Indian Health Service

Medicare Part A
Provider Outreach and Education

Published March 2009

Important

- The information contained in this presentation was current as of March 2009 and can be found in the *Indian Health Service Manual*. All manuals can be downloaded from:
  - http://www.trailblazerhealth.com/Publications/Manuals/Default.aspx?DomainID=1

Change Request (CR) 6300

- Payments on the Medicare Physician Fee Schedule (MPFS) for providers with multiple service locations:
  - Dated February 13, 2009.
  - CMS Internet-Only Manual (IOM), Pub. 100-04.
  - Transmittal 1681.
  - Different locations may be in a different payment locality than the parent provider.
  - The nine-digit ZIP code of the satellite facility is used to determine the locality.

Change Request (CR) 6300 (Cont.)

Services that are paid subject to the MPFS are adjusted based on the applicable payment locality. Medicare systems determine which locality applies using ZIP codes. In cases where the provider has only one service location, the payment locality used to calculate the fee amount is determined using the ZIP code of the master address contained in the Medicare contractors' provider file.

Roster Billing

Roster Billing

- Roster billing:
  - At least five beneficiaries on the same date are required.
  - The simplified (roster) claims filing procedure applies to providers other than Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) that conduct mass immunizations.
  - Mass immunizers attach a standard roster to a single preprinted UB-04 that contains the variable claims information regarding the service provider and individual beneficiaries.

Roster Billing (Cont.)

- The roster must contain, at a minimum, the following information:
  - Provider name and number
  - Date of service
  - Patient name and address
  - Patient date of birth
  - Patient sex
  - Patient Health Insurance Claim Number (HICN)
  - Beneficiary signature or stamped “signature on file”

Roster Billing (Cont.)

- For inpatient Part B services (12X and 22X), the following data elements are also
- needed:
  - Admission date
  - Admission type
  - Admission diagnosis
  - Admission source code
  - Patient status code

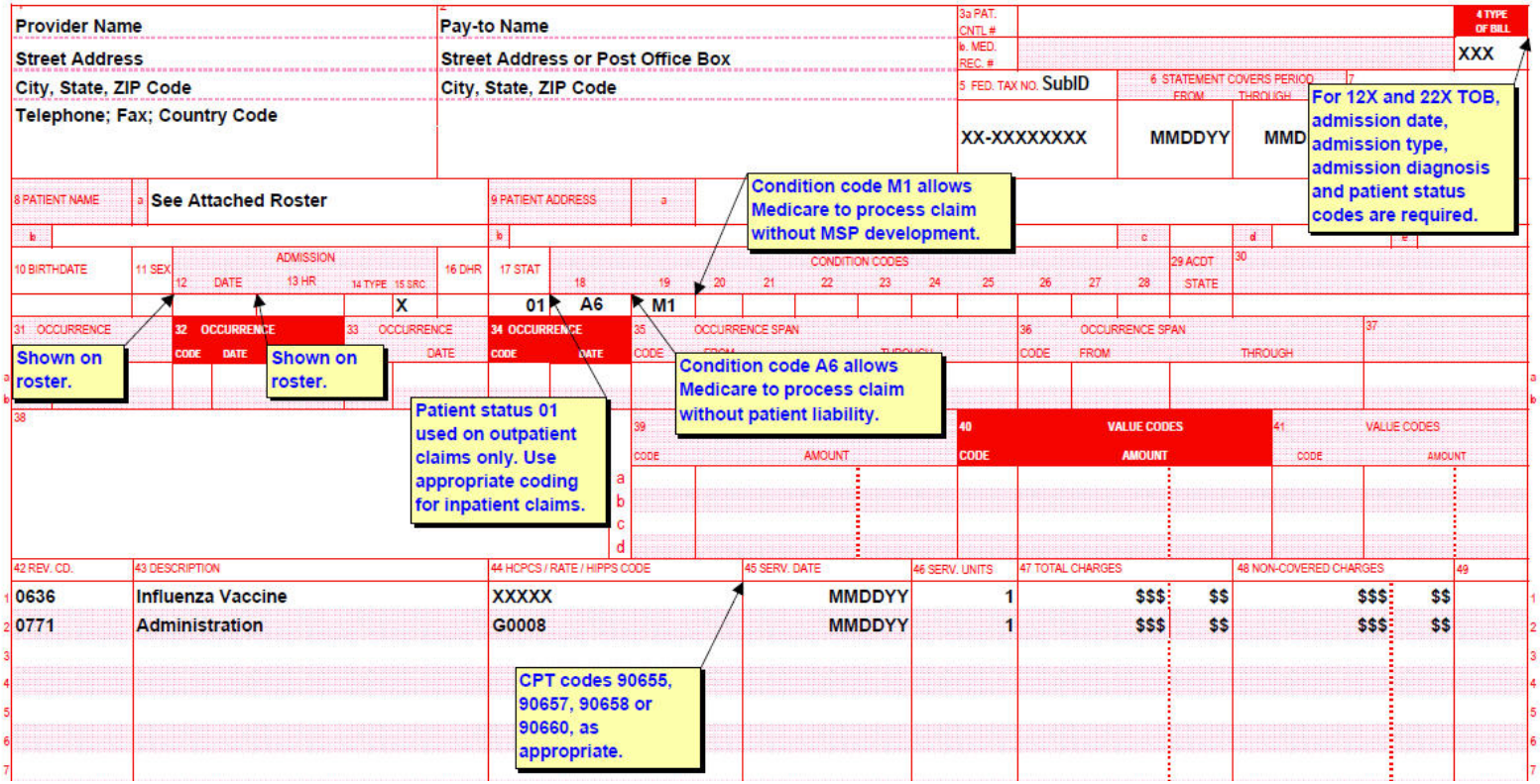
Roster Billing (Cont.)

- UB-04 shows the following preprinted information in the specific Form Locators (FLs):
  - The words “See Attached Roster” in FL 8a (Patient Name).
  - Patient status code 01 in FL 17 (Patient Status).
  - Condition code M1 in FLs 18–28 (Condition Code) (See note below).
  - Condition code A6 in FLs 18–28 (Condition Code).
  - Revenue code 0636 in FL 42 (Revenue Code), along with the appropriate HCPCS code in FL 44 (HCPCS Code).
  - Revenue code 0771 in FL 42 (Revenue Code), along with the appropriate HCPCS “G” code in FL 44 (HCPCS Code).

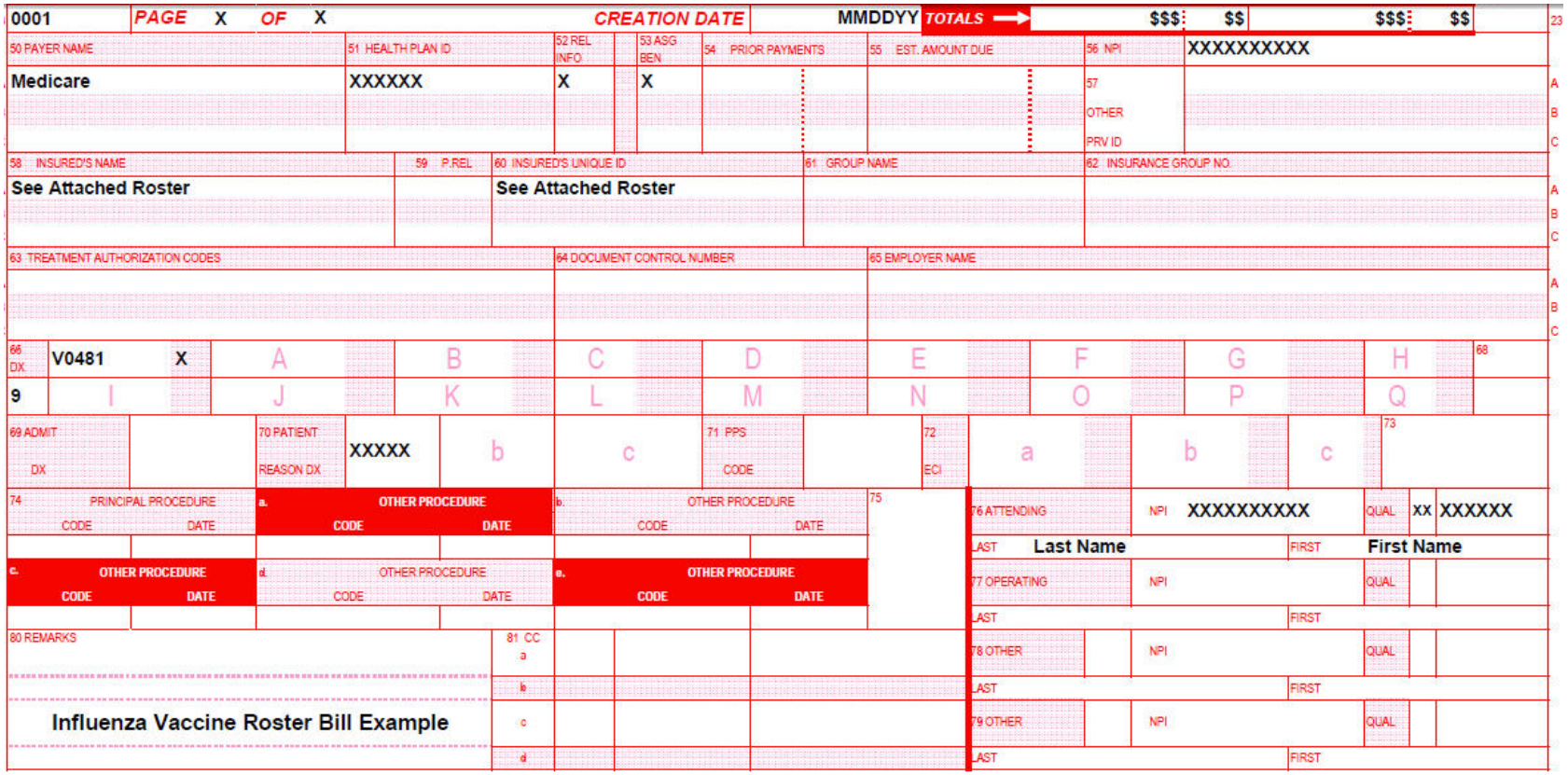
Roster Billing (Cont.)

- “Medicare” on line A of FL 50 (Payer).
- The words “See Attached Roster” on line A of FL 51.
- Diagnosis code V03.82 for PPV or V04.8 for influenza virus vaccine in FL 67 (Principal Diagnosis Code).
- The provider’s own National Provider Identifier (NPI) reported in the NPI field for the attending physician on claims submitted.
- The submission of an NPI for an ordering/referring provider is mandatory.
- After several attempts to obtain the NPI from the ordering/referring/attending/operating/other/service facility provider/purchased service provider, the provider or supplier who is furnishing the services or items shall report his own name and NPI in the Ordering/Referring/Attending/Operating/Other/Service Facility Provider/Purchased Service Provider fields on the claim.

Roster Billing (Cont.)



Roster Billing (Cont.)

