

Medicare Claims Processing Manual

Chapter 19 – Indian Health Services

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10 - General

(Rev. 2075, Issued: 10-28-10, Effective: 01-01-10, Implementation: 01-28-11)

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/Tribally owned and operated facilities under §1880. The enactment of Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (BIPA), expanded payment for Medicare services provided in IHS/tribally owned and operated facilities beyond services provided in hospitals, skilled nursing facilities (SNFs) and swing-bed facilities.

Effective January 1, 2005, §630 of the Medicare Modernization ACT (MMA), extended to IHS facilities the ability to bill for all Medicare Part B covered services and items that were not covered under BIPA. This includes all screening and preventive services covered by Medicare. Section 2902 of the Patient Protection and Affordable Care Act (ACA) indefinitely extends §630 of the MMA, retroactive to January 1, 2010.

Tribally owned and operated facilities may choose to bill the Medicare program in one of two ways. First, these tribally owned and operated facilities are authorized to enroll or become certified to participate in the Medicare program as any other provider/supplier of Medicare services. Depending upon the type of supplier/provider, these entities file claims with the local Medicare Part B carrier or fiscal intermediary (FI) serving the specific geographic region where the facility is located and follow the same coverage and claims filing requirements as any other regular Medicare provider/supplier. On the other hand, since tribally owned and operated facilities are covered under the Indian Self Determination and Education Assistance Act (ISDEA), P.L.93-638 [25 U.S.C. 450 et seq.] (commonly referred to as "638"), this affords them the option of electing the same billing rights as facilities run by the IHS. Tribally owned and operated facilities choosing this option file claims with the designated Medicare Part B carrier and designated FI used for processing IHS claims instead of with the local Medicare Part B carrier or FI serving the specific geographic region where the facility is located. Because many tribally owned and operated facilities elect to file claims with the Medicare contractors designated for IHS, many tribal facilities not actually run by IHS are considered to be IHS for Medicare billing purposes. **Unless otherwise specified, any references in this chapter to IHS providers, IHS suppliers or IHS physicians or practitioners includes: (1) tribally owned and operated facilities electing to bill as IHS; (2) tribally operated IHS facilities; (3) IHS owned and operated facilities; (4) tribally owned and IHS operated facilities.** Tribally owned and operated facilities electing to bill the local Medicare Part B carrier or FI serving their specific geographic location should look to other pertinent chapters of this manual for instructions that apply to regular Medicare providers/suppliers, not to the provisions contained in this special chapter for IHS providers billing the designated IHS carrier and FI.

In this chapter the terms IHS provider, IHS supplier and IHS physician or practitioner pertain to the following:

- IHS provider refers to all hospital or hospital based-facilities, including outpatient clinics, unless otherwise noted.
- IHS supplier refers to a freestanding (non-hospital based) entity that furnishes durable medical equipment, prosthetics, orthotics, supplies (DMEPOS), and parenteral and enteral nutrition, unless otherwise noted.
- IHS physician or practitioners refers to physician and non-physician practitioners billing for services under Medicare Part B.
- **NOTE:** The ISDEA promotes maximum Indian participation in the government and education of the Indian people; provides for the full participation of Indian tribes in certain programs and services conducted by the Federal Government for Indians and encourages the development of the human resources of the Indian people; established and carries out a national Indian education program; to encourage the establishment of local Indian school control; to train professionals in Indian education; and establishes an Indian youth intern program.

20 - Carrier and FI Designation

(Rev. 1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

The designated carrier and FI enroll IHS operated facilities, process IHS institutional claims, IHS physician and practitioner claims for IHS or tribally owned facilities and hospitals. The designated carrier may also enroll tribally operated facilities and process the practitioner claims for these facilities, if the tribally operated facility chooses. All intermediaries and carriers were notified of this selection.

Should other intermediaries and carriers receive misdirected enrollment requests or paper claims for IHS physicians or practitioners, they shall forward them to the designated carrier. However, the carriers that have tribally operated practitioners currently enrolled with them may continue to service these practitioners. In addition, for all tribally operated facilities, including Federally Qualified Health Centers (FQHCs) providing non-FQHC services, IHS physicians and practitioners may enroll with and submit bills to their local carriers, if they choose. Carriers shall 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 designated carrier. Tribally owned and operated facilities, while having a choice to bill their local carrier or the designated carrier, are prohibited from billing both entities.

See Chapter 1, §10.1.9 of Pub. 100-04, Medicare Claims Processing Manual, for more information on misdirected claims.

20.1 - Durable Medical Equipment Medicare Administrative Contractors (DME MAC) Designation

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

There are four DME MACs assigned to geographical regions. Jurisdiction for DME claims is based upon the permanent residence of the beneficiary, regardless of the location of the supplier submitting the claim. The IHS facilities shall enroll with the National Supplier Clearinghouse (NSC) to obtain a supplier number for billing DME to the assigned DME MAC. The four DME MACs are aware of the potential for enrollment from IHS facilities and have been informed of the IHS facilities unique requirements for payment of claims.

20.2 - Overview of Medicare Part B Services

(Rev. 2075, Issued: 10-28-10, Effective: 01-01-10, Implementation: 01-28-11)

Section 630 of the MMA, indefinitely extended by §2902 of the ACA, extended to IHS providers, suppliers, physicians and practitioners, independent ambulance suppliers, hospital based ambulance providers and clinical laboratory service suppliers the ability to bill for all Medicare Part B covered services and items which were not covered under BIPA. This includes all screening and preventive services covered by Medicare. This chapter contains the effective dates for services implemented under §630 of the MMA and §2902 of the ACA.

Beginning January 1, 2005, IHS providers and suppliers may bill Medicare for the following Medicare Part B services:

- DME;
- Prosthetics and orthotics;
- Prosthetic devices;
- Surgical dressings, splints and casts;
- Therapeutic shoes;
- Drugs (A/B MAC and DME MAC drugs);
- Clinical laboratory services;
- Ambulance services; and
- Screening and preventive services not already covered.

Payment is made on the AIR for IHS providers. Payment is made on the appropriate fee schedule for IHS suppliers:

- The Medicare Physician Fee Schedule (MPFS);
- The Clinical Diagnostic Laboratory Fee Schedule;
- The Ambulance Fee Schedule;
- The DMEPOS Fee Schedule;
- The Anesthesia Fee Schedule; or

- DME MAC Drugs – based on the average sales price (ASP).

The nature of the provider or supplier, the location where the service is furnished and the service being rendered determines if the carrier, FI, Part A/B MAC, or regional DME MAC shall be billed. Most services that are paid under a fee schedule are billed to either the designated carrier or the (regional) DME MAC. Some fee schedule paid services are billed to the designated FI. For example, physical therapy may be billed to the designated carrier or Part A/B MAC by an independent practitioner, but is billed to the FI or Part A/B MAC when provided by a hospital outpatient department or by a hospital-based facility.

Refer to §80.3 of this chapter for more information on the claims processing jurisdiction for claims filed by IHS independent ambulance suppliers.

Refer to §80.7.1 of this chapter for more information on the claims processing jurisdiction for claims filed by freestanding facilities for clinical laboratory services.

Refer to §90.2.1 of this chapter for more information on the services billed to DME MAC.

Refer to §90.2.1.1 of this chapter for more information on the services billed to the FI.

Refer to Chapter 1, §10.1.9 of Pub. 100-04, Medicare Claims Processing Manual, for information on misdirected claims.

30 - Medicare Part B Services

(Rev. 2075, Issued: 10-28-10, Effective: 01-01-10, Implementation: 01-28-11)

Effective July 1, 2001, §432 BIPA extended payment for the services of physician and non-physician practitioners furnished in hospitals and ambulatory care clinics (services paid under the MPFS, §1848 of the Act). Clinics associated with hospitals or which are freestanding that are owned and operated by IHS or tribally owned and IHS operated are considered to be IHS and are authorized to bill only the designated carrier for Medicare Part B (medical insurance) 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 Medicare Part B carrier for the full range of covered Medicare services, not restricted to the limitations of the BIPA provision.

- Prior to enactment of §630 of the MMA of 2003, IHS facilities were not allowed to bill for Medicare Part B services, other than those paid under the MPFS, which were covered under §1848 of the Act. Section 630 of the MMA, indefinitely extended by §2902 of the ACA, expanded the scope of items and services for which payment may be made to IHS facilities to include all other Medicare Part B covered items and services beginning January 1, 2005.

40 - Provider Enrollment

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

40.1 - Provider Enrollment with Carrier

(Rev. 1027, Issued: 08-11-06, Effective: 09-11-06, Implementation: 09-11-06)

The designated carrier shall designate a consistent method of labeling all IHS-related enrollment applications. For Form CMS-855B (11/01) submission, under item 2.A.1 Supplier Identification, check the “Other” box and manually indicate IHS, tribes or tribal organization on the line provided.

The designated carrier shall 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, submit a copy of the certification for the person and the entity. Continue to process these applications because these entities are owned by another governmental agency. Obtain a copy of the DEA certification;
- All 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.

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 designated carrier for the purposes of enrolling IHS physicians 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 designated carrier in order to enroll.

Instructions for completing the Form CMS-855S, DMEPOS Supplier Application, can be found in Pub. 100-08, Medicare Program Integrity Manual, Chapter 10. For more information on the Form CMS-855S, see §40.3 of this chapter.

40.1.1 - Entities

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

In order to enroll IHS clinics that are currently provider-based (and use the hospital's tax identification number (TIN)) and that wish to bill the designated Medicare Part B carrier, the hospital must complete a Form CMS-855B 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-855B for just the freestanding clinic (see exception for physical/occupational therapist under Reassignment in §40.1.4). The processing of these applications should be in accordance with the designated carrier's regular review and verification procedures. A separate Medicare number will be issued to the freestanding clinic.

NOTE: Tribally operated ambulatory care clinics, including those that are participating as FQHCs, are entitled to enroll their physicians and non-physician practitioners with the applicable Medicare Part B carrier like any other Medicare provider. Although FQHCs are paid on a cost basis for the professional services of physicians and 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 Medicare Part B carrier for laboratory and diagnostic tests.

40.1.2 - Individual Practitioners

(Rev. 1643, Issued: 12-05-08, Effective: 01-01-07, Implementation: 03-09-09)

For those eligible practitioners already working in or for hospitals or freestanding ambulatory care clinics, whether operated by the Indian Health Service (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 freestanding 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, for details see §40.1.4, Reassignment.

For those practitioners who are already enrolled in Medicare Part B with the designated carrier, process requests to reassign benefits in accordance with current instructions. All other physicians and practitioners must enroll in the Medicare program with the designated 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 cannot 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.

However, when an IHS provider contracts with non-IHS physicians to perform interpretations of radiological services, the physicians may be paid by the IHS facility regardless of the location of the offsite practitioner, if services are contracted in accordance with the requirements listed in §120 of this Chapter. See §120 in this Chapter for further information.

40.1.3 - Multiple Sites

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

Multiple clinics utilizing the same 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. 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.

40.1.4 - Reassignment

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

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

40.1.5 - Mobile Units

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

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

In order to purchase a professional test interpretation, the IHS physician or practitioner must have performed the technical component of the test. In order to purchase a technical component of a test, the IHS physician or practitioner must perform the professional component of the test. See Pub. 100-04, Medicare Claims Processing Manual, Chapter 1 for more information on purchased tests.

40.1.5.1 - Mobile Mammography Units

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

With respect to mobile mammography units, the law provides specific standards regarding those qualified to perform mammograms and how they should be certified. The Mammography Quality Standards Act (MQSA) requires the Secretary to ensure that all facilities that provide mammography services meet national quality standards. Effective October 1, 1994, all facilities providing screening and diagnostic mammography services (except Veteran's Affairs) must have a certificate issued by the Food and Drug Administration (FDA) to operate.

