Medicare Part B: Requirements, Processes for Enrollment & Participation
CMS—Medicine Dish
April 9, 2008

Dorothy Dupree:
Welcome to the April *Medicine Dish* broadcast. The topic for today's broadcast is "Medicare Part B and the Indian Healthcare System." I'm Dorothy Dupree, Director of the CMS Tribal Affairs Group and your host of *Medicine Dish*. Thank you for joining us today.

Today's broadcast, "Medicare Part B and the Indian Healthcare System," will provide an overview of how Medicare Part B works with the Indian Healthcare System and includes overviews of how providers enroll in the program, what services are covered, and how bills are submitted and processed. We'll be joined by experts from the CMS Central Office and a representative of the TrailBlazer Health Enterprises, the Medicare Administrative Contractor otherwise known as MAC for Indian Country. Thank you for joining us, and I'm looking forward to you, our viewing audience, calling us with your questions. All this and more on this installment of *Medicine Dish*.

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Again, I'd like to welcome you to our April 2008 *Medicine Dish* broadcast. As I mentioned earlier, the topic today is "Medicare Part B and the Indian Healthcare System." Before we move to today's presentation, I want to share with you the second segment of our new feature called "Nation Builders." You may recall that we first introduced the "Nation Builders" segment during our February show. This segment features tribal leaders and other principals who are involved in securing access to high-quality healthcare for our Indian people. We have a new guest each month who will share their views about what we, as people, can to do protect and expand American Indian and Alaska native rights and access to quality healthcare. Our intent is to highlight guests who have perspectives and experiences gained from their work as tribal leaders and professional and administrative positions. They'll share their thoughts and visions about what each of us can do in our respective roles to improve the health status of Indian people.

Today's guest is a very special person -- Valerie Davidson. Valerie is currently the Senior Director of Legal and Intergovernmental Affairs for the Alaska Native Tribal Health Consortium. She is also the chairperson of the CMS Tribal Technical Advisory Committee, a group of senior tribal leaders who advise CMS about its programs in Indian Country. Val was also appointed by the secretary as a past member of the Medicaid commission assigned to work on Medicaid reform. We're privileged today to be able to share some of her thoughts with you as she speaks about what we all can do to improve the health of our people, and the strength of our nations.

I met Val in early 2004 during the first TTAG meeting where she was appointed chair of the TTAG. Since then, I've worked closely with her, have grown to admire her tremendously, and appreciate the way in which she's able to get to the heart of whatever the Medicare or Medicaid issue is the topic of discussion at any of our TTAG meetings. She's a fierce proponent of tribal

healthcare, working long hours at her job as Senior Director of Legal and Intergovernmental Affairs, and in her role as TTAG Chair. I'd be remiss if I didn't mention that she is also a loving, dedicated mother of two wonderful daughters, Kylie and Alaina [both spelled phonetically]. Please join me in this segment of "Nation Builders" as we highlight Valerie Davidson.

[music]

Valerie Davidson:
For tribal communities and for American Indians Alaska natives, this isn't about just money. It's about the federal trust responsibility and about keeping promises that were made hundreds of years ago, and insuring that the resources are available to be able to provide basic healthcare and to provide basic access to healthcare. IHS is only funded about 57 percent of their level of need, so where does that remaining 43 percent come from? In some places it's more; some places it's less. Typically comes from third-party reimbursement, typically Medicaid, some Medicare, some S-CHIP, and some third-party, private insurance.

If you look at the amount of dollars that CMS spends on healthcare for American Indians and Alaska natives, it isn't even a rounding error in a CMS budget or even a portion of the CMS budget. It has no financial significance. However, on the individual Indian person's side those limited dollars, which aren't even a rounding error in the CMS budget or even in the CMS Medicaid budget, mean the difference between that person having access to healthcare or not. For example, the IHS has limited resources, or none in some cases, to be able to pay for patient travel. So what does a patient do when they have to buy a plane ticket from a small remote village to Anchorage at a cost of 780 dollars round-trip to be able to have an operation? That's where Medicaid comes in. Otherwise, that person foregoes care and could potentially die. If we don't have those resources to be able to cover that on the front end, what happens is it becomes an emergency, it becomes a life or death situation, and instead you end up paying for a 30 or a 50 or 60 thousand dollar Medivac from that small community into the nearest acute care facility that can provide that care in Anchorage. So by foregoing that 780-dollar ticket in the front, it ends up actually costing the Medicaid program huge dollars on the back end.

[music]

I'm here asking you today that as you're moving forward and making recommendations that you stop and you take the time personally. And I guess I challenge every one of you. You stop as you're doing your work every day, you stop and you ask the question: how is this going to impact American Indians and Alaska natives as well as tribes and tribal organizations and their unique relationship with the federal government? And I guess I would also ask that you not assume that somebody else has already asked that question, because nine times out of 10 they haven't. Again, we're not even a rounding error. Nobody necessarily even knows that we exist. Some of -- it's amazing how many people in the United States have never even met an American Indian or an Alaska native. And I can't reach out today to touch all of you, otherwise I would. I would shake your hand in a traditional Yupik way and ask for your help, that we can't do this by ourselves. We need your help. And I would challenge each and every one of you to remember the promises that have been made by people who came long before us, to make sure that we

honor commitments that were made by past presidents of the United States as well as our forefathers and our foremothers to make sure that basic healthcare is available to American Indians and Alaska natives.

