DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration
Center for Medicaid and State Operations

MEMORANDUM

DATE: June 8, 2001

FROM: Director
Disabled and Elderly Health Programs Group

SUBJECT: Medicare Payment for Physician and Nonphysician Services Under Part B in Certain Indian Providers as a Medicaid Third Party Liable Resource for Medicare/Medicaid Dual Eligibles--INFORMATION

TO: Associate Regional Administrator
Division of Medicaid and State Operations
All Regions

The purpose of this memorandum is to alert you of a statutory change that now allows Medicare payment under Part B to certain Indian providers for physician and nonphysician services and to ask that you so notify the appropriate State agencies in your region. In those States where Medicare/Medicaid dual eligibles include Indian populations, the Medicaid agencies should be made aware of this statutory change so that there is assurance that Medicaid payment for these services do not duplicate Medicare's payment for the same services (42 CFR 433.139(b)(1)).

The Indian Health Service (IHS) is the primary health care provider to the American Indian/Alaska Native (AI/AN) Medicare population. The Indian health care system, consisting of tribal, urban, and federally-operated IHS health programs, delivers a spectrum of clinical and preventive health services to its beneficiaries, via a network of hospitals, clinics, and other entities. While the Social Security Act generally prohibits payment to any Federal agency, an exception is provided for IHS facilities. Prior to the enactment of Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), reimbursement for Medicare services provided in IHS facilities was limited to services provided in hospitals and skilled nursing facilities. Effective July 1, 2001, §432 BIPA extends this Medicare payment to services of physician and nonphysician practitioners furnished in hospitals and ambulatory care clinics.

A separate memorandum providing further guidance on the payment methodology will follow.

We have attached the Program Memorandum to Medicare Intermediaries and Carriers, Transmittal AB-01-52, dated April 10, 2001, and the Questions and Answers formulated to provide as much information as possible for implementation beginning July 1, 2001.

Please forward the information in this memorandum to the appropriate State agencies in your region. Questions on Medicaid policy concerning issues related to third party liability can be directed to Robert Nakielny at (410) 786-4466 or by E-mail at Rnakielny @ hcfa.gov.

Sincerely,

//S//

Thomas E. Hamilton

Attachment

Program Memorandum
Intermediaries/Carriers

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal AB-01-52 Date: APRIL 10, 2001

CHANGE REQUEST 1576

SUBJECT: Payment of Physician and Nonphysician Services in Certain Indian Providers

Background:

The Indian Health Service (IHS) is the primary health care provider to the American Indian/Alaska Native (AI/AN) Medicare population. The Indian health care system, consisting of tribal, urban, and federally-operated IHS health programs, delivers a spectrum of clinical and preventive health services to its beneficiaries, via a network of hospitals, clinics, and other entities. While §§1814(c) and 1835(d) of the Social Security Act (the Act), as amended, generally prohibit payment to any Federal agency, an exception is provided for IHS facilities under §1880. Prior to the enactment of Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), reimbursement for Medicare services provided in IHS facilities was limited to services provided in hospitals and skilled nursing facilities. Effective July 1, 2001, §432 BIPA extends payment to services of physician and non-physician practitioners furnished in hospitals and ambulatory care clinics.

Approximately 60,000 Medicare beneficiaries are served by 47 IHS or tribal-operated hospitals. Many of the hospitals have provider-based clinics, and there are 22 free-standing IHS-operated ambulatory clinics. While the hospitals receive Medicare reimbursement (excluding physician services), the 22 IHS-operated clinics currently receive no Medicare reimbursement. Between 1000 and 1300 physicians and non-physician practitioners practice in these IHS clinics. Additionally, there are a number of part-time and full-time contract physicians and non-physician practitioners within IHS and tribal facilities that are not included in the above number. These IHS, tribe and tribal organization facilities have little or no experience in filing for Medicare Part B services. We expect these entities will bill for the services, and that physicians and non-physician practitioners will reassign their benefits to the IHS facilities.

