 80.2, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.

Surgical Services

Medicare's payment for most surgical services is made using the global surgery rules. All services considered to be part of the global package including follow-up visits, are considered to have occurred on the same day as the surgical service and are not submitted separately. Surgeons who transfer post-operative care to another practitioner will submit their claims using the date of the surgery as the date of service along with Modifier 55. The practitioner receiving the transfer of care will submit his/her post-operative services using the surgical procedure code along with the date of the surgery as his/her date of service. For more information, see the Medicare Claims Processing Manual, Chapter 12, Section 40 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf.

Maternity benefits

All expenses incurred for surgical and obstetrical care including preoperative/prenatal examinations, testing, and post-operative/postnatal services are part of the maternity package and may be billed under the appropriate surgical code on the date of delivery or termination. Charges the practitioner may impose that are not related to the delivery are incurred on the date furnished.

For more information, see the Medicare Benefit Policy Manual, Chapter 15, Section 20.1, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.

Services which transpire over to another calendar date

This category could include multiple types of services, anesthesia when the administration of anesthesia service continues to a new calendar date; the services of teaching physicians when the resident service was provided late at night and the teaching physician sees the patient the next day, MOHS surgery when the service must continue a second date if the patient cannot tolerate the original surgery.

In these cases, the date of service is the date the service concluded. The anesthesia service is billed with the date for the second day. The teaching physician is billed based on the date the teaching physician had a face-to-face with the patient. The date of service for the MOHS surgery will be the date completed.

Note: This document was developed through the A/B Medicare Administrative Contractor (MAC) Provider Outreach & Education (POE) Collaboration Team. This joint effort ensures consistent communication and education throughout the nation on a variety of topics and will assist the provider and physician community with information necessary to submit claims appropriately and receive proper payment in a timely manner.

ADDITIONAL INFORMATION

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/

DOCUMENT HISTORY

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