Dorothy Dupree:
I hope you enjoyed Valerie's thoughtful and inspiring words. Remember her, as she'll be a leader for improved healthcare for Indian people for years to come.

And now, let's turn to the main topic of today's *Medicine Dish* broadcast, "Medicare Part B and Indian Country." Medicare Part B can be an important resource in Indian Country. As people learn more about what Medicare covers and how it can benefit them and their Indian healthcare clinics, we expect to see an increase in beneficiary enrollment. As enrollment goes up, so will income to Indian healthcare facilities and services to Indian people. Our panel today will be providing you an overview of Medicare Part B as the program relates to providers. Our panel is comprised of Allen "Chip" Gillespie. We all know him as Chip, and Chip is with the Office of Financial Management here at CMS. Our second panelist is Terri Harris. Most of you have seen her before. She's been a guest on the *Medicine Dish* broadcast previously. Terri is still with the Centers for Medicare Management here at CMS. And again, another familiar face is Cindy Murphy off to my right. Cindy is still with CMS Medicare Management. And then finally, we have Denise Mohling. Denise is with Provider Education from TrailBlazers Health Enterprises.

The panel will provide a brief overview of the Medicare Part B regulations, and provide information to a few of the most commonly asked questions received from IHS tribal and urban Indian programs. Should you have questions during this *Medicine Dish* presentation, please contact us during this broadcast by following one of the two options. You can call the 800 number listed on your screen, or you can ask your question live. To ask your question -- I'm sorry -- you can fax your question to 410-786-0123 and the panel will be asked to respond.

Now, I'd like to turn the mic over to our first panelist, Chip. Chip has vast experience in enrollment matters for Indian providers, and he has graciously agreed to share that knowledge with us today. Thank you, Chip.

Allen Gillespie:
Thank you, Dorothy. It's really an honor to be here to talk to you all today. I'm going to talk to you about provider enrollment. And the purpose of provider enrollment is to insure that providers and suppliers meet all of the federal and state requirements to enroll in the Medicare program and to receive -- to be able to provide services to beneficiaries and receive payment for those services. Provider enrollment really is the gatekeeper to the Medicare program. It's usually the provider who supplies first contact with Medicare, and we want to ensure that we establish a partnership with the provider and supplier so that we're able to make sure we have the correct information in our database and payments are made correctly and timely.

I'll give you a little history of provider enrollment. Prior to 1996, contractors had their own internal systems, their own rules, their own forms, their own procedures for enrolling in Medicare. CMS, around 1995, decided that it was in the best interest of the program to centralize provider enrollment and make it a national program that would be consistent for all

providers and suppliers and for all of our contractors enrolling providers and suppliers. So in 1996, we first introduced the CMS 855, which is the enrollment form. Since that time, there have been major revisions to that form in 1999, 2001, and 2006. There have also been some minor revisions, but they have not made any major changes to the form itself. Today we have a variation of the forms. We have the CMS 855A, which is used by institutional providers that would enroll with the fiscal intermediaries. We have the CMS 855B, which is for organizational suppliers such as group practices, labs, testing facilities, MRI facilities that would enroll with the Medicare carrier or the -- in this case now -- TrailBlazer, the Medicare Administrative Contractor. We also have the CMS 855I, which is used by individual practitioners, physicians, the non-physician practitioners such as nurses and physician assistants. They would use that form to enroll and to give us their credentials. We also have the CMS 855R. It's not an enrollment form per se, but it is a form that establishes the agreement between an individual practitioner and the group they work for, letting us know that the group is allowed to bill and receive payment for that individual's work. In many cases within IHS, you have groups and you do have individual practitioners, so that 855R is a form you'd probably use quite a bit.

The final CMS enrollment form is a CMS 855S, which is used by suppliers of durable medical equipment, prosthetic, orthotics, and supplies, or DMEPOS is what they're referred to. IHS enrolls with TrailBlazer for both Part A and Part B. The big thing you have to remember here for all work done on IHS facilities, the individuals and the licenses are done through IHS requirements. If individuals would leave the IHS facility and work outside, say, in a patient's home, they have to make sure that they're credentialed properly with the state that they're working out of. Sometimes the states require licenses specific to that state.

Tribal facilities can enroll with TrailBlazer or with their local contractor, which you can determine based on your geographic location in the country. DMEPOS suppliers all enroll with the National Supplier Clearinghouse, which is located in South Carolina; it's Palmetto Government Benefits Administrator. The NSC enrolls both tribal and IHS durable medical equipment suppliers, and they -- and one thing that you do have to remember now that they've started the accreditation program for DMEPOS suppliers that they have to meet that accreditation also.

In 2006 we implemented the CMS enrollment regulation, which is found at the Code of Federal Regulations at 42CFR424500 through 555. The effective date for that regulation was June 2006. That gave us the full regulatory authority where we can -- that covers both initial enrollments. It covers updates to your information as things change such as adding practice locations and adding physicians to groups, adding services to a lab, et cetera. It also gives us the authority to revalidate enrollment applications, which we have that as a five-year cycle, which we have already started to implement in some areas.

