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://http://www.trailblazerhealth.com/Publications/Manuals/Default.aspx?DomainID=1

Reimbursement

- Inpatient care:
  - Acute care hospital
    - Diagnosis-Related Group (DRG)
  - CAH
    - 101 percent of the all-inclusive facility-specific per diem rate
- Inpatient Part B Ancillary:
  - Acute care hospital
    - All-Inclusive Rate (AIR)
  - CAH
    - 101 percent of the all-inclusive facility-specific per diem rate

Reimbursement (Cont.)

- Outpatient care:
  - Acute care hospital
    - AIR
  - CAH
    - 101 percent of the all-inclusive facility-specific per diem rate

- **Note:** These rates are established by CMS and the Indian Health Service (IHS)

Deductible

- Part A deductible:
  - Applied to inpatient claims
  - 2008 deductible is $1,024
  - 2009 deductible is $1,068
- Part B deductible:
  - Applied to outpatient claims
  - 2008 deductible is $135
  - 2009 deductible is $135

Part A Services

- Medicare Part A helps pay for medically necessary care for the following:
  - Inpatient hospital care
  - Extended care services provided in a Skilled Nursing Facility (SNF)/Swing Bed (SB) after a hospital inpatient stay
  - Home health care
  - Hospice care

Part B Medical Services

- Medicare Part B helps pay for:
  - Physicians' services
  - Outpatient hospital care
  - Diagnostic tests
  - Durable medical equipment
  - Ambulance services
  - Many other health services and supplies not covered by Medicare Part A

Benefit Period

- Benefit period:
  - A period of time for measuring the use of hospital insurance benefits
  - A period of consecutive days during which covered services furnished to a patient can be paid by the hospital insurance plan
  - A patient is eligible for 90 days of hospital care in a benefit period

Benefit Period (Cont.)

- Medicare Part A benefits include:
  - 60 full covered days and 30 coinsurance days for inpatient hospital services
  - 20 full covered days and 80 coinsurance days for skilled nursing care
  - 190 lifetime psychiatric days
  - 60 lifetime reserve days

Benefit Period (Cont.)

- Starting a benefit period:
  - Benefit period begins the first day the patient is admitted to hospital or SNF
  - The date of discharge from any inpatient or SNF stay will count as the first day of a new benefit period
  - A transfer from one hospital to another is not considered a discharge, even if the transfer is considered a discharge under the Prospective Payment System (PPS)
  - A leave of absence is not considered a discharge from the hospital

Benefit Period (Cont.)

- Ending a benefit period:
  - Ends when a beneficiary has not been an inpatient of a hospital or an inpatient of any SNF for 60 consecutive days
  - The benefits will be renewed for full and coinsurance days

SNF

- SNFs may be covered if the following conditions are met:
  - Patient's condition requires daily skilled nursing or skilled rehabilitation services that can only be provided in an SNF
  - Inpatient in a hospital at least three days in a row (not counting day of discharge)
  - Admitted to the facility within 30 days after leaving the hospital

Hospice Care

- The Hospice Medicare Benefit (HMB) is available under Part A if the beneficiary meets the following requirements:
  - Entitled to Medicare Part A
  - Is terminally ill (six months or less life expectancy)
  - Resides where the provider is certified to provide care
  - Elects the HMB

Hospice Care (Cont.)

- Claims for hospice patients are filed to the Fiscal Intermediary (FI) assigned exclusively for this process.
- For a non-terminal-related condition:
  - File to FI or Medicare Administrative Contractor (MAC)
  - Use condition code 07

Home Health Care

- Home Health (HH) care will be paid by Part A for the first 100 visits if the beneficiary meets the following criteria:
  - Enrolled in both Part A and Part B and qualified to receive the Medicare HH benefit
  - Must have a stay of at least three consecutive days in a hospital or Critical Access Hospital (CAH)

COBC

- Coordination of Benefits Contractor (COBC) responsibilities:
  - Required to investigate all Medicare Secondary Payer (MSP) records posted to the CWF
  - Required to share lead contractor information in all liability and workers' compensation cases
- Call toll-free at (800) 999-1118

COBC (Cont.)

- Contact the COBC to:
  - Report employment changes or any other insurance coverage information
  - Report a liability, auto/no-fault, or workers' compensation case
  - Ask general Medicare Secondary Payer (MSP) questions/ concerns
  - Ask questions regarding MSP letters and questionnaires

Claim Filing Time

- Medicare will accept claims with dates of service in:
  - The current year
  - The previous year
  - October, November or December of the year prior to the previous year. Services furnished during the last quarter of the year are considered furnished in the following year

EDI

- Electronic Data Interchange (EDI):
  - Electronic claims submission
  - Electronic Funds Transfer (EFT)
  - EDI Helpline: (866) 749-4302
  - System status: http://www.palmettogba.com/internet/status.nsf/System+Status?OpenFrameSet

NCDs

- National Coverage Determinations (NCDs) are CMS' medical policy related to outpatient services:
  - Replace LCDs
  - A listing of all NCDs is available on the CMS Web site at:
    - http://www.cms.hhs.gov/mcd/search.asp

LCDs

- Local Coverage Determinations (LCDs) determine whether an item or service is reasonable and necessary for a particular jurisdiction.
- Based on input from the Intermediary Advisory Committee members, the physician medical community and specialty providers.
- LCDs may be found on the TrailBlazer Web site at:

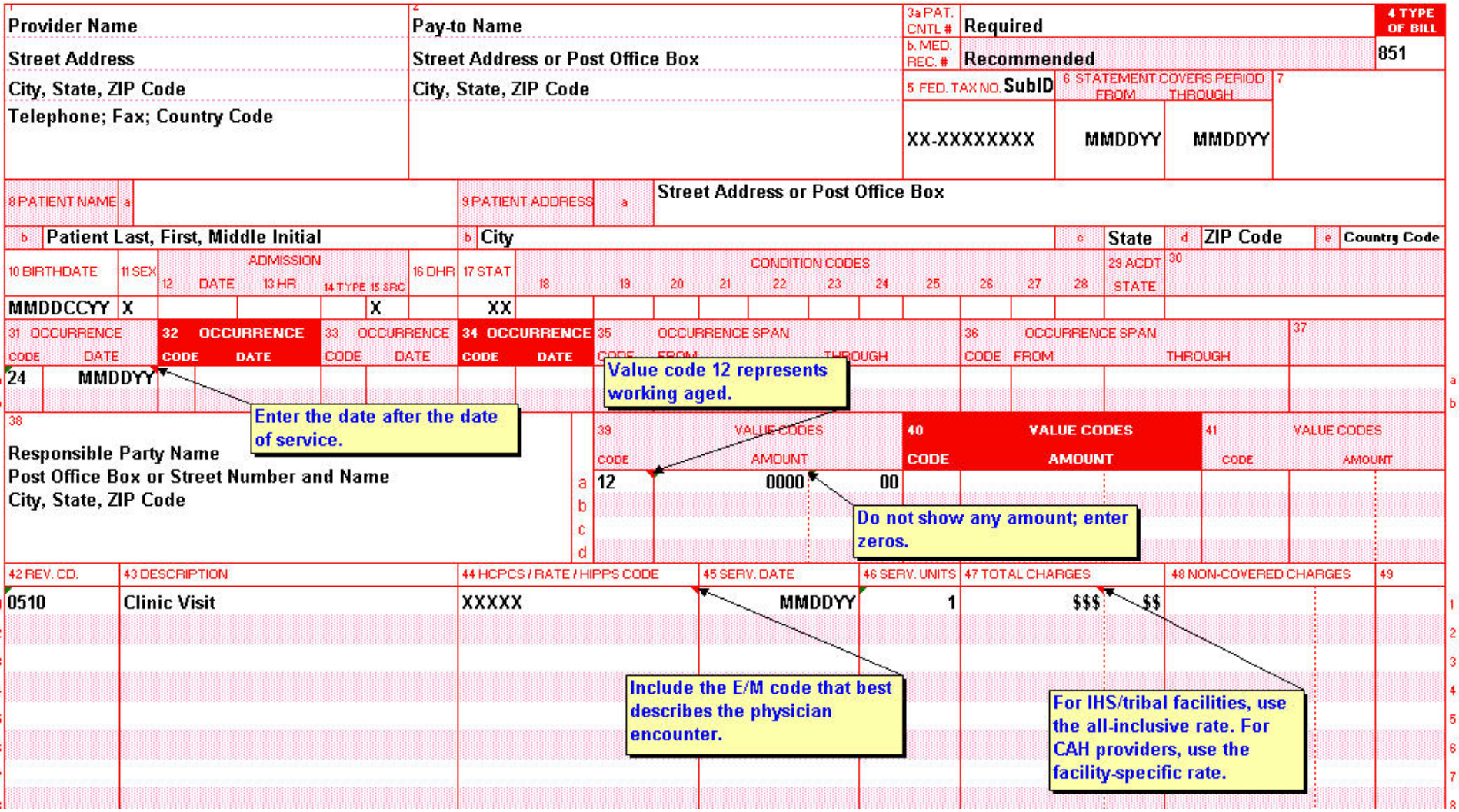
- http://www.trailblazerhealth.com/policies/Local%20Coverage%20Determinations/

