CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 241 **Date: JULY 23, 2004**

CHANGE REQUEST 3288

I. SUMMARY OF CHANGES: The legislative change in MMA section 630 of 2003 allows IHS facilities to bill for other part B services, which are not covered under §1848 of the Act. Section 630 of the MMA expands the scope of items and services for which payment may be made to IHS facilities and other suppliers in the IHS system to include all other part B covered items and service for a 5 year period beginning January 1, 2005.

NEW/REVISED MATERIAL – EFFECTIVE DATE: January 1, 2005
***IMPLEMENTATION DATE: January 3, 2005**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	19/10/General
R	19/50.1/Services That May Be Paid to HIS/Tribe/Tribal Organization Facilities
N	19/50.1.1/Services Paid Under the Physician Fee Schedule
N	19/50.1.2/Other Part B Services
N	19/50.1.2.1/ Durable Medical Equipment
N	19/50.1.2.2/Prosthetics and Orthotics
N	19/50.1.2.3/Prosthetics Devices
N	19/50.1.2.4/Surgical Dressings and Splints and Casts
N	19/50.1.2.5/Therapeutic Shoes
N	19/50.1.2.6/Drugs
N	19/50.1.2.7/Clinical Laboratory Services
N	19/50.1.2.8/Ambulance Services
R	19/70/Claims Processing
N	19/70.1/Claims Processing Requirements for BIPA §432 Services
N	19/70.2/Claims Processing Requirements for MMA §630
N	19/70.2.1/Enrollment and Billing for DMEPOS
N	19/70.2.1.1/Claims Processing for DMEPOS
N	19/70.2.1.2/Enrollment for DMEPOS
N	19/70.2.1.3/Claims Submission for DMEPOS

N	19/70.3/Enrollment and Billing for Clinical Laboratory and Ambulance Services
N	19/70.3.1/Claims Submission and Processing for Clinical Laboratory and Ambulance Services
N	19/70.3.2/Enrollment for Clinical Laboratory and Ambulance Services and Part B drugs.

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 241	Date: July 23, 2004	Change Request 3288

SUBJECT: Processing Part B Claims for Indian Health Services (IHS)

I. GENERAL INFORMATION

A. Background: Pub. 100-04, Medicare Claims Processing Manual, Chapter 19, Indian Health Service (IHS) is amended to allow IHS, tribe and tribal organization facilities to bill for all Part B services that are not paid for under the physician fee schedule. The expansion of the scope of items and services for which payment may be made to IHS facilities and suppliers includes all other part B covered items and services for a 5 year period beginning January 1, 2005. Section 1880 of the Act provides for payment to IHS facilities for services paid under the physician fee schedule. MMA §630 of 2003 allows IHS, tribe and tribal organization facilities to bill for other Part B services that are not covered under §1848 of the Act. Section 630 of the MMA expands the scope of items and services for which payment may be made to IHS facilities to include all other Part B covered items and services for a 5 year period beginning January 1, 2005. These other Part B services are paid for either under the same situations and subject to the same terms and conditions with the exception of those Part B services, which are included in the "all inclusive rate".

B. Policy: IHS, tribe and tribal organization (non-hospital or non-hospital-based) facilities may bill for all other Part B services, which are not paid under the physician fee schedule and which are not included in the Medicare IHS all-inclusive rate.

Specifically, for the five-year period beginning January 1, 2005, IHS, tribe and tribal organization facilities may bill Medicare for the following Part B services:

- Durable medical equipment
- Prosthetics and orthotics
- Surgical dressings, Splints and Casts
- Therapeutic shoes
- Drugs (DMERC and Part B)
- Clinical laboratory services
- Ambulance services

Outpatient Clinics (freestanding) operated by the IHS, furnishing Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and DMERC drugs shall enroll with the National Supplier Clearinghouse (NSC) as a "DME supplier", and comply with the supplier standards specified in 42 CFR §424.57, and submit all DMEPOS claims to the CIGNA DMERC, or at the facility's option, shall submit DME claims to the appropriate DMERC based on current DME jurisdiction rules. (NOTE: In order to bill drugs to the DMERCs, the supplier must be a pharmacy and a pharmacy license must be on file at the NSC. The NSC will give the pharmacy supplier a specific identifier.) Though CIGNA may receive claims

from any supplier, they will only route the non-CIGNA EMC claims to the appropriate DMERC. CIGNA will not perform any other DMERC functions for non-CIGNA claims. CIGNA is only the point of contact for those DMEPOS claims in their claims jurisdiction. The appropriate DMERC with the claims processing jurisdiction is the point of contact for other claims.