The other supporting program for provider enrollment is called PECOS, and that stands for Provider Enrollment Chain and Ownership System. That's our national database of everyone: every organization, owners, managers, et cetera that are all enrolled with or individually in the Medicare program. We started using PECOS for Part A fiscal and remediaries in 2002, and then for Part B for carriers in 2003. And again, it's the national repository for all enrollment information throughout the country, and all carriers and intermediaries and DME MACs will

have access to that system. The other thing that that system does, it takes all financial information and transfers it to the FISS system for Part A, and the MCS system for Part B. So, any changes to your information, specifically for payment, have to go through PECOS into those systems.

We have several initiatives we're working on right now. One is the National Provider Identifier, which will be implemented in its entirety in May 2008 -- May 23rd exactly. Right now we're using the NPI and your normal Medicare billing numbers on claims, but in a mere month or so you can only bill with NPI.

The other thing that we're working on for the enrollment process is we're going to have an Internet version of the enrollment form. Right now you can get it off our Web site, but you have to download it, fill it out, and send it in hard copy. And later in 2008, you'll be able to access it through the Internet; you'll be able to fill it out completely, and send it in via the Web. You'll also be able to go into it yourselves and make changes through the Web, and it'll be a real fast, very good system because it won't have all that time to fill out paperwork.

The one thing I'd like to say about the Internet is that it also will be something where you're not going to see the form itself. You're going to hear a series of questions or prompts that would prompt you through the enrollment process. For example, what type of provider supplier are you? Physician group, it would go to the particular parts of the enrollment form that a physician group has to complete, and would prompt you through the process. It will also make sure that you have it completely filled out and ready to be sent in, or else it will not let you send it over the Web. So it'll be a very streamlined process, and hopefully reduce the time to process the applications. We're also working on new regulatory authorities right now. Those are various forms that will be out for public comment through various -- the Physician Fee Schedule reg, the other regs that we're working on.

I'd like to go over a few things as far as filling out an 855. The main thing is to fill it out completely. The one thing, or the most prevalent reason we have to return forms or follow up on information is because providers or suppliers do not fill out the form completely. When areas are not applicable to your type of supplier, indicate that on the form. The other thing you have to do is make sure you include your National Provider Identifier. All providers and suppliers have to have a National Provider Identifier. It has to be with your enrollment application, or it will be returned. It's crucial because that's going to – again -- that's going to be on your claim in May, and without getting the right combination of information in the PECOS system could interrupt your claims being paid timely.

For all individuals on a CMS 855, I caution you to put the name, date of birth, and Social Security Number. Put their full name and the name that they have gotten the Social Security Number with. Don't put -- if they go by their middle name, first initial, middle name, don't put that. Put their full first name and their last name. We have a lot of problems with that, and we do seem to find that lots of times the date of birth is not correct -- both directions, not just making you younger. For organizations, please make sure you put your legal business name and your tax identification number. One of the requirements on the 855 is to submit the IRS 575 form that is issued by IRS that does give the legal name and the tax number. Do not use DBAs

other than where it shows you can use a DBA. But in the beginning of the form, we need your legal business name and tax number because we have problems if we don't pay the right entity then we have problems with IRS and you too would have problems with IRS.

The other form that I'd like to tell you, to caution you, to make sure it's with the form is the Electronic Funds Transfer form. It's the 588, and it's a CMS form. All Medicare payments are now being made electronically through the bank; it's not being made by paper checks any longer. So if you're currently enrolled and change your information, you have to include that Electronic Funds Transfer form with that application. If you're newly enrolling, also you have to include Electronic Funds Transfer form with the application. That's very important to make sure you do this.

And thank you very much, and now I'd like to turn it back to Dorothy.

Dorothy Dupree:
Thank you, Chip. I'd like to emphasize here too a couple of points that Chip made and just reiterate them, as it's very important that you do get the absolutely correct name and Social Security Numbers or tax ID numbers on your form. We've received a few calls throughout the last couple of years that -- from individuals who are asking us why it's taking so long or why there are delays and so forth. And the reason is, is because we do check those identifiers, your name and your related ID numbers, against other databases and if there's inconsistencies, such as transposition of numbers and so forth, it will reject and will have to -- and that creates another large delay. So please re-verify all of your information as you've completed your application forms.

Also, Chip, I've also received calls from people who have needed assistance about filling out the forms because they are…they're lengthy forms and they do require a lot of information. So, what is your advice to them if they need technical assistance?

Allen Gillespie:
I think the best thing you can do for technical assistance is to call TrailBlazer. A lot of unique situations arise and the TrailBlazer folks, their customer service folks or their enrollment people, will be very happy to answer questions. I think that's important. I think it's good to establish that relationship with the contractor, because, you know, their job is to enroll you; their job is to make sure they have the information correct so you're paid correctly. So don't hesitate to call TrailBlazer with your questions even before you fill out the form. If you have questions about corporate structures and things like that, that's important to do that.

Dorothy Dupree:
Thank you.

Allen Gillespie:
Mm-hmm.

Dorothy Dupree:

Appreciate that response. And now we're going to turn to the area of services that are covered by Medicare Part B. There are two parts to Part B: physician and practitioner services, which are billed to the designated carrier; and institutional services, which are billed to the designated fiscal intermediary, or AB MAC. Terri Harris will share her knowledge on how Medicare covers services for independent practitioners. Terri?