MSPQ

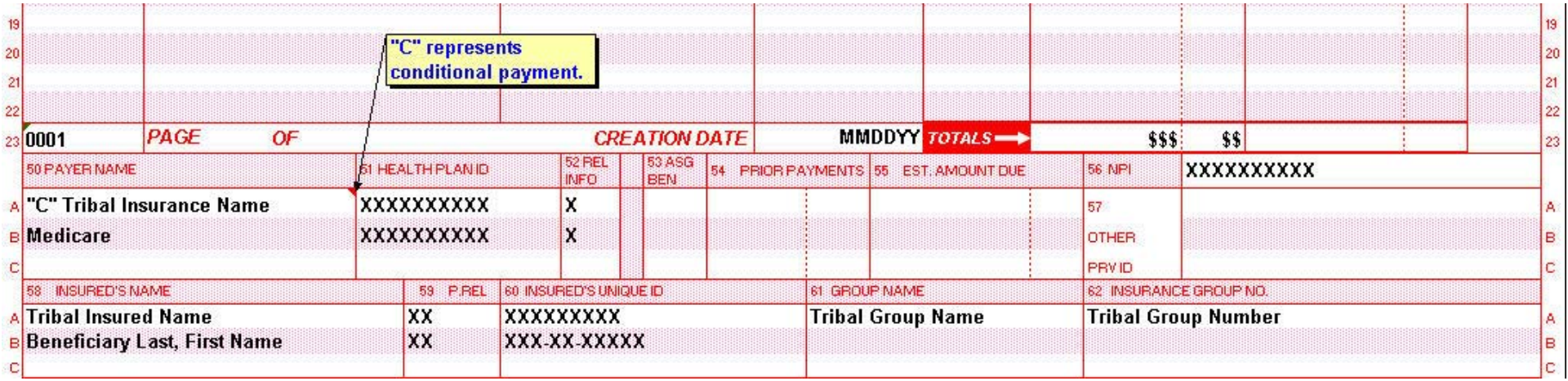
- Medicare Secondary Payer Questionnaire (MSPQ):
  - Every inpatient admission
  - Quarterly for outpatient admission
  - Hard copy or online
  - No signature is needed
  - Retained for 10 years from date of service

Conditional Payment

- Conditional payment:
  - Value code and “0000.00” for payment
  - “C” before primary insurance company name
  - Valid remarks:
    - Annual maximum
    - Applied to deductible
    - Pre-existing condition
    - Forgoing lien; please pay conditionally (liability)
    - Tribal self-insured


Provider Name
Street Address
City, State, ZIP Code
Telephone; Fax; Country Code
Pay-to Name
Street Address or Post Office Box
City, State, ZIP Code
3a PAT. CNTL #
b. MED. REC. #
Required
Recommended
4 TYPE OF BILL
851
5 FED. TAX NO. SubID
XX-XXXXXXXX
6 STATEMENT COVERS PERIOD
FROM
THROUGH
MMDDYY
MMDDYY
8 PATIENT NAME
Patient Last, First, Middle Initial
9 PATIENT ADDRESS
Street Address or Post Office Box
City
State
ZIP Code
Country Code
10 BIRTHDATE
MMDDCCYY
11 SEX
X
ADMISSION
12 DATE
13 HR
14 TYPE
15 SRC
X
16 DHR
17 STAT
XX
CONDITION CODES
18
19
20
21
22
23
24
25
26
27
28
29 ACDT STATE
30
31 OCCURRENCE
CODE
DATE
24
MMDDYY
32 OCCURRENCE
33 OCCURRENCE
34 OCCURRENCE
35 OCCURRENCE SPAN
36 OCCURRENCE SPAN
FROM
THROUGH
37
Enter the date after the date of service.
Value code 12 represents working aged.
38
Responsible Party Name
Post Office Box or Street Number and Name
City, State, ZIP Code
39 VALUE CODES
CODE
AMOUNT
12
0000
00
40 VALUE CODES
41 VALUE CODES
Do not show any amount; enter zeros.
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATE / HIPPS CODE
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
0510
Clinic Visit
XXXXX
MMDDYY
1
$$$
$$
Include the E/M code that best describes the physician encounter.
For IHS/tribal facilities, use the all-inclusive rate. For CAH providers, use the facility-specific rate.

Conditional Payment (Cont.)



Outpatient Services

- Outpatient:
  - A person who is not admitted by the hospital as an inpatient, but registered on the hospital records as an outpatient
- Outpatient services:
  - Facility services and supplies covered during an outpatient encounter

Outpatient Services (Cont.)

- Two types of services:
  - Therapeutic services assist the physician in treatment of the patient (i.e., services incident to the physician's services)
  - Diagnostic services, such as diagnostic X-rays or laboratory services

Outpatient Services

- Outpatient services provided by IHS hospitals are reimbursed according to the specific AIR:
  - Encounter with a physician or non-physician practitioner
  - “Incident to” provisions
  - Physician must personally see patient periodically and sufficiently often to reassess the course of treatment

Outpatient Services (Cont.)

- Outpatient services:
  - Appropriate revenue code
  - Appropriate HCPCS code
  - One unit
  - Total charge
  - Date of service

Outpatient Services (Cont.)

Revenue Code (FL 42)	HCPCS Code (FL 44)	Date of Service (FL 45)	Service Units (FL46)	Charge (FL 47)
0510	99213	08/10/2008	1	181.00
0001			1	181.00

Multiple Visits

- Multiple visits:
  - Visits with more than one health professional and multiple visits with the same health professional that take place during the same day at a single location within the hospital (including the hospital-based satellite) constitute a single visit
  - IHS providers should not report more than one for the number of visits in the Units column of the UB-04 for this scenario
  - The only exception to the “all-inclusive” encounter is when the patient returns later to the emergency room with an unrelated condition
    - A second unit of service is then allowed on the claim
  - If the services are billed separately on two bills, one of the bills will reject and deny as a duplicate bill
  - An adjustment to the paid claim will be required to receive the appropriate payment

Multiple Visits (Cont.)

- Multiple outpatient encounters on the same day should not be billed unless:
  - Patient is seen in the clinic in the morning, and later the same day an unrelated emergency causes the patient to go to the emergency room
    - Two visits may be billed
    - Do not file two separate bills

Outpatient Services

Revenue Code (FL 42)	HCPCS Code (FL 44)	Date of Service (FL 45)	Service Units (FL46)	Charge (FL 47)
0510	99213	08/10/2008	2	362.00
0001			2	362.00

Remarks: First DX goes with clinic visit; second DX goes with ER visit.

Diagnostic Laboratory Services

- Diagnostic laboratory services:
  - Examination of materials derived from the human body for the diagnosis, prevention or treatment of any disease or impairment, or for assessment of the health of a human being
- Billing/reimbursement:
  - Part of the outpatient AIR

Radiological and Pathological Services

- Radiological:
  - Services of X-rays or rays from radioactive substances used for diagnostic or therapeutic purposes
- Pathological:
  - Clinical and anatomical pathology
- Billing:
  - Part of the outpatient AIR

Self-Administered Drugs and Biologicals

- Self-administered drugs are not covered by Medicare
- Outpatient visits with a clinical pharmacist for pharmacy refills are not covered
- Drugs or biologicals must be put directly into a durable medical equipment item or a prosthetic device
  - Part of the AIR outpatient visit

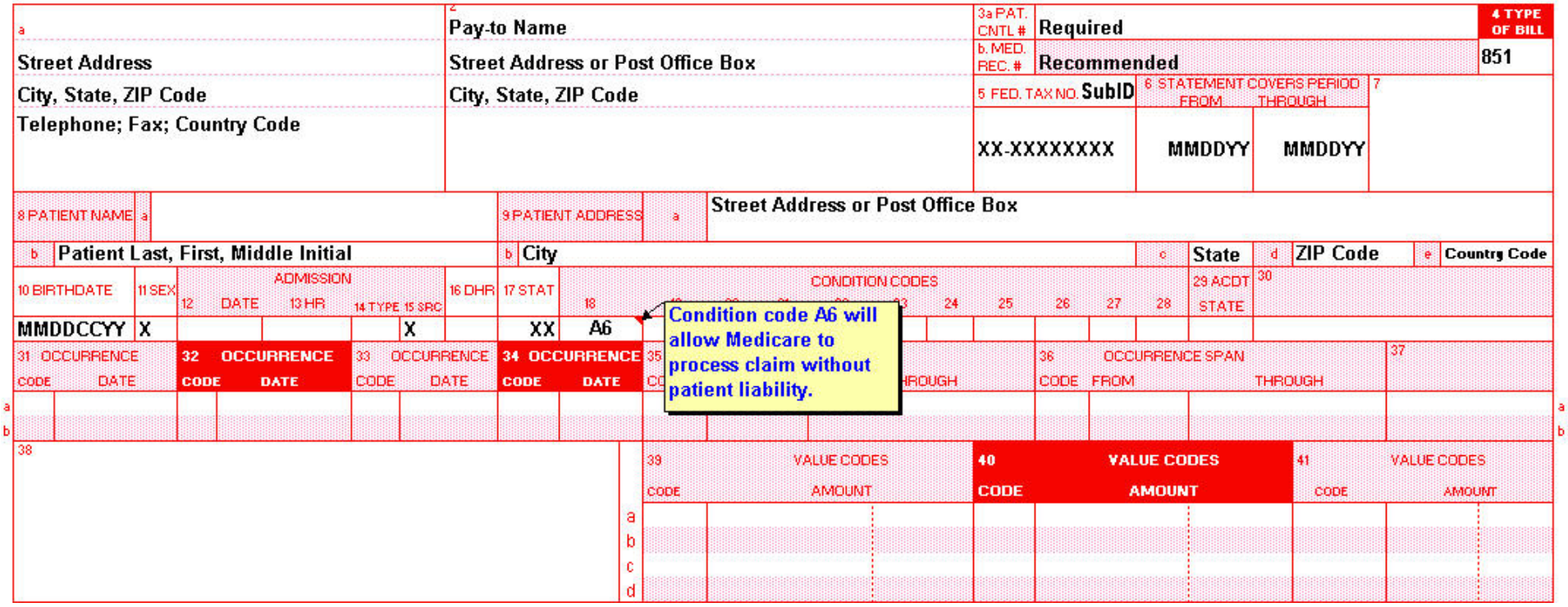
Vaccines

- Effective January 1, 2006, vaccines (pneumococcal pneumonia, influenza virus and hepatitis B virus) and their administration provided by IHS/tribally owned and/or operated hospitals and hospital-based facilities are paid in addition to the AIR or facility-specific rate for CAHs

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

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

Flu and Clinic Example (Cont.)