An IHS tribe and tribal organization facility furnishing clinical laboratory services shall enroll with and bill Trailblazers and meet the applicable requirements of the Clinical Laboratory Improvement Amendment (CLIA) requirements as specified in 42 CFR §493(ff).

An IHS tribe and tribal organization facility furnishing ambulance services must meet the requirements of 42 CFR §410.41 and must enroll with and bill Trailblazers.

Drugs billed to Part B carriers must enroll with and bill Trailblazers.

IHS and tribally operated hospitals and clinics associated with hospitals that meet the definition of provider-based in 42 CFR 413.65, and which are currently reimbursed under the all-inclusive rate for services paid under the physician fee schedule shall continue this practice. If and when these facilities decide to bill for items on the DMEPOS fee schedule, then they will have to enroll as a supplier through the National Supplier Clearinghouse (NSC) and bill the appropriate DMERC. They will not be allowed to reroute these DMEPOS claims through CIGNA.

C. Provider Education: A provider education article related to this instruction will be available at http://www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3288.1	Effective January 1, 2005, the VMS and DMERCs shall process claims for DMEPOS and drugs covered by the DMERCs submitted by Indian Health Service (IHS), tribe and tribal non-hospital or non-hospital-based facilities. These claims shall be identified by specialty code "A9".	VMS, DMERCs

3288.2	CIGNA (Region D DMERC) shall accept all DMEPOS claims submitted by outpatient (freestanding) clinics operated by the IHS and will forward EMC claims to the appropriate DMERC for processing. For paper claims, CIGNA will follow their usual procedures for claims outside its jurisdiction. If the outpatient clinics (freestanding) operated by the IHS choose to send the claims directly to the appropriate DMERC that has jurisdiction for the claim that DMERC will process the claim.	VMS Region D DMERC
3288.3	Region A, B, and C DMERCs shall accept IHS DMEPOS claims from CIGNA and process such claims as they would normally.	DMERCs, Regions A, B, and C
3288.4	If a claim is received from an outpatient (freestanding) clinic operated by the IHS before with a date of service prior to January 1, 2005, they shall deny the claim with reason code 26 (Expenses incurred prior to coverage).	VMS, DMERCs
3288.5	If a claim is received from an outpatient (freestanding) clinics operated by the IHS containing an item/service that is not covered in this instruction that service will be denied with reason code 96 (Non-covered charges).	VMS, DMERCs
3288.6	Enrollment of IHS, tribe and tribal facilities providing DMEPOS must be provided through the National Supplier Clearinghouse (NSC). The NSC must start accepting enrollment applications from IHS, tribe and tribal organization facilities providing DMEPOS beginning September 1, 2004.	National Supplier Clearinghouse
3288.7	Enrollment of IHS facilities providing clinical laboratory and ambulance services and Part B drugs must be provided through Trailblazers. These IHS, tribe and tribal organization facilities must meet all the usual enrollment requirements for Trailblazers. Trailblazers must start accepting enrollment applications from IHS, tribe and tribal facilities providing clinical laboratory and ambulance services and Part B drugs. IHS facilities must bill Trailblazers for these services beginning September 1, 2004.	Trailblazers