Terri Harris:
Thank you, Dorothy. Over the years, CMS has become familiar with healthcare delivery systems established for federally recognized tribes and the unique government-to-government relationship that exists between tribes and the federal government. Originally, Medicare services available to the Indian Health Service were limited to Part A Hospital and Skilled Nursing Facility Services, as defined by Section 1880 of the Social Security Act. This began to change in 2001 with the implementation on July 1st of Section 432 of the Benefits Improvement and Protection Act, known as BIPA. This section extended payment to the IHS for services of physician and non-physician practitioners furnished in hospitals and ambulatory care clinics. This meant that clinics associated with hospitals and freestanding clinics owned and operated by HIS, or tribally owned but IHS operated, are considered to be IHS and are authorized to bill Medicare for Part B services identified in Section 432 of BIPA.

On January 1, 2005, another legislative change through the 2003 Medicare Modernization Act, known as MMA, further broadened the scope of services for which Indian Country providers could bill Medicare. It allowed IHS facilities to bill for all items and services of Part B not covered under Section 1848 of the Social Security Act. However, this authority is only for a five-year period of time beginning January 1, 2005, and ending December 31, 2009. Medicare has paid for physician services under Section 1848 of the Social Security Act. Section 1848(c) of the Social Security Act requires that national uniform relative values be established for physician work, practice expense, and malpractice expense. For calendar year 2008, the Physician Fee Schedule was published in the Federal Register on November 27th.

It's important I spend the remaining portion of my time identifying services covered under Medicare Part B. I won't discuss payment of these services, as that will be discussed later by Cindy Murphy in her presentation. Medicare Part B covers the following services: services performed by physicians, which is defined as a doctor of medicine, osteopathy, podiatry, or optometry legally authorized to practice medicine and surgery by the state in such function or action is performed; this also includes chiropractors, anesthesiologists, and services of certified registered nurse anesthetists, clinical psychologists, and certified registered nurses; non-physician practitioner services, which include physician assistant services, which must be supervised by a physician, nurse practitioner, clinical nurse specialist, certified nurse midwife, and clinical social worker. These services I just mentioned were part of the original Part B services authorized under BIPA 432. There's no time limitation to these services being available to IHS, such as the five-year limit for other Part B services available under MMA 630.

Part B services added as a result of MMA 630 include the following. I'll start with preventive services, which includes prostate cancer screening, colorectal cancer screening, glaucoma screening, only for individuals determined to be at high-risk for glaucoma, mammography screening -- which means a radiologic procedure furnished to a man or a woman with signs or

symptoms of breast disease, a personal history of breast cancer, or a personal history of breast biopsy proven benign breast disease -- screening pap smears, screening pelvic exams, ultrasound screening for abnormal aortic aneurisms, diabetes screening, cardiovascular screening blood tests, bone mass measurement, and diabetes self-management training services for beneficiaries who have been diagnosed as having diabetes. These services are rendered by a national nutrition professional or a registered dietician: vaccines, which are pneumococcal vaccines, flu vaccine, and Hepatitis B vaccine. Medicare also pays for smoking and tobacco use sensation counseling and the "Welcome To Medicare" exam.

CMS Tribal Affairs developed a preventive service poster as seen on your screen, which lists preventive services. The poster was distributed to IHS and tribal facilities, so the next time you see one of these posters please take time to familiarize yourself with Part B preventive services. To continue with the list of Part B services extended to IHS per MMA 630, other services include: outpatient rehab therapy services, which includes physical therapy, occupational therapy, and speech-language pathology; medical nutrition therapy for beneficiaries with diabetes or a renal disease, these services are rendered by a nutritional professional or a registered dietician; ambulance services when other methods of transportation are contraindicated by the individual's condition; clinical lab services and tele-health services; diagnostic services, such as diagnostic x-ray tests and x-ray radium and radiologic isotope therapy; services and supplies include surgical dressings, splints, and cast devices used for reduction of fractures and dislocations; blood products; transfusions, and blood clotting factors for hemophiliac patients; drugs covered are [unintelligible] for dialysis patients, these drugs are used for anemia management for beneficiaries with renal disease; all drugs used as an anti-cancer, chemotherapeutic agent, which also includes acute anti-emetic for anti-cancer, chemotherapeutic regiment that are not self-administered prescription drugs used in immunosuppressive therapy, and antigens prepared by a physician; prosthetics other than dental that replaces all or part of an internal body organ, including colostomy bags and supplies directly related to colostomy care. It also covers leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements, orthotic devices, durable medical equipment, which includes iron lungs, oxygen tents, hospital beds, and wheelchairs. And Medicare Part B also pays a bonus for a health professional shortage area.

This list of Part B services is quite long, and I don't expect that you'll remember them all. These slides of my presentation will be available to you on the CMS Web site. You can also find detailed information concerning Medicare payments to IHS facilities at www.cms.gov/manuals, Internet Only Manuals, Publication 100-04, Chapter 19, Indian Health Services. Thank you for your time and I'll be available to answer any questions as time is scheduled at the end of today's broadcast. Now, let me turn this back to Dorothy.

Dorothy Dupree:
Thank you, Terri. I want to make one point as Terri was going over the services that she did distinguish between those services that were made available under BIPA 432 and those services that were made available under MMA 630. It's important to distinguish the two because the services under BIPA, as Terri indicated, have no time limit; they are available on an ongoing basis. However, the MMA 630 services have a five-year limit and it will end as of today with no additional authorities extended, that we're aware of, that will end December 31, 2009. So

familiarize yourself with those types of services, and if there is no extension then there will be no ability to continue to bill for the services that were extended to you under MMA 630.

Okay. Now we're going to turn to Cindy Murphy. Cindy will explain how Medicare Part B coverages work for outpatient institutional services. Cindy?