All IHS providers billing for services rendered by a mobile mammography unit under reassignment must complete §§1, 4, and 14 of Form CMS-855B. The certification number for the mammography equipment must be entered in §4.1.5 of Form CMS-855B. For more information on the MQSA file, see Chapter 18, §20.1.2 of Pub. 100-04, Medicare Claims Processing Manual.

40.1.6 - Clinical Laboratory, Ambulance and Medicare Part B Drugs

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

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

These instructions apply to freestanding or independent clinical labs and independent ambulance suppliers, but not to hospital-based ambulance providers or hospital lab services.

40.2 - Provider Enrollment with FI

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

New IHS providers, including Critical Access Hospitals (CAHs) follow the same application process as any other provider enrolling in Medicare with the designated FI. Instructions for completing the Form CMS-855A, Application for Health Care Providers that will bill Medicare FIs are found in Pub. 100-08, Medicare Program Integrity Manual, Chapter 10.

Section 1865 of the Social Security Act and pursuant regulations provide that IHS owned/tribally operated and IHS owned/operated facilities accredited by the Joint Commission of Accreditation of Healthcare Organization (JCAHO) or the American Osteopathic Accreditation (AOA) are deemed to meet the Medicare Conditions of Participation (COPS). A Federal survey is required for facilities without JCAHO or AOA accreditation.

Tribally owned and operated facilities are generally under the state survey agency jurisdiction. However, the state or the tribe may request that the survey be conducted by a Federal surveyor.

Freestanding FQHCs enroll with the designated FQHC intermediary.

40.2.1 - Provider Enrollment with FI - Ambulatory Surgical Services (Rev. 1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

For dates of service prior to January 1, 2008, IHS providers that want to bill for surgeries on the ambulatory surgical center (ASC) list and receive the ASC rate must contact their designated FI. IHS providers are certified by one of several national accrediting organizations recognized by the Centers for Medicare and Medicaid Services (CMS) and meet the conditions for performing ASC procedures.

The IHS hospital outpatient departments are not certified as separate ASC entities. The ASC indication merely means that CMS approved them to bill for ASC services and be paid based on the ASC rates for services on the ASC list. In order to bill for ASC services, the hospital outpatient department must meet the conditions of participation for hospitals defined in 42 CFR, Part 482.

Authority for Medicare to pay IHS hospital outpatient departments using the freestanding ASC rates was incorporated into Public Health Service regulations on December 27, 1989. The first IHS hospital requested to bill separately for ASC procedures at the appropriate ASC group payment amounts in March 1987. HCFA (now CMS) approved payment of the ASC group payment amounts for dates of service on or after October 1, 1987. Previously, the hospital was reimbursed for ASC procedures at the Office of Management and Budget (OMB) negotiated all inclusive rate (AIR) for outpatient hospital services. The rationale for approving this request was that the hospital was already JCAHO certified, encompassing the ability to perform outpatient surgical procedures, and that acute care hospitals providing surgical inpatient or outpatient services can perform any surgical procedures within their capacity and capability.

For dates of service prior to January 1, 2008, in order for IHS providers to bill for ASC procedures and receive payment based on the ASC rates published in the **Federal Register**, the designated FI must update the IHS/ASC cert indicator on the provider file to 'Y'. A 'Y' in this field indicates that the IHS provider or ASC is certified under IHS and their claims should be processed through ASC Pricer, ensuring the IHS provider is paid based on the ASC price rather than the AIR. Reimbursement is made based on the AIR until the FI updates the IHS/ASC cert indicator to a 'Y'.

See §§100.6 and 100.6.1 of this chapter for information on the payment policy and claims processing for ASC services.

NOTE: Effective for dates of service on or after January 1, 2008, the FI no longer processes claims for IHS ASCs. All IHS ASC providers, including hospital outpatient departments requesting payment based on freestanding ASC rates and ASCs affiliated with a hospital but operating as a distinct entity for the purpose of performing outpatient surgical services must enroll with and submit their claims to the designated carrier.

40.2.2 - Provider Enrollment with FI - Services Under Arrangements (Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

If an IHS provider is unable to provide all the services a beneficiary that is a registered outpatient of the provider needs, the provider may provide those services "under arrangements", via a contract with another entity. Section 1862(a)(14) of the Social Security Act prohibits payment for nonphysician services furnished to hospital inpatients and outpatients unless the services are furnished by the hospital either directly or under an arrangement. All services that are furnished by a hospital, either directly or under arrangement, to a registered hospital outpatient during a hospital encounter are subject to the hospital bundling requirements. 42 CFR 482.12(e) spells out the criteria for contracted services as they apply to a hospital's COPS in the Medicare program. The IHS provider's governing body must be responsible for services furnished in the provider whether or not they are furnished under contracts. The governing body must ensure that the services performed under a contract are provided in a safe and effective manner. The IHS provider must maintain a list of all contracted services, including the scope and nature of the services provided. Chapter 5, §10.3 of Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual sets forth general Under Arrangement guidelines. The provider must exercise professional responsibility over the arranged-for services rather than merely serving as a billing conduit.

In accord with the above-cited law, regulation, and policy, IHS providers are responsible for furnishing medically necessary services to their registered outpatients either directly or under arrangement. Service unbundling is prohibited; only the provider can bill for services furnished to its inpatients and outpatients. The CMS recommends that when services are provided under arrangements the contract should specify how much the IHS provider will pay for each contracted service. The entity furnishing the services under

arrangements with the provider must agree to accept the IHS provider's payment as payment in full, and may not charge the beneficiary for such services.

The Office of the Inspector General is authorized to impose a civil money penalty against any individual who knowingly and willingly presents, or causes to be presented, a bill or request for payment, for items or services furnished under Medicare, that is inconsistent with an arrangement under §1886(a)(1)(H) of the Social Security Act or is in violation of the requirement for an arrangement. See 42 CFR 1003 for more information on civil money penalties, assessments and exclusions.

40.3 - Provider Enrollment with DME MAC

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

All IHS providers and suppliers that do not currently have a supplier number and want to bill for DMEPOS items must enroll with the NSC.

Beginning July 1, 2005, IHS providers (including CAHs) and pharmacies were eligible to begin billing for DME. The NSC must accept enrollment applications from IHS and tribally operated hospitals (including CAHs) or hospital-based facilities and pharmacies providing DME beginning April 1, 2005.

All IHS facilities and pharmacies, whether operated by the IHS or a tribe, enrolled by the NSC, shall meet all required standards as set forth in 42 CFR 424.57. Compliance with the standards will be verified by the review procedures for all other DMEPOS suppliers except as discussed herein.

All IHS facilities and pharmacies, whether operated by the IHS or a tribe, shall be exempt from the comprehensive liability insurance requirements under 42 CFR 424.57(c)(10).

All IHS facilities and pharmacies, whether operated by the IHS or a tribe, shall be exempt from the requirement to provide any State licenses for their facility/business. For example, if a DMEPOS supplier indicates on its application that it will be providing hospital beds and is located in a State that requires a bedding license, such license is not required. However, if they provide a DMEPOS item that requires a licensed professional in order to properly provide the item, they shall provide a copy of the professional license. The licensed professional may be licensed in any State or have a Federal license. For example, a pharmacy does not need a pharmacy license, but shall have a licensed pharmacist on staff.

Site visits shall be conducted for all facilities of the IHS enrolling as IHS suppliers. For enrollment purposes Medicare recognizes those facilities operated by the IHS and those facilities operated by the tribes.

The IHS enrollment shall be in accordance with the instructions provided for all DMEPOS suppliers on the Form CMS-855S, except for the following clarifications.

- Facilities operated by the IHS, including pharmacies are considered a Federal government organization. An Area Director of the IHS must sign the §15 Certification Statement of the Form CMS-855S, be listed in §6 of the form and sign the letter required by §5 of the form which attests that the IHS will be legally and financially responsible in the event that there is any outstanding debt owed to CMS.
- Facilities, including pharmacies that are tribally operated are considered tribal organizations. The §15 Certification Statement of the Form CMS-855S must be signed by a tribal official who meets the definition of an authorized official in accordance with the page 2 definitions shown on the Form CMS-855S. The same authorized official must be listed in §6 of the Form CMS-855S and must sign the letter required by §5 of the form which attests that the tribe will be legally and financially responsible in the event that there is any outstanding debt owed to CMS.

The CMS shall provide the NSC with a list of facilities of the IHS which distinguishes between IHS operated and tribally operated. On the list the NSC shall use the column entitled, “FAC OPERATED BY”, for this purpose.

Chapter 10 of Pub. 100-08, Medicare Program Integrity Manual contains additional information on the Form CMS-855S.

NOTE: Drugs furnished by tribally owned and operated facilities, including pharmacies that are covered under Medicare Parts A and B will continue to be covered and paid under the Medicare fee for service programs. Facilities shall continue to bill their carrier, FI and DME MAC for these drugs after the implementation of Medicare Part D.

40.4 - NSC Supplier Number

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

To enable direct billing of DMEPOS, an IHS supplier must enroll with the NSC as a “DME Supplier”, secure a Medicare supplier billing number and comply with the supplier standards specified in 42 CFR §424.57, and submit all DME claims to the appropriate DME MAC based on current DME jurisdiction rules. The NSC shall provide identifiers which identify IHS suppliers and IHS providers to facilitate proper reimbursement by DME MACs.

All IHS suppliers that do not have a supplier number for billing a DME MAC should complete a Form CMS-855S and obtain a supplier number from the NSC. There are two ways to obtain a supplier number from the NSC:

- 1) Facilities may call the NSC to request an application for Form CMS-855S. Once the facility has completed the Form CMS-855S, it shall be submitted to the NSC at the address indicated on the form; or

2) Alternatively, facilities may go to the CMS Web site, cms.hhs.gov/providers/enrollment/default.asp, and download the Form CMS-855S. The application may be completed and submitted to the NSC.

Pharmacies located in IHS providers must apply for and receive an NSC supplier number to bill for prescriptions.

50 - Reporting Requirements and Specifications

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

In order to facilitate report generation and data collection regarding IHS physicians, practitioners and services, the designated carrier shall assign PINs to each IHS physician and practitioner in a manner that will allow the designated carrier to ascertain which facilities are IHS, Indian tribe or tribal organization. For example, the designated carrier may establish PINs that will allow the identification of each IHS facility, Indian tribe, and tribal organization facility. Providers 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 Current Procedural Terminology (CPT) code and modifier, for each provider.

NOTE: Beginning May 23, 2007, it is mandatory that the National Provider Identifier (NPI) be used in place of UPINs and PINs.

60 - Incentive Payments

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

In accordance with §1833(m) of the Act, IHS physicians who provide covered professional services in any rural or urban health professional shortage area (HPSA) are entitled to an incentive payment. IHS physicians providing services in either a 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 the case. The key to the

incentive payment is where the service is actually provided (place of service). For example, an IHS 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. See Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §250.2, for information on billing and payment in a HPSA pertinent to FI claims.

Section 413a of the MMA requires that a 5 percent bonus payment be established for physicians in a designated physician scarcity area (PSA). Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, §§90.4 and 90.5 contains more information on billing and payment in a PSA pertinent to carrier claims. See Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §250.2.1, for information on billing and payment in a PSA pertinent to FI claims.

A physician may be eligible for both the HPSA and PSA bonuses.

70 - Covered Medicare Part B Services That May Be Paid to IHS Providers, Physicians and Practitioners **(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)**

Medicare Part B covers medically necessary expenses incurred for the following medical and other health services:

- Diagnostic x-ray tests, and other diagnostic tests;
- Physician services;
- Anesthesia services (anesthesiologist, certified registered nurse anesthetist);
- Practitioner services (clinical nurse specialist, clinical psychologist, clinical social worker, nurse mid-wife, nurse practitioner, physician assistant);
- Drugs and biologicals incident to a physician's service;
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
- Implantable prosthetic devices;
- Drugs used with infusion pumps;
- Epoetin Alfa (EPO);
- Clinical diagnostic laboratory tests;
- Physical therapy, occupational therapy (OT), speech-language pathology and audiology services;
- Ambulance services;
- Medical Nutrition Therapy (MNT);
- Diabetes self management training (DSMT);
- Telehealth; and

Hemophilia clotting factors for hemophilia patients competent to use these factors (without supervision).