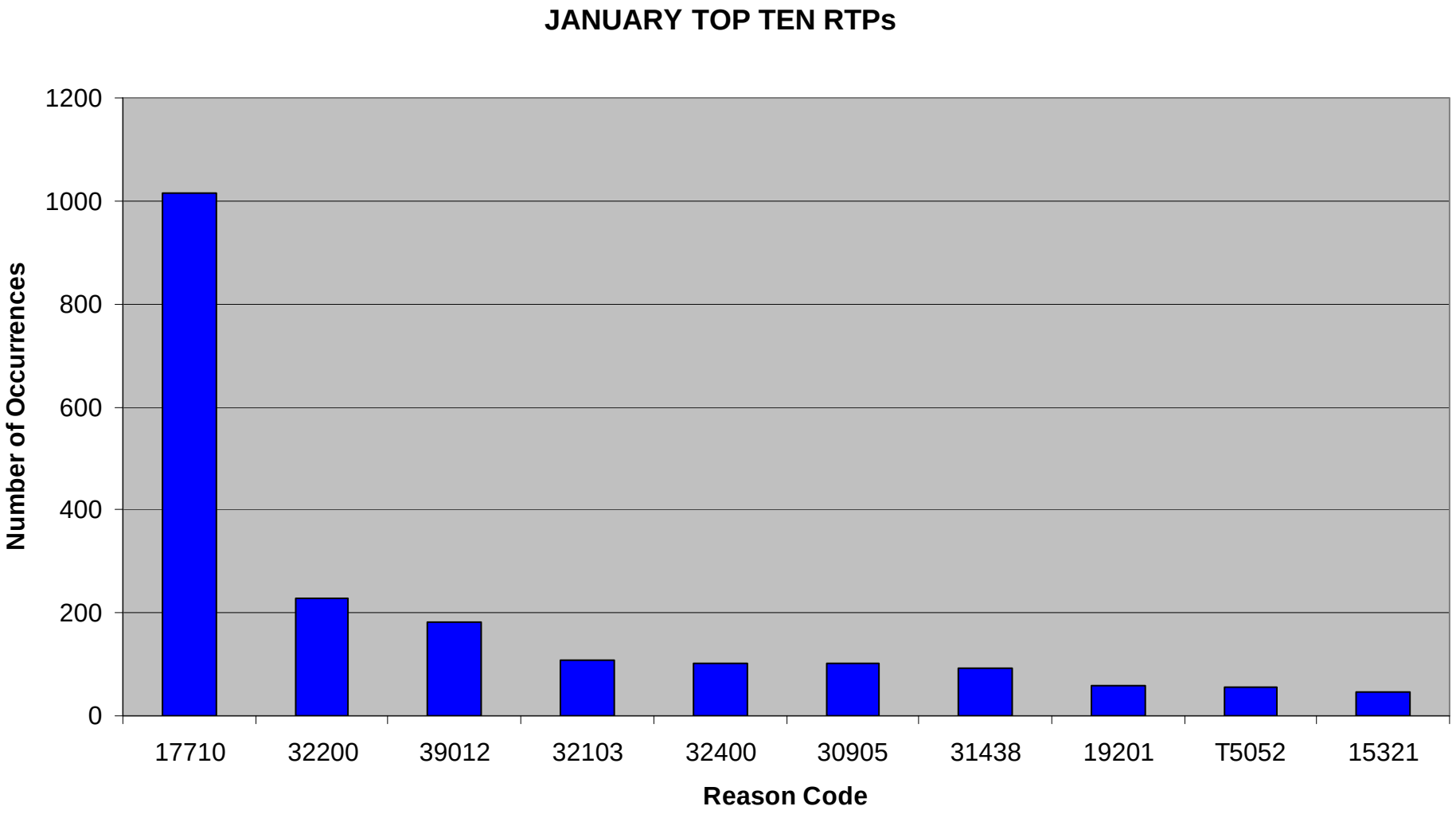


Roster Billing (Cont.)

	PATIENT INFORMATION					
	HIC Number	Last Name	First Name	Initial	Date of Birth	Gender
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						

Top Billing Errors

January 2009



January 2009 (Cont.)

- Top Return to Provider (RTP) errors:
  - 17710 – Outpatient claims may not contain ICD-9-CM procedure codes:
    - Resolution: Remove ICD-9-CM procedure codes from claim.
  - 32200 – Principal diagnosis codes V048 and/or V0382 are present without condition code A6:
    - Resolution: Add condition code A6 (FLs 18–28) on all influenza or pneumococcal vaccines.

January 2009 (Cont.)

39012 – Claim submitted past timeliness filing; justification is required:

- Resolution: Add remarks explaining the reason the claim is being filed outside the timely filing guidelines.

32103 – The NPI submitted on the claim is not on the NPI crosswalk:

- Resolution: If correct, the National Plan and Provider Enumeration System (NPPES) should be contacted to verify that the Online Survey Certification and Reporting (OSCAR)/Provider Identification Number (PIN) corresponds with the NPI in its files.

January 2009 (Cont.)

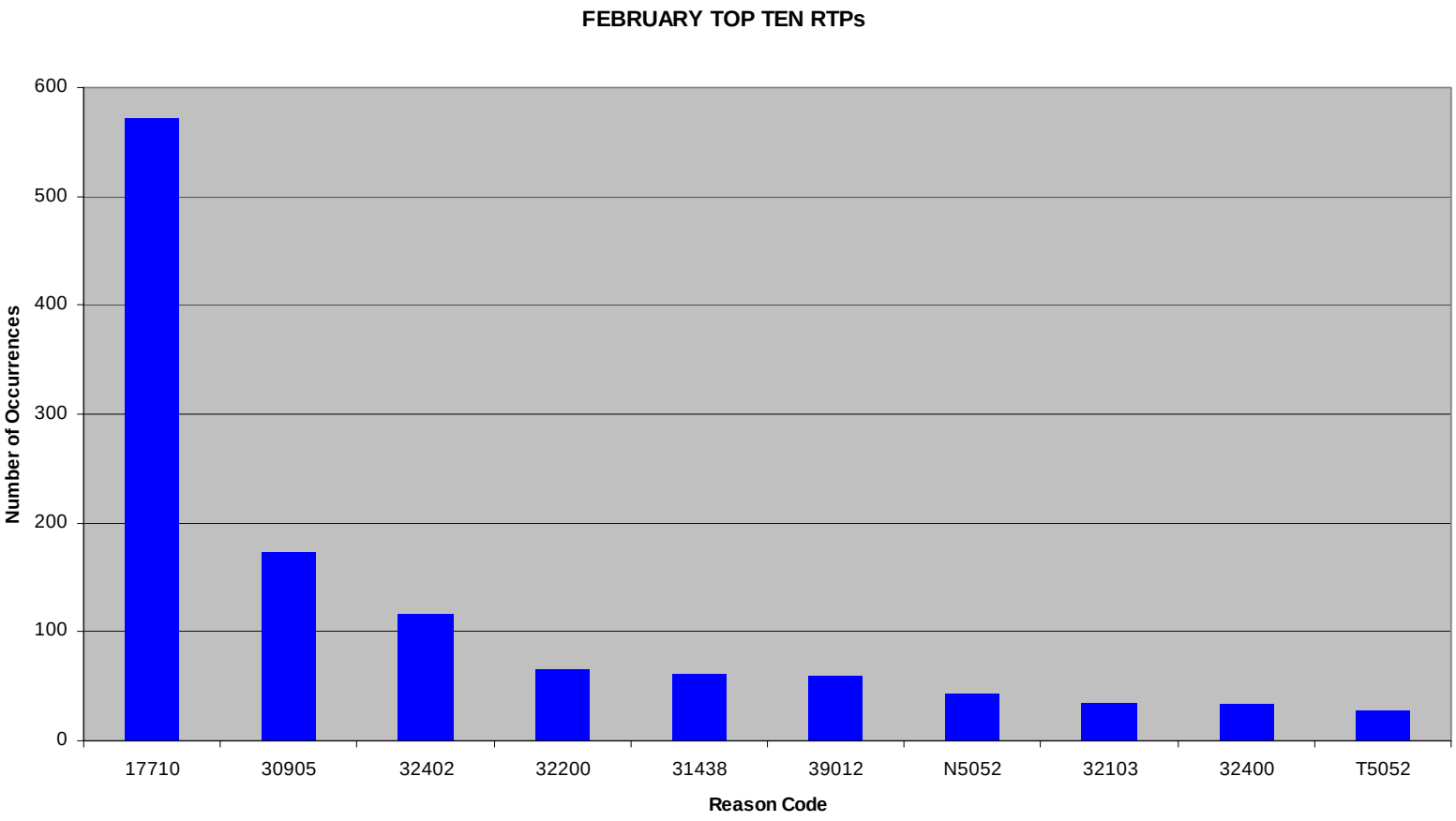
32400 – A HCPCS code is required for the line item being edited:

- Resolution: Add the appropriate HCPCS code to the line item in FL 44.

30905 – No record of processing an original claim for this adjustment:

- Resolution: Submit the claim as an original bill.

February 2009



February 2009 (Cont.)

- Top Return to Provider (RTP) errors:
  - 17710 – Outpatient claims may not contain ICD-9-CM procedure codes:
    - Resolution: Remove ICD-9-CM procedure codes from claim.
  - 30905 – No record of processing an original claim for this adjustment:
    - Resolution: Submit the claim as an original bill.

February 2009 (Cont.)

32402 – The HCPCS code is either missing or is invalid for the revenue code:

- Resolution: Verify that the HCPCS code submitted is valid; correct or add the HCPCS code in FL 44.

32200 – Principal diagnosis codes V048 and/or V0382 are present without condition code A6:

- Resolution: Add condition code A6 (FLs 18–28) on all influenza or pneumococcal vaccines.

February 2009 (Cont.)

31438 – A HCPCS code is required when condition code A6 is present on the claim:

- Resolution: Add the appropriate HCPCS code for influenza or pneumococcal vaccines.

39012 – Claim submitted past timeliness filing; justification is required:

- Resolution: Add remarks explaining the reason the claim is being filed outside the timely filing guidelines.

Billing Guidelines for Vaccines

- Vaccines:
  - If a physician sees a beneficiary for the sole purpose of administering the influenza virus vaccine, the pneumococcal vaccine, and/or the hepatitis B vaccine, they may not routinely bill for an office visit.
  - However, if the beneficiary actually receives other services constituting an “office visit” level of service, the physician may bill for a visit in addition to the vaccines and their administration, and Medicare will pay for the visit in addition to the vaccines and their administration if it is reasonable and medically necessary.

Billing Guidelines for Vaccines (Cont.)

- Billing guidelines for pneumococcal pneumonia:
  - Revenue codes:
    - 0636 Pharmacy, drugs requiring detailed coding
    - 0771 Preventive care services, vaccine administration
  - CPT/HCPCS codes:
    - 90732© Pneumococcal vaccine
    - G0009 Administration of pneumococcal vaccine

Billing Guidelines for Vaccines (Cont.)

- Diagnosis codes:
  - V0382 Pneumococcal vaccine
  - V063.6 Both pneumococcal vaccine and influenza vaccine
- Condition code:
  - A6

Billing Guidelines for Vaccines (Cont.)

- Billing guidelines for influenza virus:
  - Revenue codes:
    - 0636 Pharmacy, drugs requiring detailed coding.
    - 0771 Preventive care services, vaccine administration.
  - CPT/HCPCS codes:
    - 90655© Flu vaccine no preservative 6-35 months of age.
    - 90656© Flu vaccine no preservative 3 & older.
    - 90657© Flu vaccine, 6-35 months, im.
    - 90658© Flu vaccine age 3 & over, im.
    - 90660© Flu vaccine, nasal.
    - G0008 Administration of influenza virus vaccine.

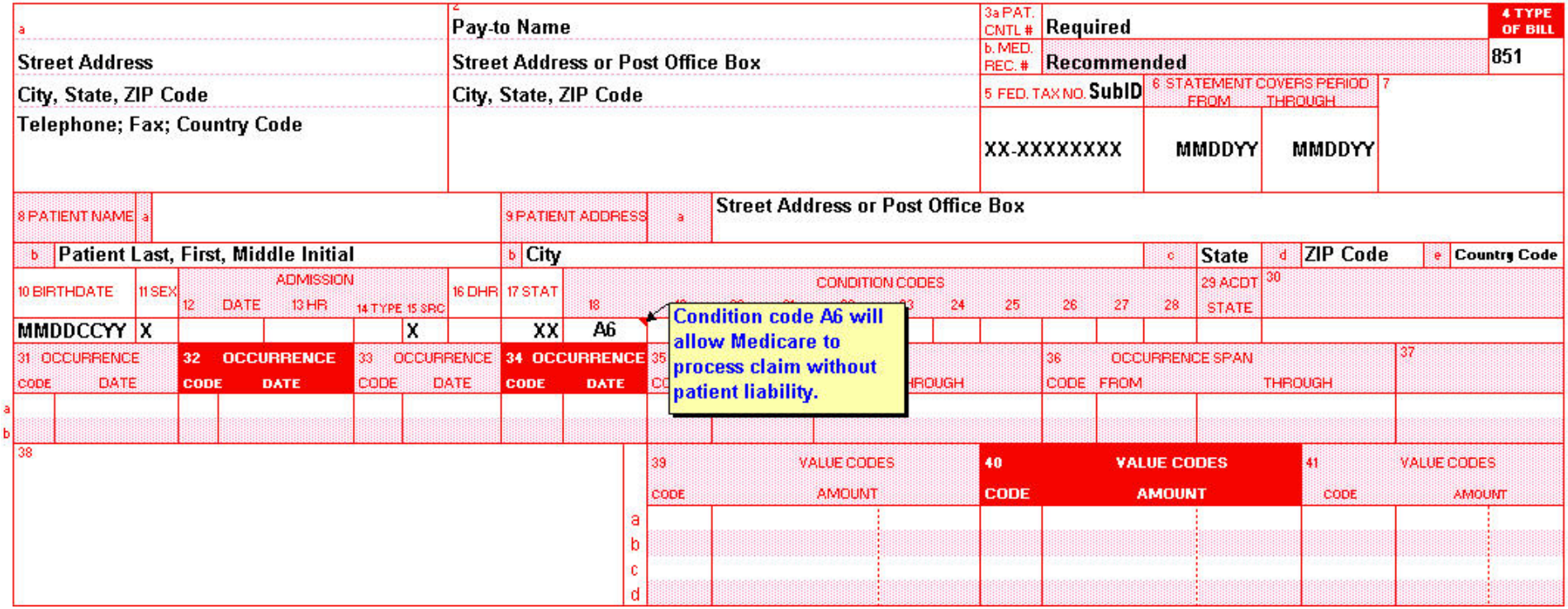
Billing Guidelines for Vaccines (Cont.)