3288.8	VMS and DMERCs shall identify DMEPOS claims submitted by IHS, tribe and tribal facilities and waive coinsurance and deductible for these beneficiaries.	VMS, DMERCs
3288.9	VMS and DMERCs shall apply all other current edits, including CMN requirements.	VMS, DMERCs
3288.10	The entire MSN shall be suppressed for DMEPOS, DMERC drugs, clinical laboratory, ambulance services, Part B drugs.	VMS, DMERCs, Trailblazers
3288.11	Trailblazers shall apply the claims processing requirements in Pub.100-04, Chapter 16 of the IOM for claims for clinical laboratory services.	Trailblazers
3288.12	Trailblazers shall apply the claims processing requirements in Pub.100-04, Chapter 15 of the IOM for claims for ambulance services.	Trailblazers
3288.13	Trailblazers shall apply the claims processing requirements in Pub. 100-04, Chapter 17 of the IOM for claims for drugs.	Trailblazers
3288.14	Payment for most clinical laboratory claims shall be based on the clinical laboratory fee schedule issued annually. Payment is based upon where the service is performed.	Trailblazers
3288.15	Payment for certain clinical laboratory services is based upon reasonable charge. Trailblazers shall subject the reasonable charge amounts to the Part B deductible and coinsurance unless otherwise specified in the coverage and payment rules.	Trailblazers
3288.16	Payment for ambulance claims shall be based on the ambulance fee schedule and processed based on point of pickup.	Trailblazers
3288.17	Payment for Part B drug claims shall be based on the ASP drug fee schedule.	Trailblazers
3288.18	Payment for the DMEPOS claims shall be based on the DMEPOS fee schedule. These claims shall be priced using the appropriate fee schedule based on beneficiary address.	VMS, DMERCs
3288.19	Payment for drugs billed to the DMERCs shall be based on the Average Sales Price (ASP) Drug Fee Schedule. (See above for drugs billed to Local Part B carriers.)	VMS, DMERCs
3288.20	HIS, tribe and tribal non-hospital or non-hospital based facilities shall bill for all other Part B services, which are not paid for under the physician fee schedule.	Trailblazers

3288.21	Payment shall be made for claims with dates of service on or after January 1, 2005, for durable medical equipment furnished by IHS, tribe and tribal facilities.	DMERCs
3288.22	Payment shall be made for claims with dates of services on or after January 1, 2005, for prosthetics and orthotics furnished by IHS, tribe and tribal facilities.	DMERCs
3288.23	Payment shall be made for claims with dates of service on or after January 1, 2005, for prosthetic devices furnished by IHS, tribe and tribal facilities.	DMERCs
3288.24	Payment shall be made for claims with dates of service on or after January 1, 2005, for surgical dressings furnished by IHS, tribe and tribal facilities.	DMERCs
3288.25	Payment shall be made for claims with dates of service on or after January 1, 2005, for splints and casts furnished by IHS, tribe and tribal facilities. Splints and casts used for the reduction of a fracture or dislocation shall be paid on a reasonable charge basis.	Trailblazers
3288.26	Payment shall be made for claims with dates of service on or after January 1, 2005, for therapeutic shoes furnished by IHS, tribe and tribal facilities.	DMERCs
3288.27	Payment shall be made for claims with dates of service on or after January 1, 2005, for drugs billed to the DMERCs furnished by IHS, tribe and tribal facilities.	DMERCs

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: January 1, 2005 **Implementation Date: January 3, 2005** **Pre-Implementation Contact(s):** Angie Costello at 410-786-1554 or acostello@cms.gov. **Post-Implementation Contact(s**): Appropriate Regional Office	**Funding is available through the regular budget process for costs required for implementation.**

Medicare Claims Processing Manual

Chapter 19 – Indian Health Services

Table of Contents
(Rev. 241, 07-23-04)

10 - General

(Rev. 241, Issued 07-23-04, Effective: 01-01-05, Implementation: 01-03-05)

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 the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), payment for Medicare services provided in IHS facilities was limited to services provided in hospitals and skilled nursing facilities. Effective July 1, 2001, §432 BIPA extended payment to services of physician and non-physician practitioners furnished in hospitals and ambulatory care clinics. This means that clinics associated with hospitals and freestanding clinics that are owned and operated by IHS or that are tribally owned but IHS operated are considered to be IHS and are authorized to bill only the selected carrier for Part B services identified in §432 of BIPA 2000. Other clinics associated with hospitals and freestanding clinics that are not considered to be IHS (i.e., IHS owned but tribally operated or tribally owned and operated) can continue to bill the local Part B carrier for the full range of covered Medicare services and are not restricted to the limitations of the BIPA provision.