80 - Carrier - Payment Policy and Claims Processing

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

80.1 - Carrier - Medicare Part B Physician and Practitioner Services Paid Under the Medicare Physician Fee Schedule (MPFS) - Payment Policy

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

Prior to the enactment of BIPA, reimbursement for Medicare services provided in IHS facilities was limited to services provided in hospitals and SNFs. Effective July 1, 2001, §432 BIPA extended payment to services of IHS physicians and practitioners furnished in hospitals and ambulatory care clinics.

The services that may be paid to IHS physicians and practitioners under the MPFS are as follows:

- Services for which payment is made under §1848 of the Act. Section 1848(j)(3) defines physician services paid under the MPFS. Although anesthesia services are considered to be physician services, these services are not included on the physician fee schedule database. Anesthesia services are covered and are reimbursed using a separate payment method (see §1848(d)(1)(D)). Also, included are diagnostic tests (see §1861(s)(3)), covered drugs and biologicals furnished incident to a physician service (see §1861(s)(2)(A) and (b)) and DSMT services (see 1861(s)(2)(S)).
- Services furnished by a physical therapist (which includes speech-language pathology services furnished by a provider of service) or occupational therapist as described in §1861(p) of the Act for which payment under Medicare Part B is made under the MPFS.
- Services furnished by a registered dietitian or nutrition professional (meeting certain requirements) as defined in §105 of BIPA for MNT services for beneficiaries with diabetes or renal disease.
- Screening mammography services are paid under the MPFS based on the BIPA provision when rendered in a physician's office.
- Drugs provided by a physician in the office setting are paid using the ASP from the Medicare Part B Drug Pricing File supplied to all carriers and intermediaries by CMS.
- Audiologists can directly bill Medicare but only for diagnostic tests.
- Payment for telehealth services under Medicare Part B are covered as described in Pub. 100-04, Medicare Claims Processing Manual, Chapter12, §190.

- Services furnished by a practitioner described in §1842(b)(18)(C) of the Act for which payment under Medicare Part B is made under the MPFS. The specific non-physician practitioners included and the appropriate payment percentage of the fee schedule amount are:

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

See Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, for information on billing by physicians and practitioners.

Subject to national coverage determinations and local coverage determinations (LCDs), pay for services included in the MPFS database that have the following status indicators:

- A = active
- C = carrier-priced code
- R = restricted coverage (if no relative value units (RVUs) are shown, service is carrier priced)
- E = excluded from physician fee schedule by regulation

For more information on status indicators, see Pub. 100-04, Medicare Claims Processing Manual, Chapter 23, §30.2.2.

80.2 - Carrier - Claims Processing Requirements

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

1. Claims will be submitted by IHS physicians and practitioners using either the American National Standards Institute Accredited Standards Committee (ANSI ASC) 837P or Form CMS-1500.
2. The designated carrier shall supply IHS physicians and practitioners with any billing software that would normally be given to physician and non-physician practitioners.
3. The designated carrier shall place the demonstration code 40 on all IHS physician and practitioner claims.
4. The effective date (date service was provided) for covered services to be paid is on or after July 1, 2001. Timely claims filing requirements are not waived. Pub. 100-04, Medicare Claims Processing Manual, Chapter 1, §70 contains more information on timely claims filing requirements.
5. The designated carrier shall process IHS physician and practitioner claims using their LCD. Refer to Pub. 100-08, Medicare Program Integrity Manual, Chapter 3, §3.5.1.1 for more information on LCDs. The carrier has three options:
 - Develop LCDs specifically for IHS physician and practitioner claims;
 - Use existing LCDs for the State in which the carrier resides; or
 - Use existing LCDs for any State for which they process claims.

The designated carrier shall specify which LCD they will use for processing IHS physician and practitioner 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 designated carrier shall use the Medicare Part B Drug-Pricing File accessed at www.cms.hhs.gov/providers/drugs/default.asp. However, if a drug or biological is not currently listed in the drug-pricing file, the designated carrier shall price the drug or biological utilizing current Medicare drug payment policy. (See Pub. 100-04, Medicare Claims Processing Manual, Chapter 17, §20.)
8. The designated carrier shall train IHS physician and practitioner staff to complete correctly Form CMS-1500 and the electronic formats.
 - The designated carrier shall return as unprocessable any claim with missing or incomplete information in accordance with Chapter 1, Section 80.3.2, Handling Incomplete and Invalid Claims.
9. The IHS physicians and practitioners shall submit claims as if they were a group practice.

- All IHS physicians and practitioners must apply for a group billing number via the normal processes. The designated carrier shall educate IHS physicians and practitioners on these processes.
- All IHS physicians and practitioners who do not currently have Medicare billing numbers with the IHS, tribe, and tribal organization with the designated carrier shall apply for them via the normal processes described in §40.1 Provider Enrollment with Carrier in this chapter. The designated carrier shall educate IHS physicians and practitioners 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 IHS physicians and other practitioners must contact the designated carrier to initiate the enrollment process.

10. The designated carrier shall identify all IHS physicians and practitioners by their PINs. PINs shall be assigned in a manner that will allow the designated carrier to identify which facilities are IHS, tribes, or tribal organizations. All IHS physicians and practitioners will be assigned a UPIN in accordance with current practices. See §50 Reporting Requirements for more information about PINs and UPINs.

11. The designated carrier shall use all current edits (including current duplicate logic and Correct Coding Initiative edits) on claims from IHS physicians and practitioners. Medical review will be done in accordance with current procedures.

The IHS physicians and practitioners need not submit line items for non-covered services. If non-covered services are billed, then the designated carrier shall process the line items for non-covered services and show on the remittance advice (RA) that Medicare did not cover the services.

12. The claim will post to history, update the deductible information, and update utilization. The deductible and coinsurance will apply. IHS physicians and practitioners shall not collect the deductible or coinsurance from the beneficiary.

13. The Common Working File (CWF) will subject IHS physician and practitioner claims to the working aged edit(s) using the Medicare Secondary Payer (MSP) Auxiliary (AUX) file. Where the beneficiary is shown as working aged but IHS physicians and practitioners have not submitted MSP information, the CWF will reject the claim to the designated carrier, which will reject to IHS physicians and practitioners.

14. The IHS physician and practitioner claims will be processed through the CWF using existing edits.

15. A RA will be sent to IHS physicians and practitioners for each claim. See Pub. 100-04, Medicare Claims Processing Manual, Chapter 2, Remittance Notice to Providers for more information on the RA.

16. Medicare summary notices (MSNs) will be suppressed.

17. Third party payer crossover claims will not be suppressed. See Chapter 28 of Pub-100-04, Medicare Claims Processing Manual for more information on crossover claims.
18. Interest shall be calculated on IHS physician and practitioner claims that are not paid timely, in the same manner as any other claim. See Pub. 100-04, Medicare Claims Processing Manual, Chapter 1, §80 for more information on interest calculation.
19. Normal activities for fraud and abuse, MSP, and medical review will be required for IHS physician and practitioner claims. Aberrances that may indicate potential fraudulent behavior should be reported to the applicable regional office.
20. The contractor shall process claims for Medicare Railroad retiree beneficiaries.
21. The IHS physicians and practitioners are not included in the Medpar directory since these facilities treat only the AI/AN population, except in an emergency situation.

80.3 - Carrier - Ambulance Services - Payment Policy (Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

Effective July 1, 2005, Medicare Part B payment may be made to IHS independent ambulance suppliers that furnish ambulance services. IHS independent ambulance suppliers bill the designated carrier for services.

Payment for independent ambulance supplier claims shall be based on the ambulance fee schedule and processed based on point of pickup (POP). Medicare Part B deductible and coinsurance amounts are applied, but are waived by the IHS.

For more information on the ambulance fee schedule see Pub. 100-04, Medicare Claims Processing Manual, Chapter 15. See Chapter 15, §10.3 for information on POP.

80.3.1 - Carrier – Ambulance Services - Claims Processing (Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

Medically necessary ambulances provided by an IHS ambulance supplier are paid based upon Chapter 15 of Pub. 100-04, Medicare Claims Processing Manual. Suppliers must report an origin and destination code for each ambulance service billed.

Modifier Reporting –

Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of “x”, represents an origin code or a destination code. The pair of alpha codes creates one modifier. The first position alpha code equals origin; the second position alpha code equals destination. Origin and destination codes are listed below:

D - Diagnostic or Therapeutic Center other than P or H when these are used as origin codes

E - Residential, Domiciliary, Custodial Facility (Other than an 1819 Facility)

G - Hospital based dialysis facility (hospital or hospital related)

H – Hospital

I - Site of Transfer (e.g., airport or helicopter pad) between modes of ambulance transport

J - Nonhospital based dialysis facility

N - SNF (1819 Facility)

P - Physician's Office (Includes health maintenance organization (HMO) non-hospital facility, clinic, etc.)

R – Residence

S - Scene of Accident or Acute Event

X - (Destination code only) intermediate stop at physician's office enroute to the hospital (includes HMO non-hospital facility, clinic, etc.)

All claims processing requirements in Chapter 15 of Pub. 100-04, Medicare Claims Processing Manual, shall apply to ambulance claims submitted by IHS independent ambulance suppliers.

The MSN is suppressed.

80.4 - Carrier - Vaccines and Vaccine Administration - Payment Policy (Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

Medicare Part B payment may be made to IHS physicians and practitioners that furnish vaccines including pneumococcal pneumonia virus (PPV), influenza virus and hepatitis B virus. Medicare Part B payment may be made to IHS physicians and practitioners for the administration of these vaccines. Payment for the administration of the vaccine is based on the MPFS. Payment is made by the carrier. See Chapter 18 of Pub. 100-04, Medicare Claims Processing Manual for more information on this benefit.

80.4.1 - Carrier - Vaccines and Vaccine Administration - Coverage Policy

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

Pneumococcal Pneumonia Vaccinations

The Medicare Part B program covers PPV and its administration when furnished in compliance with any applicable State law by any provider of services or any entity or individual with a supplier number. This includes revaccination of patients at highest risk of pneumococcal infection. Typically, these vaccines are administered once in a lifetime except for persons at highest risk. See Chapter 18 of Pub. 100-04, Medicare Claims Processing Manual for more information on this benefit.

Hepatitis B Vaccine

The Medicare Part B program provides coverage of hepatitis B vaccine and its administration, furnished to a Medicare beneficiary who is at high or intermediate risk of contracting hepatitis B. See Chapter 18 of Pub. 100-04, Medicare Claims Processing Manual for more information on this benefit.

Influenza Virus Vaccine

The Medicare Part B program covers influenza virus vaccine and its administration when furnished in compliance with any applicable State law by any provider of services or any entity or individual with a supplier number. Typically, these vaccines are administered once a year in the fall or winter. Medicare does not require, for coverage purposes, that a doctor of medicine or osteopathy order the vaccine. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision. See Chapter 18 of Pub. 100-04, Medicare Claims Processing Manual for more information on this benefit.

80.5 - Carrier - Screening and Preventive Services

(Rev. 2075, Issued: 10-28-10, Effective: 01-01-10, Implementation: 01-28-11)

Medicare Part B makes payment for the following screening and preventive services:

- Pelvic exam;
- Glaucoma screening;
- Bone mass measurements;
- Prostate cancer screening;
- Colorectal cancer screening;
- Screening pap smear;
- Screening mammography;
- Cardiovascular screening blood tests;
- Diabetes screening tests;

- DSMT;
- Influenza virus vaccine and its administration, pneumococcal vaccine and its administration; hepatitis b virus and its administration;
- Initial physician physical exam (IPPE) – Welcome to Medicare;
- MNT; and
- Smoking and tobacco-use cessation (counseling/screening).

