Medicare Claims Processing Manual

Chapter 19 - Indian Health Service

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Note: The entire chapter is based on PM AB-02-150. Therefore, there is no separate crosswalk.

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10 - Introduction

(Rev.)

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 the 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 extended payment to services of physician and nonphysician practitioners furnished in hospitals and ambulatory care clinics.

This means that freestanding clinics or those associated with hospitals that are operated by IHS (either IHS owned or tribally owned) are considered to be IHS and are authorized to bill only the selected carrier (see §20) for Part B services identified in §432 of BIPA 2000. Other freestanding clinics or those associated with hospitals 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 these instructions.

- 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 of the Act, 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 of the Act.

Many of the IHS hospitals have provider-based clinics. Also, there are 22 freestanding IHS-operated ambulatory clinics. While the hospitals have previously received Medicare

reimbursement (excluding physician services), prior to July 1, 2001, the 22 IHS-operated clinics received no Medicare reimbursement.

Covered services for Medicare beneficiaries are described in the Medicare Benefit Policy Manual.

IHS hospitals are reimbursed under the DRG Perspective Payment System (PPS) for inpatient services. IHS hospitals are exempt from outpatient PPS, but are still required to file claims with appropriate HIPPA coding requirements.

20 - Claims Processing Jurisdiction

(Rev.)

TrailBlazer Health Enterprises, LLC, was selected as the Part B specialty carrier to enroll IHS operated facilities and process IHS physician and nonphysician practitioner claims for those facilities. TrailBlazer is also the current fiscal intermediary for all IHS hospitals, skilled nursing facilities, and any other facilities that normally bill the intermediary. The selected carrier may also enroll tribally operated facilities and process the practitioner claims for these facilities, if the tribally operated facilities choose.

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.

Should other intermediaries and carriers receive misdirected IHS enrollment requests or paper claims, they will forward them to the selected intermediary or carrier.

30 - Provider Enrollment

(Rev.)

The selected carrier and/or intermediary should follow the Medicare Program Integrity Manual, Chapter 10, for general enrollment requirements; however, IHS has been granted the following exceptions:

The selected carrier or intermediary designates a consistent method of labeling all IHS-related enrollment applications. For example, along with identifying their specialty, each IHS applicant should check the "Other" box and indicate IHS on the line provided under item 2.A.1 on the Form CMS-855B (11/01).

Each provider based clinic that does not have its own Tax ID number can be listed as a practice location to its parent provider. If the Tax ID number is owned by the hospital, the provider based clinic can be listed as a practice location and request a separate

Provider identification numbers (PIN), thereby allowing the clinic to use the hospital's Tax ID number and specifying the pay to address for payment to be sent to the clinic.

For those states that Qualifier.net does not verify licensure - If a physician is a W-2 employee with the IHS and is currently enrolled with another carrier, the selected carrier and/or intermediary could query the other carrier to determine if that carrier verified the license. If so, the selected carrier and/or intermediary can accept that as verification of licensure. This process must be documented and must be present in the enrollment files.

For physician and nonphysician practitioner services furnished in IHS hospitals and ambulatory care clinics, they only need to be legally authorized to furnish services in a state.

July 1, 2001, was used as the date the entity began practicing at their location and for the date the practitioner became associated with the IHS entity.

Sections 5 and 6 of the Form CMS-855A and Form CMS-855B do not have to be completed; however, the authorized representative and any delegated officials (Sections 15 and 16) have to be included in Section 6.

Form CMS-855s can be processed for IHS entities without an actual street address. However, we would expect to see directions to the location of the entity and/or any other description leading to the location of the entity.

IHS providers/suppliers were allowed to use a computer generated Forms CMS-855, CMS-855R and CMS-855C when certain conditions were met. As of October 1, 2002, only the 11/01 versions of the Form CMS-855s are acceptable. Any electronically generated forms must be generated from the CMS Provider Enrollment Web site.

Contractors should direct all enrollment questions or requests concerning providers, suppliers or individual practitioners operated by or associated with the IHS, Indian tribes, or tribal organizations to the designated carrier's and/or intermediary's provider enrollment department.

30.1 - Provider Enrollment Applications

(Rev.)

See Medicare Program Integrity Manual, Chapter 10, and http://cms.hhs.gov/providers/enrollment/ for general instructions on provider enrollment.

Computer generated enrollment forms, approved by CMS, were accepted from IHS enrollees until July 1, 2002, at which time the selected carrier began 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;

- Carriers and intermediaries accept these application in hardcopy only, no electronic copies;

- Carriers and intermediaries accept only completed applications and not "fragments" or pieces of an application; and

- An 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 reimbursement. CMS reserves the right to cease the use of any electronically produced Form CMS-855 at any time.