Cindy Murphy:
Thank you, Dorothy. I'm going to talk about the primary institutions that provide care in Indian Country. These are hospitals, including Critical Access Hospitals, and tribally owned Federally Qualified Health Centers, or FQHCs. There are a number of other potential institutions, which currently do not exist in Indian Country: they are Comprehensive Outpatient Rehabilitation Facilities, or CORFs; Rehabilitation Agencies, sometimes called ORFs; Renal Dialysis Facilities, or RDFs; and Skilled Nursing Facilities, SNFs. I realize Skilled Nursing Facilities have beds and provide inpatient services under Part B, but they also provide a great many outpatient Part B services of a rehabilitative nature.

How are all these things paid for? Well, the ones that are paid on the all-inclusive rate are hospital outpatient services, diabetes self-management training, medical nutrition therapy, and services incident to those of a physician. All of those services were covered either prior to BIPA or through BIPA.

Then MMA 630 came along at the end of 2003 and effective with January 1, 2005, the following additional services became covered: orthotics and prosthetics; surgical dressings; ambulance services; clinical labs tests, whether in independent labs or hospital-based labs; therapies, again primarily occupational therapy, physical therapy, and speech language pathology; durable medical equipment; Medicare Administrative Contractor drugs, that means those drugs paid for by DME MACs.

How are all these things paid? Well, the great majority of them are paid on the Medicare Physician Fee Schedule. Some of them are also paid on the clinical diagnostic laboratory fee schedule, some on the ambulance fee schedule, both for independent ambulance companies and hospital-based ambulances, or last of all, the durable medical equipment -- or DME -- prosthetic, orthotic, and supplies says in DMEPOS' fee schedule. Last of all, there are services paid by the DME MAC using the average sales price for DME MAC drugs. In addition, and I skipped it, there's the anesthesia fee schedule, which pays for anesthesia services for hospital outpatients.

Finally, we have the vaccines. The vaccines covered under this part of the law are pneumococcal, influenza, and Hepatitis B. Pneumococcal and influenza are paid at 100 percent, and Hepatitis B carries the usual 20 percent co-insurance, even though that's waived for American Indians. All vaccines are paid at 95 percent of AWP. All administrations of vaccines are paid on the Medicare Physician Fee Schedule.

There are lots of screening and preventive services, and I'm going to go over them again even though Terri mentioned all of them earlier. They are the vaccines we just discussed, a pelvic exam and a screening pap smear, and then there are three services, which, in an institution, must occur during a clinic visit. These are prostate screening services, cardiovascular screening blood

tests, and diabetes screening tests. Glaucoma screening is covered for those at high-risk, bone mass measurement, colorectal cancer screening, diabetes self-management training, and medical nutrition therapy, which is available to beneficiaries who have either diabetes or renal disease.

There's also something called the Individual Physician Physical Examination, or Welcome to Medicare Exam. During this exam, one instance of an abdominal aortic aneurism screening via ultrasound is also covered. Additional preventive services include smoking cessation and screening mammography.

And now, let me turn this back over to Dorothy. Dorothy?

Dorothy Dupree:
[laughs] Thanks, Cindy. You did make a point earlier in your presentation; you were talking about fees that were not charged to Indians.

Cindy Murphy:
Yes.

Dorothy Dupree:
But that's, if I understand it correctly, those fees are not charged then individually as long as they're receiving services through a facility of the Indian Health Service.

Cindy Murphy:
As long as they get their facilities through an Indian Healthcare Facility or even a tribally owned but IHS-run facility or a tribal facility, then they are not charged any co-insurance or deductible. Those are waived by the Indian Health Service. It's a little different for Contract Health Services, but I don't think we want to get into that right now.

Dorothy Dupree:
No, we don't have time for that in our presentation today. Okay, I just wanted to distinguish that, because it's important and we didn't want to give the impression that regardless of where they went they wouldn't get charged. It's if they received the service it's the Indian Health Service that picks up those fees for them on their behalf.

Cindy Murphy:
That's correct.

Dorothy Dupree:
Okay, great. And now for the last, and certainly not least, of panel members we'll turn to Denise Mohling. Denis is in the Provider Education Section of TrailBlazer Health Enterprises, who is the AB Medicare Administrative Contractor, or what is called J4 or Jurisdiction 4. Denise handles Part B for all of Indian Country. Denise will talk about billing and payment for Part B services. Denise?

Denise Mohling:

Thank you, Dorothy, for inviting me to participate in today's edition of *Medicine Dish*. I'd like to take this time to say hello to the Indian Health Service, or IHS, and tribal facilities that currently submit Medicare claims to TrailBlazer Health Enterprises. I've been asked to give a brief overview of Medicare Part B billing and the relationship between IHS and TrailBlazer.

To begin, I'll be providing a little history into how this partnership began. Prior to the enactment of the Benefit Improvement and Protection Act -- or BIPA -- of 2000, reimbursement for Medicare services provided in IHS facilities was limited to services provided in hospitals and Skilled Nursing Facilities. TrailBlazer was the Fiscal Intermediary, or FI, for these services. Section 432 of BIPA extended payment for services of physician and non-physician practitioners who are covered by Part B. CMS issued Change Request 1576 on April the 10th, 2001, advising that TrailBlazer had been selected as the Part B carrier to enroll IHS, tribe and tribal organizations, and to process the physician and non-physician practitioner's claims.