Payment is made for the screening and preventive services listed, excluding vaccines, based on the MPFS. Chapter 18 of Pub. 100-04, Medicare Claims Processing Manual contains more information on the payment of screening and preventive services, including the method of payment for vaccines.

Effective January 1, 2005, payment is made by the carrier for the services of IHS physicians and practitioners furnished in hospitals and ambulatory care clinics for screening and preventive services covered under §630 MMA, indefinitely extended by §2902 of the ACA.

80.6 - Carrier - Clinical Laboratory Services - Payment Policy (Rev. 2075, Issued: 10-28-10, Effective: 01-01-10, Implementation: 01-28-11)

Medicare Part B payment may be made to freestanding facilities for covered clinical laboratory tests. Freestanding facilities are paid for clinical laboratory tests covered as a result of §630 MMA, indefinitely extended by §2902 of the ACA, based on the clinical laboratory fee schedule.

80.6.1 - Carrier - Clinical Laboratory Services - Claims Processing (Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

Some clinical laboratory procedures or tests require FDA approval before coverage is provided. Laboratory services furnished by a freestanding facility are covered under Medicare Part B if the laboratory is an approved independent clinical laboratory. However, as is the case of all diagnostic services, in order to be covered these services must be related to a patient's illness or injury (or symptom or complaint) and ordered by a physician. A small number of laboratory tests can be covered as a screening and preventive service. Freestanding facilities bill clinical laboratory services to the designated carrier.

See §80.1 of Chapter 15 of Pub. 100-02, Benefit Policy Manual, for more information on this benefit.

See Chapter 16 of Pub. 100-04, Claims Processing Manual, for detailed claims processing instructions.

See Pub. 100-08, Medicare Program Integrity Manual, Chapter 10, for laboratory/supplier enrollment guidelines.

See Pub. 100-07, Medicare State Operations Manual for laboratory/supplier certification requirements.

80.7 - Carrier – Medical Nutrition Therapy (MNT) - Payment Policy (Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

Section 105 of BIPA permits Medicare coverage of MNT when furnished by a registered dietician (RD) meeting certain requirements. See Chapter 4, §§300 through 300.6 of Pub. 100-04, Medicare Claims Processing Manual, for more information on these requirements.

Medical nutrition therapy services rendered by an RD who is an individual practitioner or member of a group practice may be provided in a beneficiary's home if the physician adequately documents the need for having the services provided in the beneficiary's home in his/her written orders. Under these circumstances, the practitioner may render the MNT services in the beneficiary's home and bill the designated carrier under the practitioner's or group practice's carrier issued PIN. Even if the practitioner has contracted with an IHS provider to provide MNT in the hospital outpatient department, the practitioner may, during hours not included in the contracted services, provide MNT in the beneficiary's home, and submit a bill to the designated Medicare Part B carrier, using the PIN of the practitioner or group practice. Payment is made by the carrier based upon the fee schedule.

80.7.1 - Carrier – MNT - Claims Processing (Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

If the RD providing the services is an employee of an independent or free standing clinic and the services are provided in the clinic, the services are billed to the designated carrier.

See Chapter 4, §§300 through 300.6 of Pub. 100-04, Medicare Claims Processing Manual, for more information on the Healthcare Common Procedure Coding System (HCPCS) codes used to bill MNT to the carrier.

80.8 - Dual Eligibility (Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

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

80.9 - Carrier Claims Processing and Payment Policy for ASC Claims (Rev. 1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Effective for services on or after January 1, 2008, the designated IHS carrier shall accept and pay for claims submitted by IHS and tribal hospitals that elect to enroll as ASC facilities. See Pub. 100-04, Medicare Claims Processing Manual, Chapter 14, for information on ASC claims processing. See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, for information on ASC payment policy.

90 - DME General Information

(Rev.2075, Issued: 10-28-10, Effective: 01-01-10, Implementation: 01-28-11)

The DME MACs process claims for items of DMEPOS for use **in the beneficiary's home**. Beginning January 1, 2005, Medicare Part B makes payment for medically necessary items of DME, prosthetics, orthotics, and supplies to IHS suppliers that furnish DME for use in the **beneficiary's home**. See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, §110 for more information on this benefit.

Note that the DME MACs make payment for DMEPOS only in cases where the beneficiary medically needs the equipment in his or her home. Items provided during an inpatient hospital or SNF stay are included in the payment made to the hospital or SNF, with certain exceptions. (See Chapter 6, §20.3 of Pub. 100-04, Medicare Claims Processing Manual for exceptions to SNF consolidated billing, and Chapter 20, §110.3 for exceptions to DMEPOS provided for fitting and training prior to an inpatient discharge.) More information regarding when items of DMEPOS are billed to a DME MAC or to an FI is outlined below.

For more information on jurisdiction, payment policy, and claims processing rules for DMEPOS, see Chapters 1 (for general information of submitting Medicare claims), 17 (for information specific to drugs paid by the DME MACs), and 20 (for information specific to DMEPOS items and services) of Pub. 100-04, Medicare Claims Processing Manual.

90.1 - Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Payment Policy

(Rev. 2075, Issued: 10-28-10, Effective: 01-01-10, Implementation: 01-28-11)

Section 630 of the MMA, indefinitely extended by §2902 of the ACA, permits IHS suppliers to directly bill for itemized DMEPOS with dates of service (DOS) on or after January 1, 2005. Previously IHS suppliers could not directly bill Medicare for DMEPOS.

90.1.1 - Licensure to Dispense Drugs

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

In order to bill drugs to the DME MACs, the supplier must be a pharmacy. States may not regulate the qualifications of Federal employees who are carrying out their authorized Federal activities within the scope of their employment. However, IHS employees are not subject to state licensure laws and IHS pharmacy departments are not licensed by

individual states. IHS pharmacies are currently licensed in accordance with Federal statutes and regulations and the IHS facility is accredited in accordance with statutes and regulations. IHS pharmacy departments agree to use the IHS facility's DEA number consistent with Federal law. Therefore, IHS pharmacies are "deemed" as being licensed and therefore may bill the DME MACs for those drugs the DME MACs cover. IHS pharmacies are considered IHS suppliers.

90.1.2 - Payment

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

Surgical dressings, splints, casts, DME and other devices used for reductions of fractures and dislocations are paid based on the DMEPOS fee schedule. Claims will be priced using the appropriate DMEPOS fee schedule based on the beneficiary's address.

Payment for DME MAC-covered drug claims shall be based on the ASP fee schedule or other sources (See Pub. 100-04, Medicare Claims Processing Manual, Chapter 17, §20).

Payment for prosthetics and orthotics is based on the DMEPOS fee schedule by the FI and DME MAC.

90.2 - DMEPOS Claims Processing Rules

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

90.2.1 - Services Billed to the DME MAC

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

Effective July 1, 2005, IHS suppliers and IHS providers (including CAHs) shall bill the appropriate DME MAC for DME.

Although, parenteral and enteral nutrients, equipment, and supplies meet the definition of the prosthetic benefit, they are separately billable to the DME MAC for home use. Ostomy, tracheostomy, and urological supplies meet the definition of this benefit and are billed to the DME MAC by IHS suppliers. See §120 of Chapter 15 of Pub. 100-02, Medicare Benefit Policy Manual for more information on this benefit.

Claims for surgical dressings provided by IHS suppliers shall be billed to the appropriate DME MAC. Claims for splints and casts provided by IHS suppliers should be billed to the appropriate carrier. See §100 of Chapter 15 of Pub. 100-02, Medicare Benefit Policy Manual for more information on this benefit.

Effective July 1, 2005, Medicare Part B payment may be made to IHS suppliers that furnish drugs covered by the DME MAC. The DME MAC drug categories are oral anti-cancer, oral anti-emetic, immunosuppressives, and drugs used for with DME, such as external infusion pumps and nebulizers. Medicare Part B drugs incident to a physician's service shall be billed to the designated carrier when provided in freestanding facility.

See §80, Chapter 17 of Pub. 100-04, Medicare Claims Processing Manual for more information on this benefit.

Effective July 1, 2005, Medicare Part B payment shall be made to IHS suppliers and IHS providers (including CAHs) functioning as retail pharmacies dispensing pharmaceuticals to AI/AN Medicare beneficiaries. These drugs are billed to the appropriate DME MAC. The FI shall not be billed for these drugs. Drugs dispensed for self-administration are only covered when billed to the DME MAC if also specifically covered under Medicare.

Effective July 1, 2005, Medicare Part B payment may be made by the appropriate DME MAC to IHS suppliers that furnish therapeutic shoes and inserts for individuals with diabetes. See §140 of Chapter 15 of Pub. 100-02, Medicare Benefit Policy Manual for more information on this benefit.

**90.2.1.1 - Prosthetics, Orthotics and Supplies Billed to the A/B MAC
(Rev. 1957; Issued: 04-28-10; Effective Date: 01-01-09; Implementation Date: 10-04-10)**

Effective for dates of service on or after July 1, 2005, IHS providers, including CAHs shall bill the designated A/B MAC for prosthetics and orthotics under revenue code 0274 (prosthetic/orthotic devices) on type of bill (TOB) 12X (hospital inpatient part B), 13X (hospital outpatient) or 85X (Critical Access Hospital (CAH)). Medicare Part B payment may be made to IHS providers that furnish prosthetic devices which replace all or part of an internal body organ (including contiguous tissue), or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ. Ostomy, tracheostomy, and urological supplies meet the definition of this benefit and are billed to the A/B MAC by IHS providers.

Effective for dates of service on or after July 1, 2005, IHS providers (including CAHs) shall bill the designated A/B MAC for surgical dressings under revenue code 0623 (surgical dressings) on TOB 12X, 13X or 85X. Splints and casts are included in the AIR for IHS providers.

Payment is made by the A/B MAC for pharmaceuticals when billed with a clinic visit. Payment is included in the AIR.

The prosthetics, orthotics and surgical dressings HCPCS codes are updated on a periodic basis and published in a “Recurring Update Notification.”

**90.2.2 - General Claims Processing Rules for DMEPOS
(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)**

The DME MACs may only be billed for surgical dressings, splints, casts and for prosthetics and orthotics by IHS suppliers, not by IHS providers. The Region D DME MAC shall accept all DMEPOS claims submitted by IHS suppliers and shall forward

electronic media claims to the appropriate DME MAC for processing. IHS providers already bill the designated FI for DME used in the home.

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

If an IHS or an Indian tribe or tribal organization facility (hospital-based or non-hospital-based) submits an unassigned claim with dates of service on or after July 5, 2005, to the DME MAC for these Medicare Part B services, the DME MAC shall process the claim as though the IHS or an Indian tribe or tribal organization had accepted assignment of the claim.

The DME MACs shall identify DMEPOS claims submitted by IHS suppliers and waive coinsurance and deductible for these beneficiaries.

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

The MSN is suppressed.

Deductible and coinsurance amounts are applied by Medicare, but are waived by the IHS.

100 - FI Payment Policy and Claims Processing

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

Bills are submitted to the FI by IHS providers (including CAHs) using the 837I. In exceptional circumstances, a hardcopy Form CMS-1450 may be accepted by the designated FI.

The IHS providers are identified by Provider Type 08 in the Provider Specific File in the fiscal intermediary claims processing system. The FI uses specific IHS related edits, current outpatient edits for non-outpatient prospective payment system (non-OPPS) providers, and current inpatient prospective payment system (IPPS) edits on IPPS bills, as well as other edits applicable to CAHs.

Medical review is done in accordance with current procedures. IHS provider bills are processed subject to existing CWF edits. International Classification of Diseases-9 Clinical Modification (ICD-9-CM) codes are required on all bill types.