The selected IHS carrier and/or intermediary must provide notice to IHS one month prior to the discontinuance of the end of the use of the official IHS electronically produced Form CMS-855's.

As of October 1, 2002, only the 11/01 version of the Form CMS-855 is acceptable. Any electronic generated forms must 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 and/or intermediary must send the state licensing agency a letter explaining that IHS can now bill Medicare, that this is an initial enrollment effort, and that the number of verifications will be greatly reduced after this initial effort. The letter must ask the state agency to allow the contractor to send them a list of physicians for verification and waive the fees. The selected carrier must budget for this additional cost.

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

30.1.1 - Entities

(Rev.)

Generally, provider enrollment procedures in Chapter 10 of the Medicare Program Integrity Manual apply.

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" (DBA) name of the clinic could be

reflected on the Form CMS-855, if appropriate. Provider identification numbers and pay-to addresses must then be issued for each practice. The PIN will be the NPI (National Provider Identifier) when implemented. However, the payment would be made to the hospital.

A copy of the hospital Form CMS-855 must be retained by each intermediary and carrier. However, separate reviews by the intermediary and the selected carrier are not required for this application. Review may be done by a combined review operation for IHS facilities.

Any clinic that bills as freestanding must submit a new and separate Form CMS-855 for just the freestanding clinic (see exception for physical/occupational therapist under §30.1.4). 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 nonphysician practitioners under Part B like any other Medicare provider. Although FQHCs are paid on a cost basis for the professional services of physicians and nonphysician practitioners, the FQHC benefit does cover and pay for clinical laboratory and diagnostic tests. Consequently, the tribal health center can remain a FQHC and still bill Part B for laboratory and diagnostic tests.

Effective January 1, 2001, independent RHCs/FQHCs bill all laboratory services to the carrier, and provider based RHCs/FQHCs bill all lab tests to the intermediary under the host provider's bill type. In either case, payment is made under the fee schedule. HCPCS codes are required for lab services.

Refer to the Medicare Claims Processing Manual Chapter 16, "Laboratory Services," for general lab billing instructions.

Refer to the Medicare Claims processing Manual, Chapter 9, "Rural Health Clinics/Federally Qualified Health Centers," §40.4, for lab services included in the RHC/FQHC all-inclusive rate.

30.1.2 - Individual Practitioners

(Rev.)

The IHS carrier follows current individual practitioner enrollment and verification instructions for enrollment and processing requests for reassignment of benefits for eligible practitioners working in or for hospitals or freestanding 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 freestanding ambulatory care clinics, whether operated by the IHS or by an Indian tribe or tribal organization, the carrier or intermediary is required to verify licensure in only one State. The State need not be the State in which the practitioners practice. This only applies to federal employees and does not apply if the practitioner or 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 they practice with the IHS. An exception to the reassignment rules was made for physical therapist/occupational therapist (PTs/OTs), (for details see §30.1.4).

For those practitioners who are already enrolled in Medicare Part B with the selected carrier, they 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 Medicare Part B services to the IHS, tribe, or tribal beneficiary; the facility can bill if the employee reassigns his right to payment. However, the IHS, tribe, or tribal facility cannot bill for off-site services of a contract practitioner, unless the IHS, tribe, or tribal facility owns or leases the space where that contract practitioner provides the services.

30.1.3 - Multiple Sites

(Rev.)

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 PIN. The UPIN will be the NPI (National Provider Identifier) when implemented. 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" (DBA) name can be listed as the practice location.

30.1.4 - Reassignment

(Rev.)

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.

30.1.5 - Mobile Units

(Rev.)

Except as noted in §30.1.4, the IHS facility normally may not bill for mobile unit services because the IHS facility is not performing the technical or professional component of the test. Exceptions to this are:

- If the contracted entity performs services on space that the IHS facility owns or leases, the IHS facility can bill under reassignment;

- For services provided under Part A to inpatients of IHS hospital and SNFs, the hospital or SNF must bill; and

- For therapy services provided under Part B to inpatients of IHS SNFs, or other services bundled under SNF consolidated billing, the IHS SNF must bill for the service.

In order to receive payment for a purchased professional test interpretation, the IHS facility must have performed the technical component of the test, and the following conditions must apply:

- The physician or medical group from which the interpretations are purchased must be an entity independent of the IHS facility;

- The physician or medical group providing the interpretations does not see the patient;

- The physician or medical group providing the interpretations must be enrolled in Medicare;

- The IHS must keep on file the name, the provider identification number and address of the interpreting physician

In order to purchase a technical component of a test, the IHS must perform the professional component of the test.