- Diagnosis codes:
  - V0481 Influenza virus vaccine.
  - V063.6 Both pneumococcal vaccine and influenza vaccine.
- Condition code:
  - A6

Billing Guidelines for Vaccines (Cont.)

- Billing guidelines for hepatitis B virus:
  - Revenue codes:
    - 0636 Pharmacy, drugs requiring detailed coding.
    - 0771 Preventive care services, vaccine administration.
  - CPT/HCPCS codes:
    - 90740© Hep B vaccine, ill pat 3 dose im.
    - 90743© Hep B vaccine, adol, 2 dose, im.
    - 90744© Hep B vaccine, ped/adol 3 dose im.
    - 90746© Hep B vaccine, adult, im.
    - 90747© Hep B vaccine, ill pat 4 dose im.
    - G0010 Administration of hepatitis B vaccine.
  - Diagnosis code:
    - V053 Hepatitis B vaccine.

Flu and Clinic Example



Flu and Clinic Example (Cont.)

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES	49	
1	0636		90656	011009	1	10	00			1
2	0771		G0008	011009	1	15	00			2
3	0510		99212	011009	1	181	00			3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23	0001	PAGE # OF #		CREATION DATE	012009	TOTALS →	216	00		23

Repetitive Services

Repetitive Services

- IHS/tribal services that fall under repetitive services are:
  - Physical Therapy (PT)
  - Occupational Therapy (OT)
  - Speech-Language Pathology (SLP)
- For a complete listing of repetitive services, refer to CMS Pub. 100-04, Chapter 1, Section 50.2.2:

http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf

Physical Therapy

- PT billing:
  - Occurrence codes:
    - 11 – Onset of symptoms and illness
    - 29 – The date a plan was established or last reviewed for PT
    - 35 – The date treatment began for PT
  - Value code 50
    - Report the number of visits from onset
  - Revenue code 0420
  - Modifier GP

Occupational Therapy

- OT billing:
  - Occurrence codes:
    - 11 – Onset of symptoms and illness
    - 17 – The date a plan was established or last reviewed for OT
    - 44 – The date treatment began for OT
  - Value code 51
    - Report the number of visits from onset
  - Revenue code 0430
  - Modifier GO

Speech-Language Pathology

- SLP billing:
  - Occurrence codes:
    - 11 – Onset of symptoms and illness.
    - 30 – The date a plan was established or last reviewed for SLP.
    - 45 – The date treatment began for SLP.
  - Value code 52.
    - Report the number of visits from onset.
  - Revenue code 0440.
  - Modifier GN.

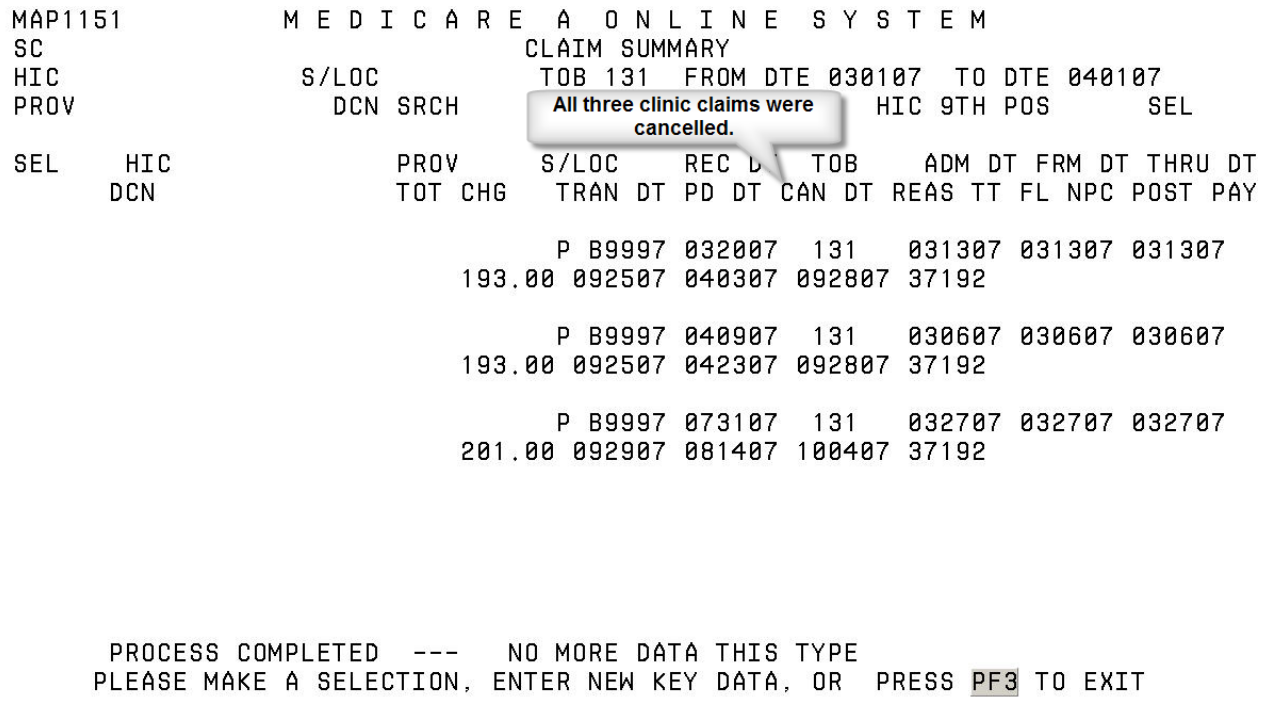
Repetitive Services

- When a patient has a clinic visit during a month when therapy services are being provided, IHS/tribal providers are required to include the outpatient visit on the monthly repetitive claim.
- If two separate claims are submitted, only one claim will be processed.
- Second claim will be rejected as a duplicate claim. An adjustment will need to be initiated on the processed claim.

Provider Example

- Claims summary for one patient.
- All clinics were canceled and remarks section reads, “Canceling to submit PT on one claim.”
- No claim was ever submitted to show three clinic visits and the therapy services.
- A provider loss in revenue of $579 for the clinic visits.
- A provider loss in revenue of a minimum of $125 for the therapy visits.

Provider Example (Cont.)



Provider Example (Cont.)

```
MAP1033       M E D I C A R E - A   O N L I N E   S Y S T E M       PAGE 03
SC                           UB92 CLAIM INQUIRY             REV CD PAGE 01
DCN                         HIC               RECEIPT DATE 060408  TOB 138
STATUS P  LOCATION B9997    TRAN DT 060608    STMT COV DT 031607   TO 031607
   ESRD HRS:        PAT TERM ILL:       MULTI-LAB:       BENEFIT SAVINGS: N
                   SERV             TOT    COV
CL   REV   HCPC MODS DATE       RATE  UNIT   UNIT    TOT CHRG    COV CHRG  NCOV CHRG
 1 0510 99211       0316   193.000     1      1      193.00     193.00
 2 0001                                              193.00     193.00




                                  ===== ===== ========== ========== ==========
                           TOTALS     1     1     193.00     193.00       0.00
37204                                                         <== REASON CODES
    PRESS PF2-103I   PF3-EXIT   PF5-UP   PF6 DOWN   PF7-PREV   PF8-NEXT   PF11-RIGHT
```

Provider Example (Cont.)

```
MAP1037        M E D I C A R E - A   O N L I N E   S Y S T E M        PAGE 07
SC                          UB92 CLAIM INQUIRY              REMARKS PAGE 01
DCN                        HIC               RECEIPT DATE 060408  TOB 138
STATUS P  LOCATION B9997   TRAN DT 060608    STMT COV DT 031607   TO 031607

                          A T T A C H M E N T S
     N  HOME HEALTH          N  PACEMAKER             N  THERAPY PT
     N  AIR/AMBULANCE        N  OP REHAB / THERAPY OT N  THERAPY RT
     N  THERAPY ST           N  THERAPY CR            N  THERAPY MS
     N  THERAPY PS           N  THERAPY SN            N  ESRD ATTACH

 REMARKS:
CANCEL PAYMENT IN ORDER TO INCLUDE ONTO PHYSICAL THERAPY VISIT.




37204                                                  <== REASON CODES
      PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF7-PREV   PF8-NEXT
```

Loss of Revenue

- Example:
  - The provider should submit one claim with the three clinic visits and the therapy visits for the month of March.
  - Provider will receive the All-Inclusive Rate (AIR) for the three clinic visits and the Medicare Physician Fee Schedule (MPFS) for the therapy services.
  - Income revenue of at least $700.

How to Void a Claim

Voiding Claims

- Steps to adjust/void claims:
  - Void all but one claim that was billed during the month.
  - When the voided claims show up on a remittance advice, adjust the remaining claim to include:
    - The two voided clinic visits.
    - All therapy visits within that month.

Voiding Claims (Cont.)

- To void/cancel a claim, remember that:
  - A void/cancel transaction can be processed electronically.
  - A bill can only be voided if it has finalized and is reflected on the remittance advice.
  - A void transaction indicates the elimination of a previously submitted bill.
  - It must be for a specific provider, specific statement dates, patient, payer, etc.
  - A void bill is sometimes followed with a new corrected bill when an adjustment is not appropriate.

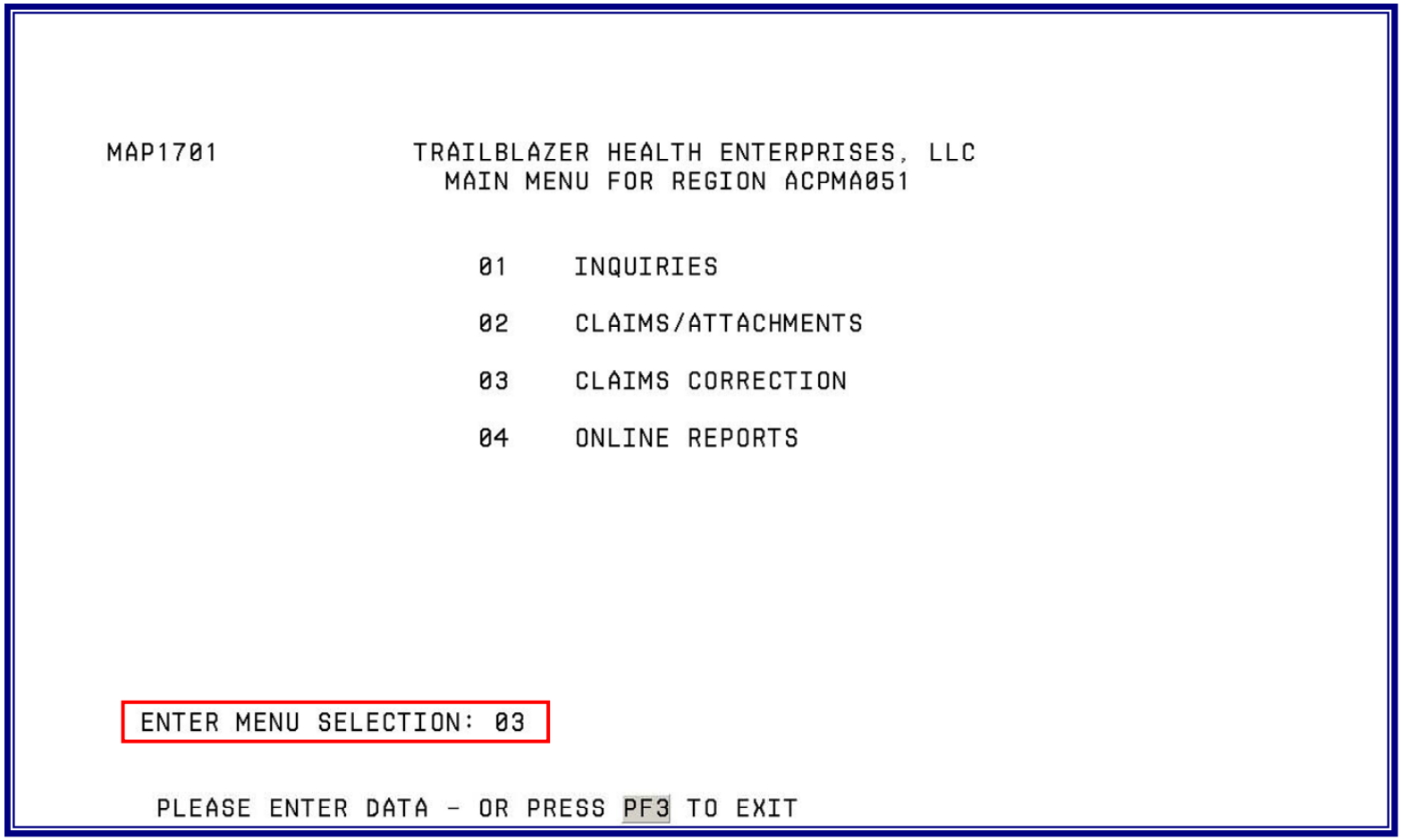
Voiding Claims (Cont.)

