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.