Carrier Selection:

TrailBlazer Health Enterprises, LLC has been selected as the Part B specialty carrier to enroll IHS, tribe and tribal organization facilities and process IHS physician and non-physician practitioner claims. TrailBlazer Health Enterprises, LLC is currently the fiscal intermediary for IHS hospitals and skilled nursing facilities. All intermediaries and carriers will be notified of this selection. Should other intermediaries and carriers receive misdirected IHS enrollment requests or claims, they will forward them to TrailBlazer Health Enterprises, LLC. In addition, to the extent necessary, the single IHS carrier will coordinate with other Medicare contractors and States to ensure that enrollment of and payment to IHS entities and individuals is efficient and accurate.

Provider Enrollment:

All contractors should redirect enrollment requests and questions regarding hospitals or free-standing ambulatory care clinics, whether operated by the IHS or by an Indian tribe, or tribal organization, facilities, or any practitioners practicing therein to the selected carrier, TrailBlazer Health Enterprises, LLC, Provider Enrollment Department, P.O. Box 660159, Dallas, TX 75266-0159. The following instructions are intended for the use of the selected carrier, TrailBlazer Health Enterprises. Designate a consistent method of labeling all IHS-related enrollment applications. For example, for each IHS application, on the first line of the Form HCFA 855, "Type of Business" use the "Other" check box and manually indicate IHS on the line provided.

Entities:

All clinics that bill as provider-base should be listed as a separate practice location on the Form HCFA-855 submitted for the hospital. A copy of the hospital Form HCFA-855 shall be placed in the intermediary file as well as the carrier file. However, separate reviews by the intermediary and carrier are not required for this application. The processing of these applications should be in accordance with your regular review and verification procedures.

Any clinic that bills as free-standing should submit a new and separate Form HCFA-855 for just the free-standing clinic. The processing of these applications should be in accordance with your regular review and verification procedures.

Note tribal federally qualified health centers (FQHCs) whether provider-based or free-standing, may elect to re-enroll as a clinic eligible for payments under BIPA rather than receive payments as a FQHC. Their claims will be submitted and processed using the selected carrier. However, we expect that most FQHCs will, at least initially, not do so because the FQHC benefit has certain advantages (e.g., administratively easier for some, broader coverage and generally higher payment levels).

Individual Practitioners:

Following your current individual practitioner enrollment and verification instructions, enroll and process requests for reassignment of benefits for those eligible practitioners working in or for hospitals or free-standing ambulatory care clinics, whether operated by the IHS or by an Indian tribe or tribal organization. **However, for practitioners enrolling to work in and reassign benefits to hospitals or free-standing ambulatory care clinics, whether operated by the IHS or by an Indian tribe or tribal organization, in order to enroll, it is necessary only to verify licensure in one State even if it is not the State in which the practitioners practice.** For those disciplines that must be legally authorized to perform services in a state, the practitioner must be legally authorized to perform the services, in at least one state, even if it is not the State where they practice with the IHS.

For those practitioners who are already enrolled in Medicare Part B with TrailBlazer Health Enterprises, LLC, process requests to reassign benefits in accordance with current instructions. All other physicians and practitioners must enroll in the Medicare program with TrailBlazer Health Enterprises.

For those individual practitioners who are employees of an IHS, tribe, or tribal facility that provides offsite care to an IHS, tribe, or tribal beneficiary, who has Medicare Part B, the facility can bill if the employee reassigns his right to payment. However, the IHS, tribe, or tribal facility can not bill for offsite services of a contract practitioner, unless the IHS, tribe, or tribal facility owns or leases the space where the services are provided, by that contract practitioner.

Reporting Requirements and Specifications:

In order to facilitate report generation and data collection regarding IHS, Indian tribe, and tribal organization facilities practitioners and services, assign Provider Identification Numbers (PINs) to each IHS, Indian tribe, and tribal organization facility in a manner that will allow you to ascertain which facilities are IHS, Indian tribe or tribal organization. For example, you may establish PINs that will allow the identification of each IHS facility, Indian tribe, and tribal organization facility. Request Unique Physician Identification Numbers (UPINs) from the registry.