For services provided to AI/AN individuals in IHS providers (including CAHs) deductible and coinsurance amounts are applied by Medicare, but are waived by the IHS, and the MSN is suppressed. Third party payers may be billed for applicable deductible and coinsurance amounts.

100.1 - FI - Medicare Part B Services Paid Under Various Fee Schedules

(Rev. 2075, Issued: 10-28-10, Effective: 01-01-10, Implementation: 01-28-11)

The legislative change in MMA §630 of 2003, which was effective January 1, 2005, and indefinitely extended by §2902 of the ACA, allows IHS providers to bill for other Medicare Part B services, not covered under §1848 of the Act. In an effort to clarify that these charges are not included in the AIR (which is the general method of payment) and to allow these facilities to acquire the appropriate certifications, IHS providers, including CAHs were allowed to begin billing separately for the following Medicare Part B services:

- Prosthetic and orthotic devices (beginning July 1, 2005);
- Surgical dressings (beginning July 1, 2005);
- Influenza, pneumococcal, and hepatitis B vaccines (beginning January 1, 2006);
and
- Ambulance services (beginning January 1, 2005).

The enactment of BIPA allowed for separate billing of certain services by physicians and practitioners, including physical therapy, occupational therapy, and speech-language pathology (including diagnostic audiology services).

100.2 - FI - Medicare Part B Services Included in the All Inclusive Rate (AIR)

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

Unless otherwise specified in this chapter, payment to IHS providers is made based on the AIR. To understand how payment is made for IHS services, it is recommended that Chapter 19 be reviewed in its entirety. Services provided in IHS providers that are considered part of the AIR include:

- Diagnostic tests (see §1861(s)(3)), covered drugs and biologicals furnished incident to a physician service (see §1861(s)(2)(A) and (b)) and DSMT services (see 1861(s)(2)(S)).
- Services furnished by a RD or nutrition professional (meeting certain requirements) as defined in §105 of BIPA for MNT services for beneficiaries with diabetes or renal disease. (These health care professionals must reassign their benefits to the hospital or hospital-based clinic.)
- The technical component of screening mammography services, and other radiological services.
- If the IHS provider purchases laboratory services from another entity, that entity bills the hospital. The hospital bills Medicare and is paid based on the AIR.

NOTE: This is not an all-inclusive list of services paid under the AIR.

100.3 - FI - Inpatient Acute Care - Medicare Part A - Payment Policy (Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

Medicare Part A provides payment to IHS providers for up to 90 days of covered inpatient hospital services in a benefit period. These services are subject to Medicare Part A inpatient deductible and coinsurance. Each beneficiary also has 60 lifetime reserve days (LTR) of inpatient hospital services to draw upon after having used 90 days of inpatient hospital services in a benefit period. Lifetime reserve days are subject to Medicare Part A LTR coinsurance. Deductible and coinsurance amounts are applied by Medicare, but are waived by the IHS.

See Pub. 100-02, Medicare Benefit Policy Manual for more information on Medicare Part A deductible, coinsurance and benefit periods.

The IHS providers are paid for covered inpatient services under the IPPS based upon diagnostic related groups (DRGs). The IPPS Pricer recognizes that IHS providers are paid at a higher wage index than other acute care hospitals.

100.3.1 - FI - Inpatient Acute Care - Medicare Part A - Claims Processing

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

All charges are combined and reported under revenue code 0100 (all-inclusive room and board plus ancillary) on type of bill (TOB) 11X (hospital inpatient). Inpatient services are billed from admission through discharge. Interim billing is not allowed.

See Chapter 1, §50.2 of Pub. 100-04, Medicare Claims Processing Manual, for more information on frequency of billing and the exceptions for interim billing.

In order to receive the appropriate payment under the IPPS, it is important that the applicable ICD-9-CM diagnosis codes as well as ICD-9-CM procedure codes are reported on the bill.

The MSN is suppressed.

100.3.2 - FI - Physician Acknowledgement Statement

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

Section 42 CFR 412.46 requires hospitals to obtain only one signed acknowledgment from physicians who are being granted admitting privileges at a particular IHS provider. The physician must complete the acknowledgment at the time that he/she is granted admitting privileges at the hospital or before, or at the time the physician admits his/her first patient to the hospital. When the hospital submits a claim, it must have on file a signed and dated acknowledgment from the attending physician that the physician has received the notice specified in 42 CFR 412.46(b). Existing acknowledgments signed by

physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.

The IHS providers must meet the conditions specified in 42 CFR 412, Subpart C, to receive payment under IPPS for inpatient hospital services furnished to Medicare beneficiaries.

The IHS providers are monitored to ensure that they are appropriately obtaining the acknowledgment statements from physicians with new admitting privileges as required at 42 CFR 412.46.

For more information on the physician acknowledgement statement see Chapter 4 of Pub. 100-10, Quality Improvement Organization Manual.

100.3.3 - FI - Social Admissions

(Rev. 1446, Issued: 02-08-08; Effective: 07-01-08; Implementation: 07-07-08)

Social admissions for patient and family convenience are not covered by Medicare. They are not billable to Medicare by IHS providers (including CAHs) on either TOB 11X (hospital inpatient) or 12X (hospital inpatient Part B). For admissions before surgery, only the scheduled surgery and related services may be billed on TOB 83X (ambulatory surgical center) if the surgery is performed on an outpatient basis and on TOB 11X if the surgery is performed on an inpatient basis. When placing a patient in a room for social reasons after discharge from an inpatient stay this portion of inpatient care may not be billed to Medicare. Medicare disallows payment for inpatient Medicare Part B ancillary services during a social admission stay when there is another bill from a different facility for an outpatient service. A TOB 12X from the admitting facility with a 13X (hospital outpatient) TOB from another hospital, a 72X (hospital based or freestanding renal dialysis center) TOB from a renal dialysis facility (RDF). Consequently, CWF will send an informational unsolicited response (IUR) to the designated FI on receipt of the 13X or 72X bill.

Medicare also disallows payment for inpatient Part B ancillary services during a social admission stay when a TOB 12X has a line item date of service (LIDOS) that is equal to or one day following the discharge date on a TOB 11X for the same provider. The CWF sends an IUR to the designated FI in this situation.

The CWF bypasses both of these edits when the beneficiary is not entitled to Medicare Part A at the time the services on TOB 12X are rendered.

See Chapter 4, §240.2 of Pub. 100-04, Medicare Claims Processing Manual, for more information on social admissions.

NOTE: Effective for dates of service on or after January 1, 2008, the FI no longer processes claims for IHS ASCs (TOB 83X). All IHS ASC providers must submit their claims to the carrier.

100.3.4 - FI - Inpatient Ancillary Services - Medicare Part B - Payment Policy

(Rev. 1511; Issued: 05-23-08; Effective Date: 01-01-08; Implementation Date: 06-23-08)

Certain inpatient hospital ancillary services are covered under Medicare Part B when coverage is no longer provided under Medicare Part A due to benefits exhausted, the beneficiary is determined to be receiving a non-covered level of care, or is not eligible for Medicare Part A benefits. Chapter 4, §240 of Pub. 100-04, Medicare Claims Processing Manual contains information on the physician services and the nonphysician medical and other health services covered under Medicare Part B when furnished by a participating IHS provider to an inpatient of the hospital, but only if payment for these services cannot be made under Medicare Part A.

The IHS providers are paid for covered inpatient Medicare Part B ancillary services based upon an all inclusive inpatient ancillary per diem rate (AIR). The AIR is established by CMS and IHS based upon a review of yearly cost reports prepared by IHS's contractor. Upon completion of the review, IHS submits the agreed upon rate to the Office of Management and Budget (OMB) for approval. Upon approval by OMB, IHS publishes the approved rate in the **Federal Register**. The AIR is established for each calendar year. The approved AIR is issued periodically in a Recurring Update Notification.

These rates are **not** facility specific and should not be confused with the all inclusive facility specific inpatient ancillary per diem rate paid to CAHs based on their cost reports. For more information on the CAHs all inclusive facility specific per diem rate, see §110.3 of this chapter.

100.3.4.1 - FI - Inpatient Ancillary Services - Medicare Part B - Claims Processing

(Rev. 1776, Issued: 07-24-09, Effective: 01-01-09, Implementation: 01-04-10)

All charges, except therapies, telehealth originating site facility fee, PPV, influenza virus and hepatitis B vaccines are combined and reported under revenue code 024X (all-inclusive ancillary) on TOB 12X (hospital inpatient Part B). Medicare Part B deductible and coinsurance amounts are applied to inpatient Medicare Part B ancillary services, but are waived by the IHS. The MSN is suppressed.

100.4 - FI - Swing-bed

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

Under §1880 of the Act, Medicare Part A provides payment for hospitalization and post hospitalization extended care in SNFs, including swing-bed SNFs.

A beneficiary is entitled to 100 days of skilled nursing care in a SNF or the swing-bed unit of an acute care hospital or CAH during each benefit period. The first 20 days are covered in full, and the remaining days are subject to Medicare Part A SNF coinsurance, but is waived by the IHS.

For more information on swing-bed services see Chapter 8, in Pub. 100-02, Medicare Benefit Policy Manual.

100.4.1 - FI - Swing-bed – Medicare Part A - Payment Policy (Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

Effective July 2002, IHS hospital swing-bed services began being paid according to the SNF prospective payment system (PPS) payment methodology. See Chapter 6, §30.6 in Pub. 100-04, Medicare Claims Processing Manual for information on SNF PPS payment methodology.

Medicare Part A coinsurance is applied to IHS swing-bed inpatient bills, but is waived by the IHS.

100.4.1.1 - FI - Swing-bed – Medicare Part A - Claims Processing (Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

Revenue code 0022 (special charges) and the Health Insurance Prospective Payment System (HIPPS) codes are reported on the bill along with the accommodation revenue codes. Services are itemized and billed with the appropriate revenue code that describes the service on TOB 18X (hospital swing bed). Medicare swing-bed bill processing instructions are found in Chapter 6, §30 in Pub. 100-04, Medicare Claims Processing Manual.

The MSN is suppressed.

100.4.2 - FI - Swing-bed - Inpatient Ancillary Claims - Medicare Part B - Payment Policy (Rev. 1511; Issued: 05-23-08; Effective Date: 01-01-08; Implementation Date: 06-23-08)

The IHS providers are paid for covered inpatient Medicare Part B ancillary services based upon an all inclusive inpatient ancillary per diem rate (AIR). The AIR is established by CMS and IHS based upon a review of yearly cost reports prepared by IHS's contractor. Upon completion of the review, IHS submits the agreed upon rate to the OMB for approval. Upon approval by OMB, IHS publishes the approved rate in the **Federal Register**. The AIR is established for each calendar year. The approved AIR is issued periodically in a Recurring Update Notification.

Medicare Part B coinsurance is applied to IHS hospital Medicare Part B inpatient ancillary bills, but waived by the IHS.

See §100.3.4 of this chapter for more information on the all inclusive inpatient ancillary per diem rate.

100.4.2.1 - FI - Swing-bed - Inpatient Ancillary Claims - Medicare Part B - Claims Processing

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

The IHS hospital swing-bed Medicare Part B inpatient ancillary bills revert to inpatient Medicare Part B ancillary bills and are submitted under the regular hospital (or CAH) provider number (not the swing-bed provider number) with revenue code 0240 (all inclusive ancillary) on TOB 12X (inpatient Part B). The MSN is suppressed.

100.5 - FI - Outpatient - Medicare Part B - Payment Policy

(Rev. 1511; Issued: 05-23-08; Effective Date: 01-01-08; Implementation Date: 06-23-08)

The IHS providers are paid for covered outpatient services based upon an all inclusive outpatient per visit rate (AIR). The AIR is established by CMS and IHS based upon a review of yearly cost reports prepared by IHS's contractor. Upon completion of the review, IHS submits the agreed upon rate to OMB for approval. Upon approval by OMB, IHS publishes the approved rate in the **Federal Register**. The AIR is established for each calendar year. The approved AIR is issued periodically in a Recurring Update Notification.

