

Indian Health Service Part A and Part B

Updated October 2023



Contents

Introduction 1

Introduction to Medicare..... 2

 Overview 2

 Four parts of Medicare 2

 Deductibles, coinsurance and premiums 3

 Lifetime reserve days (LTR)..... 3

 Railroad retirement beneficiary 5

 Mandatory electronic claim submission..... 5

 Timely filing requirements..... 5

Definitions..... 6

Hospital..... 6

Critical access hospital (CAH)..... 7

Federally qualified health center (FQHC)..... 7

Provider-based and freestanding entities..... 8

Physician 8

Non-physician practitioner (NPPs) 8

Grandfathered tribal federally qualified health centers 9

Medical necessity 11

Definition of limited coverage..... 11

NCDs..... 11

LCDs 11

Reasons for non-coverage 12

Medicare statutory exclusions 12

Exclusions from coverage 12

Routine services and appliances..... 13

Services related to and required as a result of services that are not covered under Medicare..... 13

Provider enrollment..... 14

 NPI 14

Enrollment forms	14
Supporting documents.....	15
Enrollment application cover sheets	15
Provider Enrollment, Chain and Ownership System (PECOS).....	15
Internet-based Pecos	15
Application fee and screening process	16
Screening process	16
Application fee.....	17
Hardship exceptions	18
Returned applications	19
Application processing.....	19
Contact person.....	19
Changing Tax ID.....	19
Individual practitioners	20
Physician assistants (PAs).....	20
Contracted radiologists	20
Reciprocal billing and fee-for-time compensation arrangements (formerly locum tenens arrangements).....	20
Mobile mammography units.....	21
Medical students	22
Part B do not forward (DNF) initiative	22
Electronic data interchange.....	23
Electronic claims.....	23
Electronic remittance advice	23
Patient registration/screening.....	24
Eligibility inquiry resources	25
Interactive voice recognition (IVR) system.....	26
Hospice	26
<i>Part A</i>	26
<i>Part B</i>	26
Home health.....	27

MSP	28
MSP questionnaire (MSPQ).....	28
Recurring outpatient services.....	29
Beneficiary signature	29
Retention of MSPQ.....	30
Tribal self-funded insurance.....	30
Part A MSP adjustments	30
Benefits Coordination & Recovery Center (BCRC).....	31
References.....	31
Medicare Part A hospital insurance	32
IPPS/DRG.....	32
Inpatient hospital coverage conditions	33
Definition of inpatient.....	33
Benefit period	34
LTR days	34
Counting an inpatient day	34
Inpatient services	35
Appropriate short inpatient hospital stays	35
Documentation requirements for Medicare inpatient admissions	36
Inpatient admission procedures	36
Patient authorization – Part A/B.....	37
Request for payment for provider services.....	37
Statement to permit payment of Medicare benefits to provider, physician and patient	37
Signature by someone other than the Patient	37
Notices to beneficiaries	38
Important Message from Medicare	38
HINN	39
Three day/One day payment window	40
Condition code 51	40
Diagnostic services.....	40

Diagnostic services furnished to inpatients.....	41
Therapeutic services	41
Drugs and biologicals furnished to inpatients	42
Inpatient admission changed to outpatient.....	42
Inpatient services same month as repetitive services.....	43
Inpatient services in connection with dental services	43
Inpatient hospital stays associated with pregnancy	43
Services under arrangement during an inpatient stay	43
Non-covered inpatient services.....	44
Social admissions	44
Determining covered/non-covered days and charges	44
Billing requirements for non-covered days	45
Inpatient no-pay billing instructions	45
Ancillary services	46
Inpatient pneumococcal pneumonia, influenza virus and hepatitis B vaccines.....	47
Pre-entitlement.....	47
Discharge or death on first day of entitlement or participation	47
New occurrence code to report date of death	48
Discharge	48
Definition of a discharge	48
Discharge status coding guidelines.....	48
Discharge status changes	48
Incorrect assignment of patient status codes	48
Discharge status codes.....	49
Repeat admissions.....	49
Condition code B4	49
Leave of absence.....	50
Transfers between hospitals	50
Same-day transfers from participating hospital to participating hospital	51
Same-day transfer billing procedures	51
Cost outlier – Reason code 37045.....	51

Billing frequency requirements	52
IPPS hospital	52
IHS swing bed facilities	52
Beneficiary eligibility	53
Admission and certification orders	54
Swing bed claim submission	55
Acute care hospitals	55
CAHs.....	57
Billing	57
General billing	57
Swing bed payment	57
Swing bed inpatient ancillary claims.....	57
CAHS	58
CAH eligibility.....	58
Inpatient CAH services	58
Documentation requirements for Medicare inpatient admissions	58
CAH swing bed services.....	58
96-hour rule	59
Outpatient services provided prior to an inpatient admission	59
CAH reimbursement	59
Inpatient reimbursement	59
Inpatient ancillary Part B reimbursement	59
Swing bed reimbursement	59
Outpatient reimbursement	59
Ambulance reimbursement	60
Deductible and coinsurance.....	60
FQHCS.....	61
Scope of the program	61
FQHC eligibility	61
Implementation of a PPS for FQHCs.....	61
FQHC reimbursement	62

Covered services.....	62
HCPSC reporting	63
Multiple encounters on the same day	63
Deductible and coinsurance.....	63
Medicare Advantage (MA) plans.....	63
FQHC billing	64
References.....	64
Credit balance report.....	65
Reporting requirements	65
What to report.....	65
Who reports	65
How to report	65
Cost reports	66
Acute care hospital	66
CAH.....	67
Part B outpatient services	68
Definition of hospital outpatient.....	68
AIR and no face-to-face encounter	68
Types of outpatient hospital services.....	69
Therapeutic services provided in an outpatient hospital setting.....	69
Diagnostic services.....	70
Diagnostic laboratory services.....	70
Reference lab	70
Incident to provisions	71
Compliance with state law for incident to services	73
Anticoagulant clinic visit.....	74
Medication therapy	74
Clinical pharmacist encounter	74
Incident to services	75
Evaluation and management service.....	75
Hospital outpatient billing procedures	76

HCPCS codes	76
Outpatient reimbursement	76
Services included in the encounter rate	76
Multiple visits on the same day	77
Outpatient services under arrangement.....	77
ESRD bundling	78
ESRD consolidated billing	78
ESRD FAQs	78
Physician fee schedule	80
Non-physician fee schedule services	80
UB-04 claim form requirements	81
IHS-specific types of bill.....	82
Third digit	82
Additional Part A claim requirements	83
Inpatient.....	83
Outpatient.....	84
POA Indicator.....	84
Point of origin (source of admission)	85
Type of admission (visit type).....	85
Split your Medicare Part A services.....	86
Part B CMS-1500 claim form.....	87
Outpatient services	88
Vaccines.....	88
Influenza vaccines.....	88
Pneumococcal pneumonia vaccine (PPV).....	89
Hepatitis B vaccine.....	89
Billing requirements.....	90
Condition code A6	90
FQHC.....	90
Part B claims.....	90
Roster billing	91

Filing roster bills to Part A using DDE.....	91
Filing roster claims to Part B.....	91
General information.....	92
Outpatient observation services.....	92
Reporting observation hours	93
Documentation	93
Discharge instructions	93
Admission following medical observation	93
Non-coverage.....	94
Billing requirements	94
Part A.....	94
Reimbursement.....	94
Part B	95
Outpatient therapy services	95
Coverage under Part B.....	95
Enrollment of therapists.....	96
Conditions of coverage and payment.....	96
Orders/Referrals and need for care.....	96
Plan of care.....	96
Certification and recertification	97
Physical therapy assistant (PTA).....	97
Outpatient therapy coding requirements	98
Occurrence code.....	98
Therapy rendered in freestanding clinic.....	98
Repetitive services	98
Audiology services	99
Billing requirements for therapy and audiology	100
Screening and preventive services	101
Ambulance services	102
Billing instructions	102
Part A.....	102

Part B.....	103
Reference.....	103
Prosthetics, orthotics and surgical dressings	104
Splints and casts.....	104
Surgical dressings	104
Billing requirements	105
Reimbursement.....	105
Telemedicine services	106
Billing instructions	107
Part A.....	107
Part B	107
Other Part B services.....	108
ASCs.....	108
General background for IHS and Tribal ASCS.....	108
Definition of ASC.....	108
ASC services on ASC list	108
Facility and physician allowance.....	109
References.....	109
Anesthesia services.....	109
Modifiers.....	110
CRNA.....	110
Time.....	110
Dental services	111
Reference.....	112
Diagnostic tests	113
Standing orders	114
Ordering provider.....	114
Electrocardiogram (ECG or EKG).....	115
Laboratory services	116
Clinical laboratory tests	116
Diagnostic laboratory tests	116

Diagnosis coding requirements	117
Modifier 90	117
Claim requirements	117
Foot care.....	118
Maternity services	119
Modifiers	120
Medically Unlikely Edits (MUEs)	120
Ophthalmology	121
Provider qualifications	121
Ophthalmologist/Physician.....	121
Optometrist.....	121
E/M.....	121
Diabetic retinopathy services.....	121
POS	122
POS codes 05, 06, 07 and 08.....	122
Incentive programs.....	123
Hospital value-based reporting	123
ASC quality measures	123
Partners in compliance	124
Definition of compliance	124
Overview	124
Importance of documentation	125
General principles of documentation	125
Appeals	127
Overpayments.....	128
Interest rate charged on overpayments.....	128
FISS claims processing	129
Reason Code File	129
Status/Location information sheet.....	129
Claim status pending location.....	129
Finalized locations.....	130

RTP process	130
DDE	130
Claims correction.....	130
CWF.....	131
Remittance advice.....	132
Medicare standard electronic PC-Print software	132
PC-Print software for Part A.....	132
Medicare Remit Easy Print software for Part B.....	132
Reason and remark codes.....	133
Claim adjustment reason codes (CARCs).....	133
Remittance advice remark codes (RARCs).....	133
ANSI codes.....	133
Group codes.....	134
Negative reimbursement remit.....	134
Requesting duplicate remits	135
Reference.....	135
Part A adjustments and voids (cancels)	136
Adjustment procedures.....	136
Third-Digit Frequency Adjustment Identification	136
Hard copy claim instructions	137
Condition codes.....	137
Adjustment reason codes.....	138
Adjustment bills inholding time limitation for filing claims.....	138
Void (cancel) procedures	138
Hard copy claim instruction	138
Condition codes.....	139
Adjustments and cancels performed in DDE.....	139
Appendix A: Part A AIR when no face-to-face encounter on same day	140
Appendix B: Part B Tribal self-insurance and MSP.....	143
Appendix C: Traditional healers.....	145
Appendix D: “Grandfathering” provisions for certain Indian Health Service Tribal facilities.	146

Review/Revision history 149

Introduction

The information contained in this manual was obtained from various Internet Only Manuals (IOMs) developed by CMS, and pertains to both Part A and Part B.

Unless otherwise specified, any references in this manual to Indian Health Service (IHS) providers include:

- Tribally owned and operated facilities electing to bill as IHS. Tribally operated IHS facilities.
- IHS-owned and -operated facilities.
- Tribally owned and IHS-operated facilities.

The chapter developed exclusively for IHS is located in [CMS IOM Pub.100.04 Medicare Claims Processing Manual, Chapter 19.](#)

Introduction to Medicare

Overview

Medicare is a health insurance program administered by the federal government. It provides health insurance for individuals age 65 and older, disabled individuals younger than 65, and any individual who has chronic kidney disease, otherwise known as end stage renal disease (ESRD).

Medicare legislation was passed in July 1965 and became effective July 1966. Medicare is also known as Title XVIII of the Social Security Act.

The CMS, under the Department of Health and Human Services, has primary responsibility for the Medicare program. There are several components of CMS at the Regional Office (RO) level: Division of Medicare, Division of Medicaid, and Division of Health Standards and Quality. The Division of Health Standards and Quality works with the state licensure and certification agencies.

Four parts of Medicare

There are four parts to the Medicare program:

- Hospital insurance (Part A) helps pay for inpatient hospital care, inpatient care in a skilled nursing facility (SNF), home health care and hospice care. Medicare Part A has deductibles and coinsurance but is generally premium-free. IHS facility types that submit claims to Part A include acute care, critical access hospitals (CAHs), and federally qualified health centers (FQHCs).
- Medical insurance (Part B) helps pay for doctors' services, outpatient hospital services, durable medical equipment (DME) supplies, ambulance services, and a number of other medical services and supplies that are not covered by the Medicare hospital insurance. Medicare Part B has premiums, deductible and coinsurance amounts for which the beneficiary is responsible. Premiums, deductible and coinsurance amounts are set each year according to formulas established by law. New payment amounts begin each January 1.
- Medicare Advantage (Part C) is a Medicare program that gives beneficiaries more choices among health plans. Everyone who has Medicare Part A and/or B is eligible, except those who have ESRD and were not in a Medicare Advantage plan at the onset of this condition. Medicare Advantage plans replace the "traditional" red, white and blue Medicare card coverage. Providers must contact the plan to determine coverage information and claim filing instructions.
 - Open enrollment to join a plan is October 15 through December 7
 - Disenrollment from a plan is January 1 through February 14

- Prescription drug coverage (Part D) may be selected by a beneficiary to help lower prescription drug costs and help protect against higher costs in the future. Medicare prescription drug coverage is insurance that private companies provide, and is available to everyone with Medicare. Beneficiaries choose the drug plan and pay a monthly premium. Like other insurance, if beneficiaries decide not to enroll in a drug plan when they are first eligible, they may pay a penalty if they choose to join later.

Deductibles, coinsurance and premiums

Although IHS providers do not collect deductibles or coinsurance from American Indian (AI)/Alaskan Native (AN) beneficiaries, the Medicare payment will be reduced by the deductible or coinsurance amounts when applicable. IHS providers may collect deductibles and coinsurance amounts from non-AI/AN beneficiaries.

Lifetime reserve days (LTR)

IHS does not utilize LTR days.

Medicare Beneficiary Identifier (MBI)

Medicare beneficiaries are issued a health insurance identification card that identifies:

- Beneficiary name
- MBI
- Hospital insurance (Part A) effective dates
- Medical insurance (Part B) effective dates

It is extremely important that the beneficiary's name and MBI are entered on the claim as they appear on the health insurance card whether billed electronically or hard copy. To ensure accuracy, please check the patient's health insurance card or make a copy for your records.

Replacement cards can be ordered through the Social Security Office by calling (800) 772-1213.

Railroad retirement beneficiary

IHS facilities that are enrolled with a designated IHS MAC will submit railroad claims to the designated IHS MAC (currently Novitas).

Tribal facilities enrolled with other MACs will submit claims to the designated railroad Medicare contractor.