Prior to enactment of §630 of the Medicare Modernization Act (MMA) of 2003, IHS facilities were not allowed to bill for other part B services, which are not covered under §1848 of the Act. Section 630 of the MMA expands the scope of items and services for which payment may be made to IHS facilities to include all other part B covered items and services for a 5 year period beginning January 1, 2005.

The following facilities, which were unable to bill for practitioner services prior to BIPA, may now be paid as described in the manual:

- Outpatient departments of IHS operated hospitals that meet the definition of provider-based in 42 CFR 413.65; and
- Outpatient clinics (freestanding) operated by the IHS.

The following facilities, which were not limited by §1880, may be paid for services under BIPA or may be paid under another authority under which it qualifies.

- Outpatient departments of tribally operated hospitals that are operated by a tribe or tribal organization; and
- Other outpatient facilities that are tribally operated regardless of ownership. This includes Federally Qualified Health Centers (FQHCs).

Under §630 of the MMA, in addition to the foregoing listed entities, the following types of entities may bill for §630 MMA services as described in §§50 and 70 of this chapter.

- *Other IHS freestanding clinics that are operated by IHS, Indian tribes or tribal organizations.*

- *Any IHS, tribe, or tribal organization supplier of a service payable under §630 of MMA.*

50.1 – Services That May Be Paid to IHS/Tribe/Tribal Organization Facilities and Suppliers

(Rev. 241, Issued 07-23-04, Effective: 01-01-05, Implementation: 01-03-05)

50.1.1 Services Paid Under the Physician Fee Schedule

The services that may be paid to IHS, tribe, and tribal organization facilities *under the Medicare physician fee schedule* 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. Although anesthesia services are considered to be physician services these services are not included on the physician fee schedule database. Anesthesia services are covered and are reimbursed using a separate payment method (see §1848(d)(1)(D)). Also, included are diagnostic tests (see §1861(s)(3)), covered drugs and biologicals furnished incident to a physician service (see §1861(s)(2)(A) and (b)) and Diabetes Self-Management Training services (see 1861(s)(2)(S)).

- 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.

- Services furnished by a registered dietitian or nutrition professional (meeting certain requirements) as defined in §105 of BIPA for medical nutrition therapy services for beneficiaries with diabetes or renal disease.

- Screening mammograms services are now paid under the physician fee schedule based on the BIPA provision. The specific non-physician practitioners included and the appropriate payment percentage of the fee schedule amount are:

Practitioner Services	Percentage of Physician Payment

Certified Registered Nurse Anesthetist (medically directed)	50 percent
Certified Registered Nurse Anesthetist (non-medically directed)	100 percent
Clinical Nurse Specialist	85 percent
Clinical Psychologist	100 percent
Clinical Social Worker	75 percent
Nurse Mid-Wife	65 percent
Nurse Practitioner	85 percent
Nutrition Professional/ Registered Dietitian	85 percent
Occupational Therapist	100 percent
Physical Therapist	100 percent
Physician Assistant	85 percent

Subject to national coverage determinations and local medical review policies, 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.

Audiologists can directly bill Medicare but only for diagnostic tests. For laboratory services, if the IHS, tribe or tribal facility were paying for the laboratory services then the IHS, tribe or tribal facility would bill through the hospital through the hospitals all-inclusive rate.

Payment for telehealth under Medicare Part B includes professional consultations, office visits and other outpatient visits, individual psychotherapy, pharmacological management and the psychiatric diagnostic interview examination as identified by CPT codes 99201 through 99215, 99241 through 99275, 90804 through 90809, 90862 and 90801. For more information see the Medicare Benefit Policy Manual--chapter 15, section 270.