- Cancellations are a three-step process:
  - Press “Tab” to the Condition Code field and indicate why the claim is being cancelled by entering the claim change reason code in the first available Condition Code field on claim page 1.
  - Add remarks if necessary as to why the claim is being cancelled.
  - Press “F9” to save the cancellations.

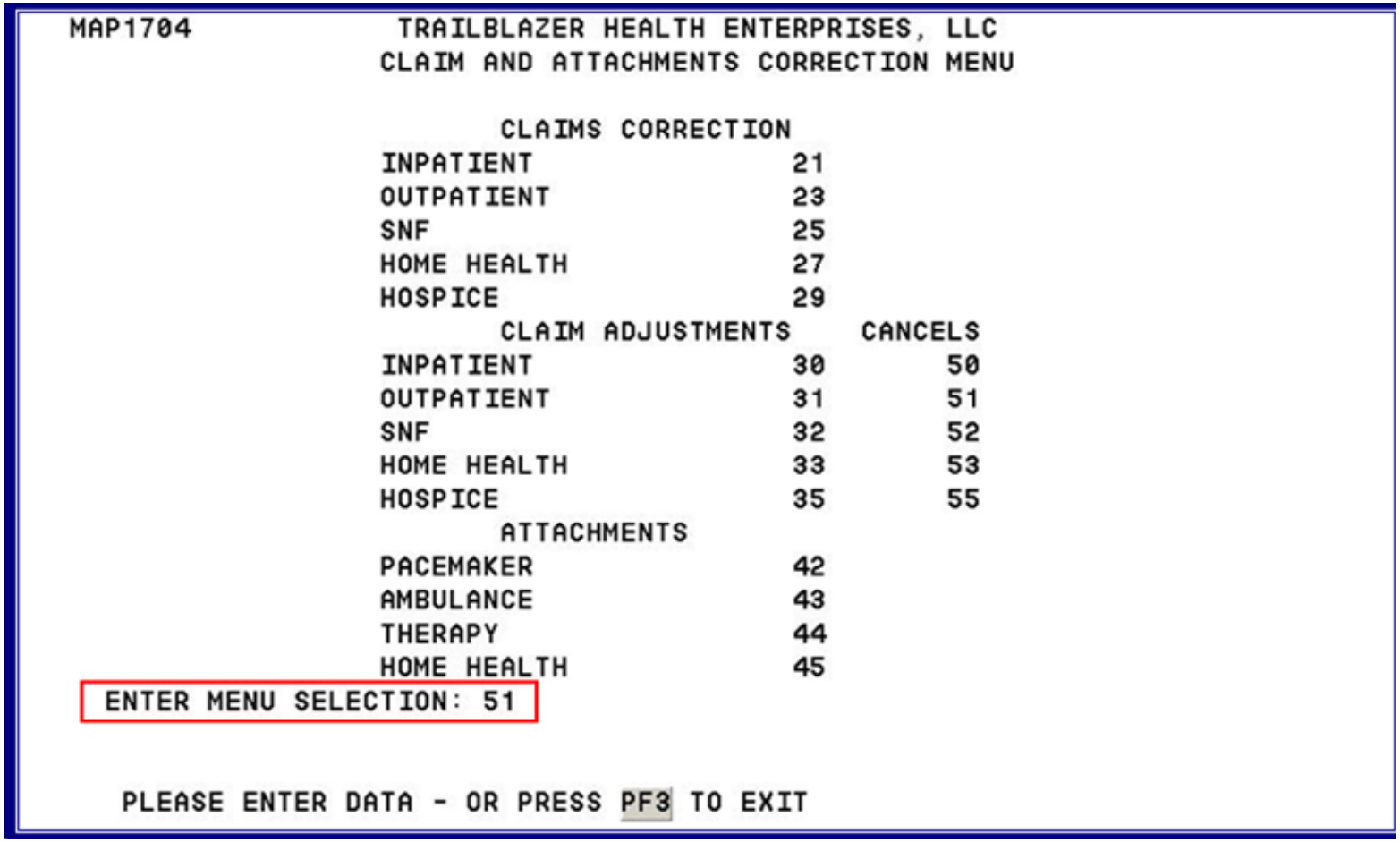
Voiding Claims (Cont.)

- To void/cancel a paid claim:
  - Enter the Claim Cancels option that matches your provider type and press “Enter.”
  - The S/LOC field defaults to “P.”

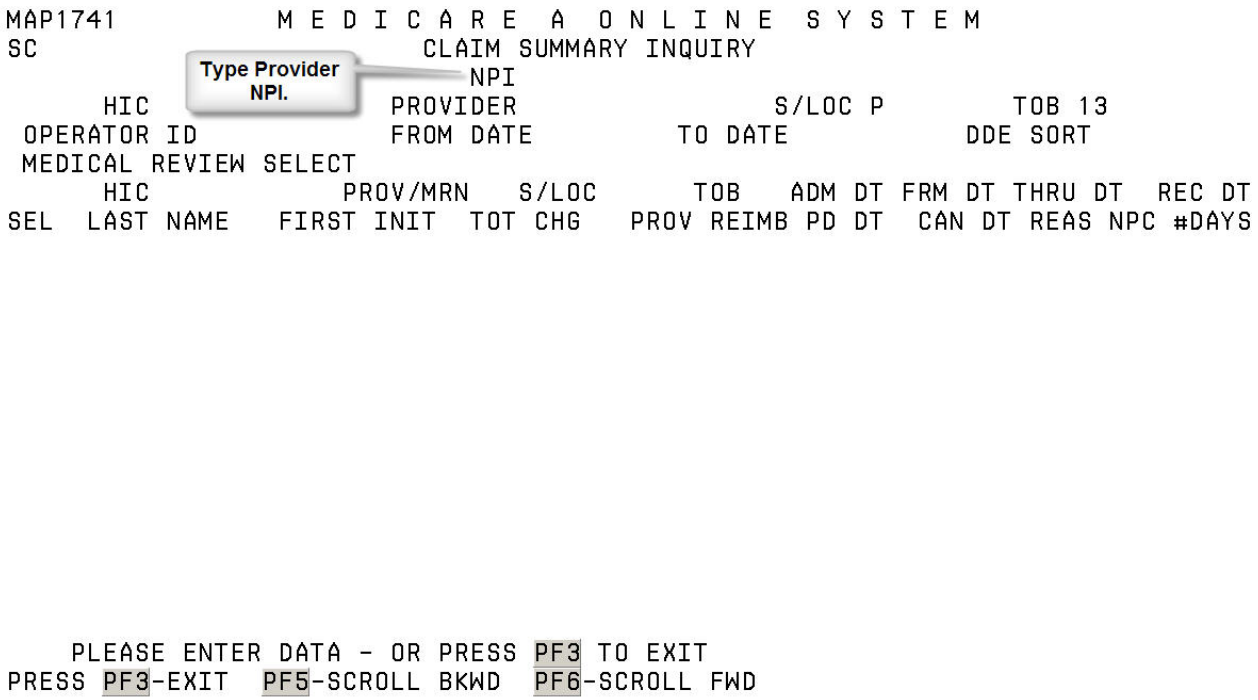
Voiding Claims (Cont.)



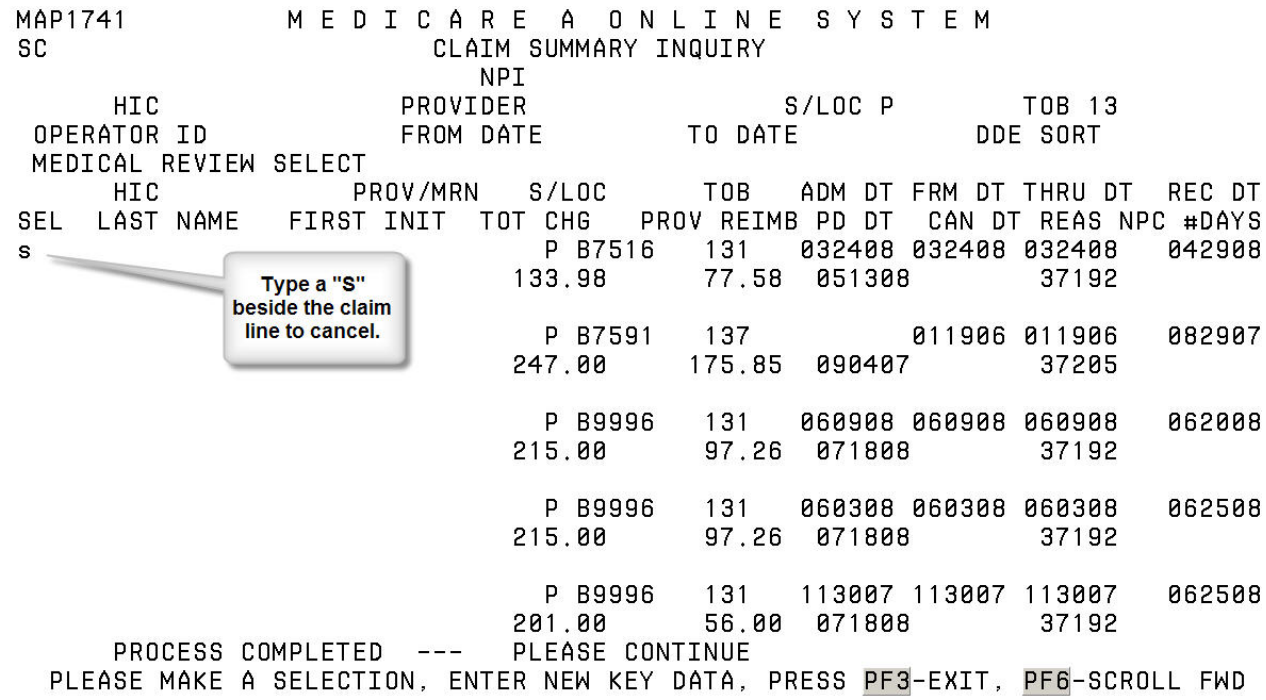
Voiding Claims (Cont.)



Void/Cancel Procedures



Void/Cancel Procedures (Cont.)