TrailBlazer began our Part B partnership with IHS by attending a national conference in Nashville, Tennessee in April of 2001. Soon after we attended this conference, we hit the road providing two-day training sessions for each IHS area office that included an overview of Medicare Part B, how to complete enrollment applications, and EDI. The picture you are looking at is the TrailBlazer team that conducted this training.

Effective with dates of service July 1, 2001, IHS began submitting Part B professional claims. So exactly what is Part B? Part B is medical insurance. It helps pay for physician and non-physician services, durable medical equipment, medical services and supplies not covered under part A, and ambulance services. Payment for professional services is paid based on a fee schedule, not an all-inclusive rate or flat rate like your facility fees for outpatient Part B services. At the beginning of each year, the Physician's Fee Schedule is updated and posted to the TrailBlazer Web site. You'll find the fee schedule for your location under the first tab titled, "Fee schedules." You can download the entire fee schedule or look up the allowable for a particular code. Medicare Part B pays 80 percent of the allowed amount for physician's services.

All services reported to the Medicare program by a physician or non-physician practitioner must demonstrate medical necessity. Medical necessity is defined as those services that are reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body member, and are not excluded under another provision of the Medicare program. Coverage of certain procedures is limited by the diagnosis. If the diagnosis listed on the claim isn't the same as one of those listed as covered for the procedure, the procedure is denied. Limited coverage may be the result of a national policy established by CMS or by Local Coverage Determination, or an LCD, established by TrailBlazer. The official version of TrailBlazer's LCDs may be viewed on our Web site. There are services rendered in Indian Health Facilities that are under limited coverage. These services include routine foot care, physical therapy, EKGs, stress tests, and ophthalmology services. LCDs provide information regarding documentation requirements along with covered diagnosis. It's best to view these articles periodically as coverage guidelines may change.

My job responsibilities include teaching IHS Medicare Part B guidelines. This includes coverage criteria on the LCDs, and how to properly submit your Medicare claims. Even though I

am a Certified Professional Coder, I am not allowed to teach code in classes. I can help with the billing side, such as providing you with informational modifiers if a procedure requires a referring provider, or if the procedure has limited coverage. We do offer computer-based training, or CBT, modules that offer CME and CEU credit for physicians, non-physician practitioners, and coders. These modules are developed by our medical directors and their clinical staff. You can view these training modules by going to the TrailBlazer Web site and selecting “computer-based training” under the education link. Physicians can obtain documentation and coding guidelines on evaluation and management codes, including office visits, initial hospital visits, and consultations.

I’d now like to take a few minutes to review some of the top billing errors and how to resolve them. One of the top errors continues to be eligibility. This isn’t just patient eligibility; it also includes physician eligibility. For patient eligibility, it’s very important to screen your patients periodically. More and more, American Indian and Alaska native patients are enrolling with Medicare Advantage plans, which are replacing traditional Medicare. Physician eligibility is being affected by lack of claims submission. When you enroll a provider, you must be ready to file claims. Otherwise, after four consecutive quarters of no claims submission their Medicare Provider Number will be deactivated. To reactivate the provider, you will be required to complete the enrollment process again.

Medical necessity is another top denial. As mentioned previously, review the LCDs posted to our Web site for coverage criteria for procedures you perform.

Duplicates remain one of the top errors, not just within Indian Health. Check claims status either through GPNET or our interactive voice recognition system prior to resubmitting a claim.

One more denial I’d like to discuss is routine services. Remember, Medicare covers services based on a medical need. Routine services, such as eye exams or dental check-ups, are not covered. Unless you need a denial from Medicare for other insurance coverage, there’s no need to submit these services.

A final topic I’d like to address is NPI. As of March 1, 2008, Part B claims were to be submitted with an NPI in the rendering and pay-to fields. Currently, you can submit claims with the NPI and Legacy. However, effective May 23, 2008, claims will only be accepted with an NPI. If you’re having claims reject due to an NPI issue, please contact customer service to determine what the message means. If they’re not able to assist you, they’ll have you call EDI, enrollment, or INPES [spelled phonetically]. If you’ve followed this process and are still having difficulty, please contact me.

Before I turn this presentation back to Dorothy, I’d like to share with you the progress that has been made by IHS regarding Part B payments. The chart you’re viewing is for Part B payments made during calendar years 2003 through 2007, that’s January through December. As you can see from this chart, the Part B reimbursement has increased since 2003. In 2005, we had a substantial increase in Part B payments, which we feel were Indian Health sites attempting to catch up on old claims before the time limit was up. The totals you see for 2008 are for the months of January and February.

Thank you, and I look forward to seeing or speaking to you soon. And now, let me turn this back to Dorothy.

Dorothy Dupree:
Thank you, Denise. I do have one question. You did mention in your presentation LCDs, which are Local Coverage Determinations, and this is in addition to the instructions that we, CMS, give to TrailBlazer. What would necessitate an LCD?

Denise Mohling:
An LCD we use for additional documentation guidelines and telling them what diagnoses. Because CMS will give us general guidelines, but so far as providing diagnosis we do that in an LCD.

Dorothy Dupree:
Okay.

Denise Mohling:
So they can go back when they submit their claim, if it denies for medical necessity they can go back to the LCD and they can look to see if they have a covered diagnosis.