50.1.2 – Other Part B Services

(Rev. 241, Issued 07-23-04, Effective: 01-01-05, Implementation: 01-03-05)

IHS, tribe and tribal organization facilities can bill for all other part B services, which are not paid under the physician fee schedule and which are not included in the Medicare IHS all-inclusive rate.

For the 5 year period beginning January 1, 2005, IHS, tribe, and tribal organization facilities may bill Medicare for the following part B services:

- *Durable medical equipment*
- *Prosthetics and orthotics*

- *Surgical dressings, and splints and casts*
- *Therapeutic shoes*
- *Drugs (DMERC and Part B drugs)*
- *Clinical laboratory services, and*
- *Ambulance services*

Durable medical equipment, prosthetics and orthotics, surgical dressings, therapeutic shoes and DMERC drugs must be billed to the DMERC. Supplies must enroll with the National Supplier Clearinghouse to obtain a Supplier Number to bill the DMERC.

Splints and casts, Part B Drugs, clinical laboratory services and ambulance services must be billed to Trailblazers. Providers must enroll with Trailblazers.

50.1.2.1 – Durable Medical Equipment

(Rev. 241, Issued 07-23-04, Effective: 01-01-05, Implementation: 01-03-05)

For the 5 year period beginning January 1, 2005, Part B payment may be made to IHS, tribe and tribal organization facilities that furnish durable medical equipment for use in the patient's home. See section 110 of chapter 15 of the Benefit Policy manual for more information on this benefit.

50.1.2.2 – Prosthetics, and Orthotics

(Rev. 241, Issued 07-23-04, Effective: 01-01-05, Implementation: 01-03-05)

For the 5 year period beginning January 1, 2005, Part B payment may be made to IHS, tribe and tribal organization facilities that furnish prosthetics (artificial legs, arms, and eyes) and orthotics (leg, arm, back, and neck braces). See section 130 of chapter 15 of the Benefit Policy manual for more information on this benefit.

50.1.2.3 – Prosthetic Devices

(Rev. 241, Issued 07-23-04, Effective: 01-01-05, Implementation: 01-03-05)

For the 5 year period beginning January 1, 2005, Part B payment may be made to IHS, tribe and tribal organization facilities that furnish prosthetic devices which replace all or part of an internal body organ (including contiguous tissue), or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ. Parenteral and enteral nutrients, equipment, and supplies and ostomy, tracheostomy, and urological supplies meet the definition of this benefit. See section 120 of chapter 15 of the Benefit Policy manual for more information on this benefit.

50.1.2.4 – Surgical Dressings and Splints and Casts

(Rev. 241, Issued 07-23-04, Effective: 01-01-05, Implementation: 01-03-05)

For the 5 year period beginning January 1, 2005, Part B payment may be made to IHS, tribe and tribal organization facilities that furnish surgical dressings and splints, casts, and other devices used for reductions of fractures and dislocations. See section 100 of chapter 15 of the Benefit Policy manual for more information on this benefit.

50.1.2.5 – Therapeutic Shoes

(Rev. 241, Issued 07-23-04, Effective: 01-01-05, Implementation: 01-03-05)

For the 5 year period beginning January 1, 2005, Part B payment may be made to IHS, tribe and tribal organization facilities that furnish therapeutic shoes and inserts for individuals with diabetes. See section 140 of chapter 15 of the Benefit Policy Manual for more information on this benefit.

50.1.2.6 – Drugs

(Rev. 241, Issued 07-23-04, Effective: 01-01-05, Implementation: 01-03-05)

For the 5 year period beginning January 1, 2005, Part B payment may be made to IHS, tribe and tribal organization facilities that furnish Drugs (Part B drugs and DMERC drugs). Part B drugs shall be billed to Trailblazers. See section 80 of chapter 17 of the Medicare Claims Processing Manual for more information on this benefit.