Medicare Part B deductible and coinsurance amounts are applied to outpatient services, but are waived by the IHS.

These rates are **not** all inclusive inpatient ancillary per diem rates and should not be confused with the all inclusive inpatient ancillary per diem rates paid to IHS providers for services covered under Medicare Part B when coverage is no longer provided under Medicare Part A. For more information on the all inclusive inpatient ancillary per diem rates, see §100.3.4 of this chapter.

100.5.1 - FI - Outpatient - Medicare Part B - Claims Processing

(Rev. 2075, Issued: 10-28-10, Effective: 01-01-10, Implementation: 01-28-11)

All charges, except for therapies, telehealth originating site facility fee, PPV, influenza virus vaccine, hepatitis B vaccine and hospital-based ambulance services are combined and reported under revenue code 0510 (clinic visit) on TOB 13X (hospital outpatient).

Regardless of the number of times a patient is seen in a given day at a particular IHS provider, the outpatient services should be billed only once (i.e., all-inclusive). An exception is when a patient is seen for a clinic visit, then returns to the emergency room later on the same day, at the same provider, for an unrelated condition (or vice versa). Two clinic visits may be billed in this instance. The remarks section of the bill shall

include a narrative describing the situation and why two clinic visits are being billed. When a medical visit and an emergency visit occur on the same day, condition code G0 (distinct medical visit) shall be reported on the claim.

While at least one face-to-face encounter with a physician or non-physician practitioner is required for an initial visit to count as a billable encounter, the same is not always true of return visits to obtain follow-up care ordered by the physician or non-physician practitioner during the initial visit. If a physician or non-physician practitioner orders a specific procedure or test which cannot be furnished until a later date after the date of the initial visit with the physician or non-physician practitioner, and the procedures or tests are medically necessary, then it is appropriate for the return encounter to be billed on the date the procedure or test is furnished and for the provider to receive an additional AIR payment even if the beneficiary did not interact with a physician or non-physician practitioner during the return visit.

Examples of medically necessary reasons for return visits would include a requirement that the beneficiary fast for 12 hours prior to an ordered test, or that a chest X-ray be provided two weeks following the initiation of antibiotic treatment for pneumonia. In addition, if a beneficiary must return on another day for a medically necessary test ordered during an initial visit because the test cannot be performed on the day it is ordered due to provider or patient constraints that cannot be overcome, the return visit would be considered medically necessary.

See Chapter 18, §10 of Pub. 100-04, Medicare Claims Processing Manual, for detailed billing instructions for vaccines. Chapter 12 of Pub. 100-04 contains detailed billing instructions for outpatient therapy services provided by an occupational or physical therapist. See Chapter 15 of Pub. 100-04 for detailed billing instructions for ambulance services.

The MSN is suppressed.

100.6 - FI - Ambulatory Surgical Center (ASC) - Medicare Part B - Payment Policy **(Rev. 1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)**

Qualified IHS providers are reimbursed at the ASC rates published in the **Federal Register**. Medicare Part B deductible and coinsurance amounts apply to ASC services, but are waived by the IHS.

See §40.2.1 of this chapter for information on enrolling with the designated FI to receive payment for ASC services based on the ASC rates.

NOTE: Effective for dates of service on or after January 1, 2008, the FI no longer processes claims for IHS ASCs. All IHS ASC providers must submit their claims to the carrier.

100.6.1 - FI - ASC - Medicare Part B - Claims Processing
(Rev. 1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Charges are reported under revenue code 0360 (operating room services) or 0490 (ambulatory surgical care) on TOB 83X (ambulatory surgical center). ASC surgeries are identified with CPT codes 10000-69979 only. One bill is required for all services provided on the day a surgical procedure is performed.

*Exception: Revenue code 0276 (intraocular lenses) and charges may be reported separately to report the intraocular lens for cataract surgeries.

The attending/operating UPINs are required in Form Locators 82 and 83 (A-B) on all 83X TOBs.

If all surgeries performed are not on the ASC list published in the **Federal Register** they should not be reported as surgeries, but rather as clinic visits with TOB 13X and revenue code 0510 (clinic).

If an admission occurs within 1 day of the ASC services, those charges must be included on the inpatient claim, if the principal diagnosis for admission and those outpatient services are the same.

The MSN is suppressed.

NOTE: Effective for dates of service on or after January 1, 2008, the FI no longer processes claims for IHS ASCs. All IHS ASC providers must submit their claims to the carrier.

100.7 - FI - Critical Access Hospital (CAH) Inpatient - Medicare Part A - Payment Policy
(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

The IHS CAHs are paid 101 percent of the all inclusive facility specific per diem rate established on a yearly basis from the most recently filed cost report information for covered inpatient services (on and after January 1, 2004). An average of 96 hours of acute inpatient care in a CAH shall be paid by Medicare Part A.

See Chapter 3, §30.1.1.1 of Pub. 100-04, Medicare Claims Processing Manual, for more information on the payment of inpatient CAH claims.

100.7.1 - FI - CAH Inpatient - Medicare Part A - Claims Processing
(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

All charges are combined and reported under revenue code 0100 (all-inclusive room and board plus ancillary) on TOB 11X (hospital inpatient). Inpatient services are billed from admission through discharge.

The MSN is suppressed.

100.7.2 - FI - CAH Ancillary Services - Medicare Part B - Payment Policy

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

Certain inpatient CAH ancillary services are covered under Medicare Part B when coverage is no longer provided under Medicare Part A due to benefits exhausted, the beneficiary is determined to be receiving a non-covered level of care, or is not eligible for Medicare Part A benefits. Chapter 4, §240 of Pub. 100-04, Medicare Claims Processing Manual contains information on the physician services and the nonphysician medical and other health services covered under Medicare Part B when furnished by a participating IHS provider to an inpatient of the CAH, but only if payment for these services cannot be made under Medicare Part A.

The IHS CAHs are paid for covered inpatient Medicare Part B ancillary services based upon 101 percent of an all inclusive facility specific per diem rate that is established on a yearly basis from prior year cost report information. Medicare Part B deductible and coinsurance amounts are applied to inpatient Medicare Part B ancillary services, but are waived by the IHS.

100.7.2.1 - FI - CAH Ancillary Services - Medicare Part B - Claims Processing

(Rev. 1776, Issued: 07-24-09, Effective: 01-01-09, Implementation: 01-04-10)

All charges, except therapies, telehealth originating site facility fee, PPV, influenza virus and hepatitis B vaccines are combined and reported under revenue code 024X (all-inclusive ancillary) on TOB 12X (hospital inpatient Part B). The MSN is suppressed.

See §§100.10 and 100.11 of this chapter, for more information on the payment of vaccines and their administration and therapy services.

100.8 - FI - CAH Swing-bed - Medicare Part A - Payment Policy

(Rev. 1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

The IHS CAH swing-bed services are paid 101 per cent of an all inclusive facility specific per diem rate. Medicare Part A coinsurance is applied to IHS CAH swing-bed inpatient bills, but is waived by the IHS.

100.8.1 - FI - CAH Swing-bed - Medicare Part A - Claims Processing

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

Services are itemized and billed with the appropriate revenue code that describes the service on TOB 18X (hospital swing-bed). Technical criteria for swing-bed admissions

apply (i.e., 3 day qualifying hospital stay, 30 day transfer requirements, etc.) but CAH swing-bed providers are not required to report revenue code 0022 or HIPPS codes. The MSN is suppressed.

For more information on the technical criteria for Medicare Part A coverage of SNF services see Chapter 8, §20 in Pub. 100-02, Medicare Benefit Policy Manual.

100.8.2 - FI - CAH Swing-bed - Inpatient Ancillary Claims - Medicare Part B - Payment Policy

(Rev. 1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

The IHS CAHs are paid for covered inpatient Medicare Part B ancillary services based upon 101 percent of an all inclusive facility specific per diem rate that is established on a yearly basis from prior year cost report information. Medicare Part B deductible and coinsurance amounts are applied to inpatient Medicare Part B ancillary services, but are waived by the IHS.

100.8.2.1 - FI - CAH Swing-bed - Inpatient Ancillary Claims - Medicare Part B - Claims Processing

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

The IHS CAH swing-bed Medicare Part B inpatient ancillary bills revert to inpatient Medicare Part B ancillary bills and are submitted under the regular hospital (or CAH) provider number (not the swing-bed provider number) with revenue code 0240 (all inclusive ancillary) on TOB 12X (inpatient Part B). The MSN is suppressed.

100.9 - FI - CAH Outpatient - Medicare Part B - Payment Policy

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

The IHS CAHs are paid for covered outpatient services based on 101 percent of an all inclusive facility specific per visit rate that is established on a yearly basis from prior year cost report information for both facilities electing Standard Method I and Optional Method II billing.

For services provided in IHS CAHs, deductible and coinsurance amounts are applied by Medicare, but are waived by the IHS. Third party payers may be billed for applicable deductible and coinsurance amounts.

See Chapter 4, §§250.1 and 250.2 of Pub. 100-04, Medicare Claims Processing Manual, for more information on the payment of Method I and II CAH outpatient claims.

See §§100.10 and 100.11 of this chapter, for more information on the payment of vaccines and their administration and therapeutic services.

100.9.1 - FI - CAH Outpatient - Medicare Part B - Claims Processing

(Rev. 1776, Issued: 07-24-09, Effective: 01-01-09, Implementation: 01-04-10)

All charges, except therapies, telehealth originating site facility fee, PPV, influenza virus vaccine, hepatitis B vaccine, and hospital-based ambulance services are combined and reported under revenue code 0510 (clinic visit) on TOB 85X (CAH).

Non-patient lab specimens are billed on TOB 14X (hospital other).

The MSN is suppressed.

See Chapter 18, §10 of Pub. 100-04, Medicare Claims Processing Manual, for detailed billing instructions for vaccines. See Chapter 5 of Pub. 100-04 for detailed billing instructions for therapy services. See Chapter 15 of Pub. 100-04 for detailed billing instructions for ambulance services.

100.9.1.1 - FI - CAH Election of Method I or Method II

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

See Chapter 4, §250 of Pub. 100-04, Medicare Claims Processing Manual, for information on the election of Standard Method I or Optional Method II IHS CAH billing for professional services.

100.10 - FI - Vaccines and Vaccine Administration - Payment Policy

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

Effective January 1, 2006, IHS providers, including CAHs are paid separately from the AIR for certain vaccines and their administration. See Chapter 18 of Pub. 100-04, Medicare Claims Processing Manual for more information on the payment of PPV, influenza virus, and hepatitis B vaccines. The administration of vaccines is paid based on the MPFS.

The Medicare Part B deductible and coinsurance does not apply to PPV and influenza vaccines. The Medicare Part B deductible and coinsurance are applied to the hepatitis B vaccine, but are waived by the IHS.

100.10.1 - FI - Vaccines and Vaccine Administration - Claims Processing

(Rev. 1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

These vaccines are reported on TOB 12X, 13X, 83X, or 85X along with the appropriate revenue codes and HCPCS codes as found in billing instructions in Chapter 18, §10.2 of Pub. 100-04, Medicare Claims Processing Manual.

No clinic visit shall be billed if vaccine and its administration are the only service received. Vaccines and their administration may be billed with or without a clinic visit.

The MSN is suppressed.

NOTE: Effective for dates of service on or after January 1, 2008, the FI no longer processes claims for IHS ASCs (TOB 83X). All IHS ASC providers must submit their claims to the carrier.

100.11 - FI - Physical Therapy, Occupational Therapy, Speech-Language Pathology and Diagnostic Audiology Services - Payment Policy

(Rev. 1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Effective January 1, 2006, IHS providers are paid separately from the AIR for physical therapy, OT, speech-language pathology and diagnostic audiology services. Payment for services to IHS providers on TOB 12X, 13X or 83X is made based on the MPFS. Payment for services to IHS CAHs on TOB 85X is made based on reasonable cost.

