Program Memorandum Intermediaries/Carriers

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

Transmittal AB-02-150 **Date: OCTOBER 25, 2002**

CHANGE REQUEST 2055

SUBJECT: Payment of Physician and Nonphysician Services for 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), 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 or which are freestanding that are owned and operated by IHS or 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 or which are freestanding 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, not restricted to the limitations of the BIPA provision.

The following facilities, which were unable to bill for practitioner services prior to BIPA, may now be paid as described in this Program Memorandum (PM).

- 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).

For Medicare purposes, a tribally owned and operated facility is not considered a facility of the IHS and is not limited by the restrictions of §1880.

Carrier Selection**:**

TrailBlazer Health Enterprises, LLC was selected as the Part B specialty carrier to enroll IHS operated facilities and process IHS physician and non-physician practitioner claims for those facilities. TrailBlazer Health Enterprises, LLC (selected carrier) is currently the fiscal intermediary for IHS hospitals and skilled nursing facilities. The selected carrier may also enroll tribally operated facilities and process the practitioner claims for these facilities, if the tribally operated facilities choose. All intermediaries and carriers were notified of this selection.

Should other intermediaries and carriers receive misdirected enrollment requests or paper claims for IHS operated facilities and their practitioners, they will forward them to the selected carrier. However, for those carriers that have tribally operated practitioners currently enrolled with them, they may continue to service these practitioners. In addition, all tribally operated facilities, including FQHCs, may enroll with and submit bills to their local carriers, if they choose. Carriers should service these tribally operated facilities and their practitioners in accordance with their normal procedures. However, IHS operated facilities may only enroll with and submit bills to the selected carrier. Tribally owned and operated facilities, while having a choice to bill their local carrier or the selected carrier, are prohibited from billing both entities.

Provider Enrollment:

The selected carrier should designate a consistent method of labeling all IHS-related enrollment applications. For example, for each IHS application, the first line of the Form CMS-855 (1/98 version or CMS approved IHS version), under "Type of Business", check the "Other" box and manually indicate IHS on the line provided. Or, if the Form CMS-855 (11/01) is submitted, under item 2.A.1, check the "Other" box and manually indicate IHS on the line provided.

The selected carrier must follow these enrollment requirements:

- All applications are subject to the same processing times as all other provider enrollment applications;
- If a person or entity has been issued a Drug Enforcement Agency (DEA) certification, report the number on the application. Continue to process these applications because these entities are owned by another governmental agency. Obtain a copy of the DEA certification;
- IHS entities may not have an actual street address. Continue to process these applications because these entities are owned by another governmental agency. In addition, obtain directions to the location of the entity and/or other descriptions, leading to the location.

Applications:

Computer generated enrollment forms, approved by CMS, can be accepted from IHS enrollees until July 1, 2002, at which time the selected carrier will begin transitioning IHS providers to the 11/01 version of the Form CMS-855s. The following conditions must be met when the IHS computer generated enrollment form is utilized:

- All pages of the submitted computer generated Form CMS-855 must display the official watermark date;
- Accept these applications in hard copy only, no electronic copies;
- Accept only completed applications and not "fragments" or pieces of an application;
- The IHS generated Form CMS-855 will only be accepted by the selected carrier for the purposes of enrolling IHS and tribal facilities and practitioners for Medicare Part B payment.

As of October 1, 2002, only the 11/01 version of the Form CMS-855 will be accepted. Any electronic generated forms will have to be generated from the CMS Provider Enrollment Web site. Any other enrollment forms submitted by IHS, tribes or tribal organizations after October 1, 2002 will be returned to the provider. The provider will then have to complete a new Form CMS-855 and submit to the selected carrier in order to enroll.

The selected carrier must ask the state-licensing agency to allow the contractor to provide a list of physicians for verification of licensure and request that any fees be waived. This is in lieu of the selected carrier having to send individual letters requesting verification of licensure and being subjected to a fee. The selected carrier must budget for this additional cost related to this activity.

As an alternative, if the physician is a W-2 employee with the IHS and is enrolled with another carrier, the selected carrier should query the other carrier to determine if that carrier verified the license. If so, the selected carrier can accept that as verification of licensure. This process must be clearly documented and must be present in the enrollment files.

Entities:

In order to enroll IHS clinics that are currently provider-based (and use the hospital's tax identification number) and that wish to bill Part B, the hospital must complete a Form CMS-855-B and enroll as a "group". Each clinic would be reflected on the Form CMS-855 as a practice location. The "doing business as" name of the clinic could be reflected on the Form CMS-855, if appropriate. Provider identification numbers (PINs) and pay-to addresses must then be issued for each practice. However, the payment would be made to the hospital.

Any clinic that bills as freestanding should submit a new and separate Form CMS-855 for just the freestanding clinic (see exception for physical/occupational therapist under Reassignment). The processing of these applications should be in accordance with the selected carrier's regular review and verification procedures.

NOTE: Tribally operated ambulatory care clinics, including those that are participating as FQHCs, are entitled to enroll their physicians and non-physician practitioners under Part B like any other Medicare provider. Although FQHCs are paid on a cost basis for the professional services of physicians and non-physician practitioners, the FQHC benefit does not cover and pay for clinical laboratory and diagnostic tests. Consequently, the tribal health center can remain an FQHC and still bill their Part B carrier for laboratory and diagnostic tests.