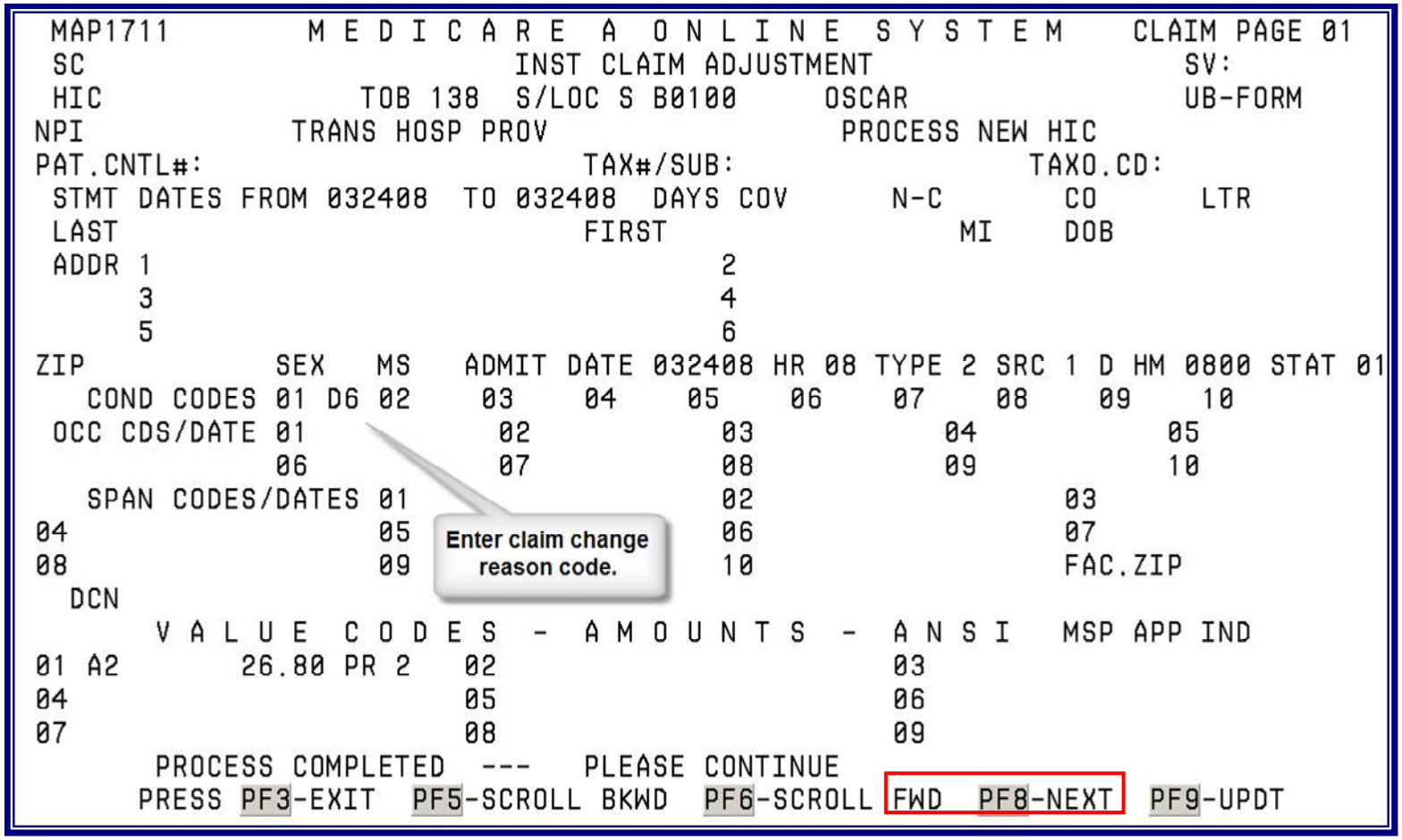


Void/Cancel Procedures (Cont.)

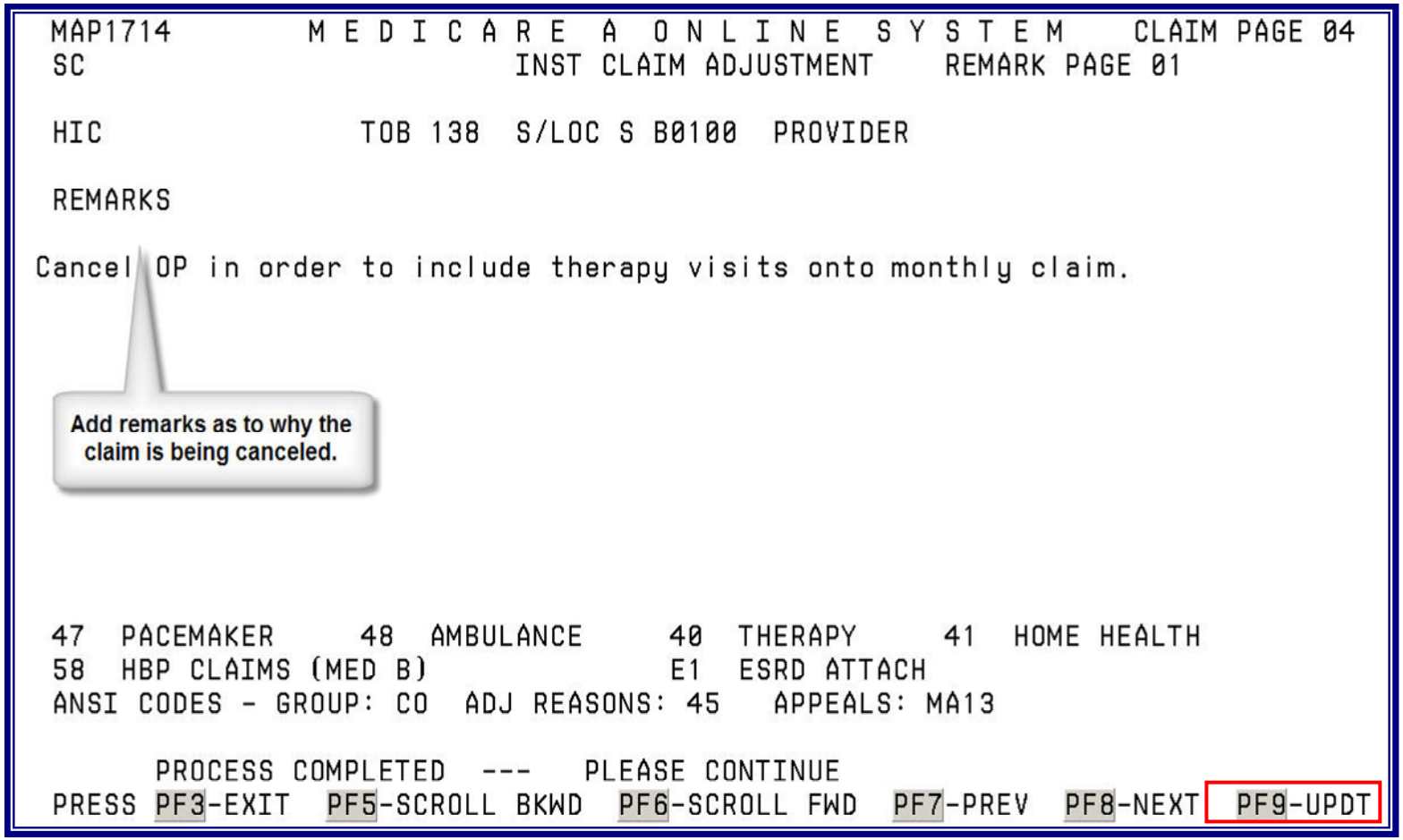
- Enter the claim change reason code in the first available Condition Code field on claim page 1. Valid claim change reason codes for cancellations are:
  - D5 – Cancel only to correct an HIC number or CMS Certification Number (CCN).
  - D6 – Cancel only to repay a duplicate payment or correct an error.

  Note: No other changes can be made on a void.
- Press “F8” twice to forward to claim page 3.

Void/Cancel Procedures (Cont.)



Void/Cancel Procedures (Cont.)



Void/Cancel Procedures (Cont.)

- Press “F9.”
- If the system automatically takes you back to MAP 1741, you have successfully submitted the void.
- Select the next claim to cancel, or press “F3” to return to the Claims Correction Menu.
- If you are not returned to MAP 1741 automatically, errors exist. Press “F1” to see the narrative for the reason code that displays in the lower left corner of the screen.
- When you have finished reviewing the narrative, press “F3” one time to return to the claim. Make your correction and press “F9.” Repeat the process (F1, F3, F9) until you return to MAP 1741.

Claims Adjustment

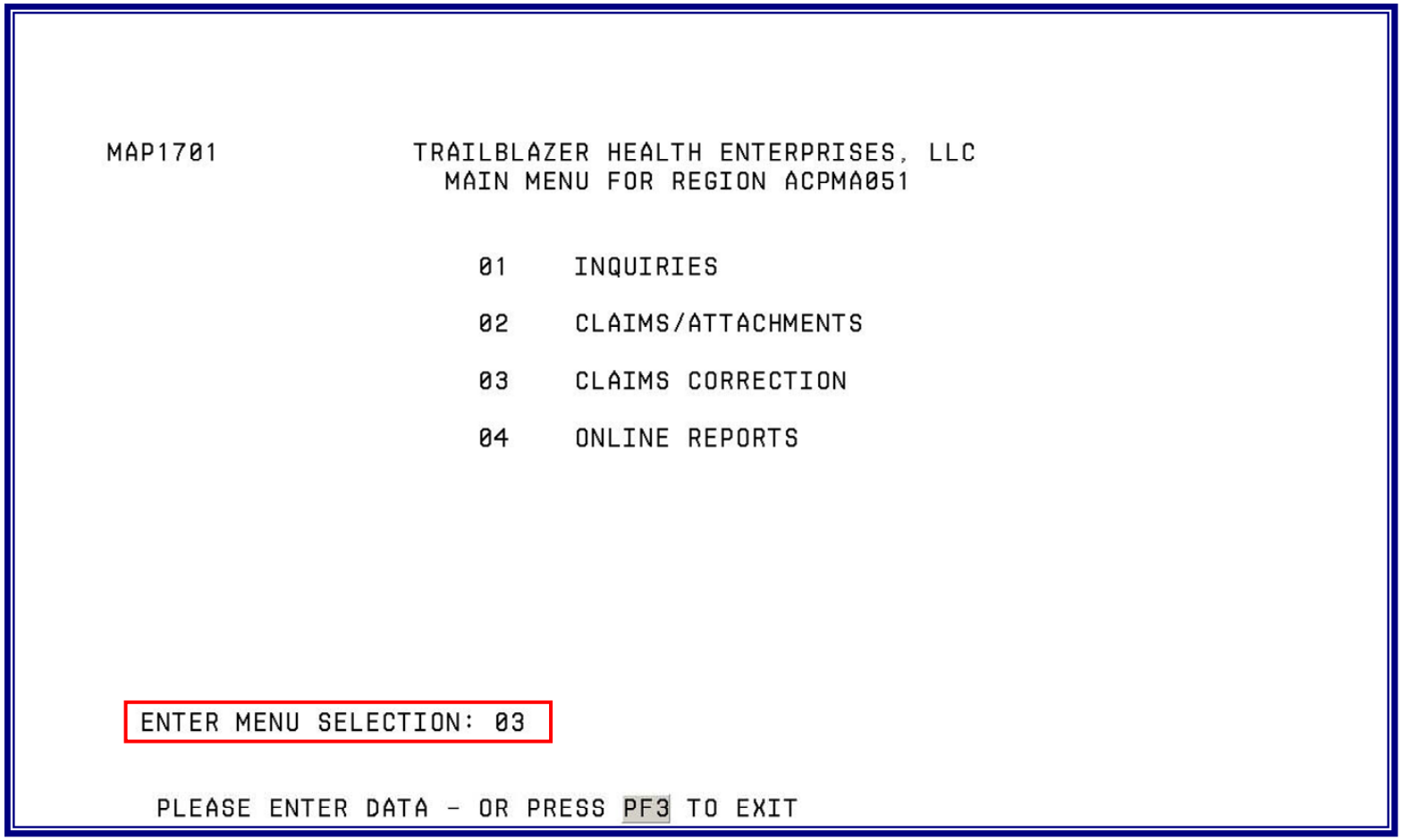
Adjusting Claims

- Adjustments are a four-step process:
  - Enter a claim change reason code on claim page 1.
  - Enter an adjustment reason code on claim page 3.
  - Make your adjustment on the applicable page(s) and add remarks on claim page 4 if necessary.
  - Press “F9” to save the adjustment.