Mandatory electronic claim submission

The Administrative Simplification Compliance Act (ASCA) prohibits Medicare coverage of claims submitted to Medicare on paper except in limited situations. The following circumstances meet the criteria for exception from the mandatory electronic billing requirement:

- Small provider. A small provider is a hospital with fewer than 25 full-time employees or a physician's office with fewer than 10 employees.
- Disruption in electricity or phone/communications systems expecting to last more than two business days. If duration is expected to be less than two business days, providers are to hold claims until services are restored.
- A provider that is not a small provider but submits fewer than 10 Medicare claims per month (not more than 120 claims per year).

Enforcement will be conducted on a post-payment basis and will entail investigation of providers that are submitting paper claims. Medicare contractors will request information from the selected providers to establish that they meet criteria for submission of paper claims. If no response to the contractor inquiry is received within 45 calendar days from the date of the request letter, or if a provider's response does not establish eligibility to submit paper claims, the Medicare contractor will notify the provider by mail that any paper claims received 90 days after the initial request letter will be denied and advised to resubmit electronically.

Timely filing requirements

As a result of the Patient Protection and Affordable Care Act (PPACA), all claims for services furnished on or after January 1, 2010, must be filed no later than one calendar year from the date of service. This includes adjustments or corrections to previously processed claims.

Definitions

Hospital

Acute care hospitals follow the Medicare Conditions of Participation in Title 42 CFR Part 412, Subpart C and Part 482.

A hospital (other than tuberculosis or psychiatric) is an institution that:

- Is primarily engaged in providing to inpatients, by or under the supervision of physicians:
- Diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons.
- Rehabilitation services for the rehabilitation of injured, disabled or sick persons.
- Maintains clinical records on all patients.
- Has bylaws in effect concerning its staff of physicians.
- Requires that every patient must be under the care of a physician.
- Provides 24-hour nursing service by or supervised by a registered professional nurse and has a licensed practical nurse or registered professional nurse on duty at all times.
- Has in effect a hospital utilization review plan.
- Is licensed or is approved by the state or local licensing agency as meeting the standards established for such licensing.
- Meets other health and safety requirements of the Secretary of Health and Human Services. These additional requirements may not be higher than comparable ones prescribed for accreditation by the Joint Commission on Accreditation of Hospitals, with certain exceptions specified in the law.
- Is not primarily for the care and treatment of mental diseases.
- May be approved as a swing bed facility to provide extended care services if it is a rural hospital with fewer than 50 beds or if pursuant to demonstration authority.

Critical access hospital (CAH)

A CAH follows the Medicare Conditions of Participation in Title 42 CFW Part 485, Subpart F.

A CAH is a small facility that gives limited outpatient and inpatient hospital services to people in rural areas.

To be eligible as a CAH, a facility must be a current participating Medicare hospital, a hospital that ceased operations on or after November 29, 1989 or a health clinic or health center that previously operated as a hospital before being downsized to a health clinic or health center. The facility must be located in a rural area of a state that has established a Medicare rural hospital flexibility program, or must be located in a Metropolitan Statistical Area (MSA) of such a state and be treated as being located in a rural area based on a law or regulation of the state. It also must be located more than a 35-mile drive from any other hospital or CAH unless it is designated by the state, prior to January 1, 2006, to be a "necessary provider." In mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles. In addition, the facility must make available 24-hour emergency care services, provide not more than 25 beds for acute (hospital level) inpatient care or, in the case of a CAH with a swing bed agreement, swing beds used for SNF-level care.

Designation by the state is not sufficient for CAH status. To participate and be paid as a CAH, a facility must be certified as a CAH by CMS during the enrollment process.

Federally qualified health center (FQHC)

FQHCs follow the Medicare Conditions of Participation in Title 42 of CFR Part 405, Subpart X and Part 491.

An FQHC is a facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general supervision of a physician.

- An entity may qualify as an FQHC if it meets at least one of the following criteria:
 - Receiving a grant under Section 330 of the Public Health Service (PHS) Act.
 - Receiving funding from such a grant under a contract with the recipient of a grant and meets the requirements to receive a grant under Section 330 of the PHS Act.
- Determined by the Secretary to meet the requirements for receiving such a grant based on the recommendation of the Health Resources and Services Administration within PHS (FQHC look-alike).
- Was treated by CMS as a comprehensive federally funded health center as of January 1, 1990.
- Is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1, 1991.

Designation by the state is not sufficient for FQHC status. To participate and be paid as an FQHC, a facility must be certified as an FQHC by CMS during the enrollment process.

Provider-based and freestanding entities

The following information regarding provider-based and freestanding entities can be found in 42 CFR Section 413.65 of the Federal Register.

“Provider-based entity” means a provider of health care services or a rural health clinic (RHC), as defined in 42 CFR Section 405.2401(b), that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider under the ownership and administrative and financial control of the main provider, in accordance with the provisions of this section. A provider-based entity comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under the Medicare or Medicaid program, and the personnel and equipment needed to deliver the services at that facility. A provider-based entity may, by itself, be qualified to participate in Medicare as a provider under 42 CFR Section 489.2 and the Medicare conditions of participation do apply to a provider-based entity as an independent entity.

“Freestanding facility” (also known as physician-directed) means an entity that furnishes health care services to Medicare beneficiaries and that is not integrated with any other entity as a main provider, a department of a provider, remote location of a hospital, satellite facility or a provider-based entity.

Physician

“Physician” means doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery or dental medicine (within the limitations in IOM Pub. 100-01, Chapter 5, Subsection 70.2), doctor of podiatric medicine (within the limitations in IOM Pub. 100-01, Chapter 5, Subsection 70.3) or doctor of optometry (within the limitations in IOM Pub. 100-01, Chapter 5, Subsection 70.5) and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a state in which he performs this function. The services performed by a physician within these definitions are subject to any limitations imposed by the state on the scope of practice.

Non-physician practitioner (NPPs)

NPPs can be a health care provider who meets state licensing obligations to provide specific medical services. Medicare payments may be made for qualifying services of many NPPs. Some of these practitioners include: anesthesiology assistant, audiologist, certified nurse specialist (CNS), certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical psychologist (CP), licensed clinical social worker (LCSW), nurse practitioner (NP), physician assistant (PA), physical and occupational therapists, registered dietitian/nutrition professional and speech-language pathologist (SLP).

Grandfathered tribal federally qualified health centers

This is intended for grandfathered tribal (FQHCs that were provider-based clinics on or before April 7, 2000, submitting institutional claims to MACs for services provided to Medicare beneficiaries.

Effective for dates of service on or after January 1, 2016, IHS and tribal facilities and organizations that met the conditions of 42 CFR 413.65(m) on or before April 7, 2000, and have a change in their status on or after April 7, 2000 from IHS to tribal operation, or vice versa, or the realignment of a facility from one IHS or tribal hospital to another IHS or tribal hospital such that the organization no longer meets the Conditions of Participation (CoPs), may seek to become certified as grandfathered tribal FQHCs. These grandfathered tribal FQHCs would be required to meet all FQHC certification and payment requirements.

The FQHC prospective payment system (PPS) adjustment for grandfathered tribal clinics would not apply to a currently certified tribal FQHC, a tribal clinic that was not provider-based as of April 7, 2000, or an IHS-operated clinic that is no longer provider-based to a tribally-operated hospital. This provision would also not apply in those instances where both the hospital and its provider-based clinic(s) are operated by the tribe or tribal organization.

Grandfathered tribal FQHCs will be paid the lesser of their charges or a grandfathered tribal FQHC PPS rate for all FQHC services furnished to a beneficiary during a medically necessary face-to-face FQHC visit. The grandfathered PPS rate equals the Medicare outpatient per visit payment rate paid to them as a provider-based department, as set annually by the IHS.

From January 1, 2015 through December 31, 2015, the grandfathered tribal FQHC PPS rate is \$307. The grandfathered tribal FQHC PPS rate will not be adjusted by the FQHC PPS Geographic Adjustment Factor (GAF) or be eligible for the special payment adjustments under the FQHC PPS for new patients, patients receiving an IPPE or an AWW. The rate is also ineligible for exceptions to the single per diem payment that is available to FQHCs paid under the FQHC PPS. In addition, the Medicare Economic Index (MEI) or a FQHC market basket adjustment that is applied annually to the FQHC PPS base rate, will not apply to the grandfathered tribal FQHC PPS rate.

Grandfathered tribal FQHCs will be paid for services included in the FQHC benefit, even if those services are not included in the IHS Medicare outpatient all-inclusive rate. Services included in the IHS outpatient all-inclusive rate, but not in the FQHC benefit will not be paid.

Grandfathered tribal FQHCs are subject to the payment requirements under the FQHC PPS. The five FQHC payment G-codes shall be used by grandfathered tribal FQHCs when submitting claims under the PPS based on the services furnished. Grandfathered tribal FQHCs shall use the specific payment code that corresponds to the type of visit that qualifies the encounter for Medicare payment. Each grandfathered tribal FQHC shall report a charge for the visit code that would reflect the sum of regular rates charged to both beneficiaries and other patients for a typical bundle of services that would be furnished per diem to a Medicare beneficiary.

Additional information on the coverage and payment requirements for FQHC visits is available in the [IOM CMS IOM Pub. 100-02, Medicare Benefit Policy Manual, Chapter 13](#).

Additional information regarding the services that are qualifying visits is available on the [FQHC PPS](#) center page on the CMS website.

MACs shall generally pay 80 percent of the lesser of the grandfathered tribal FQHC's charge for the FQHC payment code or the grandfathered tribal FQHC PPS rate.

Coinsurance will generally be 20 percent of the lesser of the actual charge or the grandfathered tribal.

For claims that consist solely of preventive services that are exempt from beneficiary coinsurance, contractors shall pay 100 percent of the lesser of the actual charge or the grandfathered tribal FQHC PPS rate, and no beneficiary coinsurance would be assessed.

For claims that include a mix of preventive and non-preventive services, MACs shall use the current methodology established under the FQHC PPS to calculate coinsurance.

Medical necessity

CMS is required by the Social Security Act to ensure that payment is made only for those medical services that are reasonable and necessary.

“Medical necessity” is defined as services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member and are not excluded under another provision of the Medicare program.

Definition of limited coverage

Coverage of certain procedures is limited by the diagnosis and/or frequency. If the diagnosis listed on the claim is not the same as one of those listed as covered for the procedure, the procedure is denied as not medically necessary. If the procedure has a frequency limit, claims will deny as not medically necessary if frequency has been exceeded.

Medicare has a number of policies including national coverage determinations and local coverage determinations that describe coverage criteria.

NCDs

NCDs are developed by CMS to describe the circumstances for Medicare coverage nationwide for a specific medical service procedure or device. NCDs generally outline the conditions for which a service is considered to be covered (or not covered) under Section 1862(a) (1) or other applicable provisions of the Social Security Act.

NCDs are CMS’ medical policy relating to outpatient services. A listing of all [NCDs](#) is available on the CMS NCD web page.

Examples of NCDs that IHS facilities perform include diabetes self-management training (DSMT) and medical nutrition therapy (MNT).

LCDs

CMS indicated that in the absence of statute regulations or national coverage policy, Medicare contractors are to develop LCDs to describe when and under what circumstances an item or service will be covered. The MAC must also develop LCDs to clarify or provide specific details on national coverage guidelines.

Examples of LCDs that IHS facilities perform include routine foot care, ophthalmology, therapy services, wound care and EKGs. Coverage guidelines for these and other LCDs are located on the [LCD/Medical Policy](#) page of our website.

Reasons for non-coverage

Services denied by the Medicare program as not medically necessary or reasonable fall into these general categories:

- Experimental and Investigational.
- Not safe and effective.
- Limited coverage based on certain criteria.
- Obsolete tests.
- Number of services exceeds the norm and no medical necessity demonstrated for the extra number of services.

Note: In the event a non-native patient is treated and services may fall under limited/national coverage limitations, providers should be aware of the advance beneficiary notice of non-coverage (ABN) and the requirements. Complete guidelines along with a copy of the ABN can be found in the CMS [Medicare Advance Written Notices of Non-Coverage](#)

Medicare statutory exclusions

Exclusions from coverage

Certain items and services are excluded from coverage under both Medicare Part A and Part B:

- Not reasonable and necessary. Items and services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are not covered.
- No legal obligation to pay for or provide.
- Services furnished or paid by government institutions (exception to this rule is IHS filing Medicare claims).
- Services not provided within the United States (only a few exceptions). Services resulting from acts of war.
- Personal comfort items.
- Self-administered drugs and biologicals. (Part B does not pay for self-administered drugs unless they meet the requirements established for durable medical equipment (DME) suppliers. Medicare Part D will consider payment on self-administered drugs and biologicals.)
- Eye exams for the purpose of prescribing, fitting or changing eyeglasses or contact lenses in the absence of disease or injury to the eye.
- Routine immunizations (except influenza vaccine, pneumococcal vaccine and hepatitis B vaccine).

- Physicals, laboratory tests and X-rays performed for screening purposes (except screening mammograms, screening Pap smears and various other mandated screening services).
- X-rays and physical therapy provided by chiropractors.
- Hearing aids and hearing examinations for the purpose of fitting a hearing aid; hearing tests that have not been ordered by a doctor.
- Routine foot care (i.e., cutting or removal of corns and calluses; trimming, cutting, clipping or debriding of nails; and other hygienic and preventive maintenance care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of either ambulatory or bedfast patients, and any other service performed in the absence of localized illness, injury or symptoms involving the foot). Refer to the Novitas LCD for routine foot care guidelines.
- Supportive devices for the feet.
- Custodial care (help with bathing, dressing, using the bathroom and eating) at home or in a nursing home.
- Cosmetic surgery (unless required for prompt repair of accidental injury or for improvement of a malformed body member).
- Charges made to the Medicare program for services furnished by a physician or supplier to his immediate relatives or members of his household.
- Routine dental services (i.e., care, treatment, filling, removal or replacement of teeth, dentures).
- Acupuncture.
- Paid or expected to be paid under workers' compensation.
- Non-physician services provided to a hospital inpatient that were not provided directly or arranged for by the hospital.

Routine services and appliances

Routine physical checkups: eyeglasses, contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses; eye refractions by whatever practitioner and for whatever purpose performed; hearing aids and examinations for hearing aids; and immunizations (except for influenza, pneumonia and hepatitis B) are not covered.

Services related to and required as a result of services that are not covered under Medicare

Medical and hospital services are sometimes required to treat a condition that arises as a result of services that are not covered because they are determined to be not reasonable and necessary or because they are excluded from coverage for other reasons. Services related to non-covered services, including services related to follow-up care and complications of non-covered services that require treatment during a hospital stay, in which the non-covered service was performed, are not covered services under Medicare. Services not related to non-covered services are covered under Medicare.