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
			A
			B
			C

66 DX												68
9	V0481	X	A	B	C	D	E	F	G	H		
	I		J	K	L	M	N	O	P	Q		

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

Repetitive Services (Cont.)

- 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

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

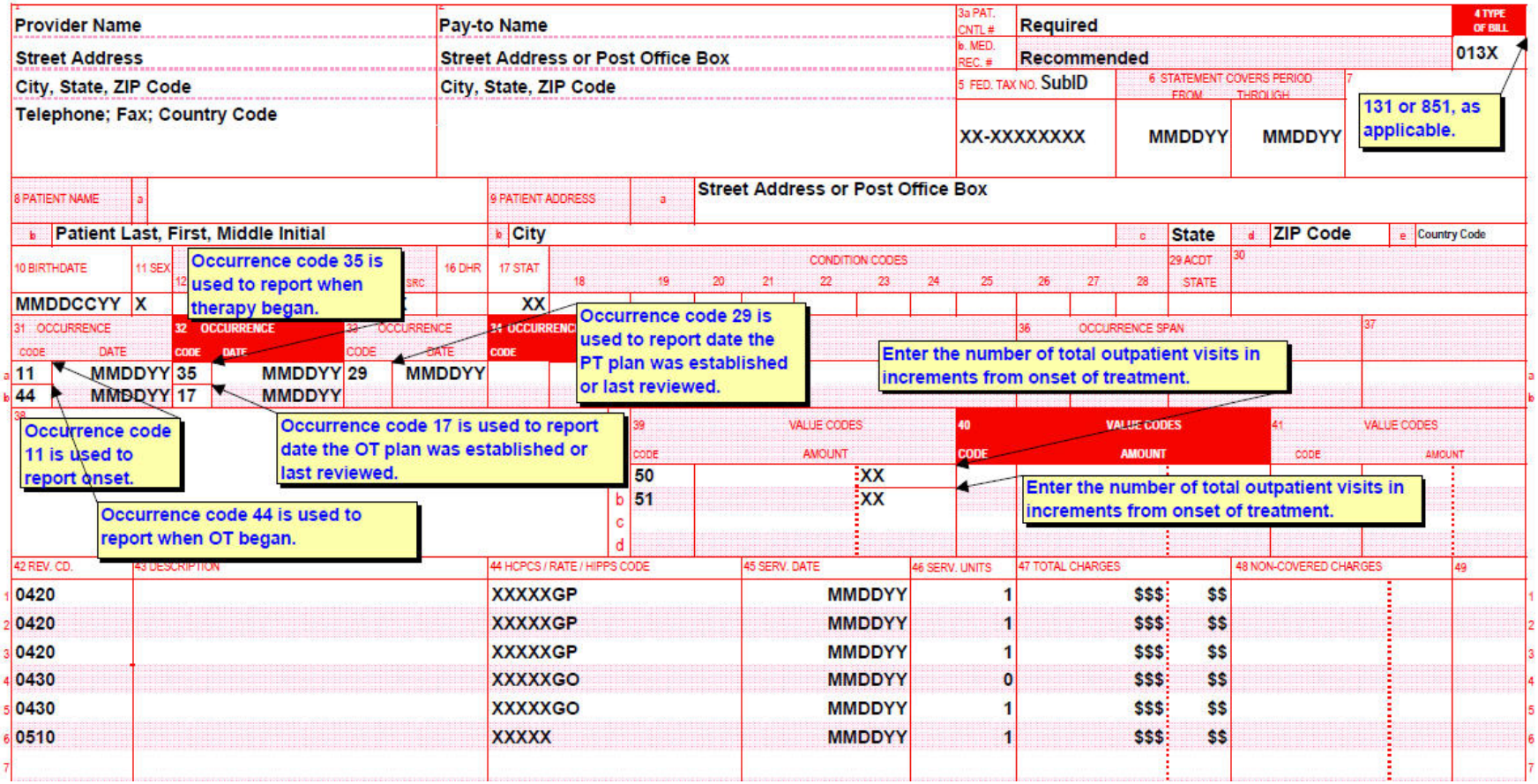
Occupational Therapy

- 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

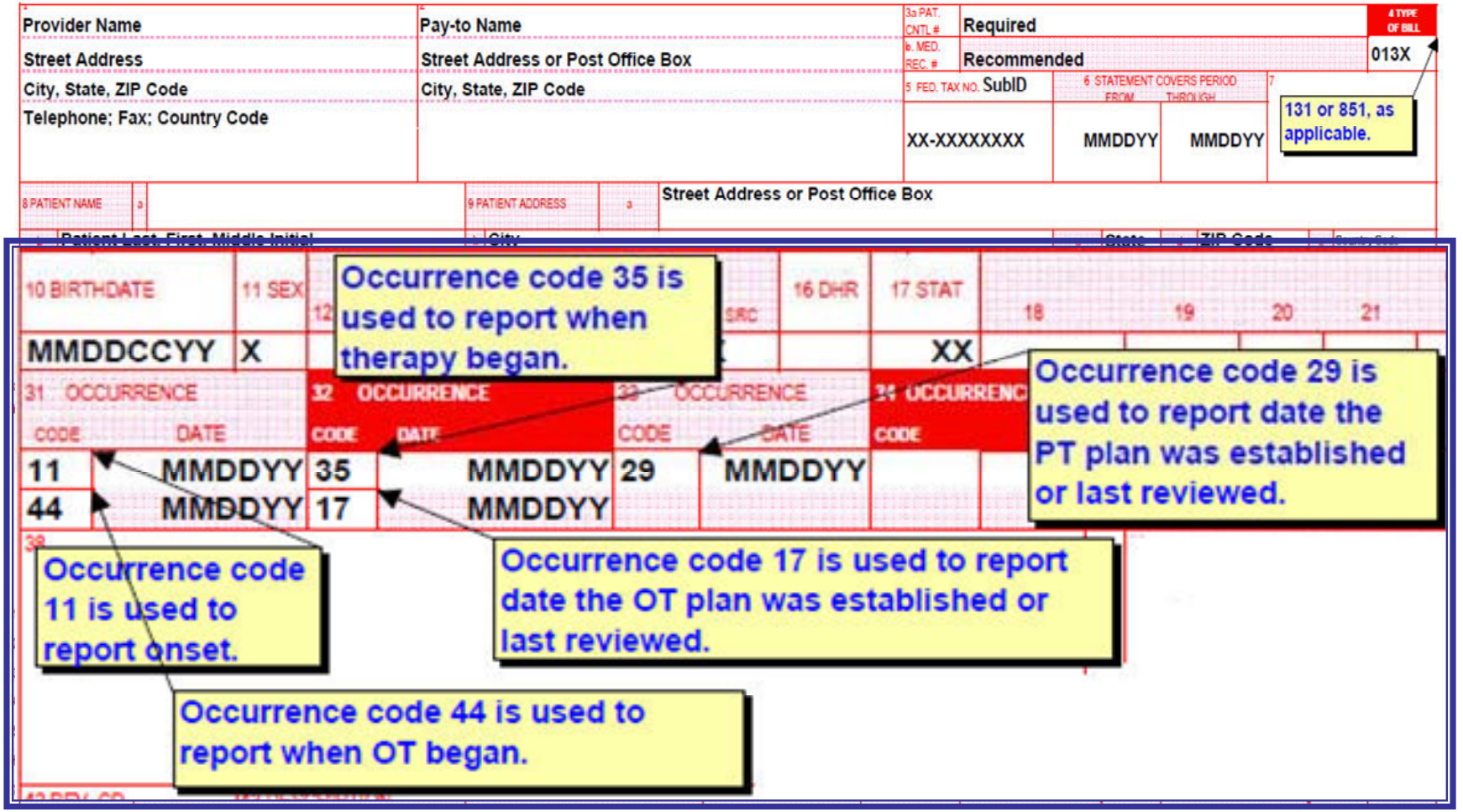
Speech-Language Pathology

- 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

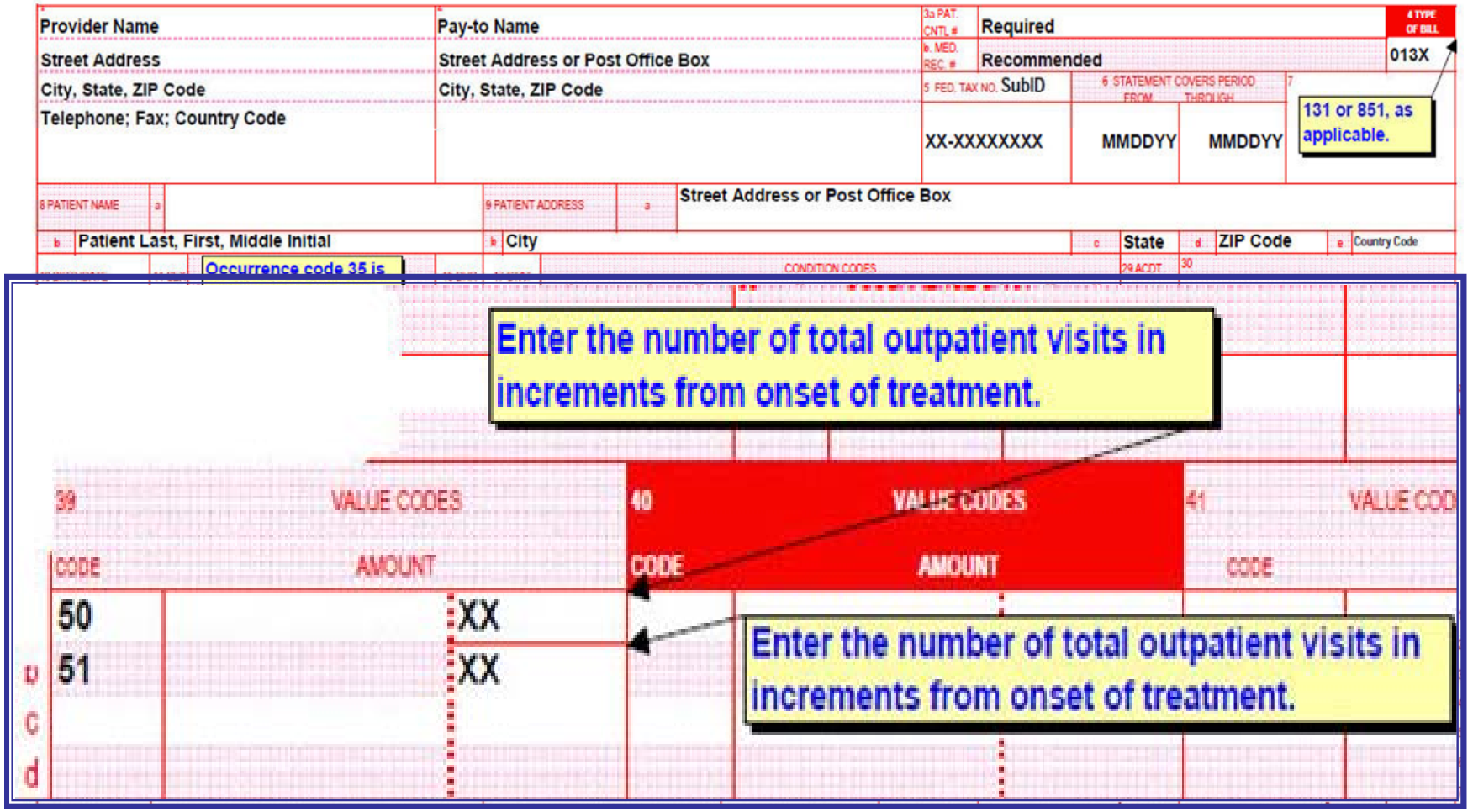
Billing Example



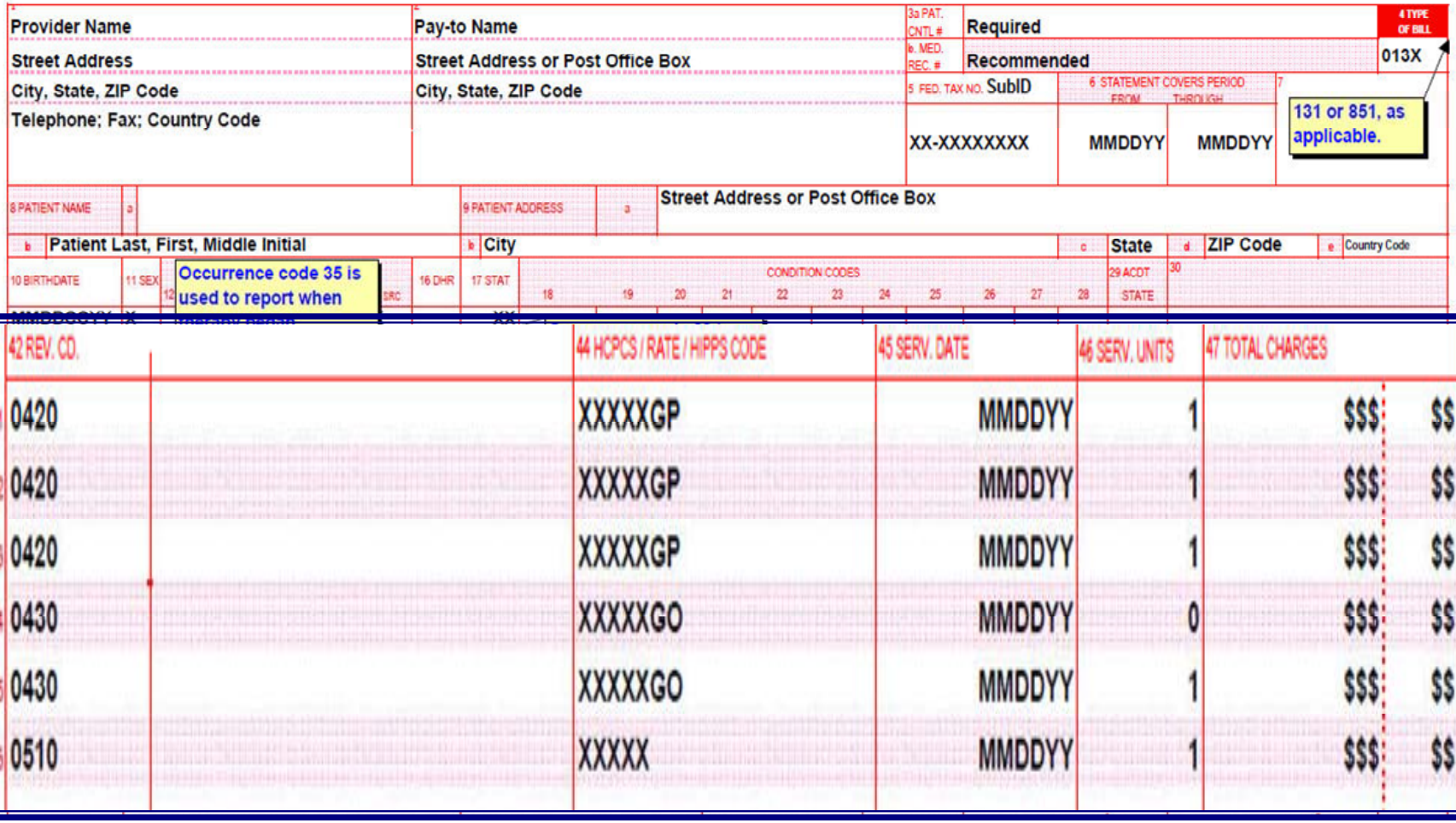
Billing Example (Cont.)



Billing Example (Cont.)



Billing Example (Cont.)



Audiology

- Audiology:
  - Payment for services to IHS providers on TOB 12X or 13X is made based on the MPFS
  - Payment for services to IHS CAHs on TOB 85X is made based on reasonable cost

Audiology (Cont.)

- Diagnostic Testing:
  - Audiological diagnostic testing refers to tests of the audiological and vestibular systems, e.g., hearing, balance, auditory processing, tinnitus and diagnostic programming of certain prosthetic devices, performed by qualified audiologists
  - Audiological tests require the skills of an audiologist and shall be furnished by qualified audiologists or, in states where it is allowed by state and local laws, by a physician or Non-Physician Practitioner (NPP)