PIN assignments will allow the identification of each IHS, Indian tribe, or tribal entity and the generation of the following reports from the PINs:

- Names, locations and number of IHS entity enrollments;
- Names, locations and number of Indian tribe or tribal entity enrollments;
- Names, locations and number of individual practitioner enrollments;
- Names and number of reassignments;
- Receipt, pending and processing times for all applicants; and
- Allowed charges and allowed frequencies, per quarter, by CPT code and modifier, for each provider.

Workload:

Assign a coordinator dedicated to enrolling IHS, Indian tribe, or tribal organization facilities and practitioners, available for consultation with central office and regional offices, as well as IHS, Indian tribe, and tribal organization facilities and practitioners. In addition, in order to meet the July 1, 2001, legislative implementation deadline, this workload should be separate from all other enrollment workloads and be completed as quickly as possible upon receipt within the current acceptable enrollment time limits.

Payment Policy:

Since January 1, 1992, Medicare has paid for physicians' services under §1848 of the Act, "Payment for Physicians' Services." The Act requires that payments under the fee schedule be based on national uniform relative value units (RVUs) that reflect the relative resources required to perform each service. Section 1848(c) of the Act requires that national RVUs be established for physician work, practice expense, and malpractice expense.

BIPA requires that payment shall be made for Medicare services included in §1848 provided by a hospital or an ambulatory care clinic (whether provider-based or free-standing) that is operated by the IHS or by an Indian tribe or tribal organization. Services are paid for under the same situations and subject to the same terms and conditions as would apply if the services were furnished in or at the direction of such a hospital or clinic that was not operated by such service, tribe, or organization.

Services That May be Paid to IHS/Tribal Organization Facilities:

The services that may be paid to IHS, tribe, and tribal organization facilities are as follows:

- Services for which payment is made under §1848 of the Act. Section 1848(j)(3) defines physician services paid under the physician fee schedule. Also, included are diagnostic tests, covered drugs and biologicals furnished incident to a physician service.

- Services furnished by a physical therapist (which includes speech language pathology services furnished by a provider of service) or occupational therapist as described in §1861(p) of the Act for which payment under Part B is made under a fee schedule.

- Services furnished by a practitioner described in §1842(b)(18)(C) of the Act for which payment under Part B is made under a fee schedule.

- The specific non-physician practitioners included and the appropriate payment percentage of the fee schedule amount are:

Practitioner Services	Percentage of Physician Payment
Nurse Practitioner	85 percent
Clinical Nurse Specialist	85 percent
Nurse Mid-Wife	65 percent
Physician Assistant	85 percent
Physical Therapist	100 percent
Occupational Therapist	100 percent
Clinical Psychologist	100 percent
Clinical Social Worker	75 percent

Pay for services included in the Medicare Physician Fee Schedule Database that have the following status indicators:

- A = active
- C = carrier-priced code
- R = restricted coverage (if no RVUs are shown, service is carrier priced)
- E = excluded from physician fee schedule by regulation

For Medicare covered outpatient drugs use the standard payment methodology.

Do not pay IHS, tribe, or tribal organization facilities for other Part B services. For example, do not pay IHS, tribe, and tribal organization facilities for durable medical equipment, prosthetics, orthotics, and supplies, clinical laboratory services, ambulance services or any service paid on a reasonable charge basis. Do not pay for preventive services (e.g., flu shots).

Incentive Payments:

In accordance with §1833(m) of the Act, physicians who provide covered professional services in any rural or urban health professional shortage area (HPSA) are entitled to an incentive payment. Physicians providing services in either rural or urban HPSA are eligible for a 10 percent incentive payment. It is not enough for the physician merely to have his/her office or primary service location in an HPSA, nor must the beneficiary reside in an HPSA, although frequently this is case. The key to the incentive payment is where the service is actually provided (place of service). For example, a physician providing a service in his/her office, the patient's home, or in a hospital qualifies for the incentive payment as long as the specific location of the service is within an area designated as an HPSA. For instructions on how to implement payment incentive policy, see the Medicare Carriers Manual, Part 3, §3350.