The IHS may be the entity that orders the test from the mobile unit, or the tests may have been ordered by a different physician or group. An example of the latter situation is when the attending physician orders radiology tests from the IHS and the IHS purchases the tests from a mobile imaging center. The IHS may not markup the charge for a test from the purchase price.

These exceptions are not applicable for clinical diagnostic laboratory tests.

40 - Provider Education/Training

(Rev.)

The Division of Provider Information Planning and Development, Provider Communications Group, CMM, 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 or intermediary to which they are directed to submit claims.

The Resident Training Program is designed to educate graduating resident physicians about the Medicare program, and incorporates electronic training materials such as a comprehensive CD-ROM training manual. This particular training has been found helpful by both graduating residents and physicians who are new to the Medicare program and would therefore be helpful for the IHS education effort.

In addition to the Resident Training Program, there are also other Web-based training (WBT) mechanisms currently available on the http://cms.hhs.gov/medlearn Web site, which allows physicians and other practitioners and their staff to access information that will strengthen their understanding of Medicare billing procedures. The Web site 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 WBT 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).

These WBT courses are free of charge and are available 24 hours a day, 7 days a week. Also, many of these WBT courses have continuing education credits associated with them.

50 - Carrier/Intermediary Reporting Requirements and Specifications

(Rev.)

In order to facilitate report generation and data collection regarding IHS, Indian tribe, and tribal organization facilities practitioners and services, carriers assign PINs to each IHS, Indian tribe, and tribal organization facility in a manner that will allow ascertaining which facilities are IHS, Indian tribe, or tribal organization. The UPIN will be the NPI (National Provider Identifier) when implemented. For example, carriers may establish

PINs that will allow the identification of each IHS facility, Indian tribe, and tribal organization facility. Carriers 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.

Carriers must 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.

Intermediaries will use provider numbers assigned by the CMS regional office. (See State Operations Manual, §2779.)

60 - Medicare Payment Policy

(Rev.)

The BIPA of 2000 requires that payment be made for Medicare services included in §1848 of the Act provided by a hospital or an ambulatory care clinic (whether provider-based or freestanding) 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. An exception to this is hospital outpatient PPS (OPPS). IHS hospitals are not included in OPPS. The IHS hospitals are paid under an OMB-approved All-Inclusive Rate methodology for outpatient services. Inpatient services are paid under PPS.

Since January 1, 1992, Medicare has paid for physicians' services under Physicians Fee Schedule (MPFS). See Chapter 23 of the Medicare Claims Processing Manual. 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.

60.1 - Incentive Payments

(Rev.)

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 a HPSA, nor must the beneficiary reside in a 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 a HPSA. For instructions on the payment incentive process, see Chapter 12 of this manual.

60.2 - Dual Medicare/Medicaid Eligibility

(Rev.)

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

60.3 - Primary and Secondary Payer

(Rev.)

B3-2309.3, A3-3153.1, HH-232.3, HM-260.3, & SNF-280.3

In the case of contract health services to American Indian/Alaska Native and their dependents covered under the IHS program and Medicare, Medicare is the primary payer and IHS the secondary payer.

60.4 - Outpatient Perspective Payment System

(Rev.)

Federal Register: November 30, 2001 (Volume 66, Number 231)

Outpatient services provided by the hospitals of the Indian Health Services (IHS) are not subject to OPPS payment calculations at this time. They will continue to be paid under separately established rates.

60.5 - Deductible and Coinsurance

(Rev.)

CR2055

In each calendar year, a cash deductible must be satisfied before payment can be made by Medicare. After the deductible has been satisfied, the patient normally is responsible for a coinsurance amount of 20 percent of the allowed charges.

This deductible and coinsurance will be applied for Medicare payment to IHS; however, the IHS, tribe, or tribal organization facility will not collect the deductible or coinsurance from the beneficiary. In effect, the IHS will be assuming the beneficiary's deductible and co-insurance expenses.

70 - Allowable Costs

(Rev.)

Allowable costs are the costs actually incurred by the IHS, which are reasonable in amount and necessary and proper to the efficient delivery of services.

The allowability of costs is governed by the applicable Medicare principles of reimbursement for provider costs as set forth in 42 CFR 413 and the Medicare Provider Reimbursement Manual. These are the general Medicare principles that define allowable costs of hospitals and other facilities paid on a reasonable cost or cost related basis.

70.1 - Services That May Be Paid to IHS/Tribal Organization Facilities

(Rev.)