50.1.2.7 – Clinical Laboratory Services

(Rev. 241, Issued 07-23-04, Effective: 01-01-05, Implementation: 01-03-05)

For the 5 year period beginning January 1, 2005, Part B payment may be made to IHS, tribe and tribal organization facilities that furnish clinical laboratory services. See section 80.1 of chapter 15 of the Benefit Policy Manual for more information on this benefit.

50.1.2.8 – Ambulance Services

(Rev. 241, Issued 07-23-04, Effective: 01-01-05, Implementation: 01-03-05)

For the 5 year period beginning January 1, 2005, Part B payment may be made to IHS, tribe and tribal organization facilities that furnish ambulance services. See chapter 10 of the Benefit Policy Manual for more information on this benefit.

70 – Claims Processing

(Rev. 241, Issued 07-23-04, Effective: 01-01-05, Implementation: 01-03-05)

70.1 - Claims Processing Requirements for BIPA §432 Services

(Rev. 241, Issued 07-23-04, Effective: 01-01-05, Implementation: 01-03-05)

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

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

3. The selected carrier shall 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. Timely claims filing requirements are not waived.

5. The selected carrier shall process IHS, tribe, or tribal organization facilities claims using their local medical review policy (LCD). The carrier has three options:

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

The selected carrier shall specify which LCD they will use for processing IHS, tribe, and tribal organization facility claims.

6. Payment is to be made based on the Medicare locality in which the services are furnished in accordance with current jurisdictional pricing guidelines.

7. The selected carrier shall use the drug-pricing file accessed at www.cms.hhs.gov/providers/drugs/default.asp. However, if a drug or biological is not currently listed in the drug-pricing file, the selected carrier shall price the drug or biological utilizing current Medicare drug payment policy. (See Pub. 100-04, Medicare Claims Processing Manual, Chapter 17, section 20.)

Note: The drug- pricing file and payment policy referenced above is for CY 2004 only. Beginning in CY 2005, we will have a new drug pricing file and a new drug payment policy.

The selected carrier shall train IHS, tribes, and tribal organization staff to complete correctly Forms CMS-1500 and the electronic formats.

- The selected carrier shall return as unprocessable any claim with missing or incomplete information, following current procedures with one exception:
- Within one year after receipt of the first paper claims from an IHS or tribal provider the selected carrier may hold unprocessable claims for the purpose of educating the provider, but may not hold any unprocessable claim for more than 60 days after receipt of the claim.

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 shall 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 with the selected carrier shall apply for them via the normal processes. The selected carrier shall 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 shall identify all IHS, tribes, and tribal organization facilities and practitioners by their PINs. PINs shall 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 a UPIN in accordance with current practices.

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

12. 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.

13. 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.

14. IHS, tribes, and tribal organizations' claims will be processed through the CWF using existing edits.

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

16. Medicare summary notices will be suppressed.

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

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

19.00Normal activities for fraud and abuse, MSP, and medical review will be required for IHS, tribes, and tribal organization claims. Aberrances that may indicate potential fraudulent behavior should be reported to the applicable regional office.

20. The contractor shall process claims for Medicare Railroad retiree beneficiaries.

21. IHS, tribe, and tribal facilities are not included in the Medpar directory since these facilities treat only the American Indian/Alaska Native population, except in an emergency situation.

70.2 - Claims Processing Requirements for MMA §630

(Rev. 241, Issued 07-23-04, Effective: 01-01-05, Implementation: 01-03-05)

For the 5 year period beginning January 1, 2005, IHS, tribe, and tribal organization facilities may bill Medicare for the following part B services:

- *Durable medical equipment,*
- *Prosthetics and orthotics,*
- *Prosthetic devices,*
- *Therapeutic shoes,*
- *Surgical dressings and splints and casts,*
- *Drugs (Part B and DMERC)*
- *Clinical laboratory services, and*
- *Ambulance services.*

70.2.1 – Enrollment and Billing For DMEPOS

(Rev. 241, Issued 07-23-04, Effective: 01-01-05, Implementation: 01-03-05)

70.2.1.1 – Claims Processing for DMEPOS

(Rev. 241, Issued 07-23-04, Effective: 01-01-05, Implementation: 01-03-05)

Effective January 1, 2005, the DMERCs shall process claims for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies, and Drugs (DMEPOS) submitted by IHS, tribe and tribal organizations. DMERCs may only be billed by free-standing clinics, not by hospital-based clinics or hospital outpatient departments. Hospitals and hospital-based clinics already bill the designated FI for DME used in the home.