Dual Eligibility:

The Omnibus Budget Reconciliation Act of 1989 requires mandatory assignment of claims for physician services furnished to individuals who are eligible for Medicaid, including those individuals eligible as qualified Medicare beneficiaries.

Standard System:

There are no standard system changes.

Common Working File:

The Common Working File (CWF) should be modified to recognize demonstration project number 40. In addition, modify CWF logic for error code ER 74X1,when the demonstration project number is equal to 40, bypass this edit.

Claims Processing:

Below are the claims processing requirements for BIPA §432.

1. Claims will be submitted by IHS, tribes, or tribal organizations by either using the Form HCFA-1500 or equivalent electronic standard formats.

2. The carrier must supply IHS, tribes, and tribal organizations with any billing software that would normally be given to physician and non-physician practitioners.

3. The carrier will place the demonstration code, 40, on all IHS, tribe, and tribal claims.

4. The effective date (date service was provided) for covered services to be paid is on or after July 1, 2001.

5. The carrier will process IHS, tribe, or tribal organizations facilities claims using their local medical review policy (LMRP). The carrier has three options:

- Develop LMRPs specifically for IHS, tribe, and tribal facilities claims;
- Use existing LMRPs for the State in which the carrier resides; or
- Use existing LMRPs for any State for which they process claims.

The carrier must specify which LMRP they will use for processing IHS, tribe, and tribal facility claims.

6. Payment is to be made based on the Medicare locality in which the services are furnished.

7. The carrier will use its own locality pricing for drugs, biologicals and other carrier-priced codes.

8. The carrier must train IHS, tribes, and tribal organization staff to correctly complete Form HCFA-1500 and the electronic formats. Refer to the Provider Education/Training section.

- The selected carrier will return as unprocessable any claim with missing or incomplete information, following current procedures.

9. IHS, tribes, and tribal organizations will submit claims as if they were a group practice.

- All IHS, tribes, and tribal organizations must apply for a group billing number via the normal processes. The selected carrier must educate IHS, tribes, and tribal organizations on these processes.

- Physicians and other practitioners, who do not currently have Medicare billing numbers with the IHS, tribe, and tribal organization contractor(s) must apply for them via the normal processes. The selected carrier must educate IHS, tribes, and tribal organizations on these processes. It is the IHS, tribes, and tribal organizations' responsibility to notify their physicians and other practitioners of the need for enumeration. The physicians and other practitioners must contact the selected carrier to initiate the enrollment process.

10. The selected carrier will identify all IHS, tribes, and tribal organization facilities and practitioners by their PINs. PINs will be assigned in a manner that will allow the selected carrier to identify which facilities are IHS, tribes, or tribal organizations. All IHS, tribe, and tribal facilities, physician and non-physician practitioners will be assigned an UPIN in accordance with current practices.

11. The selected carrier will use all current edits (including current duplicate logic) on claims from IHS, tribes, and tribal organizations. Medical review will be done in accordance with current procedures.

12. IHS, tribes, and tribal organizations need not submit line items for non-covered services. If non-covered services are billed, then the selected carrier shall process the line items for non-covered services and show on the remittance advice that Medicare did not cover the services.

13. The claim will post to history, update the deductible information, and update utilization. The deductible and co-insurance will apply. IHS, tribe, or tribal organization facilities will not collect the deductible or co-insurance from the beneficiary.

14. The CWF will subject IHS, tribes, and tribal organization's claims to the working aged edit(s) using the MSP AUX file. Where the beneficiary is shown as working aged but IHS, tribes, and tribal organizations have not submitted Medicare secondary payer (MSP) information, the CWF will reject the claim to the selected carrier, which will reject to IHS, tribe, or tribal organizations.