  - Medicare is not authorized to pay for these services when performed by audiological aides, assistants, technicians or others who do not meet the qualifications

Audiology (Cont.)

- Hearing Aids and Auditory Implants:
  - Hearing aids or examination for the purpose of prescribing, fitting or changing hearing aids are excluded from coverage
  - Certain devices that produce perception of sound by replacing the function of the middle ear, cochlea or auditory nerve are payable by Medicare as prosthetic devices
  - These devices are indicated only when hearing aids are medically inappropriate or cannot be utilized due to congenital malformations, chronic disease, severe sensorineural hearing loss or surgery

Audiology (Cont.)

- The following are prosthetic devices:
  - Cochlear implants and auditory brain stem implants, i.e., devices that replace the function of cochlear structures or auditory nerve and provide electrical energy to auditory nerve fibers and other neural tissue via implanted electrode arrays
  - Osseointegrated implants, i.e., devices implanted in the skull that replace the function of the middle ear and provide mechanical energy to the cochlea via a mechanical transducer

Audiology (Cont.)

- Diagnostic audiology services:
  - TOB 12X, 13X or 85X
  - Appropriate revenue code
  - Appropriate HCPCS
  - Services using devices that do not require the skills of an audiologist are not covered audiological diagnostic tests

Audiology (Cont.)