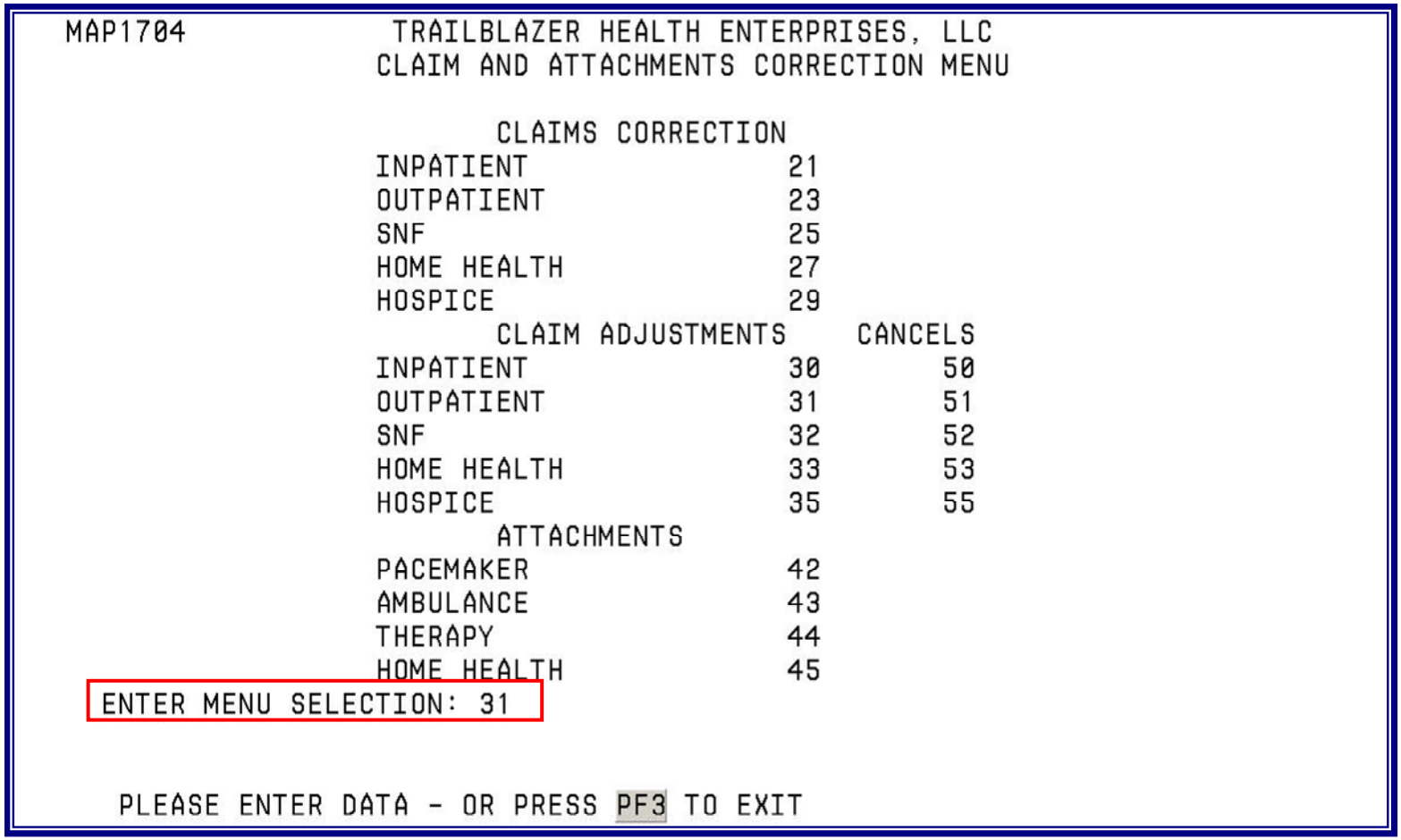
Adjusting Claims (Cont.)

- Main Menu:
  - To adjust paid claims, enter the claims adjustment option that matches your provider type and press “Enter.”
  - The Claim Summary Inquiry screen (MAP 1741) will appear.

Adjusting Claims (Cont.)



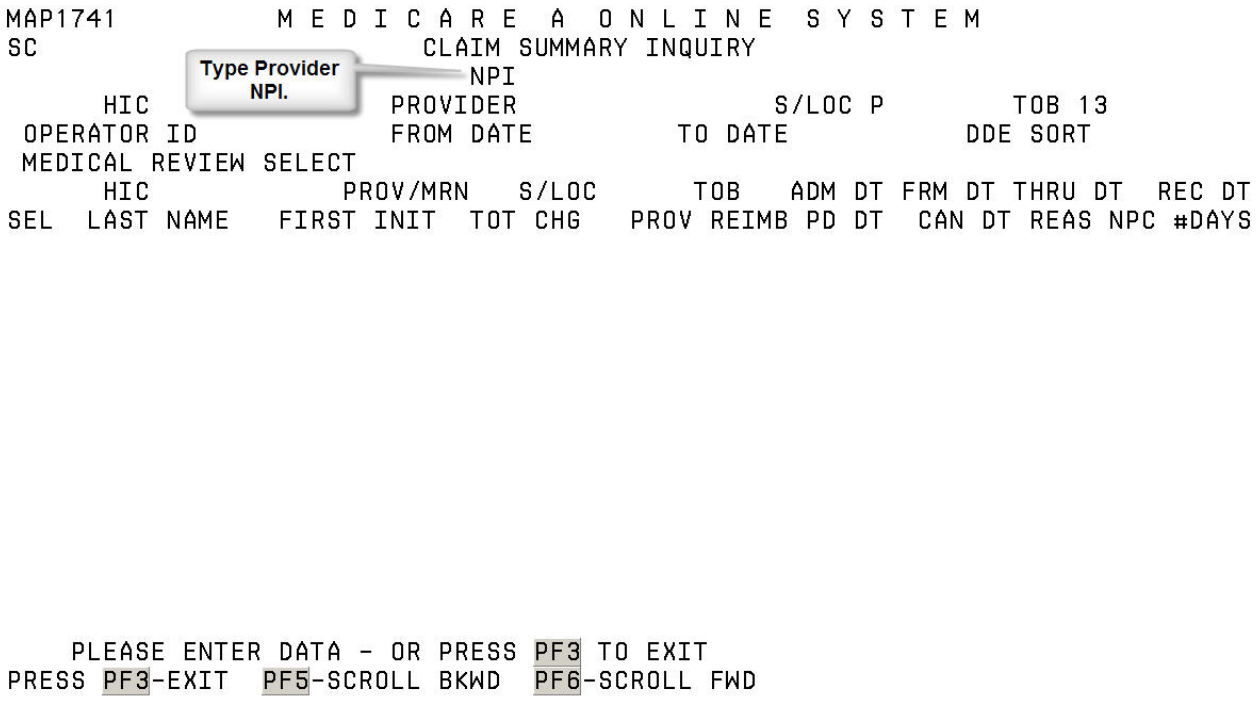
Adjusting Claims (Cont.)



Adjusting Claims (Cont.)

- Claim Summary screen:
  - Enter the provider's NPI.
  - Press "Enter."
  - The S/LOC field defaults to "P" to display claims in a "P" (Processed) status/location.
  - To display claims in an "R" (Reject) status/location, type "R" in the S/LOC field.

Adjusting Claims (Cont.)



Adjusting Claims (Cont.)

- Type the beneficiary's HIC number in the HIC field.
- Press "Tab" to the S/LOC fields and enter "B9997" after the "P" or "R."
- Change the type of bill, if necessary.
- You may also enter the "from" and "through" dates. Press "Enter."
- To select a claim, press "Tab" until the cursor moves under the SEL field and is to the left of the HIC number of the claim you want to adjust.
- Type "S" in the SEL field and press "Enter." After pressing "Enter," claim page 1 (MAP 1711) appears.

Adjusting Claims (Cont.)

```
MAP1741          M E D I C A R E  A  O N L I N E  S Y S T E M
SC                        CLAIM SUMMARY INQUIRY
                             NPI
      HIC                PROVIDER                 S/LOC P        TOB 13
 OPERATOR ID             FROM DATE          TO DATE           DDE SORT
 MEDICAL REVIEW SELECT
      HIC             PROV/MRN   S/LOC      TOB   ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME   FIRST INIT  TOT CHG   PROV REIMB PD DT  CAN DT REAS NPC #DAYS
s                               P B7516   131   032408 032408 032408   042908
                              133.98      77.58  051308         37192

                                P B7591   137          011906 011906   082907
                              247.00      175.85 090407         37205

                                P B9996   131   060908 060908 060908   062008
                              215.00      97.26  071808         37192

                                P B9996   131   060308 060308 060308   062508
                              215.00      97.26  071808         37192

                                P B9996   131   113007 113007 113007   062508
                              201.00      56.00  071808         37192
     PROCESS COMPLETED  ---   PLEASE CONTINUE
  PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, PRESS PF3-EXIT, PF6-SCROLL FWD
```

Type a "S" to select the claim for adjustment.

Adjusting Claims (Cont.)

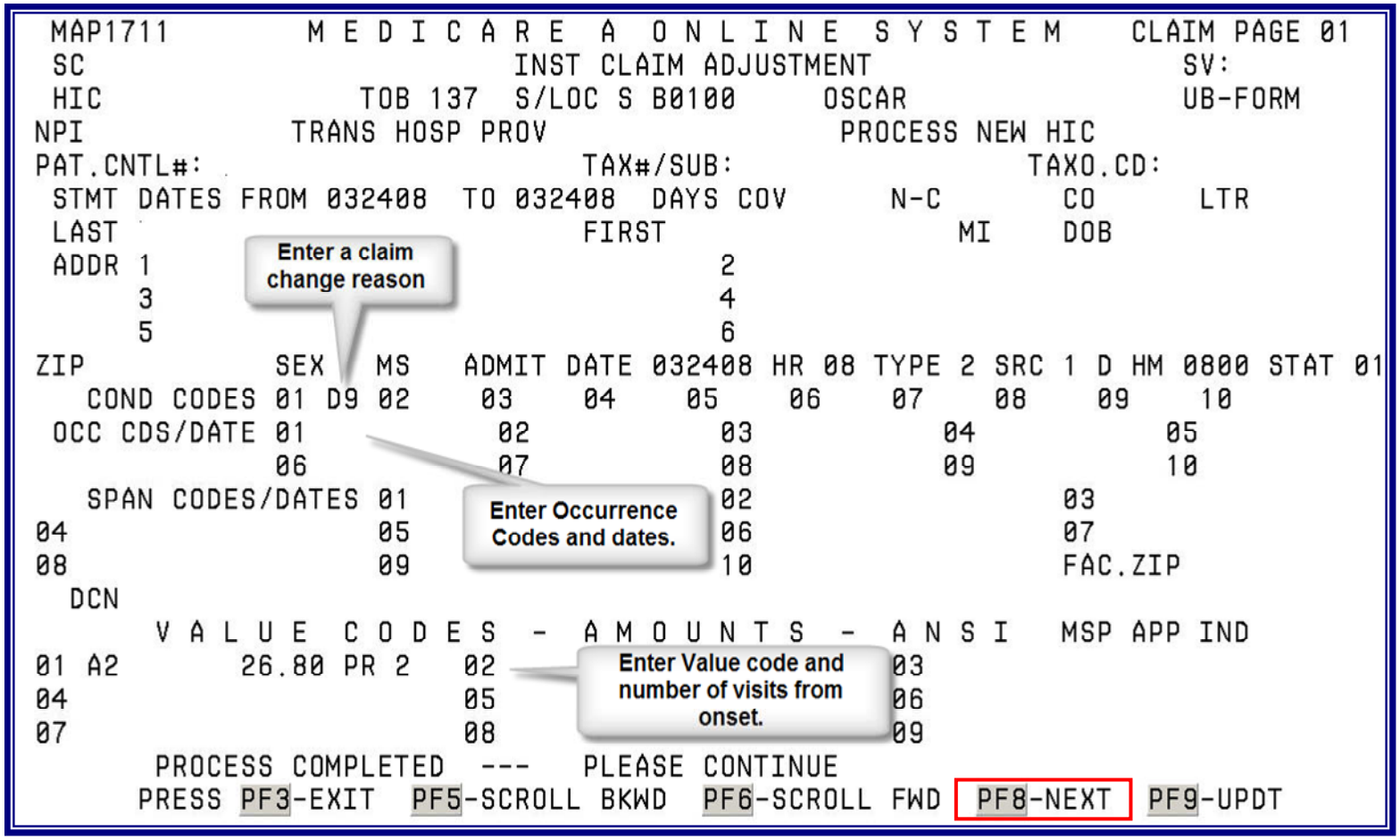
- Claim page 1:
  - Press “Tab” to the Condition Code field and indicate why the claim is being adjusted by entering the claim change reason code in the first available Condition Code field on claim page 1.
  - Only one code is allowed per claim.
  - Press “F8” to page 3.