15. IHS, tribes, and tribal organization's claims will be processed through the CWF using existing edits.

16. A remittance advice will be sent to IHS, tribes, and tribal organizations for each claim.

17. Medicare summary notices will be suppressed.

18. Third party payer crossover claims will not be suppressed.

19. Interest shall be calculated on IHS, tribes, and tribal organizations' claims that are not paid timely, in the same manner as any other claim.

20. Normal activities for fraud and abuse, MSP, and medical review will be required for IHS, tribes, and tribal organization claims. Aberrancies that may indicate potential fraudulent behavior should be reported to the applicable regional office.

Provider Education/Training:

The Division of Provider Education and Training, Provider Billing and Education Group, Center for Health Plans and Providers has a number of training options available which could help educate IHS/tribe/tribal organizations on how to enroll, bill, and be paid for physician services so that they would be able to bill and be paid under §432 of BIPA.

Entities, physicians, and other practitioners must enroll in the Medicare program with the Medicare carrier to which they are directed to submit claims.

Resident Training Program. This program is designed to educate graduating resident physicians about the Medicare program, and incorporates electronic training materials i.e., a computer-based training (CBT) module, along with a comprehensive training manual. This particular training has been found helpful by graduating residents and would be helpful for the IHS education effort.

In addition to the Resident Training Program, there are also other CBTs currently available on the **hcfa.gov.medlearn** web site which allow physicians and other practitioners and their staff to access information that will strengthen their understanding of Medicare billing procedures. The website also contains a listing of other educational products that we currently have available, including a section on upcoming events, and links to Medicare contractors and other educational partners' web sites.

Some of the CBT modules currently available for IHS education purposes are as follows:

1. **Introduction to the World of Medicare** (provides basic information about the Medicare program).

2. **Front Office Management** (provides the essential knowledge and skills needed for "checking-in" Medicare patients).

3. **ICD-9-CM Diagnosis Coding** (provides information on the use of the ICD-9 manual for correct diagnosis coding for Medicare).

4. **Medicare Secondary Payer** (provides basic information about Medicare as a secondary payer).

All of the CBT courses are free of charge and are available 24 hours a day, 7 days a week.

The *effective date* for this Program Memorandum (PM) is July 1, 2001.

The *implementation date* for this PM is July 1, 2001.

Funding for implementation activities will be provided to the contractor through the regular budget process.

This PM may be discarded after July 1, 2002.

If you have any questions, contact Terri Harris at (410) 786-6830.

INDIAN HEALTH SERVICE (IHS), TRIBE AND TRIBAL ORGANIZATIONS

Medicare Part B Physician Service Billing
Business Office Coordinators/PSG Meeting

1. Our patients may see multiple providers during the same day i.e., podiatrist, internist, cardiologist, and physical therapist---can we bill for each provider and services rendered?

A. Yes, HCFA will pay Indian Health Service (IHS), tribe, and tribal organization facilities for each service for which payment is made under section 1848 of the Social Security Act. Section 1848(j)(3) defines physician services, which includes drugs and biological that are not self-administered (1861(2)(s) medical and other health services). Also included are diagnostic tests and services incident to a physician service. Services furnished by a physical therapist (which includes speech language pathology services furnished by a provider of service) or occupational therapist for which payment under part B is made under the physician fee schedule (PFS). Also, services furnished by a practitioner described in section 1842(b)(18(C) of the Act for which payment under part B is made under the PFS.

2. Preventative services, flu shots, clinical lab, are not paid under the PFS. These are paid under a separate fee schedule. Will the Health Care Financing Administration (HCFA) consider reimbursing IHS for these services?

A. HCFA does not have the statutory authority to pay for these services because they are not paid under section 1848 of the Act. The Benefit Improvement and Protection Act of 2000 (BIPA), section 432 only extends payment to services furnished in IHS, tribe, and tribal facilities that are under section 1848 of the Act.

3. Screening Mammography, prostrate and prostrate specific anti-body tests, not currently being paid under PFS, but will be a Medicare covered service in the future. How will IHS be reimbursed? What certification i.e., Food and Drug Administration (FDA), are required for these payments?