Vestibular and Audiologic Function Tests

Search LCDs/LMRPs

Effective: 3/1/2008
Status: Active
Revision Date: 12/19/2008

LCD Title

Vestibular and Audiologic Function Tests - 4F-67AB-R1

Contractor's Determination Number

4F-67AB (L26596)

Contractor Name

TrailBlazer Health Enterprises

Contractor Number

- 04001.
- 04002.

Contractor Type

- MAC - Part A.
- MAC - Part B.

AMA CPT/ADA CDT Copyright Statement

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CMS National Coverage Policy

- *Medicare Benefit Policy Manual* - Pub. 100-02, Chapter 15, Sections 80.3 and 80.6.
- *Medicare National Coverage Determinations Manual* - Pub. 100-03.
- *Medicare Claims Processing Manual* - Pub. 100-04:
  - Chapter 12, Section 30.3.
  - Chapter 13.
- Correct Coding Initiative - *Medicare Contractor Beneficiary and Provider Communications Manual* - Pub. 100-09, Chapter 5.
- Social Security Act (Title XVIII) Standard References, Sections:
  - 1861(II)(2) Payments to Audiologists.
  - 1861(II)(3)(B) Qualifications of Audiologists.
  - 1862(a)(1)(A) Medically Reasonable & Necessary.
  - 1862(a)(1)(D) Investigational or Experimental.
  - 1862(a)(7) Screening (Routine Physical Checkups).
  - 1833(e) Incomplete Claim.

Primary Geographic Jurisdiction

- CO - 04101.
- NM - 04201.
- OK - 04301.
- TX - 04401:
  - Indian Health Service.
  - End Stage Renal Disease (ESRD) facilities.

Audiology (Cont.)

Indications

- Vestibular function tests and/or diagnostic audiometric tests are covered when testing is for the purpose of determining the appropriate **medical or surgical** treatment for disorders of auditory, balance and other neural systems.
- For conductive hearing loss, hearing should be retested after medical or surgical treatment or observation. For sensorineural hearing loss, the audiologist or physician will recommend when reasonable and necessary repeat testing should be done. Since hearing may change or fluctuate, it is important to detect this as early as possible to prevent further loss and to obtain medical treatment if needed. Billing for any testing assumes that the provider has a reasonable expectation that the patient will require medical or surgical treatment. Repeat testing for age-related hearing loss either as a follow-up or to screen for hearing aids is non-covered.
- Audiologic testing (CPT codes 92553, 92557, 92568, 92569) may be performed for patients on continuing (current) long-term (more than 14 days) use of antibiotics known to be ototoxic, such as streptomycin and aminoglycosides.
- If a physician refers a beneficiary to an audiologist for evaluation of signs and symptoms associated with hearing loss or ear injury, the audiologist's diagnostic services are covered, even if the only outcome is the prescription of a hearing aid.
- Services by an independent audiologist to beneficiaries in a Part B SNF stay (beneficiaries who have exhausted their Part A covered SNF stay) are payable under Part B. The provider should bill these services directly to the Part B Carrier.
- Diagnostic analysis of cochlear or brain stem implant and programming are audiology diagnostic services covered under the "other diagnostic test" benefit. Audiological diagnostic tests before and periodically after implantation of auditory prosthetic devices are covered services.

Observation

- Placing a patient in observation status allows the physician to make a medical determination. Physician's decision to admit is complex:
  - Signs/symptoms of patient
  - Medical predictability of adverse reaction
  - Tests ordered
  - Diagnostic procedures

Observation (Cont.)

- Policy:
  - Classified as acute care services
  - Usually does not exceed 24 hours
  - Limited to 48 hours (CMS policy)
- Billing:
  - Type of Bill (TOB) 131
- Reimbursement:
  - Outpatient AIR

Observation (Cont.)

- Observation services begin and end with an order by a physician or other qualified licensed practitioner:
  - The order for observation services must be written prior to initiation of the service, as documented by a dated and timed order in the patient's medical record
  - The order may not be backdated
  - Orders should be clear for the level of care intended, such as "admit to inpatient" or "admit for observation"

Observation (Cont.)

- Observation services end when the physician or other qualified licensed practitioner orders an inpatient admission, a transfer to another health care facility or discharge
- The inpatient stay begins on the date and time of the new order
- Standing orders for observation services are not acceptable since it is not necessary to employ observation services for every patient in a given category, e.g., every emergency department patient, to reach a clinical decision about the appropriate next step in the patient's care

Outpatient Treated as Inpatient

- PPS hospitals only:
  - Diagnostic services provided *three days* immediately preceding the date of the beneficiary's admission are considered inpatient services and are included on the inpatient claim, unless there is no Part A coverage

DSMT

- Diabetes Self-Management Training (DSMT) services:
  - CMS-approved national accreditation
  - Diabetes is a condition of diagnosed abnormal glucose metabolism
  - Must be face-to-face time with patient
  - DSMT and Medical Nutrition Therapy (MNT) services cannot be provided on the same date
  - Provided in a outpatient setting

DSMT (Cont.)

- Qualifying diagnoses:
  - Diabetes:
    - Type 1
    - Type 2
    - Gestational
  - Renal:
    - Non-dialysis kidney disease
    - Post-kidney transplants

DSMT (Cont.)

- Training requirements:
  - Following an evaluation of the beneficiary's need for training, the treating provider must order DSMT
  - Must be included in a comprehensive Plan of Care (POC)
  - Must be reasonable and necessary for treating or monitoring the beneficiary's condition
  - When training under a POC is changed, the treating provider must sign it

DSMT (Cont.)

- In the initial DSMT benefit, none of the 10 hours must be provided in a group setting unless special conditions exist:
  - No group class is available within two months of the date the training is ordered
  - The beneficiary has special needs resulting in hearing or vision problems or language limitations
  - The physician orders additional insulin training

DSMT (Cont.)

- Initial DSMT coverage:
  - Ten hours per year in the first year
  - Continuous 12-month period. Need not be on a calendar-year basis

DSMT (Cont.)

- Follow-up DSMT coverage:
  - Two hours per calendar year in subsequent years
  - Hours can be spread over any number of visits during the year
  - One visit = 30 minutes

DSMT (Cont.)

- Billing DSMT:
  - Bill Type 131 or 851
  - Revenue code 510
  - HCPCS:
    - G0108 – Diabetes outpatient self-mgmt training service, individual, per 30 minutes
    - G0109 – Diabetes outpatient self-mgmt training services, group session, (two or more), per 30 minutes

Inpatient Services

- Inpatient hospital services:
  - Part A benefit
  - Physician certifies need for inpatient care
  - Level of care – medically necessary
  - All medically necessary services provided are billed under revenue code 0100 (all-inclusive revenue code)

Notices to Beneficiaries

- An Important Message (IM) From Medicare
- Hospital Issued Notices of Non-Coverage
- Quality Improvement Organization (QIO) Monitoring of Hospital Admission Notices

Notices to Beneficiaries (Cont.)

- Hospitals must notify Medicare beneficiaries who are hospital inpatients about their hospital discharge appeal rights
- Hospitals must issue the IM within two calendar days of admission, must obtain the signature of the beneficiary or his representative and provide a copy at that time
- This can be located on the CMS Web site: http://www.cms.hhs.gov/BNI/Downloads/RevisedImportantMessageFromMedicare05_2007.pdf

Notices to Beneficiaries (Cont.)

Patient Name: _____

Patient ID Number: _____

Physician: _____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
OMB Approval No. 0938-0692

AN IMPORTANT MESSAGE FROM MEDICARE ABOUT YOUR RIGHTS

AS A HOSPITAL INPATIENT YOU HAVE THE RIGHT TO:

- Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here:

_____
Name of QIO

_____
Telephone Number of QIO

_____

YOUR MEDICARE DISCHARGE RIGHTS

PPS/DRG

- Predetermined rate for inpatient hospitalization based on:
  - Diagnosis
  - Procedure (if applicable)
  - Age
  - Sex
  - Discharge status

PPS/DRG (Cont.)