Provider enrollment

The provider/supplier enrollment process is a critical function that assures only qualified and eligible hospitals, clinics, providers and suppliers are enrolled in the Medicare program and receive reimbursement for services rendered to beneficiaries. All regulations regarding Medicare provider enrollment can be found in the CMS IOM [Pub. 100-08, Medicare Program Integrity Manual, Chapter 15](#).

Hospitals, clinics, providers and suppliers who wish to be certified for participation in the Medicare program or requesting a change of information/address must complete the applicable provider enrollment application (CMS-855). A CMS-855 application is required when a Change of Ownership (CHOW) has occurred, change of tax ID, changes in authorizing or delegated officials, NPI changes and change of address.

NPI

The NPI is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Anyone eligible to enroll with Medicare must first apply for an NPI number. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about health care providers, such as the state in which they live or their medical specialty. All Medicare claims are submitted with the billing, rendering and/or ordering provider's NPI instead of the PTAN or legacy identifier.

The purpose of the NPI is to:

- Simplify billing.
- Replace multiple provider numbers.
- Help with coordination of benefit payments.

An NPI must be obtained before submitting an initial application to Medicare. The Medicare application must contain the NPI.

CMS developed the [National Plan and Provider Enumeration System \(NPPES\)](#) to assign these unique identifiers.

Enrollment forms

The Medicare enrollment applications are forms issued by CMS. The forms collect general information to ensure that the applicant is qualified and eligible to enroll in the Medicare program. The current version of the application form must be submitted; otherwise your application will be returned with a requirement to resend on the latest version. CMS enrollment forms can be found in the [Enrollment Center](#) of our website.

Supporting documents

Additional documentation may be required with the application. This could include:

- Tax documents (IRS CP575). CMS-588 (EFT authorization).
- Copies of any state licenses or certifications.
- If applicable, copies of Clinical Laboratory Improvement Amendments (CLIA), Food and Drug Administration (FDA) and/or diabetes program certifications.
- Copy of attestation for government and tribal organizations.

If you are newly enrolling or revalidating your enrollment, you must provide all applicable documentation. For changes, only submit documents applicable to that change.

Refer to the application form for a list of documents that may be required.

Enrollment application cover sheets

Novitas Solutions has developed application cover sheets that should be used with all enrollment forms. The cover sheet ([Part A](#)) ([Part B](#)) ensures that the application is processed by an IHS enrollment specialist. Below is the link to the forms:

Provider Enrollment, Chain and Ownership System (PECOS)

The PECOS is a national database that supports the provider enrollment function. This database is used to house all provider information that can be used to verify provider information, add new providers into the system or make changes to existing Medicare providers during the enrollment process.

Since 2003, the Medicare contractor adds or updates enrollment information in PECOS whenever an enrollment application is received and processed.

Internet-based Pecos

CMS has established Internet-based PECOS as an alternative to the paper (CMS-855) application process. Internet-based PECOS allows providers, clinics and hospitals to enroll or make a change in their Medicare enrollment information that is on file with Medicare.

In August 2010, CMS issued instructions advising that effective September 1, 2010, IHS facilities may use Internet-based PECOS or the paper enrollment application (CMS-855) to initially enroll or submit a change of information.

For assistance with using online PECOS, please visit the [Enrollment Center](#) of our website.

Application fee and screening process

CMS published a final rule with comment period entitled “Medicare, Medicaid and Children’s Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers (CMS-6028-FC).” This rule was published February 2, 2011, in the *Federal Register*.

The rule finalized the following provisions, effective March 25, 2011:

- Establishment of provider enrollment screening categories.
- Submission of application fees.
- Suspensions of payment based on credible allegations of fraud.
- Authority to impose a temporary moratorium on the enrollment of new Medicare providers and suppliers of a particular type in a geographic area.

The application fee applies to all new Part A and Part B hospitals, FQHCs, ambulances, DME suppliers and ASCs, and for revalidation and addition of practice locations. It does not apply to enrollment of physicians or NPPs in a clinic, Part B clinics or updates/changes to a Part B application.

Screening process

Beginning March 25, 2011, Medicare placed newly enrolling and existing providers and suppliers in one of three levels of categorical screening: limited, moderate or high. IHS hospitals, FQHCs, ASCs, clinics, physicians and NPPs are in the limited category. For providers and suppliers in the limited category, Medicare will process initial, revalidation and new location applications in accordance with existing instructions. Ambulances and DME suppliers will be processed under the moderate level of screening and subject to a site visit by the Medicare contractor.

IHS hospitals, FQHCs, ASCs, clinics, physicians and NPPs are in the limited category. For providers and suppliers in the limited category, Medicare will process initial, revalidation and new location applications in accordance with existing instructions. Ambulances and DME suppliers will be processed under the moderate level of screening and subject to a site visit by the Medicare contractor.

Application fee Application fee

The Affordable Care Act (ACA) requires a fee for applications for any provider who submits an 855A or 855B application (except physicians and NPPs and Part B clinics).

The application fee is prescribed by CMS and will vary from year to year.

The fee applies to institutional providers that are:

- Initially enrolling in Medicare,
- Adding a practice location, or,
- Revalidating their enrollment information.

The application fee applies to Part A hospitals and FQHCs along with Part B ASCs, ambulance and DME suppliers.

CMS issued instructions on June 6, 2011, revising the application fee process for IHS. The following institutional providers may also submit application fee payments via the Intra-Governmental Payment and Collection (IPAC) system:

- IHS providers.
- All other federally owned and/or operated providers and suppliers (e.g., Veterans Affairs (VA) hospitals).

The application fee can be paid in IPAC prior to submission of the enrollment form. A copy of the confirmation page must be submitted with the enrollment form.

IHS locations using the IPAC system will need to provide:

- CMS' Agency Location Code (ALD) 75050080.
- An explanation of the payment (i.e., provider enrollment fee).
- The Treasury Account Symbol as 75X0511.

Tribal facilities without access to IPAC must make payments electronically through the [CMS Medicare enrollment form](#).

If the fee or hardship exception is not received at the time of the application submission, a letter will be sent, and the provider will be granted 30 calendar days to pay the fee.

The application will not be processed until proof of payment has been received.

The provider will not be provided another opportunity to request a hardship exception.

Failure to pay the fee within 30 days could result in deactivation of the provider's billing privileges.

Hardship exceptions

A provider or supplier requesting a hardship exception from the application fee must include with its enrollment application a letter (and any supporting documentation) that describes the hardship and why the hardship justifies an exception.

If a paper CMS-855 application is submitted, the hardship exception letter must accompany the application. If the application is submitted via Internet-based PECOS, the hardship exception letter must accompany the certification statement.

Hardship exception letters will not be considered if they were submitted separately from the application or certification statement, as applicable. If the contractor receives a hardship exception request separately from the application or certification statement, it will return it to the provider and notify the provider via letter, e-mail or telephone that it will not be considered.

Hardship exceptions will not be granted when the provider simply asserts that the imposition of the application fee represents a financial hardship. The provider must make a strong argument to support its request, including providing comprehensive documentation (which may include, without limitation, historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements and tax returns). CMS will determine if a hardship is acceptable.

Returned applications

Provider enrollment applications may be immediately returned to the provider in many instances. The most common reasons are:

- No signature on the CMS-855 application.
- Application contains a copied or stamped signature.
- Signature on the application is not dated.
- Applicant completed the form in pencil.
- Application was faxed or e-mailed.
- Contractor received the application more than 60 days prior to the effective date listed on the application (does not apply to new Part A and ASC applications, which cannot be received more than 30 days prior to the effective date).

Application processing

The application process is located in the [Enrollment Center](#) of our website.

Contact person

Section 13 appears in each CMS-855 application and should be completed by providing a contact person familiar with the application being submitted. If there are any additional documentation requests, the contact person will be notified.

The contact person is only valid for the application being processed and will not be added to the enrollment system as someone to always contact in case of questions. If there is no contact person listed in section 13, then either the provider, authorizing or delegated official will be contacted.

Changing Tax ID

When there is a change in the provider's (hospital, clinic, ASC, ambulance) tax ID, the enrollment requirements differ between Part A and Part B.

Part A requirements

As long as there is not a change of ownership, complete the CMS-855A as a change of information and attach new tax document showing legal business name and Tax ID.

No application fee required.

Part B requirements

Complete the CMS-855B as a new enrollee. This will require at least one physician application (855I) and the CMS-588 EFT to be submitted with the 855B, along with required supporting documentation. A new group PTAN will be issued.

No application fee is required for physician-directed clinics; however, it will apply to ASCs and ambulance providers.

Individual practitioners

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.

The Patient Protection and Affordable Care Act (PL 111-148) amended Section 221 of the Indian Health Care Improvement Act (IHCIA) to provide as follows:

- Licensed health professionals employed by a tribal health program shall be exempt, if licensed in any state, from the licensing requirements of the state in which the tribal program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and Education Assistance Act (ISDEAA) (25 U.S.C. 450, et seq.).

On July 5, 2011, the IHS, as the agency responsible for interpreting the IHCIA, issued guidance indicating that Section 221 is self-implementing. Thus, pursuant to the statutory provision, any physician or practitioner need only be licensed in one state – regardless of whether that state is the one in which the practitioner practices – if he is employed by a tribal health program performing services as permitted under the ISDEAA.

Contracted radiologists

On December 5, 2009, CMS issued change request (CR) 1643, which defines and describes the mechanisms to be used when IHS providers contract with non-IHS physicians for tele-radiological interpretations. Due to the geographic extent of IHS areas, physician services are frequently rendered by non-IHS physicians. The arrangements for payment in this situation are unique to IHS facilities and the IHS Medicare contractor.

CR1643 gives IHS the authority to enroll contracted non-IHS physicians as employees of their facility, even if that contracted physician is not performing services within the IHS building. The non-IHS physician must enroll with the designated IHS Medicare contractor using the CMS-855R, reassigning their billing rights to the IHS facility.

Reciprocal billing and fee-for-time compensation arrangements (formerly locum tenens arrangements)

For details, please refer to our article on [Reciprocal Billing and Fee-For-Time Compensation Arrangements \(formerly Locum Tenens Arrangements\)](#).

Mobile mammography units

The Mammography Quality Standards Act (MQSA) provides specific standards regarding those qualified to perform screening and diagnostic mammograms and how they should be certified. The 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 VA facilities) must have a certificate issued by the FDA to continue to operate.

Mammography facilities that perform screening mammography's are not to release screening mammography X-rays for interpretation to physicians who are not approved under the facility's certification number unless the patient has requested a transfer of the mammography from one facility to another for a second opinion or unless the patient has moved to another part of the country where the next screening mammography will be performed. Interpretations are to be performed only by physicians who are associated with the certified mammography facility.

To bill Medicare for contracted services rendered by a mobile mammography unit located at an IHS/tribal facility, the CMS-855A and/or CMS-855B application must be updated to include the FDA certification number of the unit.

A copy of the contract and FDA certification will be required with the application.

Attach a cover letter on the IHS/tribal facility's letterhead explaining why the updated application is being submitted.

Complete the following sections in either the CMS-855A and/or CMS-855B forms:

- Section 1A – Change of Medicare information. Enter PTAN and NPI in second column.
- Section 1B – Practice location information.
- Section 3 – Complete adverse legal history for authorizing official.
- Section 4A – Check the "Add" box and enter the FDA certification number.
- Section 4D – Complete this section only in the CMS-855A application.
- Section 4E – Complete this section only in the CMS-855A application.
- Section 6 – Complete 6A and 6B for authorizing official.
- Section 13 – Contact person.
- Section 15 or 16 – Signature of authorizing official.

To bill for the interpretation of these mammograms, the physician will be required to complete the enrollment process (if not currently enrolled with IHS facility) to become a provider for the IHS/tribal facility providing the mammograms. This includes completing the CMS-855I application.

Medical students

A student is considered an individual who participates in an accredited education program (i.e., medical school) that is not an approved Graduate Medical Education (GME) program. A student is never considered to be an intern or a resident. Medicare does not pay for any service furnished by a student.

Any contribution and participation of a student to the performance of a billable service (other than the review of systems and/or past family/social history) must be performed in the physical presence of a teaching physician or physical presence of a resident in a service meeting the requirements set forth in the teaching physician guidelines.

Students may document services in the medical record; however, the documentation of an evaluation and management (E/M) service by a student is limited to documentation related to the review of systems and/or past family/social history. The teaching physician may not refer to a student's documentation of physical exam findings or medical decision-making in his personal note. If the medical student documents E/M services, the teaching physician must verify and re-document the history of present illness as well as perform and re-document the physical exam and medical decision-making activities of the service.

For guidelines on medical students, please review the CMS [IOM Pub. 100-04, Medicare Claims Processing Manual, Chapter 12](#).

Part B do not forward (DNF) initiative

Medicare contractors are required to use "return service requested" envelopes for mailing all hard copy remittance advices (RAs.) When the U. S. Postal Service (USPS) returns an RA due to an incorrect address, we will process as follows:

- The provider or supplier file with provider enrollment will be flagged as "DNF." Until the provider or supplier furnishes a new address, no further payments or RAs will be generated.
- Once the new address is received from the provider or supplier, we will verify the address and update the provider or supplier file with provider enrollment.
- Any funds that have been suspended will be released to the provider or supplier and all RAs that have been held will be reissued.

Note: CMS requires corrections to all addresses before the Medicare contractor can begin paying the provider/supplier again.

Electronic data interchange

Electronic data interchange (EDI) is the process of transacting business electronically, including submitting claims electronically (paperless claims processing), as well as electronic funds transfer (EFT) and electronic inquiry for claim status and patient eligibility.

Electronic claims

Medicare providers can easily take advantage of the many benefits of submitting claims electronically. Medicare claims turn around faster and are reimbursed sooner, thus improving cash flow. Payment for electronic claims may be released after 14 days; payment for paper claims can be issued on the 29th day following receipt of the clean claim.

Electronic remittance advice

The Medicare electronic remittance advice (ERA) provides payment information on all claims and adjustments. By receiving payment information electronically, you can post payments automatically, saving valuable time and improving accuracy by programming an interface with the 835 ERA files.

For more information, please visit the [EDI Center](#) of our website.

Patient registration/screening

During patient registration, it is important for front office staff to identify whether a beneficiary's expenses should be covered by other insurance before, or in addition to, Medicare. This information helps the office determine who to bill and how to file claims with Medicare.

This is not an easy task. There are many insurance benefits a patient could have and many combinations of insurance coverage to consider before determining who pays and when. Depending on the type of additional insurance coverage a patient has (if any), Medicare may be the primary payer for a patient's claims or be considered the secondary payer.

There are several tasks the front office personnel or person who receives initial patient information performs that are vital to the efficiency and financial welfare of the health care organization to which they belong.