A. These services are currently not paid under the PFS and therefore will not be paid to IHS, tribe or tribal facilities. However screening mammography will be paid under the PFS beginning January 1, 2002. The FDA requires a valid provisional certificate, or a valid certificate, indicating that the supplier meets all certification requirements for conducting an examination or procedure involving mammography. The FDA's web page provides additional information.

4. Participation Agreements? Will each IHS service unit/facility be required to complete the enrollment application for each physician, mid-level practitioner, nurse specialist and physical therapist? Will HCFA accept a national enrollment or a service unit/facility enrollment and not each applicable provider?

A. Facilities and practitioners must follow current enrollment, verification and assignment instructions. The selected carrier will enroll all IHS, tribe and tribal facilities and practitioners. For those facilities, which are already enrolled in Medicare part, B with the selected carrier need not re-enroll, however, all practitioners must reassign their benefits.

5. Enrollment forms for every provider e.g., locums, contract, emergency room coverage, etc. This is a concern because of the volume and turn over. Can a facility enrollment form be considered?

A. All facilities and practitioners must use the standard enrollment form (HCFA 855) and the re-assignment of benefits form (HCFA 855R).

6. For teaching, resident, and intern hospitals, how are they to handle the billing? What are the special rules that apply to these types of hospitals?

A. The statute authorizes us to pay for the services of residents through the part A program only and not the part B program. Put another way, resident services are paid for within the graduate medical employee (GME) program payments. We have no supervision requirements when residents are paid under GME, but they cannot submit part B bills. To the extent that teaching and supervision of these residents is paid for, however, it is reflected in the GME payment the program receives.

The qualified services of a teaching physician (e.g. beyond basic teaching/supervision) would be payable under part B. This physician, if fully licensed, would be able to enroll and bill for part B services like any other fully licensed physician. In this situation, the teaching physician must do more than supervision of a resident to qualify for part B payment. Supervising/teaching physicians who wish to receive such payment must provide and document services that are beyond the basic teaching and supervision activities, and submit bills under part B of the Medicare program. (See the Carriers Manual, part III, chapter 15, section 15016 for further instructions.)

Students – medical students, physician assistant students, or nurse practitioner students are not considered to be residents. A student may participate in a physician's service other than the taking of a patient's history, any contribution by a medical student to the performance of a service that is billable by a physician must be rendered in the physical presence of the physician. The physician must review, amend as necessary, and sign all documentation by the student. The physician must also document the extent of student's involvement in the billable procedure.

7. State Licensure (in a particular state), under current policy, IHS providers are required to have a state license but not necessarily in the State of practice. What will the provider-licensing requirement be for IHS?

A. For practitioners enrolling to work in and reassign benefits to hospitals or free-standing ambulatory care clinics, whether operated by the IHS, tribe or tribal organization, in order to enroll, it is necessary only to verify licensure in one State even if it is not the State in which the practitioners practice.

8. UPIN Number. Do we have to have a UPIN Number for each provider?

A. All IHS, tribe and tribal facilities and all practitioners must have a UPINs and all physicians and non-physician practitioners must have a PIN.

9. Can the selected contractor give priority to IHS for UPIN assignment for providers?

A. Yes, there will be a separate track for enrollment of IHS, tribe and tribal organization facilities.

10. A contract physician has his/her own practice, and works under a contract with IHS. The contract physician already has a UPIN. How will the carrier handle the billing of the same contract provider with the same UPIN billing from multiple/different facilities?

A. All IHS, tribe and tribal organization claims that would normally be submitted to local contractors for procession will be submitted to and processed by the selected carrier. All edits that would otherwise prohibit processing in this manner shall be bypassed for IHS, tribe and tribal organization claims.