Dorothy Dupree:
Okay. All right. Great. And let me remind everyone at this point that all of the presentations by today's speakers can be downloaded at www.cms.hhs.gov/center/ir.asp. Now, it's time we move to that segmentation where we will open our phones and faxes to you, our audience. As a reminder, you have two options as to how you can contact us. You can call the 1-800 number listed on your screen and ask your questions live, or you can fax your questions to 410-786-0123 and the panel will be asked to respond. If we don't know the answer, we'll take your contact information and get back to you.

While you call in, I'd like to take this opportunity to share with you a brief informational video on diabetes as it relates to American Indian and Alaska natives. We all know how devastating this disease can be for our people. Please take every opportunity that you can to remind people to take all of the steps they can to protect their health. Please note that diabetes screening is a covered Medicare Part B Service.

[clip]

Narrator: The future of our people is threatened by diabetes, but we can fight it by controlling our blood sugar.
Female Speaker: I choose healthy foods.
Male Speaker: I exercise every day and keep my blood sugar close to normal.
Male Speaker: I always take my medications.
Narrator: Control your diabetes because our young ones look up to you. We must take charge for our future generations. Control your diabetes for life. Call 1-800-438-5383.

Dorothy Dupree:
Well we're at the end of our *Medicine Dish* program where we do open our phones again to you, our audience. So please, while we're waiting for calls and questions to come in I do have some questions that I will be asking the panel and asking them to respond. And please, the viewing audience, begin calling in with your questions at the 1-800 number or the fax number. For those of you who do not want to talk live on the phone, please fax your questions to 410-786-0123.

The first question I have I'll address to Terri. Terri, does Medicare cover respiratory therapy care?

Terri Harris:
Medicare covers respiratory therapy care in only two settings. That's the institutional settings and also in comprehensive outpatient rehab facilities, which so far there are no IHS facilities that are CORFs.

Dorothy Dupree:
Ah, none, huh?

Terri Harris:
None yet.

Dorothy Dupree:
Is that a challenge [laughs]?

Terri Harris:
[laughs] It could be. It could be.

Dorothy Dupree:
Okay. My next question is for Chip. Chip, how does the NPI relate to provider enrollment?

Allen Gillespie:
Okay. The NPI is actually a national number that's your numerate with the national provider, the national INPES system. It's a number you'll use for all your claims, whether it's Medicare, Medicaid, or private insurance. You get the number before you enroll in Medicare as opposed to the current process, which Medicare, once you enroll, Medicare gives you a billing number. But you'll get your NPI before you enroll in Medicare, Medicare then will basically authorize that number to bill Medicare once we've processed your enrollment application. So it is something you have to get before you enroll, and it's not part of the enrollment process.

Dorothy Dupree:
Thank you. We do have a call from Susan in California. Susan, welcome to *Medicine Dish*. Please ask your question.

Susan:

Thank you. Recent court decisions and perhaps legislation have allowed tribal health programs to charge eligible Indians for services. I'm wondering how that might impact these CMS decision that we are not liable or if we waive co-payments and deductibles for Medicare eligible Indians?

Dorothy Dupree:
Cindy, do you want to take this?

Cindy Murphy:
Yes, I think I can. What happens is that it's actually the Indian Health Service that waives the Medicare co-insurance and deductible, those what we call beneficiary percentage or share of the payment amount. So when IHS facilities, or tribal facilities, bill to Medicare to the designated AB MAC, which is TrailBlazers, those claims are processed as if there were a deductible, but the deductible is never collected from the American Indian or Native Alaskan. It's just part of the calculation Medicare goes through when they determine how much to pay to the IHS or tribal facility. Did I get that right, Denise?

Denise Mohling:
You got that right, yes [laughs].

Cindy Murphy:
Thanks.

Dorothy Dupree:
Okay, Susan, does that answer your question?

Susan:
In a way. So, in a broad sense then, even if our tribal facilities are charging eligible Indians for their own co-pay, if you will, or a charge for a service, this will not get us into any problems with Medicare in the routine waiving of co-payments and deductibles?

Dorothy Dupree:
Again, it's not the Medicare program that waives the premiums and co-pays, that's a decision made by the Indian Health Service. And whether or not you, as a tribal facility, are following the Indian Health Service guidelines is really a decision made locally between you and the Indian Health Service. We don't get involved in that discussion and it wouldn't have any impact here on the Medicare program as we administer it today.

Susan:
Okay, great, thank you.

Dorothy Dupree:
You're welcome. Our next caller is Cindy from Denver. Cindy, welcome to *Medicine Dish*. Could you please ask your question?

Cindy:

Hi Dorothy. My first question is for Denise, I believe, since TrailBlazers processes IHS and tribal claims. Do you have any sense of what the percentage of claims are successfully paid in their first submission to TrailBlazers?

Denise Mohling:
With IHS, the percentage is great. We're looking at probably about 85 to 90 percent. When I go out to look for top billing errors, sometimes I have a hard time finding them because their claims are coming in clean, really good the first time.

Cindy:
Okay, thank you.

Denise Mohling:
Uh-huh.

Cindy:
I have one more question too, if you will. You talked about routine services not being paid. That does not include things like Medicare preventive services, is that correct?

Denise Mohling:
That's correct. What I see with routine services when I'm out looking at denied claims will be like a dental exam, and that's just a Medicare program exclusion, or routine eye checks. Medicare covers eye exams, but only if there's a condition, you know. We do cover for diabetes, but if they submit it as a routine eye exam that's not covered. And yes, the preventative services Medicare does -- we do consider for IHS, yes.