The office staff should:

- Copy the Medicare card and/or other insurance cards.
- Obtain essential patient information through use of completed medical information/history and insurance forms.
- Determine Medicare eligibility.
- Obtain appropriate information to allow the claim to be submitted to the appropriate insurance payer.

Quarterly data analysis identifies three errors that could be significantly reduced or eliminated by providers who have an effective patient screening process in place.

The three-patient screening-related billing errors identified are:

- Medicare Advantage (MA) plan denials.
- Medicare secondary payer (MSP) denials.
- Beneficiary eligibility denials.

The following are suggestions to assist your existing patient screening office procedures:

- Verify the patient's name and Medicare number to his Medicare card. The name used on all documents should match the Medicare card exactly.
- The patient's name and Medicare number should match the claim that is submitted to Medicare.
- Patient eligibility can be obtained from the Medicare card. However, if the patient joins an MA plan or terminates Part B coverage, the patient may continue to carry the Medicare card. Don't only use the Medicare card as a guarantee of Medicare eligibility.
- Periodically verify the patient's insurance information to determine if any changes have occurred. If changes have occurred, the patient's records should be updated accordingly. Collection and maintenance of up-to-date patient and insurance information is critical for offices in today's insurance environment.
- Verify a picture ID of the patient to ensure the Medicare beneficiary/recipient is not a victim of identity theft and the Medicare identification is not being used without knowledge or consent.
- Failure to perform adequate patient screening and maintain up-to-date files can be viewed as a violation of the provider agreement with Medicare. Patients must be prompted to share other possible coverage that may be primary to Medicare.
- A few minutes of patient screening during each patient's visit can save providers time and money later.

Eligibility inquiry resource

There are several options to check patient eligibility:

- [Novitasphere](#):
Novitasphere is a FREE, secure internet portal for providers, billing services, and clearinghouses. The portal contains eligibility details for Part A and Part B providers.
- [FISS Manual](#):
Part A providers can access the Common Working File to verify eligibility using the Fiscal Intermediary Shared System (FISS):
- [Interactive Voice Response: \(IVR\)](#):
This service is accessed via your telephone simply by calling the toll-free provider customer service telephone number: 1-855-252-8782

Hospice

Medicare payment may only be made for covered Medicare services to beneficiaries electing the hospice benefit when the services are unrelated to the treatment of the terminal illness for which hospice care was elected.

Part A

When hospitals provide covered Medicare services to a hospice beneficiary that is unrelated to the treatment of the terminal illness, they should use condition code 07 on the claim for these services.

Condition code 07 is defined as treatment of a non-terminal condition for a hospice patient. The condition code indicates that the patient is a hospice enrollee, but the provider is not treating his terminal condition and is therefore requesting regular Medicare reimbursement.

Part B

For Part B professional (CMS-1500) claims, Medicare payment may only be made to the attending physician who is not an employee of the designated hospice, or when a service is unrelated to the patient's terminal condition.

An individual enrolling in hospice may elect an attending physician, who will have a significant role in the determination and delivery of the patient's medical care. The attending physician is not an employee of the hospice and does not receive compensation from the hospice. The GV modifier should be used when services are rendered by the attending physician.

The GW modifier is used when a service is rendered to a patient enrolled in a hospice and the service is unrelated to the patient's terminal condition.

Home health

Section 1842(b)(6)(F) of the Social Security Act required consolidated billing of all home health services while a beneficiary is under a home health plan of care authorized by a physician. Consequently, billing for all such items and services should be made to a single home health agency (HHA) overseeing that plan, and this HHA is known as the primary agency or HHA for HH PPS billing purposes.

Types of services subject to the home health consolidated billing provision:

- Skilled nursing care.
- Home health aide services.
- Physical therapy.
- Speech-language pathology.
- Occupational therapy.
- Medical social services.
- Routine and non-routine medical supplies.
- Medical services provided by an intern or resident-in-training of a hospital under an approved teaching program of the hospital in the case of an HHA that is affiliated or under common control with that hospital.
- Care for homebound patients involving equipment too cumbersome to take to the home.

Medicare payment for services subject to home health consolidated billing is made to the primary HHA, so separate Medicare payment for these services will never be made.

The primary HHA is responsible for providing these services, either directly or under arrangement. This responsibility applies to all services the physician has ordered on the beneficiary's home health plan of care.

When services are billed that fall under the home health consolidated billing, the claim will deny and the facility must contact the primary HHA.

MSP

MSP is the term used by Medicare when it is not responsible for paying a claim first.

When Medicare is secondary payer, the order of payment is the reverse of what it is when Medicare is primary. The other payer pays first, and Medicare pays second.

The role of Medicare as the secondary payer is similar to the coordination of benefits clause in private health insurance policies. By federal law, Medicare is secondary payer to a variety of government and private insurance benefit plans.

Medicare should be viewed as the secondary payer when a beneficiary can reasonably be expected to receive medical benefits through one or more of the following:

- Employer group health plan (EGHP) for working aged beneficiaries.
- Large group health plan (LGHP) for disabled beneficiaries.
- Beneficiaries eligible for end stage renal disease (ESRD)
- Auto/medical/no-fault/liability insurance.
- Veterans Affairs (VA).
- Workers' compensation plan.
- Federal Black Lung program.

Individuals **not subject** to the MSP provision include:

- Individuals enrolled in Part B only.
- Individuals enrolled in Part A based on a monthly premium.

For complete guidelines on billing MSP claims, please refer to the Novitas Medicare secondary payer specialty page ([Part A](#)) ([Part B](#)).

MSP questionnaire (MSPQ)

Providers are required to determine whether Medicare is a primary or secondary payer for each Medicare beneficiary inpatient admission and outpatient encounter prior to submitting a bill to Medicare. It must accomplish this by asking the beneficiary about other insurance coverage.

The CMS [IOM Pub. 100-05, Medicare Secondary Payer \(MSP\) Manual, Chapter 3, Section 20.2.1](#) includes a model MSPQ and a list of questions to ask the Medicare beneficiary.

MSPQs are required for every:

- Inpatient admission.
- Outpatient encounter (with the exceptions listed below).
- Start of care.

The MSPQ is not required for freestanding facilities; however, providers are still required to determine whether Medicare is primary or secondary. Therefore, the same questions can be used in a clinic setting as in a hospital.

Exceptions to the MSPQ requirement are:

- Reference lab claims (Part A type of bill (TOB) 141).
- Patients enrolled in a Medicare Advantage plan.

For inpatient hospital stays, the MSPQ should be collected with every admission.

Recurring outpatient services

Hospitals must collect MSP information from the beneficiary or his representative for hospital outpatients receiving recurring services (e.g., physical therapy).

Both the initial collection of MSP information and any subsequent verification of this information must be obtained from the beneficiary or his representative.

Following the initial collection, the MSP information should be verified once every 90 days. If the MSP information collected by the hospital from the beneficiary or his representative and used for billing is no older than 90 calendar days from the date the service was rendered, that information may be used to bill Medicare for recurring outpatient services furnished by hospitals. This policy, however, will not be a valid defense to Medicare's right to recover when a mistaken payment situation is later found to exist.

Beneficiary signature

The provider retains a copy of completed admission questionnaires in its files (or online) for audit purposes to demonstrate that development for other primary payer coverage takes place. It is not necessary for the beneficiary to sign the completed questionnaire. Claims can be submitted even if the beneficiary did not sign the questionnaire.

Retention of MSPQ

CMS may pursue providers, physicians and other suppliers under the False Claims Act and the Federal Claims Collection Act for up to 10 years after a claim is paid; therefore, it would be prudent for hospitals to retain the MSPQ for up to 10 years.

Medicare permits providers to retain hard copy questions and responses on paper, optical image, microfilm or microfiche. If the provider's admission questions are retained online, Medicare requires it to retain negative and positive responses to admission questions for 10 years after the date of service. Online data may not be purged before then.

Tribal self-funded insurance

For American Indian and Alaska Native (AI/AN) beneficiaries receiving care in an IHS/tribal/CAH, Medicare will make a conditional payment for those beneficiaries that are employed by the tribe and covered under tribal self-insurance. Medicare is primary for services rendered in an Indian Health facility; however, once the patient receives services at a non-IHS facility, the tribal self-funded insurance is primary.

During the collection of MSPQ information, if it is determined that the beneficiary is employed by the tribe, a conditional payment claim must be submitted each time the beneficiary receives either an outpatient encounter or an inpatient admission.

Medicare's systems cannot distinguish self-insurance from third-party insurance. This does not affect claims processing or payment; however, CMS' Medicare Secondary Payer Recovery Contractor (MSPRC) may later include IHS provider claims in a demand for repayment. The tribe's self-insurance is a valid defense against the inclusion of such claims; to assert this defense, the tribe must provide the MSPRC with documented proof that it was self-insured at the time the IHS facility provided the relevant services. Upon receiving the appropriate documentation, the MSPRC will remove the IHS provider claims from the debt.

Information related to Tribal self-funded insurance claims/adjustments, is available on the IHS Center of our website.

Part A MSP adjustments

Outpatient claims rejected for MSP will be posted to the beneficiary's record in the CWF and will be considered processed claims. Because these claims are posted to the CWF, if the claim is resubmitted as a new claim, it will be denied as a duplicate. Outpatient claims rejected for MSP will need to be adjusted by the provider.

If the outpatient claim was rejected in error and the MSP records have been corrected to reflect Medicare as the primary payer for the dates of service in question, the provider may initiate an adjustment for any that were previously rejected.

MSP claims are to be submitted to Medicare electronically. This includes MSP adjustments.

CMS issued CR6426 advising that effective October 5, 2009, Part A MSP claims can no longer be entered via DDE. This includes MSP adjustments.

If your system is not capable of submitting MSP claims, consider downloading [PC-ACE](#) available on our website.

MSP Contractor (formerly Benefits Coordination & Recovery Center (BCRC))

The MSP Contractor, (formerly the BCRC), is responsible to consolidate activities that support the collection, management and reporting of all other health insurance coverage for Medicare beneficiaries.

The purpose of the coordination of benefits (COB) program is to identify health benefits available to Medicare beneficiaries and to coordinate the payment process to prevent or minimize overpayments of Medicare benefits.

Reference

- CMS [IOM Pub. 100-05, Medicare Secondary Payer Manual](#)

Medicare Part A hospital insurance

Medicare Part A helps pay for medically necessary care for the following:

- Inpatient hospital care.
- Extended care services in a SNF after a hospital inpatient stay.
- Home health care.
- Hospice care.

The number of covered days used is maintained by CMS to track the beneficiary's eligible days in a benefit period. Part A coverage is renewed every time a beneficiary begins a new benefit period.

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

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. In order to receive the appropriate payment under the IPPS, it is important that the applicable ICD-10-CM diagnosis codes as well as ICD-10-CM procedure codes are reported on the bill.

IPPS/DRG

IPPS was developed so the Medicare program would pay a predetermined rate for each type of hospital discharge in accordance with a federal payment schedule. These rates, depending on the DRG, represent payment in full to the hospital for routine inpatient operating costs. Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG. The beneficiary's expense is limited to deductibles, coinsurance and non-covered items.

Under the DRG system, patients are classified according to:

- Patient diagnosis
- Patient age
- Treatment procedure
- Discharge status
- Gender

Inpatient hospital coverage conditions

Medicare Part A will pay for inpatient hospital care if all the following conditions are met:

- Patients covered under hospital insurance are entitled to have payment made on their behalf for inpatient hospital services.
- The hospital is participating in the Medicare program (in an emergency situation the patient may go to a non-participating hospital).
- The physician prescribes inpatient hospital care for the treatment of an injury or illness.
- The patient requires the kind of care that can only be provided in a hospital. The level of care the patient receives is medically necessary according to CMS regulations.

Definition of inpatient

An “inpatient” is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. A person is considered an inpatient if he was formally admitted as an inpatient with the expectation that he would remain at least overnight and occupy a bed, even if it later develops that he can be discharged or is transferred to another hospital and does not actually use a hospital bed overnight.

The physician or other practitioner responsible for a patient’s care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. The physician should use a 24-hour period as a benchmark, i.e., the physician should order admission for patients who are expected to need hospital care for 24 hours or more and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment that can be made only after the physician has considered a number of factors, including the patient’s medical history and current medical needs, the types of facilities available to inpatients and outpatients, the hospital’s bylaws and admission policies, and the relative appropriateness of treatment in each setting.

Additional factors to be considered when making the decision to admit:

- Severity of the signs and symptoms exhibited by the patient.
- Medical predictability of something adverse happening to the patient.
- Need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted.
- Availability of diagnostic procedures at the time and location where the patient presents.

Benefit period

A benefit period begins the day someone is admitted into a hospital or SNF and ends when that person has not received Medicare-covered hospital or skilled nursing care for 60 days in a row. If someone is admitted to a hospital or facility after one benefit period has ended, a new benefit period begins.

The inpatient hospital deductible will be applied for each benefit period. There is no limit to the number of benefit periods a person may have.

A transfer from one hospital to another is not considered a discharge. A leave of absence is also not considered a discharge from the hospital.

A benefit period ends when a beneficiary has not been an inpatient of a hospital or SNF for 60 consecutive days. The benefits will be renewed for full and coinsurance days only. An individual may be discharged from and readmitted to a hospital or SNF several times during a benefit period and still be in the same benefit period if 60 consecutive days have not elapsed between discharge and readmission. The stays need not be for related conditions.

Each benefit period also entitles the patient to 100 days of skilled nursing care. These services can be rendered in either a SNF or swing bed unit of an acute hospital. The first 20 days of care are covered in full, and the remaining 80 days are paid at a coinsurance rate.

LTR days

These days are saved for non-IHS hospitalization stays.

Counting an inpatient day

The number of days of care charged to a beneficiary for inpatient hospital services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method must be used in reporting the days of care for beneficiaries, even if the hospital uses a different definition for statistical or other purposes.

A part of a day, including the day of admission, counts as a full day. However, the day of discharge or death, or a day in which a patient begins a leave of absence, is not counted as a day (charges for ancillary services on the day of discharge or death are covered under Part B). If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one inpatient day.

Inpatient services

The following services or supplies are covered when provided while the beneficiary is an inpatient in the hospital:

- Semi-private accommodations, except where private accommodations are medically necessary or where semiprivate accommodations are occupied or unavailable.
- Nursing services (other than the services of a private-duty nurse or attendant) and other related services that are ordinarily furnished by the hospital for the care and treatment of inpatients.
- The use of hospital facilities (i.e., operating room) and medical social services that are customarily furnished by the hospital for the care and treatment of inpatients.
- Drugs and biologicals, supplies, appliances and equipment (e.g., wheelchairs, crutches) for use in the hospital that are ordinarily furnished by the hospital for the care and treatment of inpatients.
- Any other diagnostic or therapeutic items or services, such as X-ray and laboratory tests and physical and occupational therapy, furnished by the hospital or by others under arrangement with the hospital, which are ordinarily furnished to inpatients.