11. Can IHS Federally Qualified Health Centers (FQHC) be allowed to change from a FQHC to a clinic?

A. IHS FQHC may elect to re-enroll as a clinic eligible for payments under BIPA. If the FQHC elects to re-enroll as a clinic their claims will be submitted and processed using the selected contractor. However, we expect that most FQHCs will, at least initially, will not do so because the FQHC

benefit has certain advantages (e.g. administratively easier for some, and broader coverage). FQHCs currently can not bill and be paid for diagnostic test unless they have a part B provider number, however, under the BIPA they can remain a FQHC, also receive a part B provider number, and bill for diagnostic tests.

12. IHS has free standing emergency room services (not directly connected to a hospital). How will these locations be reimbursed?

A. Payments for these services would be based on the office visit codes. These facilities would not be eligible to receive payment for emergency room services.

13. What about Critical Access Hospitals? The rate of reimbursement currently being received does not reflect the professional component, should the professional component be reimbursed using the physician fee schedule also?

A. Yes, services furnished by a practitioner described in section 1842(b)(18)(C) of the Social Security Act will be reimbursed under the PFS for the professional service.

14. Health Professional Shortage Area (HPSA) pay a 10% Bonus. How will the carrier know who you are and apply to payment structure? We need a list of who qualifies, and how to go about qualifying.

A. The list of HPSAs will be given to the selected carrier, who will notify all facilities located in a HSPA. For further details see the Carriers Manual, part III, chapter 15, and section 15052.

15. Carrier Selection. IHS requests one carrier. Budget is a consideration for existing contracts with carriers. Training programs, enrollment support, system changes, could be handled universally for IHS, versus individual carrier requirements.

A. The HCFA will select one contractor to handle all IHS, tribe and tribal organization facility claims.

16. Regulations/Instructions. There is a request by IHS to review these as “draft” before going out. It is necessary to have input and feedback from the operational and provider side.

A. A meeting was held with representatives from IHS on February 16, which discussed the Program Memorandum (AS-01-52, dated April 10), and all questions asked during the Medicare part B Physician Service Billing BOC/PSG meeting on January 31 – February 6.

17. Dual Eligibles. How will these payments be handled?

A. The Omnibus Budget Reconciliation Act of 1989 requires mandatory assignment of claims for physician services furnished to individuals who are eligible for Medicaid, including those individuals eligible as Medicare beneficiaries.

18. What training is available from HCFA on part B implementation? Coordination of training will be required once we know the selected contractor. System changes to be considered with the short

time frame. Test bills will need to be submitted the carrier.

A. The selected contractor will handle training; however, there are a number of training options available, which could help to educate IHS, tribe and tribal organizations. Some of the computer based training modules available on the **hcfs.gov.medlearn** web site are:

- Introduction to the World of Medicare (provides basic information about the Medicare Program)
- Front Office Management (provides the essential knowledge and skills needed for "checking-in" Medicare patients);
- ICD-9-CM Diagnosis Coding (provides information on the use of the ICD-9 manual for correct diagnosis coding for Medicare); and
- Medicare Secondary Payer (provides basic information about Medicare as a secondary payer).

19. Signature on File. Release of information and assignment of benefits how often do these signatures have to be obtained?

A. Signatures should be obtained for the release of information and assignment of benefit when there is a change in the information. The physician should ask the beneficiary if there are any change in the information on the release form. If there is then the form should be updated and a signature obtained.

20. Medicare Secondary Payment (MSP) questionnaire, is this a requirement for the free standing clinics? If the MSP questionnaire does apply, are there any new rules with part B?

A. Before an individual applies for benefits under part A or enrolls under part B, the individual must complete the MSP questionnaire. The MSP questionnaire is used to obtain information on whether they are covered under a primary health plan and the nature of the coverage provided under the plan, including the name, address, and identifying number of the plan.

21. Incident to physician billing - IHS nurses provide care to patients. If the care meets the criteria for incident to billing, will IHS be reimbursed for this service? IHS requests clear guidance on the definition of Incident to a physician and what is billable.

A. For instructions on incident to physician services see the Medicare Carriers Manual, part III, chapter 15, section 2050. Further guidance can be obtained from the selected contractor.