Adjusting Claims (Cont.)

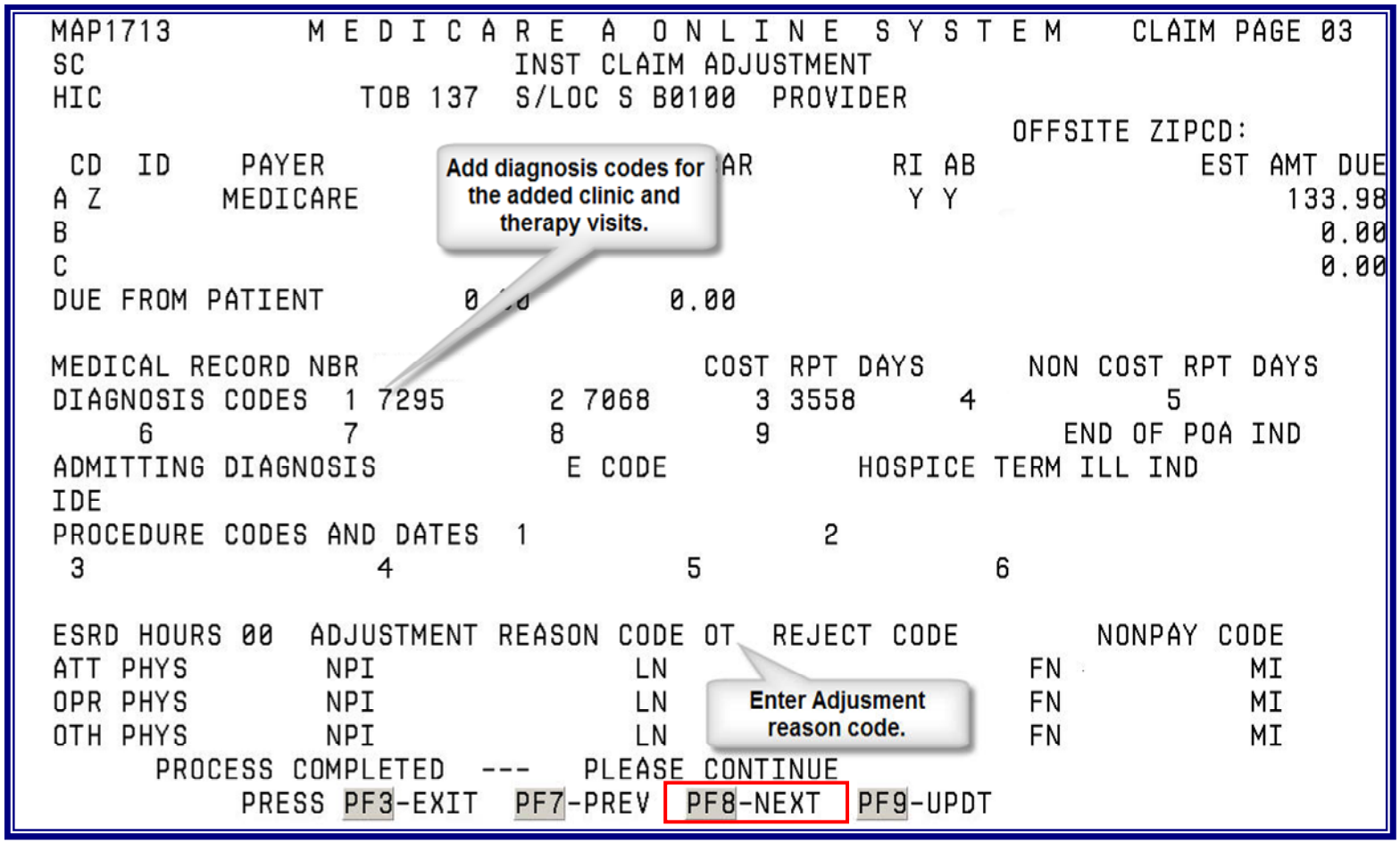
Valid claim change reason codes are:

- D0 – Changes to service dates.
- D1 – Changes to charges.
- D2 – Changes to revenue codes/HCPCS.
- D3 – Second or subsequent interim PPS bill.
- D4 – Change in Grouper input.
- D7 – Change to make Medicare the secondary payer.
- D8 – Change to make Medicare the primary payer.
- D9 – Any other change.
- E0 – Change in patient status.

Adjusting Claims (Cont.)



Adjusting Claims (Cont.)

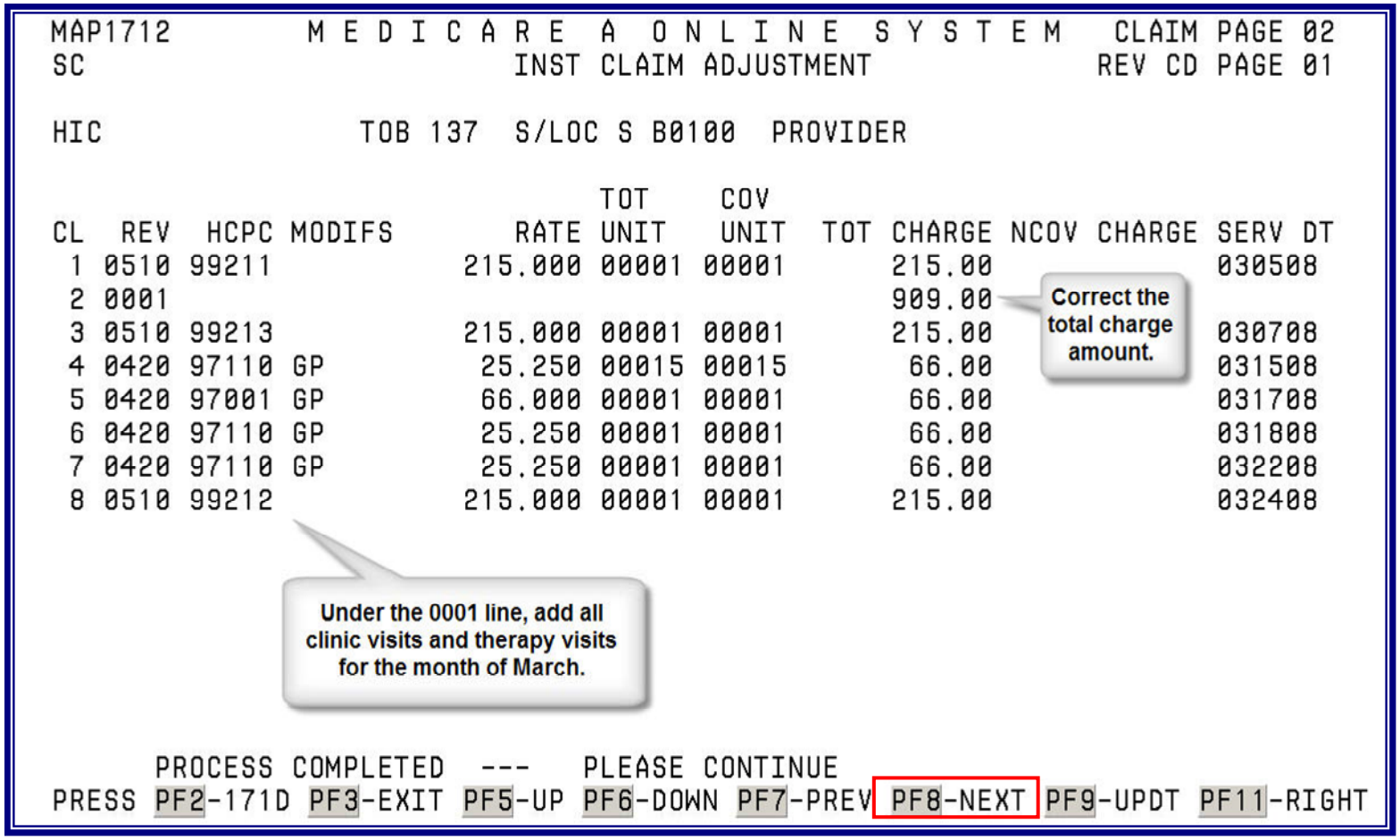


Adjusting Claims (Cont.)

Claim page 2:

- Key the added revenue code line after the 0001 line.
  - Add all therapy visits under revenue code line 0001.
  - Add any other clinic visits that occurred during the month.
- Correct the total charge amount to reflect the addition of the revenue code charges.

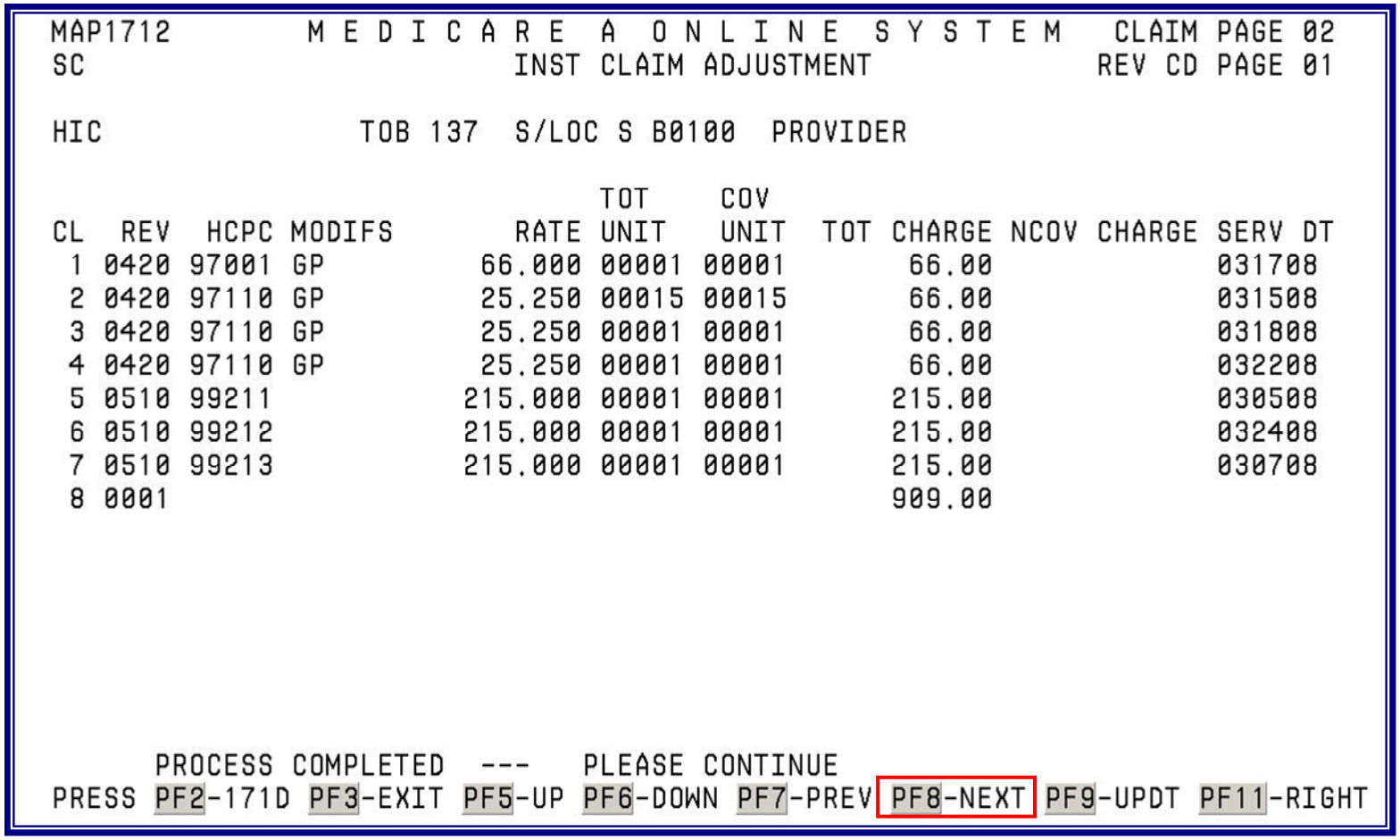
Adjusting Claims (Cont.)