The DMERCs shall identify the IHS, tribe and tribal organization facilities by specialty code.

The DMERCs shall identify DMEPOS claims submitted by IHS, tribe and tribal organization facilities and waive coinsurance and deductible for these beneficiaries.

The DMERCs shall apply all other edits, including Certificate of Medical Necessity (CMN) requirements.

The Medicare Summary Notice (MSN) messages for these claims shall be suppressed. Co Pay and Deductibles shall be waived.

Payment for these claims shall be based on the DMEPOS fee schedule. These claims will be priced using the appropriate DMEPOS fee schedule based on the beneficiary's address.

70.2.1.2 – Enrollment for DMEPOS

(Rev. 241, Issued 07-23-04, Effective: 01-01-05, Implementation: 01-03-05)

IHS, tribe and tribal organizations that do not currently have a supplier number and want to bill for DMEPOS items must enroll with the National Supplier Clearinghouse (NSC). The NSC must start accepting enrollment applications from IHS, tribe and tribal organization facilities providing DMEPOS beginning September 1, 2004.

70.2.1.3 – Claims Submission for DMEPOS

(Rev. 241, Issued 07-23-04, Effective: 01-01-05, Implementation: 01-03-05)

CIGNA (Region D DMERC) shall accept all DMEPOS claims submitted by outpatient (freestanding) clinics operated by the IHS and will forward EMC claims to the appropriate DMERC for processing. CIGNA will follow usual procedures for paper claims. If the outpatient clinics (freestanding) operated by the IHS choose to send the claims directly to the appropriate DMERC that has jurisdiction for the claim that DMERC will process the claim.

70.3- Enrollment and Billing for Clinical Laboratory and Ambulance Services and Drugs Billed for Part B services

(Rev. 241, Issued 07-23-04, Effective: 01-01-05, Implementation: 01-03-05)

70.3.1 – Claims Submission and Processing for Clinical Laboratory and Ambulance Services

(Rev. 241, Issued 07-23-04, Effective: 01-01-05, Implementation: 01-03-05)

Effective January 1, 2005, Trailblazers shall process claims for clinical laboratory and ambulance services and drugs submitted by IHS, tribe and tribal organizations.

Coinsurance and deductible for these beneficiaries shall be waived.

The Medicare Summary Notice (MSN) messages for these claims shall be suppressed.

All Claims processing requirements in Chapter 15 of IOM Pub. 100-04 shall apply to ambulance service claims submitted by IHS, tribe and tribal organization facilities.

All Claims processing requirements in Chapter 16 of IOM Pub. 100-04 shall apply to clinical laboratory services claims submitted by IHS, tribe and tribal organization facilities.

Payment for most clinical laboratory claims shall be based on the clinical laboratory fee schedule issued annually. Payment is based upon where the service is performed.

Payment for certain clinical laboratory services is based upon reasonable charge.

Payment for ambulance claims shall be based on the ambulance fee schedule and processed based on point of pickup.

Payment for drug claims shall be based on the Average Sales Price (ASP) fee schedule.

70.3.2 – Enrollment for Clinical Laboratory and Ambulance Services and Part B Drugs

(Rev.)

Enrollment of IHS, tribe and tribal organization facilities providing clinical laboratory and ambulance services and Part B drugs must be provided through Trailblazers. These IHS, tribe and tribal organization facilities must meet all the usual enrollment requirements for Trailblazers. Trailblazers must start accepting enrollment applications from IHS, tribe and tribal organization facilities providing clinical laboratory and ambulance services beginning September 1, 2004.

These instructions apply to free-standing or independent clinical labs and independent ambulance companies, but not to hospital based ambulance services or hospital lab services.