The services must be provided directly by the hospital or under an arrangement made by the hospital. Furthermore, when payment is made for an inpatient hospital stay under Part A, all services furnished during that stay must be treated as inpatient hospital services paid under Part A.

The term "inpatient hospital services" does not include extended care services (i.e., SNF) furnished by the hospital with swing bed approval. These are considered extended care services.

Appropriate short inpatient hospital stays

If an unforeseen circumstance results in a shorter beneficiary stay than the physician's reasonable expectation of at least two midnights, the patient may be considered to be appropriately treated on an inpatient basis and hospital inpatient payment may be made under Medicare Part A. Such circumstances must be documented in the medical record in order to be considered upon medical review.

Examples include:

- Death
- Transfer to another hospital
- Departure against medical advice
- Clinical improvement where the patient stayed less than the expected two midnights

Documentation requirements for Medicare inpatient admissions

Progress notes and other clinical documentation in the medical record must support the inpatient admission. In addition, the medical record must contain an inpatient [hospital admission order and a physician certification](#). Collectively, these requirements are necessary to support inpatient admission. Contractor review of inpatient admissions will focus on these requirements. HCA has developed a Medicare order form to facilitate obtaining the appropriate patient status order based on the two-midnight rule.

Inpatient admission procedures

It is important to obtain the information necessary to bill Medicare or other insurers correctly during the admission or registration interview of the beneficiary. The difficulty in obtaining this information after the patient is discharged or has completed treatment can delay billing. In addition, disclosure of this information by other entities, such as your MAC or the Social Security Administration (SSA), is severely restricted by the Privacy Act of 1972. Generally, no information about specific beneficiaries can be released without the beneficiary's express written consent.

Take the following actions during the admission or registration process:

- Obtain the beneficiary's signature on a statement incorporating the beneficiary's request for payment, authorization to release information and assignment of benefits. **Note:** This signed statement must be on file before billing Medicare. Most private insurers also require the patient's signed authorization.
- Obtain this authorization even if the patient is unable to furnish the health insurance claim (HIC)/Medicare Beneficiary Identifier (MBI) number, because the SSA cannot give the facility the HIC/MBI number and the facility cannot bill Medicare until the patient has this signed statement.
- Obtain the patient's Medicare HIC/MBI number and verify the patient's eligibility and effective date. Once the patient's HIC/MBI number and birth date have been obtained, the facility will be able to obtain eligibility information through its online inquiry functions or through the IVR system.
- Determine whether Medicare or another insurer is the primary payer. The facility is required to do this as a condition of its Medicare provider agreement.
- Make sure the patient satisfies all the statutory requirements to receive benefits for the services furnished by your facility and for inpatient admission, determining the benefit days available.

A written request for Medicare payment filed with the hospital may also serve as an application for hospital insurance entitlement filed with the SSA in the event the patient dies and has not previously applied for Medicare or Social Security benefits. The request must be filed with the hospital prior to the death of the patient.

Patient authorization – Part A/B

Request for payment for provider services

The recorded signature of the patient serves as the request for payment for the facility's provider services, for physician services for which the facility is authorized to bill, and for any other physician services furnished in your facility.

The statement signed by the beneficiary must include the language in the following form.

Statement to permit payment of Medicare benefits to provider, physician and patient

Name of Beneficiary _____ HICN/MBI _____

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in (name of provider), including physicians services. I authorized any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Signed _____ Date _____

Note: This authorization form is an example. The facility may have a document in place to obtain the necessary information.

For services furnished to inpatients of a hospital or SNF, the request is effective for the period of confinement. For services furnished on an outpatient basis, the request is effective until it is revoked.

When submitting claims under this procedure, indicate that the beneficiary's signature is in the facility's provider record by placing a "Y" in Form Locator 52 of the UB-04 claim form (Loop 2300 Segment CLM 08, 09, 10).

On the CMS-1500 claim form, for the professional services, indicate "*Signature on File*" in Item 12 of the paper CMS-1500 claim form (Loop 2300 Segment CLM 08, 09, 10).

Signature by someone other than the Patient

If the patient is unable to sign (e.g., unconscious, incompetent, in great pain, or otherwise in such a condition that he should not be asked to transact any business), his representative payee should be asked and permitted to sign on his behalf. The representative could be a relative, legal guardian or a representative of an institution (other than the provider) usually responsible for his care, or representative of a governmental entity providing welfare assistance, if present at the time of admission or start of services.

If at the time of admission or start of care, the patient cannot be asked to sign the request for payment and there is no person exercising responsibility for him, an authorized official of the provider may sign the request. Except in situations where the patient is not physically present, a provider should not routinely sign the request on behalf of any patient.

If the patient dies before the request for payment is signed, it may be signed by the legal representative of the estate or by any of the persons or institutions (including an authorized official of the provider) who could have signed it if he had been alive and incompetent.

When someone other than the patient signs the request for payment, the signer should add a brief statement explaining his relationship to the patient and the circumstances that made it impossible for the patient to sign. The provider must retain this statement in its files.

Notices to beneficiaries

CMS has clarified policy regarding issuance of the Important Message from Medicare, the hospital-issued notice of non-coverage (HINN) to AI and AN Medicare beneficiaries.

Important Message from Medicare

Hospitals must notify Medicare beneficiaries who are hospital inpatients about their hospital discharge appeal rights. This includes IHS hospitals.

The Important Message from Medicare (IM) must be delivered no later than two calendar days after admission. The initial copy may be given as part of the preadmission process, but no earlier than seven days prior to admission. If the notice is given more than two calendar days prior to admission, a follow-up copy must be delivered.

The IM must be delivered to the beneficiary in person and must be both signed and dated by the beneficiary. However, if the beneficiary is unable to understand the notice, it may be delivered to and signed by the beneficiary's legal representative or another person whom the beneficiary has indicated may act for him.

The original signed copy of the notice must be given to the patient and a copy must be retained by the hospital. The hospital determines the best method of storage of the notices. Hospitals must document timely delivery of all IM notices.

If a beneficiary or his representative refuses to sign the notice, an annotation should be placed in the patient signature line or the "Additional Information" section, or another sheet of paper may be attached to the notice.

A second copy of the signed IM must be delivered to the beneficiary as soon as possible prior to discharge, but not more than two days before the planned date of discharge. This second copy can be either a copy of the previously signed notice, or a new IM can be given. If a new IM is given, obtain the beneficiary or representative signature.

If discharge cannot be predicted in advance, the second copy may be delivered on the day of discharge; however, it must be delivered at least four hours prior to the time of discharge.

An Important Message from Medicare (Form CMS-R-193) is available on the [Hospital Discharge Appeal Notices](#) page of the CMS website.

HINN

The intent of the HINN is to inform the patient of impending liability at the time of admission or if they remain in the hospital beyond their discharge date, and what appeal rights they have. However, AI/AN Medicare beneficiaries admitted as inpatients to IHS hospitals are exempt from this provision because IHS hospitals do not hold the AI/AN beneficiary liable for services not covered by Medicare.

Non-native AI/AN Medicare beneficiaries who are treated in an IHS hospital would be subject to the notice requirement. The following requirement applies only to non-native beneficiaries, with the exception of the Public Health Service (PHS) Commission Corps pursuant to 42 USC 251(b) and non-Indian women pregnant with an Indian-eligible child pursuant to 42 CFR 36.12.

When the IHS hospital Utilization Review Committee (URC) becomes aware that the services to be furnished to a non-native patient are not covered, they should advise the patient (or his representative) in writing prior to or at the time of admission (or at the time the type of care changes during a stay) that the care is non-covered.

The [HINN](#) form and instructions are available on the BNI page of the CMS website.

Three day/One day payment window

On June 25, 2010, President Obama signed into law the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010, PL 111-192. Section 102 of the law pertains to Medicare's policy for payment of outpatient services provided on either the date of a beneficiary's admission or during the three calendar days immediately preceding the date of a beneficiary's inpatient admission to a "subsection (d) hospital" subject to the IPPS (or during the one calendar day immediately preceding the date of a beneficiary's inpatient admission to a non-subsection (d) hospital). This policy is known as the three-day (or one-day) payment window. Under the payment window policy, a hospital (or an entity that is wholly owned or wholly operated by the hospital) must include on the claim for a beneficiary's inpatient stay, the diagnoses, procedures and charges for all outpatient diagnostic services and admission-related outpatient non-diagnostic services that are furnished to the beneficiary during the three-day (or one-day) payment window.

Medicare patients often receive outpatient services prior to being admitted as an inpatient. These outpatient services can be either diagnostic or non-diagnostic (therapeutic) in nature and must be reported according to the three-day or one-day payment window.

CAH's are not subject to the payment window.

Condition code 51

Beginning April 4, 2011, providers may submit outpatient claims with condition code 51 to attest that the service is unrelated to outpatient therapeutic (non-diagnostic) services for dates of service on or after June 25, 2010. Outpatient claims received prior to April 4, 2011, that did not contain condition code 51 will need to be adjusted by the provider if they were rejected.

Reference:

- [IOM Pub. 100-04, Medicare Claims Processing Manual, Chapter 3, Section 40.3](#)

Diagnostic services

Diagnostic services are services ordered by the physician to determine a diagnosis for the patient. A service may be regarded as diagnostic if it is:

- An examination or procedure to which the patient is subjected, or which is performed on materials derived from a hospital outpatient, to obtain information to aid in the assessment of a medical condition or the identification of a disease.
- Performed on materials derived from the patient to obtain information to aid in the assessment of a medical condition or the identification of a disease.

Among these examinations and tests are:

- Diagnostic laboratory services.
- Diagnostic X-rays.
- Isotope studies.
- EKGs.
- Pulmonary function studies.
- Thyroid function tests.
- Psychological tests.
- Other tests given to determine the nature and severity of an ailment or injury.

Diagnostic services provided by the admitting hospital (or provider-based clinic of hospital) to a patient within three days prior to and including the date of the inpatient admission are deemed to be inpatient services and included in the inpatient payment unless there is no Part A coverage.

Diagnostic services furnished to inpatients

IHS providers, including CAHs, are paid by Medicare Part A for medically necessary covered diagnostic services furnished to an inpatient 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 111.

Payment is made to IHS/tribal hospitals under IPPS.

Therapeutic services

Therapeutic (non-diagnostic) services are services ordered by the physician that aid the physician in treatment of the patient (i.e., services “incident to” the physician’s services). Such services include clinic visits and emergency room services.

Therapeutic services (other than ambulance) that are related to the inpatient admission and provided by the admitting hospital (or provider-based clinic of a hospital) to a patient within three days prior to and including the date of the inpatient admission are also deemed to be inpatient services and included in the inpatient payment unless there is no Part A coverage.

Only therapeutic services that are clinically distinct or independent from the reason for the patient’s inpatient admission may be separately billed on an outpatient claim. Such separately billed services may be subject to subsequent review; therefore, medical record documentation should support that the service is unrelated to the admission.

Drugs and biologicals furnished to inpatients

IHS providers, including CAHs, are paid by Medicare Part A for medically necessary 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 111.

Payment is made to IHS/tribal hospitals under IPPS.

Inpatient admission changed to outpatient

When a patient is admitted as an inpatient, but during the course of the stay it is determined that the inpatient level of care does not meet admission criteria, the hospital may change the beneficiary's status from inpatient to outpatient and submit an outpatient claim (TOB 13X) with condition code 44 to report medically necessary Medicare Part B services that were furnished to the beneficiary **only if all** of the following conditions are met:

- The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital.
- The hospital has not submitted a claim to Medicare for the inpatient admission.
- A physician concurs with the URC's decision.
- The physician's concurrence with the URC's decision is documented in the patient's medical record.

When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be treated as though the inpatient admission never occurred and should be billed as an outpatient episode of care.

Orders and entries in the medical record, including those related to the inpatient admission, cannot be expunged or deleted and must be retained in their original form. Any change in patient status must be fully documented in the medical record, complete with orders and notes that indicate why the change was made, the care that was furnished to the beneficiary, and the participants in making the decision to change the patient's status.

When condition code 44 is appropriately used, the hospital reports the services that were ordered and provided to the patient for the entire patient encounter. Hospitals may not, however, report observation for services furnished prior to receiving a physician's order. Medicare does not permit retroactive orders or the inference of physician orders. All hospital outpatient services, including observation services, must be ordered by a physician. The clock time begins at the time observation services are initiated in accordance with a physician's order.

Hospitals may include charges for the costs of all hospital resources utilized in the care of the patient during the entire encounter. For example, a beneficiary is admitted as an inpatient and receives 12 hours of monitoring and nursing care. The hospital then changes the status of the patient from inpatient to outpatient, all criteria for billing condition code 44 are met, and the physician writes an order for observation services.

Inpatient services same month as repetitive services

When a patient is hospitalized during the same month as outpatient therapy services, the outpatient claim that contains the repetitive services will need to be submitted with occurrence span code 74 and the dates of the inpatient stay.

Inpatient services in connection with dental services

When a patient is hospitalized for a dental procedure and the dentist's service is covered under Part B, the inpatient hospital services furnished are covered under Part A. For example, both the professional services of the dentist and the inpatient hospital expenses are covered when the dentist reduces a jaw fracture of an inpatient at a participating hospital. In addition, hospital inpatient services that are necessary because of the patient's underlying medical condition and clinical status or the severity of a non-covered dental procedure are covered.

Inpatient hospital stays associated with pregnancy

Reasonable and necessary services associated with pregnancy are covered and reimbursable under the Medicare program. Because pregnancy is a condition sufficiently at variance with the usual state of health, it is appropriate for a pregnant woman to seek medical care.

Skilled medical management is appropriate throughout the events of pregnancy, beginning with diagnosis of the condition, continuing through delivery, and ending after the necessary postnatal care.

After the infant is delivered, items and services furnished to the infant cannot be covered and reimbursed under the program on the basis of the mother's eligibility.

Services under arrangement during an inpatient stay

Hospitals are required to provide all services, other than the unbundled practitioner's professional services, that are provided to their patients. Hospitals must provide all such services directly or under arrangements and bill Medicare for those services. Additionally, it is the hospital's responsibility to make sure that those individuals that the hospital permits to provide services to its patients do not inappropriately bill those patients for those services.

The facility or supplier that furnished the service must bill the IHS hospital that requested the arranged services. The hospital will include the services on their inpatient claim to Medicare and reimburse the facility or supplier for services rendered.

Non-covered inpatient services

Social admissions

There may be situations when a beneficiary is admitted to an IHS facility for social reasons, such as the following:

- Patient is scheduled for outpatient surgery and the patient may live 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 convenience. In this situation, the provider may only bill for the scheduled surgery.
- Patient was admitted as an inpatient. The patient is discharged. However, there may be situations where the family is unable to pick up the patient and the patient is placed in a room as a convenience.