- Determining covered/non-covered days:
  - Utilization based on days available for a covered stay
  - Non-covered stays, such as not medically necessary or custodial care, are not charged against a beneficiary's utilization when the provider is liable

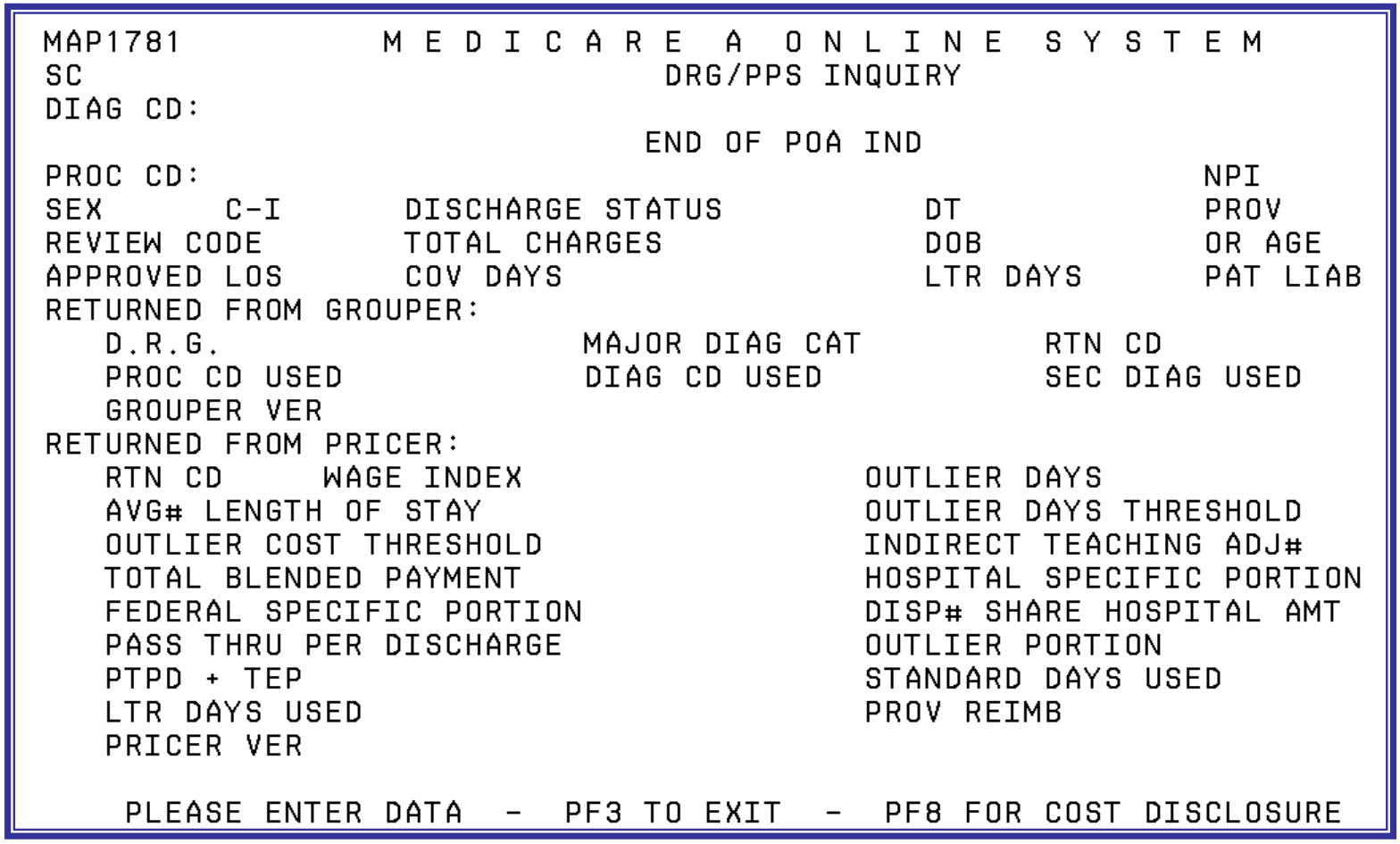
DRG Inquiry

- Direct Data Entry (DDE) inquiry:
  - Option 11
  - View specific DRG assignment and the Prospective Payment System (PPS) information