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) of the Act defines physician services paid under the physician fee schedule. Although anesthesia services are considered 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) of the Act). 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 Medicare Benefit Policy Manual, Chapter 15.)

- 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, since these services are now paid under the physician fee schedule based on the BIPA provision.

The statue authorizes Medicare to pay for the services of residents through the Part A program only and not the Part B program. Resident services are paid for within the graduate medical employee (GME) program payments. Medicare Part B has 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. Students - medical students, physician assistant students, or nurse practitioner students - are not considered residents. A student may participate in a physician's service, but 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 the student's involvement in the billable procedure.

The specific nonphysician practitioners included and the appropriate payment percentages of the fee schedule amount are:

Practitioner Services	Percentage of Physician Payment
Nurse Practitioner	85%
Clinical Nurse Specialist	85%
Nurse Mid-Wife	65%

Practitioner Services	Percentage of Physician Payment
Physician Assistant	85%
Physical Therapist	100%
Occupational Therapist	100%
Clinical Psychologist	100%
Clinical Social Worker	75%
CRNA (medically directed)	50%
CRNA (nonmedically directed)	100%
Registered Dietitian	85%
Nutrition Professional	85%

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, contractors use the standard payment methodology. Drugs furnished by facilities are billed to the intermediary. Drugs furnished by individual practitioners or incidental to payable practitioner or supplier services are paid by the carrier. See Chapter 17, "Drugs and Biologicals."

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

Audiologists can directly bill Medicare but only for diagnostic tests. For laboratory services, if the IHS, tribe, or tribal facility is paying for the laboratory service, 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 the Medicare Claims Processing Manual, Chapter 12, "Physician/Nonphysician Practitioners," §§190, and regulations published at 42 CFR 410.78 and 414.65.

70.2 - Costs Excluded From Allowable Costs

(Rev.)

Costs excluded from allowable costs are items and services not covered under the Medicare program, e.g., dental services, eyeglasses, and routine examinations are not covered. See the Medicare Benefit Policy Manual, Chapter 16, "General Exclusions from Coverage."

80 - General Billing and Claims Processing Requirements

(Rev.)

General requirements for timely filing and payment, admission processing (determining eligibility and whether Medicare is secondary, etc.), and billing data elements are applicable to billing for IHSs; except as specified in this chapter.

See Chapter 2 for general filing requirements applicable to all providers.

See Chapter 25 for general requirements for completing the Form CMS-1500 data set.

See Chapter 26 for general requirements for completing the UB-92 data set (paper, flat file and X12)).

Below are the claims processing requirements.

1. Claims will be submitted by IHS, tribes, or tribal organizations by either using Form CMS-1500 or UB-92 or equivalent electronic standard formats.

2. The selected carrier or intermediary must supply IHS, tribes, and tribal organizations with any billing software that would normally be given to hospitals, physicians, and nonphysician practitioners.

3. The selected carrier or intermediary will place the demonstration code, 40, on CWF records for all IHS, tribe, and tribal claims.

4. The effective date for physician and nonphysician covered services to be paid is on or after July 1, 2001. Timely claims filling requirements are not waived.

5. The selected carrier or intermediary will process IHS, tribe, or tribal organizations facilities claims using their local medical review policy (LMRP). The carrier or intermediary 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 or intermediary 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 or intermediary will use its own locality pricing for drugs, biologicals and other locally priced codes.

8. The selected carrier or intermediary must train IHS, tribes, and tribal organization staff to correctly complete Form CMS-1500/UB-92 and the electronic formats. Refer to the Provider Education/Training section of this chapter.

    - The selected carrier or intermediary will return as unprocessable any claim with missing or incomplete information, following current procedures except in the following circumstance. Within one year after receipt of the first paper claim for an IHS or tribal provider, the selected carrier or intermediary 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 or intermediary 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 nonphysician practitioners will be assigned an UPIN in accordance with current practices. Hospitals and other facilities that require State Agency certification or CMS Regional Office (RO) approval will use the provider number assigned by the RO.

11. The selected carrier or intermediary will use all current edits (including current duplicate logic, Correct Coding Initiative edits, OCE for non-OPPS hospitals, MCE) on claims from IHS, tribes, and tribal organizations. Medical review will be done in accordance with current procedures.

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

13. The claim will post to CWF and contractor history, update the deductible information, and update utilization. The deductible and coinsurance 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, tribe, and tribal organization 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 or intermediary, which will reject to IHS, tribe, or tribal organizations.

15. The IHS, tribe, and tribal organization 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, tribe, and tribal organization 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, tribe, 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. The 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.