The Medicare Part B deductible and coinsurance apply to therapy services and diagnostic audiology services, but are waived by the IHS.

NOTE: Effective for dates of service on or after January 1, 2008, the FI no longer processes claims for IHS ASCs (TOB 83X). All IHS ASC providers must submit their claims to the carrier.

100.11.1 - FI - Physical Therapy, Occupational Therapy, Speech-Language Pathology and Diagnostic Audiology Services - Claims Processing

(Rev. 1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Therapy services and diagnostic audiology services are reported on TOB 12X, 13X, 83X or 85X using the appropriate revenue code and HCPCS codes.

No clinic visit shall be billed if a therapy service or a diagnostic audiology service is the only service received. These services may be billed with or without a clinic visit.

The MSN is suppressed.

NOTE: Effective for dates of service on or after January 1, 2008, the FI no longer processes claims for IHS ASCs (TOB 83X). All IHS ASC providers must submit their claims to the carrier.

100.12 - *A/B MAC* - Ambulance Services

(Rev. 2102, Issued: 11-19-10, Effective: 04-01-11, Implementation: 04-04-11)

Section 630 of the MMA allows for the reimbursement of ambulance services provided by *IHS* hospital-based ambulance providers, CAHs, *and entities owned and operated by a*

*CAH, for the 5 year period beginning January 1, 2005. Section 2902 of the Affordable Care Act indefinitely extends Section 630 of the MMA, retroactive to January 1, 2010. Effective January 1, 2005, claims for ambulance services submitted by hospital-based ambulance providers **and CAHs** shall be processed by the designated **A/B MAC**.*

All claims processing requirements in Chapter 15 of Pub. 100-04, Medicare Claims Processing Manual, shall apply to ambulance service claims submitted by IHS hospital-based ambulance providers **and ambulance service claims submitted by IHS CAHs**.

100.12.1 - FI - Outpatient Hospital-Based Ambulance Services - Medicare Part B - Payment Policy
(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

Medically necessary ambulance services submitted by hospital-based ambulance providers are reimbursed based on the ambulance fee schedule.

The Medicare Part B deductible and coinsurance apply to ambulance services, but are waived by the IHS.

See Chapter 15, §30.2.4 of Pub. 100-04, Medicare Claims Processing Manual, for more information on the payment of ambulance claims.

100.12.1.1 - FI - Outpatient Hospital-Based Ambulance Services - Medicare Part B - Claims Processing
(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

Outpatient ambulance bills from hospital-based ambulance providers are submitted with revenue code 054X (ambulance) with charges for ambulance, as well as the appropriate ambulance HCPCS codes on TOB 12X or 13X.

If an outpatient encounter occurs at the same time a covered ambulance service is provided, the hospital-based ambulance providers may bill for a clinic visit (revenue code 051X) as well as the ambulance charges (revenue code 054X) and will be paid separately for each service.

The MSN is suppressed.

100.12.2 - *A/B MAC* - CAH Ambulance Services - Medicare Part B - Payment Policy
(Rev. 2102, Issued: 11-19-10, Effective: 04-01-11, Implementation: 04-04-11)

*For dates of service on or after December 21, 2000 and prior to January 1, 2004, medically necessary ambulance services **provided by** an IHS CAH **or an entity that is owned and operated by the IHS CAH** are paid based on 100 percent of the reasonable cost if the 35 mile rule for cost-based payment is met. In order for the 35 mile rule to be met, the IHS CAH **or the entity that is owned and operated by the IHS CAH**, must be the only*

provider or supplier of ambulance services that is located within a 35 mile drive of *the IHS CAH or the entity. Those CAHs that meet the 35 mile rule for cost-based payment shall report condition code B2 (CAH ambulance attestation) on their bills.*

For dates of service on or after January 1, 2004, ambulance services furnished by an IHS CAH or by an entity that is owned and operated by the IHS CAH are paid based on 101 percent of reasonable cost if the 35 mile rule for cost-based payment is met.

When the 35 mile rule for cost-based payment is not met, *the ambulance services furnished by the IHS CAH or by the entity that is owned and operated by the IHS CAH* are paid based on the ambulance fee schedule.

The IHS CAHs shall notify the *A/B MAC* whether the ambulance service meets or does not meet the 35 mile ambulance rule.

The Medicare Part B deductible and coinsurance apply to ambulance services, but are waived by the IHS.

See Chapter 15, §30.2.3 of Pub. 100-04, Medicare Claims Processing Manual, for more information on the payment of ambulance claims.

100.12.2.1 - FI - CAH Ambulance Services - Medicare Part B -Claims Processing

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

Medically necessary ambulance services originating out of an IHS CAH with a hospital-based ambulance service are submitted with revenue code 054X (ambulance) with charges for ambulance, as well as the appropriate ambulance HCPCS codes on TOB 85X. IHS CAHs that meet the 35 mile rule for cost based payment shall report condition code B2 (CAH ambulance attestation) on their bills to the FI.

If an outpatient encounter occurs at the same time a covered ambulance service is provided, the IHS CAH may bill for a clinic visit (revenue code 051X) as well as the ambulance charges (revenue code 054X) and will be paid separately for each service.

The MSN is suppressed.

100.12.3 - FI - Ambulance Services - Medicare Part A - Payment Policy

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

If an inpatient is transferred to another hospital for services under arrangement, the ambulance services are not billable to Medicare. Reimbursement for such services is part of the inpatient stay and payment is included in the IPPS payment based on the DRG.

100.13 - FI - Other Screening and Preventive Services - Payment Policy

(Rev. 2075, Issued: 10-28-10, Effective: 01-01-10, Implementation: 01-28-11)

Effective January 1, 2005, payment is made by the FI based on the AIR to IHS providers, excluding CAHs, for screening and preventive services covered under §630 of the MMA, indefinitely extended by §2902 of the ACA. Payment is made to CAHs based on cost. Screening and preventive services covered under §630 of the MMA, indefinitely extended by §2902 of the ACA, include:

- Pelvic exam;
- Glaucoma screening;
- Bone mass measurements;
- Prostate cancer screening;
- Colorectal cancer screening;
- Screening pap smear;
- Screening mammography;
- Cardiovascular screening blood tests;
- Diabetes screening tests;
- DSMT;
- MNT;
- Initial physician physical exam (IPPE) – Welcome to Medicare; and
- Smoking and tobacco-use cessation (counseling/screening).

See Chapter 18, of Pub. 100-04, Medicare Claims Processing Manual, for more information on screening and preventive services.

100.13.1 - FI - Other Screening and Preventive Services - Claims Processing

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

The screening and preventive services listed in §100.13 of this chapter are reported on TOB 12X, 13X, or 85X with revenue code 0510 (clinic visit).

Services for screening pap smears are only payable by the FI when billed with a pelvic exam. Prostate cancer screening, cardiovascular screening blood tests and screening diabetes tests are only payable by the FI when billed with a clinic visit.

Chapter 18 of Pub. 100-04, Medicare Claims Processing Manual contains more information on the payment of screening and preventive services.

100.13.2 - FI - MNT - Payment Policy

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

Section 105 of BIPA permits Medicare coverage of MNT when furnished by a RD meeting certain requirements. See Chapter 4, §§300 through 300.6 of Pub. 100-04, Medicare Claims Processing Manual, for more information on these requirements.

If the RD providing the services is either an IHS hospital employee or has contracted with an IHS hospital to provide MNT services through the hospital outpatient department, the MNT services are to be provided in the hospital outpatient department or in a provider-based clinic. Payment is made by the FI based upon the AIR.

Since hospital outpatient MNT services provided by an RD are provided on hospital property under the auspices of the hospital, MNT services provided in the home do not fit the benefit as it is generally rendered when billing to the FI. The RD employed by an IHS hospital may not be paid for services provided in the beneficiary's home.

100.13.2.1 - FI - MNT - Claims Processing

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

The MNT services provided under the auspices of the hospital are reported to the designated FI under revenue code 0510 (clinic visit). The current MNT HCPCS codes are required for the both the assessment and reassessment. The MSN is suppressed.

See Chapter 4, §§300 through 300.6 of Pub. 100-04, Medicare Claims Processing Manual, for more information on the HCPCS codes used to bill MNT to the FI.

100.14 - FI - Laboratory Services

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

- Laboratory services furnished to IHS provider inpatients are combined with other inpatient services furnished and reported under revenue code 0100 (all-inclusive room and board plus ancillary) on TOB 11X. Payment is made for inpatient laboratory services under the PPS based upon DRGs.
- Inpatient hospital laboratory ancillary services are covered under Medicare Part B when coverage is no longer provided under Medicare Part A.

The IHS providers are paid for covered inpatient hospital laboratory ancillary services based upon an AIR. All inpatient ancillary charges are combined and reported under revenue code 024X (all-inclusive ancillary) on TOB 12X.

- Laboratory services furnished to IHS provider inpatients under arrangements are combined with other inpatient services furnished and reported under revenue code 0100 (all-inclusive room and board plus ancillary) on TOB 11X. Payment is made for inpatient laboratory services under the IPPS based upon DRGs.

The term “arrangements” means arrangements that provide that Medicare payment made to the provider that arranged for the services discharges the liability of the beneficiary or any other person to pay for those services. Medicare does not pay any provider or supplier other than the IHS provider for services furnished to a beneficiary who is an inpatient.

- Charges for laboratory services furnished to outpatients of IHS providers are combined with all other outpatient charges for the same date of service and reported under revenue code 0510 (clinic visit) on TOB 13X (tribal hospitals and hospital-based clinics) Payment is made on the outpatient per visit AIR (OMB rate).
- The IHS swing-bed facilities are paid according to the SNF PPS. SNF PPS payment includes payment for all medically necessary inpatient ancillaries, including laboratory services. Revenue code 0022 and HIPPS codes are reported on the bill along with the accommodation and ancillary revenue codes. All services are itemized and billed with the appropriate revenue code that describes the service on TOB 18X.
- Charges for covered inpatient laboratory services provided in a CAH are combined with all other inpatient charges and reported under revenue code 0100 (all inclusive room and board plus ancillary) on TOB 11X. Payment is based on 101 percent of the all inclusive facility specific per diem rate.
- Inpatient CAH laboratory ancillary services are covered under Medicare Part B when coverage is unavailable under Medicare Part A.

Charges for inpatient CAH laboratory services are combined with charges for other inpatient ancillary services and reported under revenue code 024X (all-inclusive ancillary) on TOB 12X. Payment is based on 101 percent of an all-inclusive facility specific per diem rate.

- Covered CAH outpatient laboratory service charges are combined with all other outpatient charges for the date of service and reported under revenue code 0510 (clinic visit) on TOB 85X. Payment is based on 101 percent of the facility specific per visit rate.
- Swing-bed laboratory service charges are combined with all other swing bed charges in IHS CAHs and are billed under revenue code 0100 (all-inclusive room and board plus ancillary) on TOB 18X. Payment is made on a cost based per diem amount.

100.15 - FI - Drugs

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

The IHS providers, including CAHs, are paid by the FI for covered drugs and biologicals provided during a covered inpatient hospital stay. All charges are combined and reported under revenue code 0100 (all-inclusive room and board plus ancillary) on TOB 11X. Payment is made to IHS/tribal hospitals under IPPS. IHS CAHs are paid 101 percent of the all inclusive facility specific per diem rate.

The IHS providers are paid by the FI for covered drugs and biologicals provided during a clinic visit. All charges are combined and reported under revenue code 0510 (clinic visit) on TOB 13X (IHS/tribal hospitals and hospital-based clinics) or TOB 85X (CAHs). Payment is made to IHS providers under the AIR. Payment is made to IHS CAHs based upon 101 percent of the all inclusive facility specific per visit rate.