22. Freestanding clinics are not included in the hospital cost reports. Are there any differences in reimbursement under the Sec 432, i.e., lab, X-ray,

A. Yes, under the fee schedule, freestanding clinics are paid both the professional and technical components for diagnostic tests. Provider based clinics are paid the professional component under the fee schedule and get a separate facility payment.

23. Can IHS review any coding edits that are being developed per section 432 of BIPA for coding and billing purposes?

A. We don't expect any special edits; however, if any are developed we can discuss at a later date. All claims are processed using the Correct Coding Initiative (CCI) edits, which are discussed in the

CCI manual. The CCI manual is a tool used by the provider community in order to determine the appropriate billing of common procedure terminology (CPT) codes and Health Care Financing Administration Common Procedure Coding System (HCPCS) codes. Specifically, the manual addresses the inappropriate unbundling of comprehensive procedure codes into its component parts, as well as the inappropriate billing of mutually exclusive procedures, i.e., those procedures that cannot occur during the same operative session. To obtain a copy contact the U.S. Department of Commerce, Technology Administration, National Technical Information Service, Springfield, VA 22161, or (703) 605-6000 and request a copy of the Complete Manual, Version 6.3 (Component Code Sequence).

24. For care oversight and consultation and telemedicine i.e., in AK, physicians are assigned on a daily basis to interact with village health aids through telecommunications is this billable?

A. Payment for telemedicine under Medicare part B, includes services that do not require a face-to-face encounter under the traditional delivery of Medical care and consultation services, which are traditionally delivered face-to-face. Beginning 1/1/99, the Balanced Budget Act (BBA) provided for coverage and payment for consultation services provided via telecommunications systems (teleconsultation). BBA limits eligibility for teleconsultation to Medicare beneficiaries located in a rural HPSA. Emergency department services and home visits that are delivered via telecommunication are not covered under Medicare part B. The specific rules for telemedicine care plan oversight are in the Carriers Manual, part III, chapter 15, section 15513 Care Plan Oversight Services. Also, see the Carriers Manual, part III, chapter 15, and section 15506 for consultation services.

25. Will outlier components be considered in the payment of part B Services, similar to the outliers that are currently utilized in our DRG payment? Would prefer to have one adjustment for all of IHS using the same carrier.

A. There are no “outlier” payments under the fee schedule. In contrast to the “bundled” DRG based payments made under the Inpatient Hospital Prospective Payment system, each service provided is individually billed under the physician fee schedule.

26. What options exist on geographic practice cost index (GPCI) as applied to payments to IHS?

A. Services paid to IHS, tribe or tribal organization facilities are subject to the same situations, terms, and conditions as would apply if the services were furnished in or at the direction of such a hospital or clinic that was not operated by such IHS, tribe, or tribal organization. The selected contractor will determine payments in the appropriate GPCI for the clinic where the service was provided.

27. Our physicians provide services in different settings e.g., nursing homes, residence, schools, and private community hospitals, how will these services be reimbursed?

A. For those individual practitioner who are employees of an IHS, tribe or tribal facility that provides offsite care to a IHS, tribe or tribal beneficiary, who has Medicare part B, the facility can bill under reassignment from the employee. However, the IHS, tribe or tribal facility can not bill for offsite services of a contract practitioner, unless the IHS, tribe or tribal facility owns or leases the space where the services are provided.

28. How will Ambulatory Surgical Centers (ASCs) be paid?

A. ASCs are Medicare approved and certified facilities, which are different from ambulatory care clinics. The ASC is reimbursed for facility cost using the list (CPT codes) of Medicare approved services. There are eight different payment rates. If the physician performs a surgical procedure that is on the list of ASC covered procedures, physicians are paid the lower practice expense rate off the PFS. If the physician performs a surgical procedure that is not on the ASC list of approved services they are paid the non-facility rate of the PFS.

29. At our freestanding clinics, x-rays, MRI, & CAT scans may be provided for diagnostic purposes, are these services part of the PFS?

A. Yes, diagnostic tests are paid under the Medicare PFS.