DRG Inquiry (Cont.)

```
MAP1702            TRAILBLAZER HEALTH ENTERPRISES, LLC
                              INQUIRY MENU

     BENEFICIARY/CWF          10    HCPC CODES              14

     DRG (PRICER/GROUPER)     11    DX/PROC CODES           15

     CLAIMS                   12    ADJUSTMENT REASON CODES 16

     REVENUE CODES            13    REASON CODES            17

     CLAIM COUNT SUMMARY      56    ANSI REASON CODES       68

     CHECK HISTORY            FI    ZIP CODE FILE           19



   ENTER MENU SELECTION:

    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

DRG Inquiry (Cont.)



DRG Inquiry (Cont.)

- To obtain DRG assignment information, complete the following fields and press “Enter”:
  - Diagnosis code(s)
  - Procedure code(s)
  - Sex
  - C-Ind
  - Discharge status
  - Discharge date
  - DOB

Transfers Between PPS Hospitals

- Transfers Between PPS Hospitals:
  - Payment is made to the final discharging hospital at the full prospective payment rate
  - Payment to the transferring hospital is based upon a per diem rate (i.e., the prospective payment rate divided by the Average Length of Stay (ALOS) for the specific DRG into which the case falls) and the patient's length of stay at the transferring hospital

Inpatient Services

- During an inpatient stay:
  - Obtain the patient's signature
  - Obtain a copy of the Medicare card
  - MSPQ

Inpatient Services (Cont.)

- Counting inpatient days:
  - Date of admission is counted
  - Date of discharge is not counted
- If discharge or death occurs on first day of entitlement or participation, hospitals will receive payment for ancillary services

POA Indicator

- Present on Admission (POA):
  - Discharges October 1, 2007, and after
  - Return to Provider (RTP) effective April 1, 2008
  - Change Request (CR) 5679

POA Indicator (Cont.)

- Y (Yes) – Present at the time of inpatient admission
- N (No) – Not present at the time of inpatient admission
- U (Unknown) – The documentation is insufficient to determine if the condition was present at the time of inpatient admission

POA Indicator (Cont.)

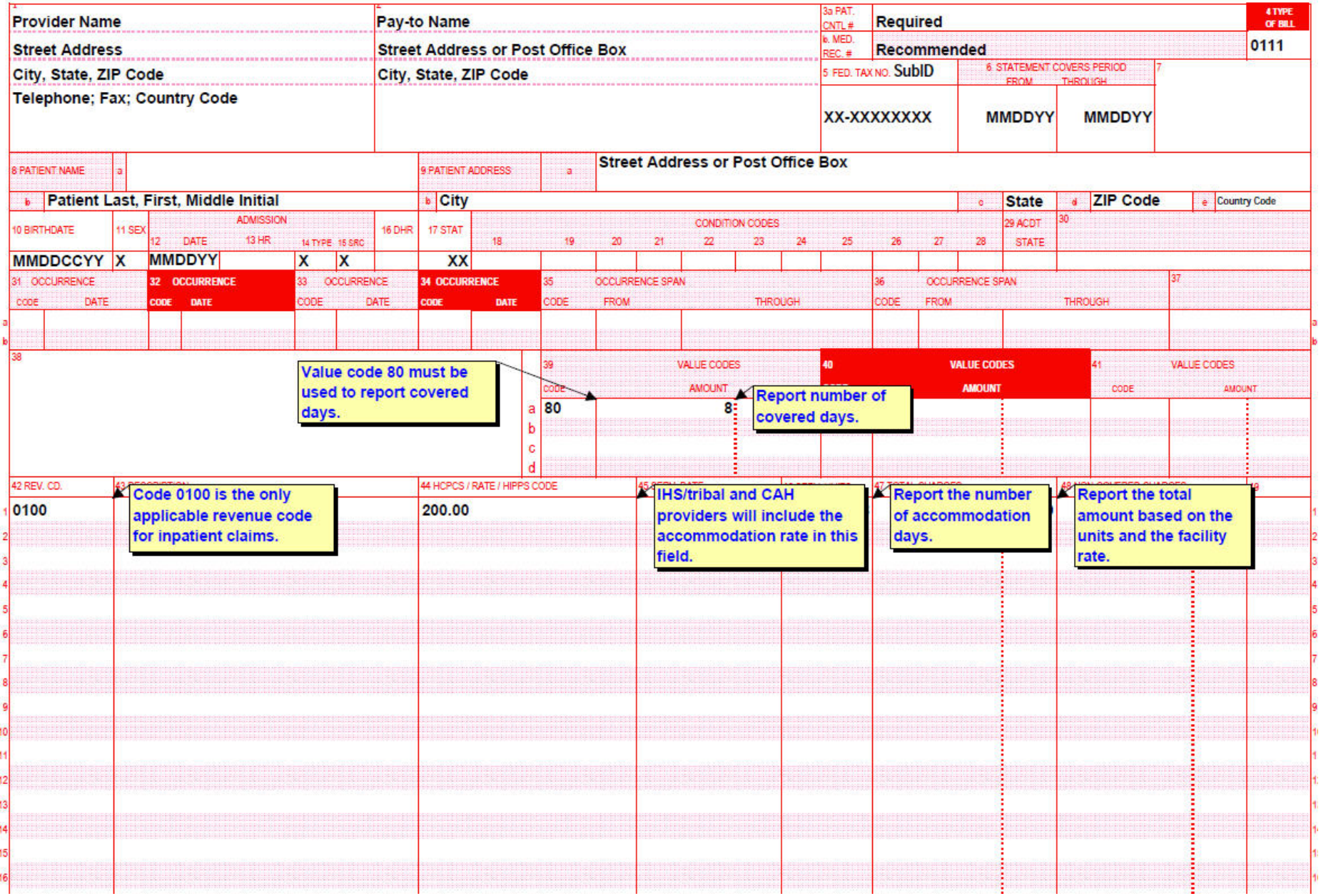
- W (Clinically Undetermined) – The provider is unable to clinically determine whether the condition was present at the time of inpatient admission
- 1 (Unreported/Not Used) – Exempt from POA reporting. This code is the equivalent code of a blank on the UB-04; however, it was determined that blanks were undesirable when submitting the data via the 4010A1

Inpatient Diagnostic Service

- No Part B payment will be made for diagnostic services provided by another hospital while the patient is considered an inpatient
- If no Part A payment is made, providers may file an inpatient Part B ancillary claim

Inpatient Drugs and Biologicals

- Drugs and biologicals provided during an inpatient covered stay are considered covered
- A drug or biological that is obtained from an outside source may also be covered
- These services are included in the all-inclusive inpatient accommodation rate


Provider Name
Street Address
City, State, ZIP Code
Telephone; Fax; Country Code
Pay-to Name
Street Address or Post Office Box
City, State, ZIP Code
3a PAT. CNTL #
b. MED. REC. #
Required
Recommended
4 TYPE OF BILL
0111
5 FED. TAX NO. SubID
XX-XXXXXXXX
6 STATEMENT COVERS PERIOD
FROM
THROUGH
MMDDYY
MMDDYY
8 PATIENT NAME
Patient Last, First, Middle Initial
9 PATIENT ADDRESS
Street Address or Post Office Box
City
State
ZIP Code
Country Code
10 BIRTHDATE
MMDDCCYY
11 SEX
X
ADMISSION
12 DATE
MMDDYY
13 HR
14 TYPE
X
15 SRC
X
16 DHR
17 STAT
XX
CONDITION CODES
18
19
20
21
22
23
24
25
26
27
28
29 ACDT STATE
30
31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37
38
Value code 80 must be used to report covered days.
39 VALUE CODES CODE AMOUNT
40 VALUE CODES AMOUNT
41 VALUE CODES CODE AMOUNT
a
b
c
d
80
8
Report number of covered days.
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATE / HIPPS CODE
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
0100
200.00
Code 0100 is the only applicable revenue code for inpatient claims.
IHS/tribal and CAH providers will include the accommodation rate in this field.
Report the number of accommodation days.
Report the total amount based on the units and the facility rate.

Provider-Liable Claims

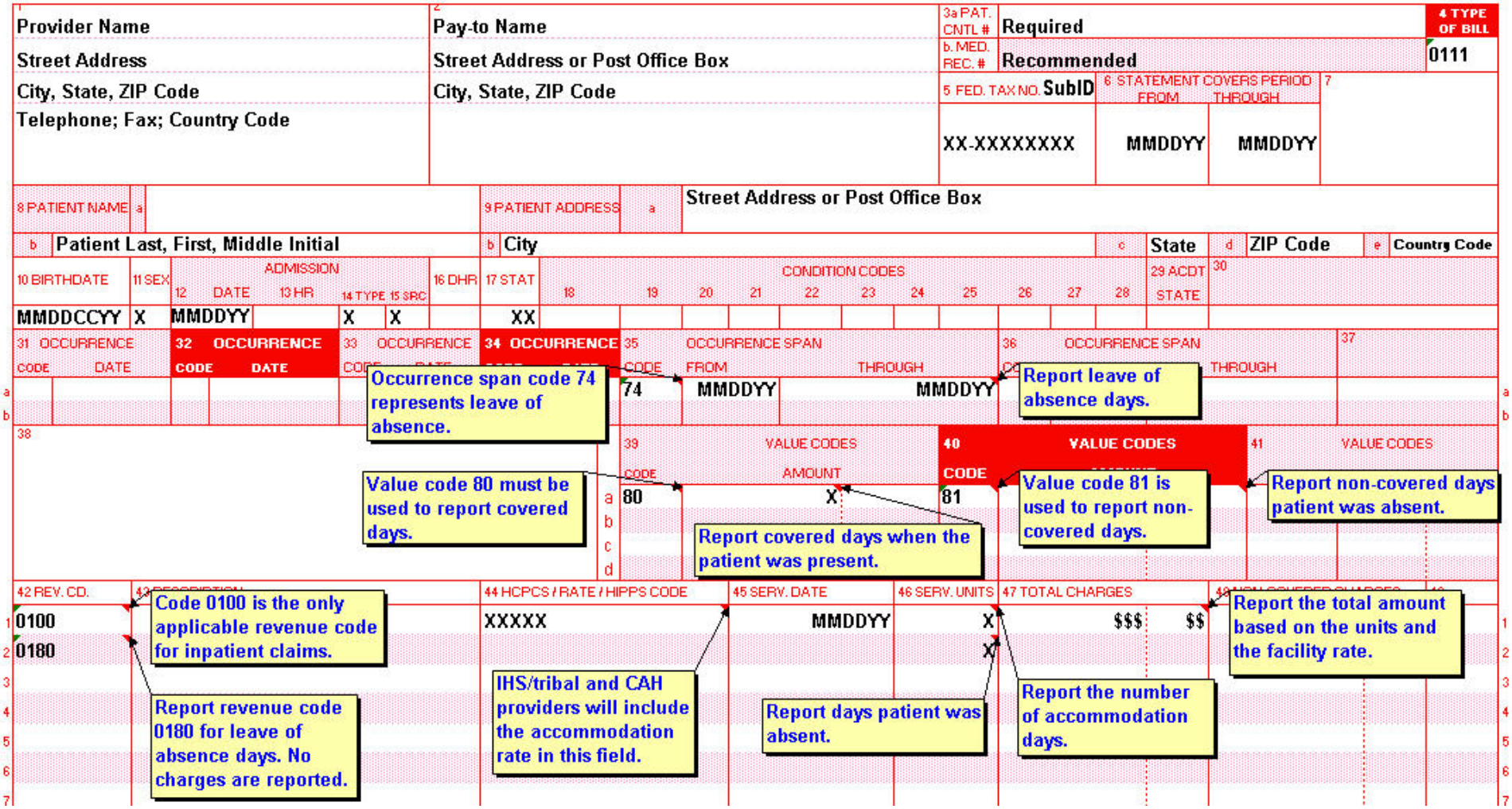
- Provider partially liable:
  - 111 TOB
  - Occurrence span code 77 with covered days
- Provider fully liable:
  - 110 TOB
  - Occurrence span code M1 with non-covered days and charges

Services Under Arrangement

- Hospitals must provide all services during an inpatient stay
- Services provided by another hospital during an inpatient stay under arrangement must be billed by the inpatient hospital

Leave of Absence

- Billing procedures:
  - Non-covered days:
    - Report the days patient was absent at midnight
  - Occurrence span code:
    - Report 74 and date patient was absent at midnight
  - Revenue code:
    - Report 0180 with days absent


Provider Name
Street Address
City, State, ZIP Code
Telephone; Fax; Country Code
Pay-to Name
Street Address or Post Office Box
City, State, ZIP Code
3a PAT. CNTL #
Required
b. MED. REC. #
Recommended
4 TYPE OF BILL
0111
5 FED. TAX NO. SubID
XX-XXXXXXXX
6 STATEMENT COVERS PERIOD
FROM MMDDYY
THROUGH MMDDYY
7
8 PATIENT NAME
9 PATIENT ADDRESS
Street Address or Post Office Box
b Patient Last, First, Middle Initial
b City
c State
d ZIP Code
e Country Code
10 BIRTHDATE MMDDCCYY
11 SEX X
ADMISSION 12 DATE MMDDYY 13 HR 14 TYPE X 15 SRC X
16 DHR
17 STAT XX
CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE
30
31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE
34 OCCURRENCE
35 OCCURRENCE SPAN CODE FROM THROUGH
74 MMDDYY MMDDYY
36 OCCURRENCE SPAN THROUGH
37
38
39 VALUE CODES CODE AMOUNT
80 X
40 VALUE CODES CODE
81
41 VALUE CODES
42 REV. CD.
0100
0180
44 HCPCS / RATE / HIPPS CODE
XXXXX
45 SERV. DATE
MMDDYY
46 SERV. UNITS
X
X
47 TOTAL CHARGES
$$$ $$
Occurrence span code 74 represents leave of absence.
Report leave of absence days.
Value code 80 must be used to report covered days.
Report covered days when the patient was present.
Value code 81 is used to report non-covered days.
Report non-covered days patient was absent.
Code 0100 is the only applicable revenue code for inpatient claims.
Report revenue code 0180 for leave of absence days. No charges are reported.
IHS/tribal and CAH providers will include the accommodation rate in this field.
Report days patient was absent.
Report the number of accommodation days.
Report the total amount based on the units and the facility rate.

Social Admissions

- Social admission for outpatient surgery:
  - If patient lives too far to come to the facility the morning of the scheduled surgery, the provider may place the patient in a room overnight for patient's convenience