Adjusting Claims (Cont.)

- Press “Home” so that the cursor is placed in the upper right corner of the screen (the Claim Page field).
- Press “Enter.” FISS will automatically reorder the revenue code that you added to appear before the 0001 line.
- Press “F8” to claim page 4.

Adjusting Claims (Cont.)



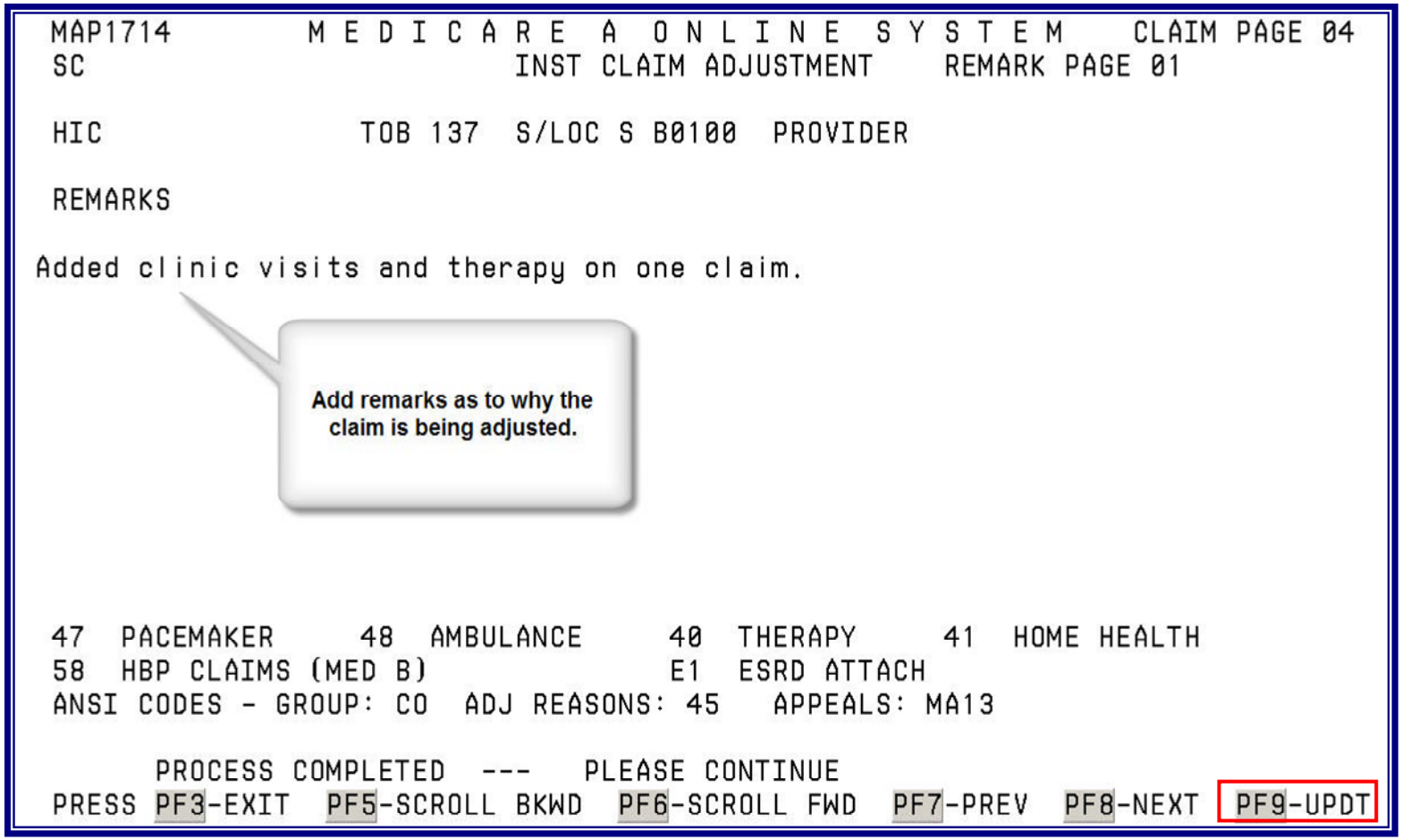
```
MAP1712        M E D I C A R E   A   O N L I N E   S Y S T E M    CLAIM PAGE 02
SC                          INST CLAIM ADJUSTMENT                REV CD PAGE 01

HIC                TOB 137   S/LOC S B0100   PROVIDER

                                        TOT     COV
CL   REV   HCPC MODIFS          RATE   UNIT    UNIT   TOT CHARGE NCOV CHARGE SERV DT
 1  0420  97001 GP           66.000  00001   00001        66.00               031708
 2  0420  97110 GP           25.250  00015   00015        66.00               031508
 3  0420  97110 GP           25.250  00001   00001        66.00               031808
 4  0420  97110 GP           25.250  00001   00001        66.00               032208
 5  0510  99211             215.000  00001   00001       215.00               030508
 6  0510  99212             215.000  00001   00001       215.00               032408
 7  0510  99213             215.000  00001   00001       215.00               030708
 8  0001                                                909.00


      PROCESS COMPLETED  ---   PLEASE CONTINUE
PRESS PF2-171D PF3-EXIT PF5-UP PF6-DOWN PF7-PREV PF8-NEXT PF9-UPDT PF11-RIGHT
```

Adjusting Claims (Cont.)

Claim page 4:

- Add remarks, if necessary, explaining why the claim is being adjusted.
- Press “F9” to submit the claim.

Adjusting Claims (Cont.)



Safeguard Programs

Three main contractors for Medical Review (MR) are:

- A/B Medicare Administrative Contractor (MAC) – TrailBlazer (Dallas):
  - Correctness of payment.
- Zone Program Integrity Contractor (ZPIC) – Health Integrity (Dallas/Baltimore):
  - Fraud.
- Recovery Audit Contractor (RAC) – Connolly Consulting (Connecticut):
  - Recovery of incorrect payments.

Safeguard Programs (Cont.)

- Smaller role in MR:
  - CERT:
    - Nationwide error rate calculation.
  - QIO – varies by state:
    - Quality reviews.

CERT

What is CERT?

- Comprehensive Error Rate Testing (CERT).
- CMS' process to determine how accurately Medicare contractors review and process claims.

CERT Methodology

CERT contractors use the following methodology:

- Random selection is made from a sample of claims submitted within a specific calendar year.
- Medical records are requested from providers who submitted the claims.
- The claims and medical records are reviewed for compliance with Medicare coverage, coding and billing rules.

RAC

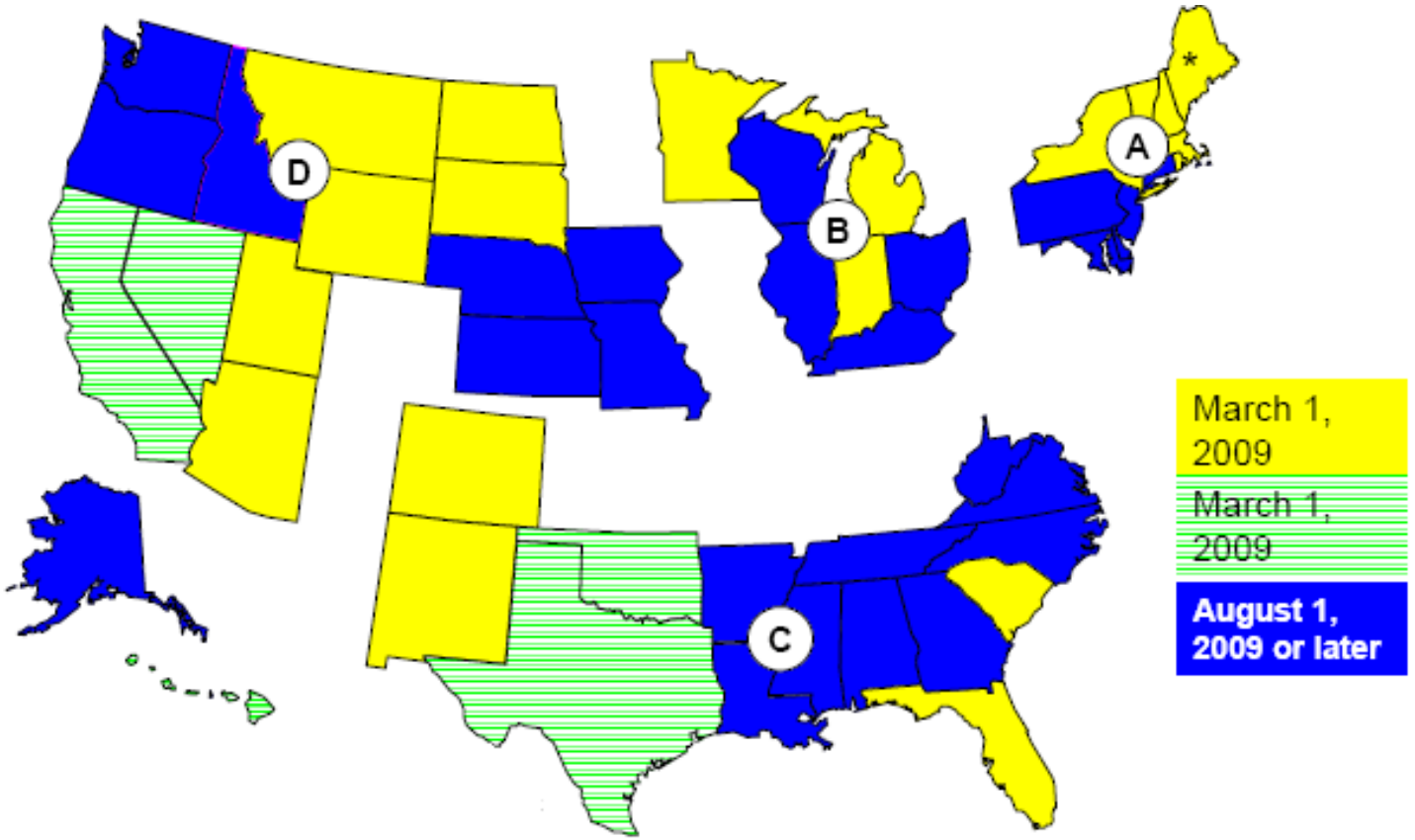
RAC Permanent Program:

- Section 302 of the Tax Relief and Health Care Act of 2006 made the RAC program permanent and required the Secretary to expand the program to all 50 states by no later than 2010.
- The goal of the recovery audit program is to identify improper payments made on claims of health care services provided to Medicare beneficiaries.

RAC (Cont.)

- Improper payments may be overpayments or underpayments.
- Health care providers that might be reviewed include hospitals, physician practices, nursing homes, home health agencies, durable medical equipment suppliers, and any other provider/supplier that bills Medicare Part A and B.
- The RACs are paid on a contingency basis.

RAC (Cont.)



A - Diversified Collection Services
B - CGI Technologies and Solutions
C - Connolly Consulting Associates
D - Health Data Insights

ZPIC

- CMS awarded the ZPIC contract for Zone 4 to Health Integrity, LLC.
- Beginning February 1, 2009, Health Integrity will perform the integrity functions for Medicare Parts A and B, Durable Medical Equipment (DME), home health and hospice, as well as the Medicare Medicaid Data Match project.
- These efforts will include the following six tasks:
  - Performing data analysis and data mining.
  - Conducting medical reviews in support of benefit integrity.
  - Supporting law enforcement and answering complaints.
  - Investigating fraud and abuse.
  - Recommending recovery of federal funds through administrative action.
  - Referring cases to law enforcement.

ZPIC (Cont.)

Health Integrity, LLC:

- Develops innovative data analysis methodologies for detecting and preventing abusive use of services early.
- Develops high-quality fraud case referrals for law enforcement .
- Identifies appropriate corrective actions.

ZPIC (Cont.)

Offices located in:

- Dallas, Texas
- San Antonio, Texas
- Houston, Texas
- Brownsville, Texas
- Denver, Colorado
- Oklahoma City, Oklahoma
- Albuquerque, New Mexico

– Health Integrity staff include: data analysts, nurse reviewers and fraud investigators.

– To contact Health Integrity, call (972) 383-0000 or visit http://www.healthintegrity.org/

Indian Health Service

Thank you for attending.

j4.ihs@trailblazerhealth.com