These social admissions are for patient and family convenience and cannot be billable to Medicare on either an 11X or 12X TOB. The following represents CMS policy:

- When a 12X TOB from an IHS/tribal facility (including CAHs) covers the same time period as a 13X TOB received from another hospital or a 72X TOB received from a renal dialysis facility (RDF):
- The 12X TOB is presumed to represent a social admission and is disallowed.
- The 13X TOB/72X TOB will be paid.
- A social admission stay does not qualify for any payment for TOBs 11X or 12X. A social admission cannot be used to satisfy the three-day prior stay for SNFs.

Determining covered/non-covered days and charges

It is important to record a day or charge as covered or non-covered (except social admits) because of the following:

- Beneficiary utilization is recorded based upon days during which the patient received hospital or SNF accommodations, including days paid by Medicare and days for which the provider was held liable for reasons other than medical necessity or custodial care.
- Days denied as not medically necessary or as custodial care are not charged against a beneficiary's utilization record when the provider is determined to be liable. When the benefits days are exhausted, IHS providers are required to file a no-pay claim.

Billing requirements for non-covered days

Where a beneficiary receives non-covered care at admission, but subsequently is furnished a covered level of care during the same hospital stay, the admission is deemed to have occurred when covered services became medically needed and rendered. The following additional entries are required on the bill:

- Form locator (FL) 35 (occurrence span code) – Include occurrence code M1 and the dates indicating the period of non-covered care.
- FL 39 (value code 80) – Report the total number of covered days.
- FL 40 (value code 81) – Report the total number of non-covered days.
- FL 41 (value code 31) – Report the total charges of the non-covered accommodations. These charges are also included as non-covered charges on the bill.
- FL 48 (non-covered charges) – These charges are also included as non-covered charges on the bill.

For more information, please review our article on [Guidelines for Billing Acute Inpatient Noncovered Days](#).

Note: This is for billing purposes only. The IHS hospital will not bill the beneficiary for days that inpatient care was no longer required.

Inpatient no-pay billing instructions

A no-pay inpatient claim is submitted to track benefit periods. These claims are filed when:

- Inpatient benefit days are exhausted.
- Determination is made after the patient is dismissed that the inpatient stay was not medically necessary.
- The patient only has Part B entitlement but has a supplemental insurance policy that will consider payment of the inpatient claim; therefore, a denial from Medicare is needed.

The following UB-04 FLs should be populated when filing for no-pay claims and the patient has a supplemental insurance that will consider payment of the claim:

- FL 4 (type of bill) – Enter the bill type as 0110
- FL 35 (occurrence span code) – Enter occurrence code M1 and the same dates indicated in the “from” and “through” dates in FL 6 (statement covers period)
- FL 39 (non-covered days) – Indicate value code 81 and the number of non-covered days
- FL 40 (value code 31) – Report the total charges of the non-covered accommodations (this is patient liability)
- FL 47 (total charges) – Indicate the total charges for each line item
- FL 48 (non-covered charges) – Indicate the total non-covered charges for each line item

Once the inpatient “no-pay” inpatient claim has been submitted to Medicare and appears on a remittance advice, providers may then bill the ancillary Part B claim (121 TOB).

Ancillary services

Payment may be made under Part B for some medical and health services when furnished by a participating hospital, SNF or swing bed (either directly or under arrangement) to an inpatient of the hospital, but only if payment for these services cannot be made under Part A. Part B payment could be made for these services if:

- The patient is not entitled to Medicare Part A.
- The admission was disapproved as not reasonable and necessary (and waiver of liability payment was not made).
- The day(s) of the otherwise covered stay during which the services were provided was not reasonable and necessary (and no payment was made under waiver of liability).
- No Part A payment is made at all for the inpatient stay because the patient’s benefits were exhausted before admission.

IHS facilities will submit an ancillary claim with a TOB 121, revenue code 0240, daily accommodation rate and total number of days based on the inpatient stay (indicated in the statement “from” and “through” dates).

Ancillary services cannot be submitted without first submitting an inpatient claim and receiving a denial based on one of the above reasons. The ancillary claim can be submitted after the denied inpatient claim has posted to a remittance notice.

Inpatient pneumococcal pneumonia, influenza virus and hepatitis B vaccines

When vaccines are provided to an inpatient of a hospital, they are covered under the vaccine benefit. Hospitals bill the vaccine (administration, vaccine and A6 condition code) under TOB 12X using the discharge date of the hospital stay or the date benefits are exhausted. Payment for these vaccines is on a reasonable cost basis for hospitals.

Pre-entitlement

When the beneficiary becomes entitled to Medicare after admission, the hospital may not bill the beneficiary or other persons for days of care preceding entitlement. Utilization is not counted for any non-entitlement days even if those days are treated as covered for outlier calculation. Therefore, the services rendered during the entire stay are billed on the UB-04 claim form as covered charges. The admission date will reflect the date of admission to the hospital while the from/through dates will only reflect the actual entitlement through discharge.

Example: Patient admitted on 01/15/ and discharged on 02/25/, the patient is not entitled to Medicare Part A until 02/01/, bill as follows:

- Bill type - 11X
- Admission date - 01/15/
- Statement covers from and through date - 02/01/-02/25/
- Covered days (VC 80) - 24
- Accommodation (room and board revenue codes) days/units - 24 covered units
- Remarks - Medicare Part A effective 02/01/

For more information, please review our article on [Billing Services Rendered Prior to Medicare Part A Entitlement \(Pre-entitlement days\)](#).

Discharge or death on first day of entitlement or participation

In special situations, program payment is not made for accommodations on the day of discharge or death, but may be made for ancillary services under Part A provided on that day as follows:

- When a patient is admitted prior to the first day of his entitlement and dies or is discharged from a participating hospital on the first day of his entitlement.
- When a patient in a non-participating hospital dies or is discharged on the first day, the hospital becomes a participating hospital.

Although in these situations a day of utilization is not counted, a spell of illness begins and any charges for covered services are applied against the inpatient hospital deductible.

New occurrence code to report date of death

The National Uniform Billing Committee (NUBC) has approved a new occurrence code to report date of death with an effective/implementation date of October 1, 2012.

Medicare systems will accept and process new occurrence code 55 used to report date of death. Occurrence code 55 and the date of death must be present when one of the following patient discharge status codes is present:

- 20 (expired)
- 40 (expired at home)
- 41 (expired in a medical facility)
- 42 (expired – place unknown)

Discharge

Definition of a discharge

The Medicare PPS considers a patient “discharged” when the patient is formally released from a hospital after receiving inpatient care. A patient is considered a “transfer” under PPS when the patient is transferred from one hospital to another hospital or is transferred from a PPS to a non-PPS setting in the same hospital.

Discharge status coding guidelines

When coding the discharge status code field (FL 17), please be careful to code the field correctly, as Medicare will continue to edit against subsequent claims. If IHS hospitals learn that post-acute care was provided to a patient for whom they submitted a claim with a discharge status code 01 (discharged to home/self-care), the hospital should submit adjustments to those claims. This policy includes those patients transferred to SNFs or home health facilities.

Discharge status changes

IHS hospital coders may have a concern about changing the patient status codes on the bill when their medical records do not support such changes. Hospitals also may be concerned with being out of compliance. CMS has alleviated these concerns by allowing providers to change the discharge status even though the medical documentation may not support such changes.

Incorrect assignment of patient status codes

The Quality Improvement Organization (QIO) implemented the Payment Error Prevention Program (PEPP), which is a national initiative to reduce the payment error rate and protect the Medicare trust fund by monitoring IPPS hospital claims and educate providers regarding payment errors.

Discharge status codes

It is very important to select the correct discharge status code for all claims to be processed correctly.

Repeat admissions

Hospitals should place a patient on a leave of absence when readmission is expected and the patient does not require a hospital level of care during the interim period. Examples could include, but are not limited to, situations where surgery could not be scheduled immediately, a specific surgical team was not available, bilateral surgery was planned, or when further treatment is indicated following diagnostic tests but cannot begin immediately. Institutional providers may not use the leave of absence billing procedure when the second admission is unexpected.

The A/B MAC reviews acute care hospital admissions occurring within 31 days of discharge from the same or another acute care hospital and makes a referral to the QIO if it appears that the two confinements could be related. Two separate payments would be made for these cases unless the QIO denies a readmission to the same hospital.

Placing a patient on a leave of absence will not generate two payments. Only one bill and one MS-DRG payment are made.

When a patient is discharged or transferred from an acute care PPS hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms related to the prior stay's medical condition, hospitals will adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.

Services rendered by other entities during a combined stay must be paid by the acute care hospital. The acute care hospital is responsible for the other entity's service, which is the normal Medicare practice.

Condition code B4

When a patient is discharged/transferred from an acute care PPS hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms unrelated to, and/or not for evaluation and management of, the prior stay's medical condition, hospitals shall place condition code B4 on the claim that contains an admission date equal to the prior admission's discharge date.

Leave of absence

A patient who requires follow-up care or surgery may be discharged and readmitted or may be placed on a leave of absence. Providers may place patients on a leave of absence when readmission is expected and the patient does not require a hospital level of care during the interim period. Examples include, but are not limited to, situations where surgery could not be scheduled immediately, a specific surgical team was not available, bilateral surgery was planned, the patient leaves for cultural medicinal purposes, or when further treatment is indicated following diagnostic tests but cannot begin immediately.

When billing for a leave of absence, report the following additional entries on the bill:

- FL 39a (non-covered days) – Indicate value code 81 and report the total non-covered days the patient is not occupying a bed.
- FL 42 (revenue code 018X to indicate the type of leave).

An adjustment bill should be submitted when the patient has been admitted to another institution.

The day the patient leaves the facility is the date of discharge. Home health or outpatient services provided during a leave of absence do not affect the leave and no discharge bill is required.

Transfers between hospitals

Transfers between hospitals occur when a patient is admitted to a hospital and is subsequently transferred to another hospital for additional treatment once the patient's condition has stabilized or a diagnosis established.

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 for the specific DRG into which the case falls) and the patient's length of stay at the transferring hospital. If the length of stay is less than one day, one day is paid. The day is also counted if the patient was admitted with the expectation of staying overnight. A per diem payment is appropriate; however, this day does not count against the patient's Medicare days (utilization days) since this Medicare day is applied at the receiving hospital. The deductible and coinsurance, where applicable, are also charged against days at the receiving hospital. If the patient is treated in the emergency room without being admitted and then transferred, only Part B billing is appropriate.

The prospective payment rate paid to each hospital is the rate specific for that hospital. Similarly, the wage index and any other adjustments are those that are appropriate for each hospital. When a transfer case results in treatment in the second hospital under a DRG different than the DRG in the transferring hospital, payment to each is based upon the DRG under which the patient was treated. Outlier payments are payable based upon the admission and discharge dates.

Same-day transfers from participating hospital to participating hospital

If the beneficiary is transferred to a participating hospital or distinct part of a participating hospital, the day is counted if it is determined to be covered.

Same-day transfer billing procedures

- FL 6 (from and through dates) – The same day is entered.
- FLs 18–28 (condition code 40) – Same-day transfer.
- FL 39a (non-covered days) – Indicate value code 81 and report one day in the field.
- FL 47 (covered charges).

Note: Because the day is not counted against the patient's Medicare days (utilization days), the charges are covered and should be reported in the column in FL 47.

Cost outlier – Reason code 37045

Reason code 37045 – This claim qualifies for a cost outlier, but occurrence code 47 is not included on the claim.

In addition to the basic prospective payment rate, additional payment may be made on claims involving cost outliers. A cost outlier occurs when the covered charges on the claim are substantially higher than the cost outlier threshold assigned to the DRG.

Software called the Pricer is used for outlier determinations. The Pricer determines the appropriate additional payment for inpatient hospital services when a hospital's charges for covered services furnished to the beneficiary, adjusted to cost, are inordinately high.

For those claims that qualify for a cost outlier, additional coding is required. The provider must determine the dollar amount of the cost outlier threshold.

Once the cost outlier threshold is known, providers must add the daily covered charges for the claim until the total exceeds the threshold amount. Non-covered days are excluded from the calculation. Providers must then submit the date of the first full day of cost outlier status (the day after the day that covered charges reach the cost outlier threshold) on the bill using occurrence code 47.

Resubmit the date of the first full day of cost outlier status (the day after the day that covered charges reach the cost outlier threshold) on the bill using occurrence code 47.

Reference

- [Outlier Claim Information and Submission Instructions](#)

Billing frequency requirements

IPPS hospital

Normally, PPS inpatient bills should be filed after discharge. However, PPS hospitals may bill 60 days after an admission and every 60 days thereafter. Interim bills for PPS hospital stays exceeding 60 days should be submitted as an adjustment for processing. Adjustment requests for PPS hospital stays exceeding 60 days can be electronically submitted.

The initial claim must indicate the following information on the UB-04:

- Form Locator 4 – TOB 112 (first interim claim).
- Form Locator 17 – Patient status 30 (still patient).

Each PPS interim adjustment bill (117) must include:

- Form Locator 4 – TOB 117 (interim adjustment) for each subsequent bill.
- Form Locator 39(a–d) – 41(a–d) – Value code 80 and the number of covered days (services from admission to the through date).
- Form Locator 47 – Covered charges.
- Form Locator 67(A–Q) – All diagnosis codes.
- Form Locator 74(a–e) – All procedure codes.

IHS swing bed facilities

A swing bed hospital is one that is approved by CMS to furnish post-hospital SNF services. The Social Security Act permits certain small hospitals to enter into a swing bed agreement with CMS where the hospital can use its beds as needed to provide skilled care. Swing bed hospitals are located in rural areas where there may be a shortage of SNFs. Hospital patients' beds can "swing" from inpatient acute care services to providing SNF-level care without the patient necessarily being moved to another part of the building.

In order to be granted and retain approval to furnish post-acute SNF-level of care via a swing bed agreement, the following requirements must be met:

- Acute care hospitals:
 - Hospital is located in a rural area based on the most recent census.
 - Hospital has fewer than 100 beds (excluding newborn and intensive care units).
 - Hospital has a Medicare provider agreement as a hospital.
 - Hospital is in compliance with SNF participation requirements.
 - Residents' rights.
 - Admission, transfer and discharge rights.
 - Resident behavior and facility practices.
 - Patient activities.
 - Social services.
 - Discharge planning.
 - Specialized rehabilitative services.
 - Dental services.
 - Hospital has not had a nursing waiver granted under Section 488.54(c) of 42 CFR.
 - Hospital has not had a swing bed approval terminated within the last two years prior to application for participation.
- CAH:
 - For a CAH to be granted approval for swing bed designation, they must also be in compliance with the SNF condition of participation and provide no more than 25 inpatient beds. All hospital type beds located in a CAH will be counted to establish the number of beds.
- Swing bed enrollment:
 - If the hospital meets the guidelines for swing bed designation, then the CMS - 855A enrollment application should be completed by adding the swing bed unit as a practice location to the hospital. Adding a practice location will require the payment of the Medicare enrollment application fee.