  - Provider may only bill for the scheduled surgery
- Social admission as inpatient:
  - Situations where the family is unable to pick up the patient when discharged, so the patient is placed in a room as a convenience

Inpatient Part B Ancillary

- Payment is made under Part B when no payment is made for the inpatient admission.
  - Billing:
    - TOB 111
      - Denial is received
    - TOB 121
    - Revenue code 0240
  - Reimbursement:
    - AIR

Inpatient Part B Ancillary (Cont.)

- Inpatient ancillary:
  - Effective July 1, 2008
  - Patient does not have Medicare Part A
  - Billing:
    - TOB 121
    - Revenue code 0240
  - Reimbursement:
    - All-inclusive ancillary per diem rate

1 Provider Name	2 Pay-to Name	3a PAT. CNTL #	Required	4 TYPE OF BILL
Street Address	Street Address or Post Office Box	b. MED. REC. #	Recommended	0121
City, State, ZIP Code	City, State, ZIP Code	5 FED. TAX NO. SubID	6 STATEMENT COVERS PERIOD FROM	THROUGH 7
Telephone; Fax; Country Code		XX-XXXXXXXX	MMDDYY	MMDDYY

8 PATIENT NAME	a		9 PATIENT ADDRESS	a	Street Address or Post Office Box
b	Patient Last, First, Middle Initial		b	City	c State d ZIP Code e Country Code

10 BIRTHDATE	11 SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
MMDDCCYY	X	MMDDYY		X	X		XX													

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a														a
b														b

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

	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	0240		XXXXX	MMDDYY	X	$$$	$$	
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								

Code 0240 is required on ancillary claims.

IHS/tribal and CAH providers will include the accommodation rate in this field.

Report the number of accommodation days.

Report the total amount based on the units and the facility rate.

No-Pay Bills

- No-payment bills are:
  - Required for inpatient claims to track benefit periods
  - Not required for inpatient bills where no Part A benefit exists
  - Examples include:
    - Non-covered inpatient admissions
    - Medicare secondary claims

No-Pay Bills (Cont.)

- Inpatient billing instructions:
  - Type of Bill (TOB) 110
  - Non-covered days – Report days
  - Occurrence span code 77 and dates of non-coverage
  - Total charges
  - Non-covered charges
- **Note:** Once the inpatient no-pay bill is processed, submit the ancillary 121 bill

Ambulance Service

- Outpatient ambulance bills:
  - 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

Ambulance Service (Cont.)

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

    http://www.cms.hhs.gov/AmbulanceFeeSchedule/02_afspuf.asp#TopOfPage

Ambulance General Coverage

- The ambulance fee payment:
  - Includes a base rate payment plus a separate payment for mileage
  - Covers the transport of the beneficiary to the nearest appropriate facility
  - Requires mandatory assignment for all ambulance services

Emergency Services

- Medicare will cover emergency ambulance services when they are:
  - Medically necessary
  - Meet the destination limits of closest appropriate facilities
  - Provided by an ambulance service that is licensed by the state

Ground Ambulance HCPCS Codes

- The appropriate ground HCPCS codes are:
  - A0426 – Ambulance Service, ALS, Non-Emergency Transport, Level 1
  - A0427 – Ambulance Service, ALS, Emergency Transport, Level 1
  - A0428 – Ambulance Service, BLS, Non-Emergency Transport
  - A0429 – Ambulance Service, BLS, Emergency Transport
  - A0432 – Paramedic Intercept, Rural Area
  - A0433 – Advanced Life Support, Level 2
  - A0434 – Specialty Care Transport

ZIP Code

- The Point of Pickup (POP):
  - Is reported by its five-digit ZIP code
  - Is the location from which patient is initially placed on board
  - Determines whether a rural adjustment applies
  - Is reported with value code A0 (zero)

Note: Only one ZIP code may be reported per claim

Applicable TOBs

- The applicable TOBs for outpatient ambulance transports are:
  - 12X – Hospital inpatient (ancillary)
  - 13X – Hospital outpatient
  - 22X – SNF, inpatient Part B only
  - 23X – SNF, outpatient
  - 85X – Critical Access Hospitals (CAHs)

Revenue Code

- Each loaded one-way trip must report a unique pair of revenue code lines:
  - 0540 – Transport
  - 0540 – Mileage

Modifiers

- Modifiers must be used in a combination of two to report:
  - Origin/destination
    - First position reports the origin of service
    - Second position reports the destination of service
  - Services provided under arrangement or directly

Origin/Destination Modifiers

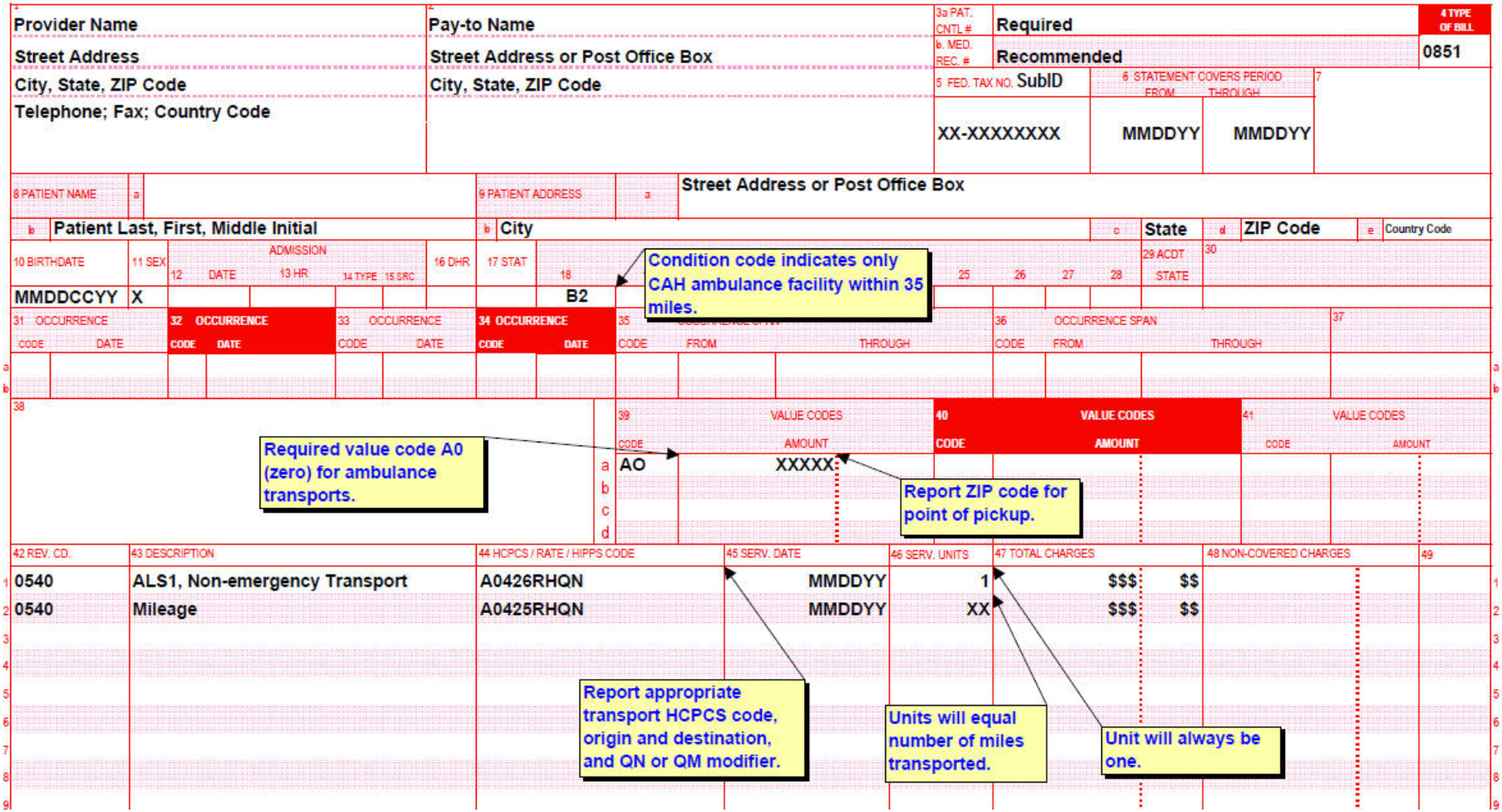
- D – Diagnostic
- E – Residential
- G – Hospital-based dialysis facility
- H – Hospital
- I – Site of transfer
- J – Non-hospital-based dialysis facility
- N – Skilled Nursing Facility (SNF)
- P – Physician's office
- R – Residence
- S – Scene of accident or acute event.
- X – Intermediate stop at physician's office en-route to hospital.

QL Modifier

- QL modifier is reported when beneficiary is pronounced dead after ambulance is called:
  - Report QL instead of the origin and destination modifier
  - Continue to report QM or QN modifier

QN/QM Modifiers

- One of the following modifiers must be reported for each trip to describe service provided:
  - QM – Ambulance service provided under arrangement by a provider of services
  - QN – Ambulance service provided under or directly by a provider of services


Provider Name
Street Address
City, State, ZIP Code
Telephone; Fax; Country Code
Pay-to Name
Street Address or Post Office Box
City, State, ZIP Code
3a PAT. CNTL #
Required
b. MED. REC. #
Recommended
4 TYPE OF BILL
0851
5 FED. TAX NO. SubID
XX-XXXXXXXX
6 STATEMENT COVERS PERIOD
FROM MMDDYY
THROUGH MMDDYY
8 PATIENT NAME
Patient Last, First, Middle Initial
9 PATIENT ADDRESS
Street Address or Post Office Box
City
State
ZIP Code
Country Code
10 BIRTHDATE
MMDDCCYY
11 SEX
X
ADMISSION
12 DATE
13 HR
14 TYPE
15 SRC
16 DHR
17 STAT
18
B2
Condition code indicates only CAH ambulance facility within 35 miles.
29 ACDT STATE
30
31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35
36 OCCURRENCE SPAN CODE FROM THROUGH
37
38
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
a AO XXXXX
Required value code A0 (zero) for ambulance transports.
Report ZIP code for point of pickup.
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 0540 ALS1, Non-emergency Transport A0426RHQN MMDDYY 1 $$$ $$
2 0540 Mileage A0425RHQN MMDDYY XX $$$ $$
Report appropriate transport HCPCS code, origin and destination, and QN or QM modifier.
Units will equal number of miles transported.
Unit will always be one.

Indian Health Service

Thank you for attending.

j4.ihs@trailblazerhealth.com