The IHS hospital swing-bed providers are paid according to the SNF PPS payment methodology for covered drugs and biologicals provided during the IHS hospital swing-bed stay. Services are itemized and billed with the appropriate revenue code that describes the service on TOB 18X.

Payment to IHS CAH swing-bed providers for covered drugs and biologicals provided during an IHS CAH swing-bed stay is included in the all inclusive facility specific per diem rate.

Supply fees are also due when multi-day supplies of any of the following self-administered drugs are provided to IHS hospital outpatients or patients of a provider-based clinic: oral anti-cancer drugs, oral anti-emetic drugs, or immunosuppressive drugs. Following the same procedures that apply to non-IHS facilities, these multi-day supplies must be billed to the appropriate DME MAC in order to collect the supplying fee. The supplying fee must be billed on the same claim as the drug itself. For a 1 day supply of the above mentioned drugs, there is no supplying fee, the facility bills the designated FI and is paid the AIR for the outpatient visit. For an IHS CAH, payment for a 1 day supply of the drug is based on 101 percent of the all inclusive facility specific per visit rate. Fiscal intermediaries will also make payment for multi-day supplies of these particular drugs when provided to a beneficiary in an inpatient Part B stay in an IHS hospital, CAH, or SNF.

For additional information regarding billing for drugs and associated supplying fees, see Chapter 17, §80.7 of Pub. 100-04, Medicare Claims Processing Manual.

100.16 – FI--Payment for Telehealth Services to Indian Health Service/Tribal Facilities and Practitioners

(Rev. 1776, Issued: 07-24-09, Effective: 01-01-09, Implementation: 01-04-10)

For background on the telehealth benefit, see Chapter 12, §190.1 in this manual. For more information on the payment of Telehealth services, see Chapter 15 of the Benefit Policy Manual. Telehealth services fall into two categories: an originating site facility service in which the beneficiary is presented to the distant site practitioner, and a distant site service which is generally some type of professional consultation.

100.16.1 – FI – Telehealth Originating Site Facility Fee – Medicare Part B – Payment Policy

(Rev. 1776, Issued: 07-24-09, Effective: 01-01-09, Implementation: 01-04-10)

Effective January 1, 2009, IHS providers, including CAHs are paid separately from the AIR for the Telehealth Originating Site Facility Fee. HCPCS code Q3014 (“telehealth originating site facility fee”) is a Part B benefit. The fee is updated each calendar year by the Medicare Economic Index announced in the annual Physician Fee Schedule Final Regulation.

IHS providers are paid for HCPCS code Q3014 at the fee schedule payment, not the provider’s usual all-inclusive payment methodology (e.g., inpatient DRG or AIR or CAH per diem). For CAHs, the payment amount is 80 percent of the fee, not 101 percent of cost.

The Medicare Part B deductible and coinsurance apply to the Telehealth Originating Site Facility Fee, but are waived by the IHS.

100.16.2 – FI – Telehealth Originating Site Facility Fee – Medicare Part B – Claims Processing

(Rev. 1776, Issued: 07-24-09, Effective: 01-01-09, Implementation: 01-04-10)

The Telehealth Originating Site Facility Fee is reported on TOB 12X, 13X or 85X along with the revenue code 0780 and HCPCS code Q3014 as described in Chapter 12, Section 190 of Pub. 100-04, Medicare Claims Processing Manual.

No clinic visit shall be billed if this is the only service received. There is no requirement that a practitioner present the patient for interactive telehealth services.

The MSN is suppressed.

100.16.3 – FI -- Payment for Distant Site Practitioner Services

(Rev. 1776, Issued: 07-24-09, Effective: 01-01-09, Implementation: 01-04-10)

Distant site services are listed in §190.3 in Chapter 12 of this manual. These services are payable only by the FI to a Method II CAH. Payment is based on 80 percent of the MPFS. Deductible and coinsurance apply, but are waived by IHS.

The MSN is suppressed.

110 - Audit

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

110.1 - Audit of IHS Cost Reports

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

All IHS hospitals that convert to CAH status are subject to audit by the FI. CMS’ audit policy can be found in Chapter 8, Contractor Procedures for Provider Audit, of Pub. 100-06, Medicare Financial Management Manual.

The CAHs are reimbursed under the Medicare Principles of Reasonable Costs. These principles are set forth in the Provider Reimbursement Manual 15-1.

For IHS hospitals that do not convert to CAH status, their cost reports are not subject to audit by Medicare.

110.2 - Method E Cost Reports

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

The IHS has used the Method E cost report since it began filing cost reports with CMS in 1998. Method E is the method of cost apportionment which is used to calculate the all inclusive outpatient per visit rate and the all inclusive inpatient ancillary per diem rate. Both of these rates are paid under Part B of the Medicare Program. For a more detailed explanation see the Provider Reimbursement Manual 15-I, Chapter 22, §2208.

The Method E cost report filed by the IHS is a modified cost report that is applicable to AIR no charge structure hospitals. The modified cost report does not use all the worksheets of the regular hospital cost report form (Form CMS- 2552). The worksheets filed by IHS are worksheet S-Part I &II, S-2, S-3, A, A-6, A-8, A-8-1, B-Part I, B-Part III, and B-1. For more detailed information see Provider Reimbursement Manual 15-II, Chapter 36.

110.3 - Critical Access Hospitals

(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

All IHS hospitals that elect CAH status, and are certified as such, are reimbursed under the reasonable cost method of reimbursement. The all inclusive inpatient per diem rate, the all inclusive outpatient per visit rate, and the all inclusive inpatient ancillary per diem rate are calculated based upon the individual CAH's cost report filed with the FI. These rates are facility specific rates and are not to be confused with the AIRs published in the **Federal Register** by the IHS for each calendar year. A CAH cost report is subject to audit by its FI. The FI can disallow costs if those costs did not comply with the Principles of Cost Reimbursement published in the Provider Reimbursement Manual 15-1. Any costs disallowed are subject to appeal by the CAH. There is also a final settlement of an IHS CAH cost report. A final settlement necessitates the issuance of a Notice of Program Reimbursement (NPR) by the FI. The NPR advises the CAH if a balance is due the hospital or the program is due repayment. The NPR also advises the CAH of any cost disallowance, its appeal and reopening rights. It should be noted that an IHS hospital that is not a CAH does not receive an NPR and does not have a final settlement.

Effective for cost reporting periods beginning on or after January 1, 2004, payment for inpatient services, other than a distinct part unit, is 101 percent of the reasonable costs. Effective for cost reporting periods beginning on or after January 1, 2004, payment for outpatient services is 101 percent of the reasonable costs. For a detailed explanation concerning payments to CAHs, see 42 CFR, §413.70. For cost reimbursement principles

see 42 CFR Part 413 and Provider Reimbursement Manual 15-1. For Cost Reports see the Provider Reimbursement Manual 15-II, the chapter on hospital cost reports.

120 – Payment to Non-Indian Health Service Physicians by Indian Health Service (IHS) Providers for Teleradiology Interpretations (Rev. 1643, Issued: 12-05-08, Effective: 01-01-07, Implementation: 03-09-09)

The IHS providers may choose to purchase or otherwise contract for teleradiology interpretation from non-IHS practitioners. Two options are available for payment for these services.

- (1) Contractual Reassignment – Under this provision, non-IHS physicians can reassign their benefits to the IHS hospital where the technical component is performed. Non-IHS practitioners providing these services shall enroll with the designated A/B MAC contractor for IHS and complete a Form CMS-855-R form for each IHS hospital performing the test. Because of IHS status, state licensure and location of the physicians is not an issue and the designated A/B MAC contractor shall make payment based on the Medicare locality in which services are rendered in accordance with current jurisdictional pricing guidelines (see §80.2, paragraph 6 of this Chapter).

Purchased Test – The purchased test method is available for all purchased diagnostic tests including radiology, and the requirements are found in Chapter 1. Payment for teleradiology interpretations under the purchased test option does not require non-IHS physicians' enrollment with the designated A/B MAC contractor for IHS. All general jurisdictional and pricing rules apply for payment for these services.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R2102CP</u>	11/19/2010	Systems Changes Necessary to Implement “Technical Correction Related to Critical Access Hospital Services”, Section 3128 of the Affordable Care Act, Pub. 118-148	04/04/2011	7219
<u>R2075CP</u>	10/28/2010	Implementation of Section 2902 of the Patient Protection and Affordable Care Act (the Affordable Care Act) for Indian Health Service (IHS) Part B Services and All Inclusive Rate (AIR) Billing for Return Visits	01/28/2011	6908
<u>R1957CP</u>	04/28/2010	Update to the HCPCS Codes for Payment of Surgical Dressings to Indian Health Service (IHS) Providers	10/04/2010	6909
<u>R1776CP</u>	07/24/2009	Telehealth Services in Indian Health Service (IHS) or Tribal Providers	01/04/2010	6493
<u>R1643CP</u>	12/05/2008	Indian Health Service (IHS) Provider Payment to Non-IHS Physicians for Teleradiology Interpretations	03/09/2009	6162
<u>R1511CP</u>	05/23/2008	Indian Health Service (IHS) Hospital Payment for Calendar Year 2008	06/23/2008	6063
<u>R1446CP</u>	02/08/2008	Update to Common Working File (CWF) Edits 7284 and 7548	07/07/2008	5907
<u>R1325CP</u>	08/29/2007	Testing and Implementation of 2008 Ambulatory Surgical Center (ASC) Payment System Changes	01/07/2008	5680
<u>R1308CP</u>	07/20/2007	Testing and Implementation of 2008 Ambulatory Surgical Center (ASC) Payment System Changes – Replaced by Transmittal 1325	01/07/2008	5680
<u>R1040CP</u>	08/25/2006	Clarifications and Additions to Chapter 19, Indian Health Services (IHS) - Replaces Rev. 1027	09/11/2006	5230
<u>R1027CP</u>	08/11/2006	Clarifications and Additions to Chapter 19, Indian Health Services (IHS) - Replaced by Rev. 1040	09/11/2006	5230
<u>R706CP</u>	10/07/2005	Payment Methodology for Rehabilitation Services in IHS/Tribally Owned and/or Operated Hospitals and Hospital-Based Facilities	01/03/2006	3934
<u>R681CP</u>	09/16/2005	Guidelines For Payment of Vaccines	01/03/2006	3967

Rev #	Issue Date	Subject	Impl Date	CR#
		(Pneumococcal Pneumonia Virus (PPV), Influenza Virus, And Hepatitis B Virus) and Their Administration Provided By Indian Health Service (IHS) Tribally Owned and/or Operated Hospitals and Hospital Based Facilities		
<u>R633CP</u>	08/03/2005	Guidelines For Payment of Vaccines (Pneumococcal Pneumonia Virus (PPV), Influenza Virus, And Hepatitis B Virus) and Their Administration Provided By Indian Health Service (IHS) Tribally Owned and/or Operated Hospitals and Hospital Based Facilities	01/03/2006	3967
<u>R611CP</u>	07/22/2005	Payment Methodology for Rehabilitation Services in IHS/Tribally Owned and/or Operated Hospitals and Hospital-Based Facilities	01/03/2006	3934
<u>R461CP</u>	02/04/2005	Processing Durable Medical Equipment (DME) Orthotics, Prosthetics, Drugs, and Surgical Dressing Claims for Indian Health Services (IHS) and Tribally Owned and Operated Hospitals for Hospital Based Facilities including Critical Access Hospitals (CAHs)	07/05/2005	3674
<u>R430CP</u>	01/14/2005	Mandatory Assignment for MMA §630 Claims	07/05/2005	3587
<u>R241CP</u>	07/23/2004	Expansion of the scope of items and services for which payment may be made to IHS facilities and suppliers	01/03/2005	3288
<u>R201CP</u>	06/10/2004	Initial Publication of Chapter	Not Applicable	3302

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