Beneficiary eligibility

Medicare will consider a swing bed stay for beneficiaries that require extended care services when the beneficiary:

- Is enrolled in Medicare Part A and has skilled days available to use.
- Has had a qualifying stay of three consecutive days in an acute care or CAH within the last 30 days.
- Has skilled needs related to the condition that was treated or arose during the hospital qualifying stay.
- Report condition code 70 and the qualifying stay dates.

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. The skilled days renew, just like inpatient benefit days, once the patient has been discharged from an inpatient stay for 60 days.

Skilled care must start within 30 days of a qualifying stay. If the patient is discharged from a swing bed but returned to skilled care within one to 30 days of a qualifying stay, then no new qualifying stay will be required. After 30 days a new three-day qualifying hospital stay will be required.

Admission and certification orders

There must be discharge orders from the inpatient stay, appropriate progress notes, discharge summary and subsequent admission orders to swing bed status, regardless of whether the patient stays in the same facility or transfers to another facility. The same inpatient-admit order cannot be used for the swing bed admission.

If the patient does not change facilities, the same chart can be used but the swing bed section of the chart must be separate with appropriate admission orders, progress notes and supporting documents.

To meet medical necessity for a swing bed stay, there must be a need for inpatient skilled care on a daily basis provided by or under the direct supervision of skilled nursing or rehabilitation professionals:

- Nursing seven days per weeks; and/or,
- Physical therapy five or more days per week.

Payment for covered post-hospital extended care services in a swing bed may be made if a physician makes the required certification. Certifications must be obtained at the time of admission or as soon thereafter as is reasonable and practicable. The routine admission order established by a physician is not a certification of the necessity for skilled care. There must be a separate signed statement indicating that the patient will require a SNF-covered level of care on a daily basis.

Recertification is required when there is a continued need for extended care services. The recertification should be no later than the 14th day after admission and no later than 30 days after the last recertification (if applicable). A certification or recertification statement must be signed by the attending physician or a physician on the hospital staff who has knowledge of the case.

Swing bed claim submission

If a patient is discharged from the same hospital that will admit the patient into swing bed, the inpatient claim must contain a discharge status of 61.

All swing bed facilities bill using:

- TOB 181.
- Occurrence span code 70 with the three-day stay prior to swing bed admission.
- Value code 80 and the total number of covered days.

Acute care hospitals

The Omnibus Budget Reconciliation Act of 1987 (OBRA) mandated the development of a Resident Assessment Instrument (RAI) for individuals residing in nursing facilities. The tool was required by law to produce a “comprehensive, accurate, standardized, reproducible assessment of each resident’s functional capacity.” This became the federally mandated Minimum Data Set (MDS) used in all Medicaid and Medicare certified nursing facilities. The MDS contains items that reflect the acuity level of the resident, including diagnoses, treatments and an evaluation of the resident’s functional status.

Swing bed hospitals are required to complete a unique two-page MDS assessment form that will be used to determine payment levels for Medicare beneficiaries. The Swing Bed MDS (SB-MDS) assessment data is submitted electronically to a National Assessment Collection Database (national database). The SB-MDS uses a subset of the MDS information and includes only those items required for payment and the ongoing analysis of swing bed utilization under the SNF PPS. A registered nurse (RN) following the Medicare PPS assessment schedule will complete or coordinate the SB-MDS data set. The RN may delegate completion of sections to staff that have clinical knowledge about the patient. The RN’s signature and date of completion are required.

After each of the assessments is completed, the information is entered into the RAVEN-SB system. The RAVEN-SB is a computerized data entry system for swing bed facilities that offers users the ability to collect SB-MDS assessments in a database and transmit those assessments in CMS standard format to the National Assessment Collection Database.

Data from the SB-MDS will be used to establish the RUG-IV group required for reimbursement under the SNF PPS. The RUG-IV classification system utilizes patient characteristics and health status information (e.g., patient needs, diagnosis, Activities of Daily Living (ADLs), cognitive status and behavioral problems) and places the resident in a Resource Utilization Group (RUG) for payment purposes. The RUG-IV group code is calculated from the MDS assessment clinical data. CMS edits and validates the RUG-IV group code of transmitted MDS assessments. Claims cannot be submitted to Medicare until the assessments have been accepted by CMS and the RUG-IV code validated by CMS must be used in billing.

For Medicare billing purposes, there is a payment code associated with each of the RUG-IV groups and each assessment apply to specific days within a resident's stay.

Facilities must send each beneficiary's MDS assessment to the state and claims for Medicare payment to the MAC on a 30-day cycle.

Revenue code 0022 (special charges) and the Health Insurance Prospective Payment System (HIPPS) codes are reported on the claim along with the accommodation revenue code. The first three positions of the HIPPS code contain the RUG-IV group code to be billed. The fourth and fifth positions of the HIPPS code contain an Assessment Indicator (AI). Services are itemized and billed with the appropriate revenue code that describes the service.

For assistance with the SB-MDS and RAVEN-SB program, please visit the Refer to the [CMS Swing Bed](#) webpage.

For information on the MDS, please review the [MDS 3.0 for Nursing Homes and Swing Bed Providers](#) page of the CMS website.

CAHs

CAHs are not required to complete the MDS process. Even though these hospitals are not required to complete the MDS assessment, processes must be in place to document the patient's need for extended care services and the medical necessity for the procedures performed.

Claims for CAH swing beds are submitted with the accommodation revenue code instead of 0022 and billed from admit to discharge. All other requirements apply (TOB, occurrence span code and value code).

Billing

Swing bed facilities will bill:

- Upon discharge of the beneficiary.
- When the beneficiary's benefits are exhausted.
- When the beneficiary's need for care changes.
- After 30 days and every 30 days thereafter.

General billing

Providers must submit a bill to Medicare Part A when a beneficiary in a swing bed ceases to need active care (occurrence code 22). IHS swing bed providers should continue submitting no-pay bills until discharge.

Swing bed payment

Acute care hospital swing beds are paid according to the SNF PPS payment methodology.

CAH swing-bed services are paid at 101% of an all-inclusive facility-specific daily rate.

Swing bed inpatient ancillary claims

When a patient remains in the swing bed unit at a skilled level of care after SNF benefit days are exhausted, an ancillary claim can be submitted. The ancillary claim is submitted under the hospital's PTAN with revenue code 0240 (all-inclusive ancillary) on TOB 12X (inpatient Part B).

CAHS

CAH eligibility

To be eligible as a CAH, a facility must be a current participating Medicare hospital or a health clinic or health center that previously operated as a hospital before being downsized to a health clinic or health center. The facility must be located in a rural area of a state that has established a Medicare rural hospital flexibility program and must be located more than a 35-mile drive from any other hospital, CAH or be certified by the state to be a “necessary provider.” In mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles. In addition, the facility must make 24-hour emergency care services available, provide not more than 25 beds for acute (hospital-level) inpatient care, and maintain a length of stay as determined on an annual average basis of no longer than 96 hours.

The 25 inpatient beds can be used interchangeably for acute or SNF-level care provided. The facility is also required to meet the conditions of participation for CAHs (42 CFR Part 485, Subpart F). Designation by the state is not sufficient for CAH status. To participate and be paid as a CAH, a facility must be certified as a CAH by CMS.

Inpatient CAH services

Items and services that a CAH provides to its inpatients are covered if they would be covered when furnished by an acute care hospital to its inpatients.

Documentation requirements for Medicare inpatient admissions

Progress notes and other clinical documentation in the medical record must support the inpatient admission. In addition, the medical record must contain an inpatient admission order and a physician certification. Collectively, these requirements are necessary to support inpatient admission. Contractor review of inpatient admissions will focus on these requirements. HCA has developed a Medicare order form to facilitate obtaining the appropriate patient status order based on the two-midnight rule.

CAH swing bed services

A CAH may use its inpatient facilities to provide post-hospital SNF care and be paid for SNF-level services if it meets the following requirements:

- CMS has certified the facility as a CAH.
- The facility provides no more than 25 inpatient beds, and the number of beds used at any time for acute care inpatient services does not exceed 15 beds.
- CMS has granted the facility swing bed approval.

96-hour rule

CAHs are no longer required to maintain documentation showing that individual stays longer than 96 hours were needed because of inclement weather or other emergency conditions, or to obtain a case-specific waiver of the 96-hour limit from a QIO or equivalent entity. Thus, intermediaries are not required to obtain documentation showing that a QIO or equivalent entity has, on request, approved stays beyond 96 hours in specific cases.

A CAH may provide acute inpatient care for a period that does not exceed, as determined on an annual average basis, 96 hours per patient. If a CAH exceeds the length of stay limit, it will be required to develop and implement a corrective action plan acceptable to the CMS regional office or face termination of its Medicare provider agreement.

Outpatient services provided prior to an inpatient admission

CAHs are exempt from the one-day and three-day window provision. Services rendered to a CAH patient are not bundled on the inpatient bill. Outpatient services must be billed as such on a separate bill from inpatient services. Outpatient services rendered on the date of admission to an inpatient setting are still billed and paid separately as outpatient services.

CAH reimbursement**Inpatient reimbursement**

Reimbursement to IHS or tribal CAHs for covered inpatient services is based on a facility-specific per diem rate that is established on a yearly basis from the most recently filed cost report information. Payment for inpatient IHS or tribal CAH services is at 100% of the facility-specific per diem rate less applicable deductible and coinsurance.

Inpatient ancillary Part B reimbursement

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.

Swing bed reimbursement

The IHS CAH swing bed services are paid an all-inclusive facility-specific per diem rate based on the cost report.

Outpatient reimbursement

Payment for outpatient IHS CAH outpatient services will be made at 101% of the facility-specific outpatient visit rate less applicable Part B deductible and coinsurance amounts.

Ambulance reimbursement

For IHS/tribal CAH-based ambulance services, the appropriate payment methodology is cost-based. One hundred percent of the reasonable cost is paid for ambulance services to CAH-based ambulance services that meet the 35-mile rule.

Deductible and coinsurance

Medicare Part A deductible and coinsurance amounts apply to CAH inpatient services provided by IHS hospitals. The Part B annual deductible applies to services covered under the CAH outpatient benefit. If the item or service is covered as a CAH outpatient service, the clinic may not charge the beneficiary more than 20% of the charges plus the deductible.

FQHCS

Scope of the program

The services offered in an FQHC are the types of services that patients receive in a doctor's office, outpatient clinic or emergency room. Such services are physician's diagnostic, treatment or consultation services. In an FQHC, a nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist or clinical social worker may also provide the services.

FQHC eligibility

An FQHC is a health center that has been designated by the federal government and provides primary and preventive health care services.

Indian health clinics qualify to be an FQHC by operating as an outpatient health program or facility, of a tribal organization under the Indian Self-Determination Act, or operating as an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act.

For more information, please visit our [FQHC specialty page](#).

Implementation of a PPS for FQHCs

FQHCs with cost reporting periods beginning before October 1, 2014, contractors will continue to pay the FQHCs using the current all-inclusive rate (AIR) system. FQHCs with cost reporting periods beginning on or after October 1, 2014, contractors will pay using the FQHC PPS. The statute requires implementation of the FQHC PPS for cost reporting periods beginning on or after October 1, 2014. FQHCs will transition into the PPS based on their cost reporting periods. The claims processing system would maintain the current system and the PPS until all FQHCs have transitioned. The FQHC PPS rate is required by statute to be adjusted based on the MEI after the first year of implementation, and either the MEI or a percentage increase in a market basket of FQHC goods and services in subsequent years. The FQHC PPS will be updated on a calendar year basis to match the PFS.

When reporting an encounter/visit for payment, the claim (77X TOB) must contain a FQHC specific payment code (G0466, G0467, G0468, G0469 or G0470) that corresponds to the type of visit.

FQHC specific payment specific codes G0466, G0467 and G0468 must be reported under revenue code 052X or under Revenue Code 0519. FQHC specific payment codes G0469 and G0470 must be reported under revenue code 0900 or 0519. Please see above link for further guidelines.

FQHC reimbursement

Payments for covered FQHC visit services furnished to Medicare beneficiaries are reimbursed the lower of the national capped amount or the clinic-specific cost per encounter rate.

The term “visit” is defined as a face-to-face encounter between the patient and a physician, non-physician practitioner, clinical psychologist or clinical social worker during which an FQHC service is rendered.

Covered services

- Covered FQHC services that are reported on the Part A claim include: Medically necessary and reasonable services.
- Physician services.
- Non-physician practitioner services when furnished by an employee of the FQHC and under the general supervision of a physician. Must be in accordance with clinic or center policies as well as any physician medical orders for care and treatment of the patient.
- “Incident to” the services of physicians or non-physician practitioners.
- Visiting nurse services to the homebound in an area where CMS has determined that there is a shortage of home health agencies.
- Outpatient diabetes self-management training and/or medical nutrition therapy for beneficiaries that meet the coverage guidelines.
- Preventive primary health services when furnished by or under the direct supervision of a physician or non-physician practitioner. Preventive primary services that are not covered include:
 - Group or mass information programs, health education classes or group education activities including media productions and publications.
 - Eyeglasses, hearing aids and preventive dental services.

Items or services that are covered under Part B, but are considered non-FQHC services (not reported on Part A claim) include:

- Certain laboratory services.
- Durable medical equipment.
- Ambulance services.
- Technical component of diagnostic tests (i.e., X-rays and EKGs).
- Technical component of some preventive services (screening pap smear, prostate cancer screening, colorectal cancer screening, screening mammography, bone mass measurements).

HCPCS reporting

Beginning with dates of service on or after January 1, 2011, FQHCs must report all pertinent services provided and list the appropriate HCPCS code for each line item along with the revenue code(s) for each FQHC visit. The additional line items and HCPCS reporting are for informational and data gathering purposes only and will not be utilized to determine current Medicare payment to FQHCs. Claims submitted without a HCPCS code will be returned to the provider for correction.

Multiple encounters on the same day

Visits with more than one health professional and multiple visits with the same health professional that take place during the same day within the clinic constitute a single visit. The exception to this rule is when the patient must return to the clinic for an emergency or urgent care situation subsequent to the first encounter that requires additional diagnosis or treatment. Or, the patient is seen in the clinic by a clinical social worker or psychologist for a mental health encounter in addition to a medical professional encounter on the same day.

When these situations happen on the same day, modifier 59 (distinct service) must be reported on the claim. All services provided for both of the covered encounter situations must be submitted on one bill with two detail lines: one detail line for the clinic visit using an office visit E/M, and the second detail line using a visit code with a 59 modifier. 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 in order to receive the appropriate payment.