Individual Practitioners:

For those eligible practitioners already working in or for hospitals or free-standing ambulatory care clinics, whether operated by IHS or by an Indian tribe or tribal organization, enroll and process requests for reassignment of benefits following the current individual practitioner enrollment and verification instructions. For practitioners enrolling to work in or reassign benefits to hospitals or free-standing ambulatory care clinics, whether operated by the IHS or by an Indian tribe or tribal organization, it is necessary only to verify licensure in one State even if it is not the State in which the practitioners practice. This only applies to federal employees and does not apply if the practitioner/physician is enrolling to work in or to reassign to an Indian tribe or tribal organization. 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 the practitioner practices with the IHS. An exception to the reassignment rules was made for physical therapist/occupational therapist (PTs/OTs), (for details see the reassignment section).

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

For those individual practitioners who are employees of an IHS, tribe, or tribal facility that provides offsite care to the IHS, tribe, or tribal Medicare Part B beneficiaries, 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 that contract practitioner provides the services.

Multiple Sites:

Multiple clinics utilizing the same tax identification number (TIN) can be enrolled as practice locations under the "owner" of the TIN (i.e., the hospital). Each clinic will be assigned a separate provider identification number (PIN). If the clinic has a separate TIN, then the clinic would have to enroll separately. Payment is made to the name associated with the TIN. The legal business name must be shown on the Form CMS-855 exactly as it appears on the Internal Revenue Service documentation. However, the "doing business as" name can be listed as the practice location.

Reassignment:

For those individual practitioners who are employees of the IHS, tribe or tribal facility that provides offsite care to the IHS, tribe or tribal Medicare Part B beneficiary, the facility can bill under reassignment from the employee. With regard to contract practitioners, the IHS, tribe, or tribal facility can accept reassignment and bill for offsite services if the space where the contract practitioner provides the service is owned or leased, by the IHS, tribe, or tribal facility.

The PTs/OTs that are employees of the IHS, tribe or tribal group practice will enroll in Medicare Part B and receive a PIN. The PTs/OTs will reassign their benefits to the facility. The entity will then bill Medicare for their services.

Mobile Units:

The entity providing the service must bill for the service. If the contracted entity performs services on space that the IHS facility owns or leases, the IHS facility can bill under reassignment.

In order to purchase a professional test interpretation, the provider must have performed the technical component of the test, and must meet the conditions described in the Medicare Carrier Manual (MCM) §3060.5. In order to purchase a technical component of a test, the provider must perform the professional component of the test, and meet the conditions described in the MCM §3060.4.

Reporting Requirements and Specifications:

In order to facilitate report generation and data collection regarding IHS, Indian tribe, and tribal organization facilities practitioners and services, the selected carrier will assign PINs to each IHS, Indian tribe, and tribal organization facility in a manner that will allow the selected carrier to ascertain which facilities are IHS, Indian tribe or tribal organization. For example, the selected carrier 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.

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 required that payment be made for §1848 Medicare services 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/Indian, 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. 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, covered drugs and biologicals furnished incident to a physician service and Diabetes Self-Management Training services. (For instructions on incident to physician services see the MCM §2050.)

- 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 are payable effective January 1, 2002, because these services are now paid under the physician fee schedule based on the BIPA provision.

The specific non-physician practitioners 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

Medicare pays 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 facilities for other Part B services. For example, do not pay IHS facilities for durable medical equipment, prosthetics, orthotics, and supplies, clinical laboratory services, ambulance services or any service paid on a reasonable charge basis.

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, through the hospitals all inclusive rate would bill through the hospital.

Payment for telehealth under Medicare Part B includes professional consultations, office visits and other outpatient visits and office psychiatry services identified by CPT codes 99201 through 99215; 99241 through 99275; 90804 through 90809 and 90862. For more information see regulations published at 42 CFR 410.78 and 414.65.

Incentive Payments:

In accordance with §1833(m) of the Act, physicians who provide covered professional services in any rural or urban geographic health professional shortage area (HPSA) are entitled to an incentive payment. Physicians providing services in either rural or urban geographic HPSA are eligible for a 10 percent incentive payment. Specifically, the service must actually be provided (place of service) within an area designated a geographic HPSA. For instructions on how to implement payment incentive policy, see §3350 of the MCM.

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. Therefore, assure that claims for services to dual eligibles are paid as assigned claims.

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 CMS-1500 or equivalent electronic standard formats.

2. The selected 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 selected 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. Timely claims filling requirements are not waived.

5. The selected 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 selected 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 in accordance with current jurisdictional pricing guidelines.

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

8. The selected carrier must train IHS, tribes, and tribal organization staff to correctly complete Forms CMS-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 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 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 with the selected carrier, 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 and Correct Coding Initiative edits) 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. Aberrances that may indicate potential fraudulent behavior should be reported to the applicable regional office.

21. The contractor will process claims for Medicare Railroad retiree beneficiaries.

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

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

The *implementation date* for this PM is October 25, 2002.

These instructions should be implemented with your current operating budget.

This PM may be discarded after July 1, 2004.

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