Dorothy Dupree:
Does that answer your question, Cindy?

Cindy:
It does, thank you.

Dorothy Dupree:
You're welcome. Thank you for calling. We do have one area that we mentioned in our presentation but we haven't really talked about, was that of FQHC services. We deal primarily in our presentation today with hospitals and the outpatients and the clinics that are operated by IHS and those tribal programs that are considered to be facilities of the Indian Health Service. I know that when we enter into the MAC arrangement -- we fully implement MAC as J4, or the Jurisdiction 4, and TrailBlazers is beginning to work through that now. We intend on transferring all of the FQHCs that are tribal FQHCs over to Jurisdiction 4 as well. That's going to take some time, we're still in the process of identifying them, but I thought it would be important to really look at, just very briefly. And, Cindy, maybe you can answer this question of what are FQHC services? And FQHCs, for the audience, stands for Federally Qualified Health Centers --

Cindy Murphy:

Right.

Dorothy Dupree:
-- otherwise known as FQHC. So, what are those services, Cindy?

Cindy Murphy:
Okay. The primary services covered by federally qualified health centers are physician and other mid-level practitioner services. The additional services covered by FQHCs are in fact the…what are called primary preventive services. And those include, for instance, the Hepatitis B vaccine, which is one of the FQHC services, screening mammograms, a number of screening blood tests, urinalysis, et cetera. However, those services are very specific. If they're not the primary preventive services or an encounter with a physician or mid-level professional then, while it may be paid for by Medicare, it won't be paid to the FQHC per se.

For free standing FQHCs, that is those that are not affiliated with a hospital or other provider, the practitioner bills the designated carrier to obtain payment for the technical components of, say the diagnostic screenings. We have those screenings: mammography, diabetes, cardiovascular blood tests, prostate cancer, colorectal cancer, et cetera. So the technical component of those would be billed by the individual practitioner to the AB MAC. It used to be to the carrier. Okay, is that clear?

Dorothy Dupree:
Okay. That's --

Cindy Murphy:
Do you need more?

Dorothy Dupree:
No [laughs]. I think you did --

Cindy Murphy:
Oh, good [laughs]!

Dorothy Dupree:
That's great. Thank you, Cindy.

Cindy Murphy:
You're welcome.

Dorothy Dupree:
We have a question faxed in from the Confederated Tribes of Siletz Indians, Chevonne Metcalf [spelled phonetically]. And I'll just read what the question is.

"According to *Medicine Dish*, diabetes management, maintenance, nutritional therapy, and preventive services such as pap smears are billable, payable services. However, when we bill for such services the claims are rejected. Rejection reason is the services are non-covered services.

We've also called Medicare to verify denial and to see if we're billing incorrectly. Medicare states routine and preventative services are non-covered services. And the question is, how do we bill for such services?"

So I can see that being a Terri question and a Denise question as well.

Terri Harris:
Yes. I'm unsure why you're getting a denial because you can certainly bill for a DSMT, MMT, and the other services that you were talking about. Those are all covered services under Medicare Part B and you should be able to bill for those services, so I'm not sure why you're getting a denial. It could be for some minor thing that you're either not including on the claim, or that you are including that you should not include.

Denise Mohling:
On routine services some of them do have parameters. So really, without looking at a claim I can't really tell you, but you can go out to the TrailBlazer Web site and we have a manual on preventative and screening that breaks down each service, the diagnosis that's supposed to be on the claim, and the frequency for that service. So that would be a good resource to go to first.

Terri Harris:
Also one thing, I think you said something about routine. So, if you're putting on the claim that it's a routine service and not a preventative service then it's probably going to reject because you're saying that it's a routine service and Medicare does not pay for routine services. We pay for these services as preventative services, but it's not considered routine.

Cindy Murphy:
Let me add to that the fact that most of the screening services have frequencies that have to be met. You can't get a mammogram every year. You can only get a mammogram every X years, depending upon how old you are. So if you bill for the particular service more frequently then Medicare guidelines require, you will get a denial.

Dorothy Dupree:
Okay. The individual, if the individual is still having problems, they can contact you, Denise?

Denise Mohling:
They can call me, yes. Yes, yes, call me.

Dorothy Dupree:
Okay. And perhaps they can fax in to what their claim is --

Denise Mohling:
I can --

Dorothy Dupree:
-- and you can take a look at?

Denise Mohling:
Yes.

Dorothy Dupree:
Okay.

Denise Mohling:
I can go out and look at the claim.

Dorothy Dupree:
Okay, great.

Denise Mohling:
If they submit to TrailBlazers.

Dorothy Dupree:
If they submit to TrailBlazer.

Denise Mohling:
Yes.

Dorothy Dupree:
Okay, great. Well, we're at the end of our *Medicine Dish* hour and the panel and I want to thank you for your participation in our broadcast on Medicare. I want to take this opportunity to remind you that our next *Medicine Dish* broadcast will be on May 14th, called, "Cost Reports for ITUs." I want to remind the audience that you can access previous broadcasts of our *Medicine Dish* programs at the NIH Web site. Instructions are on the screen. Thank you, and I hope you enjoyed and benefited from today's *Medicine Dish* hour. I'm Dorothy Dupree, your host of *Medicine Dish*, wishing you a very productive day.

[music clip]

[end tape]