Deductible and coinsurance

The deductible is waived for covered FQHC services (Part A claim) but may apply to non-FQHC services (services filed to Part B) depending on the type of service submitted. Coinsurance for covered FQHC services is 20% of the billed amount. For non-FQHC services the coinsurance is 20% of the allowed amount (unless a clinical lab service, which pays 100 percent).

Medicare Advantage (MA) plans

Whenever covered FQHC services are rendered to a patient enrolled in a MA plan, claims are submitted to Medicare Part A and supplemental payments are made to cover the difference between the MA contracted payment amount and the encounter rate.

FQHCs must report actual MA revenue and visits on the cost report. This information is used to determine the supplemental payment Medicare will make.

MA supplemental claims are submitted to Medicare Part A using revenue code 0519 with a total of the actual charges from the visit.

Non-FQHC services submitted to Part B will not be processed.

FQHC billing

TOB: 0771

Covered revenue codes:

- 0519 – Clinic visit, supplemental
- 0521 – Clinic visit
- 0522 – Home visit
- 0524 – Visit in a SNF/SB covered Part A stay
- 0525 – Visit in a SNF/SB non-covered Part A stay
- 0527 – Visiting nurse service in a home health shortage area
- 0528 – Visit to other non-FQHC site (scene of accident)
- 0780 – Telehealth originating site facility fee
- 090X – Psychiatric/psychological services

References

- [Billing Information for Rural Providers and Suppliers](#)
- [CMS IOM Pub. 100-02, Benefit Policy Manual, Chapter 13](#)
- [CMS IOM Pub. 100-04, Claims Processing Manual, Chapter 9](#)
- [Federally Qualified Health Centers \(FQHC\) Center Page](#)
- [MM9267 - Payment for Grandfathered Tribal Federally Qualified Health Centers \(FQHCs\) that were Provider-Based Clinics on or Before April 7, 2000](#)

Credit balance report

Reporting requirements

A credit balance is an improper or excess payment made to a provider as a result of patient billing or claims processing errors.

A credit balance report should be submitted to Medicare within 30 days after the close of each calendar quarter. Quarter endings are the last day of the following months: March, June, September and December. Only one report per facility should be filed at the end of the quarter.

What to report

The report should include all claims reflecting a Medicare credit balance as of the last day of the reporting quarter.

Who reports

All providers of health care services participating in the Medicare Part A program are required to submit a quarterly report. If there are multiple CMS Certification Numbers (CCNs) for specific units within the facility, a report must be submitted for each CCN (e.g., hospital with a swing bed unit). This includes acute care, CAH, swing bed and FQHC facilities.

How to report

Only outstanding credit balance claims filed on the UB-04 should be reported on the Form CMS-838. Parts A and B credit balance claims should be reported on separate forms. A credit balance certification page must be filed even if there are no credit balances to report.

Note: Providers are advised that a reminder letter is no longer mailed to providers. If the credit balance report is not postmarked by the 30th day of the month following the quarter, a demand letter will be sent to each provider with an outstanding CMS-838 report. The demand letter will inform the provider that on the 16th day from the date of the demand letter, 100% suspension of payments will be initiated. The suspension will remain at 100% until the CMS-838 report is received.

References

- [CMS-838 Credit Balance Form](#)
- [Credit Balance Status Tool Credit Balance Status Tool](#)

Fax the Medicare Credit Balance Report or certification page to:
410-891-5230
Attention: Credit Balance

Cost reports

Part A providers, other than comprehensive outpatient rehabilitation facilities and outpatient physical therapy facilities, are required to electronically file their Medicare cost reports on or before the last day of the fifth month following the end of the period covered by the cost report, in accordance with 42 CFR 413.24(f)(2)(i).

Effective September 30, 2013, IHS has to use full Method A cost reports and contain all appropriate worksheets. In addition, these cost reports are to be submitted as an electronic cost report (ECR) and must include a certification page with encryption code and original signature. For details, please visit the [Provider Reimbursement](#) manual.

The payment information is sent out in a separate letter from our Reimbursement department. The payment information is sent approximately around the same time frame.

Providers are responsible for obtaining their own Provider Statistical and Reimbursement (PS&R) reports to be used for filing all cost reports with fiscal years ending on or after January 31, 2009. A provider's delay in obtaining the PS&R will **not** result in a cost report filing extension. The [CMS PS&R web page](#) contains an overview of the system, user manuals, quick guides and other helpful information.

Reference:

[Novitas Cost reporting](#)

Part B outpatient services

Part B helps cover medically necessary services like doctors' services, outpatient care, durable medical equipment, home health services and other medical services.

Depending on the services being performed, a provider-based clinic may submit two claims for outpatient services: one claim to Part A for the facility fee and one claim to Part B for the provider's service. The Part B claim will be submitted with an outpatient place of service (POS) code (e.g., 19, 22 or 23).

Freestanding clinics will have one claim submitted to Part B. Payment for POS code 11 includes overhead and the provider's service.

Ambulatory surgical centers (ASCs) will have one claim submitted to Part B using POS 24. There should also be a separate Part B claim for the surgeon and anesthesia services.

Definition of hospital outpatient

A hospital outpatient is a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and receives services (rather than supplies alone) from the hospital.

Acute care hospitals and their provider-based clinics are reimbursed a specific all-inclusive rate (AIR) for their outpatient services. CAHs are reimbursed 101 percent of a facility-specific per diem rate based on their cost report.

AIR and no face-to-face encounter

When a beneficiary receives outpatient services in an IHS or tribally operated hospital or provider-based clinic, an encounter with a physician or NPP should occur in order to be billed to Medicare.

While a face-to-face encounter with a physician or NPP 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 NPP during the initial visit. If the beneficiary must return on a different day to receive a medically necessary procedure or test that was ordered by the physician or NPP during the initial visit, the medically necessary return visit would qualify for the AIR and should be billed as an encounter even if the beneficiary did not interact with a provider during the return visit. Documentation must support the medical necessity of the return visit and the physician's or NPP's initial visit, order and follow-up.

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.

Types of outpatient hospital services

Hospitals and their provider-based clinics provide two distinct types of services to outpatients. Both types of services are covered under the Part B benefit.

- Therapeutic services – Services that aid the physician in the treatment of his patient (i.e., services incident to the physician’s services).
- Diagnostic services, such as diagnostic X-rays or diagnostic laboratory services.

Therapeutic services provided in an outpatient hospital setting

Therapeutic services, which hospitals provide on an outpatient basis, are those services and supplies (including the use of hospital facilities) that are “incident to” the services of physicians in the treatment of patients. Such services include clinic services and emergency room services.

To be covered as “incident to” physicians’ services, the services and supplies must be furnished as an integral. Although incidental, part of the physician’s professional service in the course of diagnosis or treatment of an illness or injury. The services and supplies must be furnished on a physician’s order by hospital personnel and under a physician’s supervision. This does not mean that each occasion of service by a non-physician need also be the occasion of the actual rendering of a personal professional service by the physician. However, during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment and the patient’s progress and, when necessary, to change the treatment regimen.

A hospital service or supply would not be considered incident to a physician’s service if the attending physician merely wrote an order for the services or supplies and referred the patient to the hospital without being involved in the management of that course of treatment. The physician supervision requirement is generally assumed to be met when the services are performed on hospital premises; the hospital medical staff that supervises the services need not be in the same department as the ordering physician. However, if the services are furnished outside the hospital, they must be rendered under the direct personal supervision of a physician who is treating the patient.

Diagnostic services

A service may be regarded as diagnostic if it is:

- Diagnostic laboratory services (such as hematology and chemistry).
- Diagnostic X-rays.
- Isotope studies.
- EKGs.
- Pulmonary function studies.
- Thyroid function tests.
- Psychological tests.
- Other tests given to determine the nature and severity of an ailment or injury.

Covered diagnostic services to hospital outpatients include the services of psychologists and technicians, drugs and biologicals necessary for diagnostic study, and the use of supplies and equipment.

Diagnostic services (except reference lab) are not itemized on the outpatient claim. These services are submitted using revenue code 0510 and HCPCS 99211. Payment will be based on the AIR.

Physician services for interpretation of diagnostic services can be submitted on the Part B CMS-1500 claim form. The ordering provider's name and NPI must be entered into Item 17 and 17b.

Diagnostic laboratory services

Diagnostic laboratory tests are covered when furnished by a qualified hospital, clinical laboratory, clinic or physician's office laboratory.

Charges for laboratory services furnished to outpatients of IHS hospitals and the provider-based clinics 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.

Reference lab

When a hospital laboratory performs a laboratory service for a non-hospital patient (i.e., for neither an inpatient nor an outpatient), the hospital bills using TOB 141 and revenue codes 030X (clinical lab) and/or 031X (pathology) and the appropriate HCPCS for the test performed. Reference laboratory tests are reimbursed based on the clinical laboratory fee schedule. Laboratory services are not subject to deductible and coinsurance.

If a patient is a registered outpatient for any service at the hospital on the same day the hospital receives a reference lab specimen, the lab test on that specimen is considered a part of the AIR and not a non-patient reference lab service.

Incident to provisions

In the outpatient setting, under the “incident to” provisions, services are covered within the usual Medicare criteria and coverage guidelines, plus outpatient therapeutic services must include direct personal physician supervision.

During any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment and the patient’s progress and, where necessary, to change the treatment regimen. A hospital service or supply would not be considered “incident to” a physician’s service if the attending physician merely wrote an order for the services or supplies and referred the patient to the hospital without being involved in the management of that course of treatment.

To be covered as “incident to” physician services, the services and supplies must be furnished as an integral although incidental part of the physician’s professional service in the course of diagnosis or treatment of an illness or injury. The services and supplies must be furnished on a physician’s order by hospital personnel and under a physician’s supervision.

CMS requires direct supervision (defined below) by an appropriate physician or NPP in the provision of all therapeutic services to hospital outpatients, including CAH outpatients. CMS may assign certain hospital outpatient therapeutic services as either general supervision or personal supervision. When such assignment is made, “general supervision” means the definition specified at 42 CFR 410.32(b) (3) (i), that is, the procedure or service is furnished under the physician’s overall direction and control, but the physician’s presence is not required during the performance of the procedure. “Personal supervision” means the definition specified at 42 CFR 410.32(b) (3) (iii), that is, the physician must be in attendance in the room during the performance of the service or procedure.

Hospitals may change to general supervision for a portion of services defined as non-surgical extended duration therapeutic services (“extended duration services”) but only as specified in this manual for those services.

Pulmonary rehabilitation, cardiac rehabilitation and intensive cardiac rehabilitation services require direct supervision, which must be furnished by a doctor of medicine or osteopathy, as specified at 42 CFR 410.47 and 410.49, respectively.

In addition to physicians and clinical psychologists, licensed clinical social workers, physician assistants, nurse practitioners, clinical nurse specialists and certified nurse-midwives may furnish the required supervision of hospital outpatient therapeutic services that they may personally furnish in accordance with state law and all additional rules governing the provision of their services, including those specified at 42 CFR 410. These NPPs are specified at 42 CFR 410.27(g).

Considering that hospitals furnish a wide array of very complex outpatient services and procedures, including surgical procedures, CMS would expect that hospitals already have the credentialing procedures, bylaws and other policies in place to ensure that hospital outpatient services furnished to Medicare beneficiaries are being provided only by qualified practitioners in accordance with all applicable laws and regulations. For services not furnished directly by a physician or non-physician practitioner, CMS would expect that these hospital bylaws and policies would ensure that the therapeutic services are being supervised in a manner commensurate with their complexity, including personal supervision where appropriate.

For therapeutic services furnished during CY 2011 and after, whether in the hospital or CAH or in an on-campus or off-campus outpatient department of the hospital or CAH as defined at 42 CFR 413.65, "direct supervision" means that the physician or NPP must be immediately available to furnish assistance and direction throughout the performance of the procedure. As discussed below, the physician is not required to be present in the room where the procedure is performed or within any other physical boundary as long as he or she is immediately available.

Immediate availability requires the immediate physical presence of the supervisory physician or NPP. CMS has not specifically defined the word "immediate" in terms of time or distance; however, an example of a lack of immediate availability would be situations where the supervisory physician or NPP is performing another procedure or service that he could not interrupt. Also, for services furnished on-campus, the supervisory physician or NPP may not be so physically distant on-campus from the location where hospital/CAH outpatient services are being furnished that he could not intervene right away. The hospital or supervisory practitioner must judge the supervisory practitioner's relative location to ensure that he is immediately available.

A supervisory practitioner may furnish direct supervision from a physician office or other non-hospital space that is not officially part of the hospital or CAH campus where the services are being furnished as long as he remains immediately available. Similarly, an allowed practitioner can furnish direct supervision from any location in or near an off-campus hospital or CAH building that houses multiple hospital provider-based departments where the services are being furnished as long as the supervisory practitioner is immediately available.

The supervisory physician or NPP must have, within his state scope of practice and hospital-granted privileges, the knowledge, skills, ability and privileges to perform the service or procedure. Specially trained ancillary staff and technicians are the primary operators of some specialized therapeutic equipment, and while in such cases CMS does not expect the supervisory physician or NPP to operate this equipment instead of a technician, CMS does expect the physician or NPP to be knowledgeable about the therapeutic service and clinically able to furnish the service.

The supervisory responsibility is more than the capacity to respond to an emergency and includes the ability to take over performance of a procedure or provide additional orders. CMS would not expect that the supervisory physician or NPP would make all decisions unilaterally without informing or consulting the patient's treating physician or NPP. In summary, the supervisory physician or NPP must be clinically able to supervise the service or procedure.

Reference

[CMS IOM Pub.100-02, Benefit Policy Manual, Chapter 6, Section 20.5.2](#)

Compliance with state law for incident to services

CMS is requiring as a condition of Medicare payment that "incident to" services be furnished in compliance with applicable state law. This policy strengthens program integrity by allowing Medicare to deny or recoup payments when services are furnished not in compliance with state law. We also eliminated redundant regulations for each type of practitioner by consolidating the "incident to" requirements for all practitioners that are permitted to bill Medicare directly for their services, reducing the regulatory burden and making it less difficult for practitioners to determine what is required in order to bill Medicare for "incident to" services. This portion of the final rule with comment period is effective on March 3, 2014.

Note: 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.

Reference

[CMS IOM Pub. 100-04, Claims Processing Manual, Chapter 19, Section 40.1.2.](#)

Anticoagulant clinic visit

The following is clarification when the patient is under the primary physician care plan and the pharmacist is rendering services for surveillance of the patient's status. According to IHS' standing orders and clinic protocol, a key element of the services provided appears to be monitoring Coumadin® (warfarin) patients to ensure that laboratory Prothrombin Time (PT)/International Normalized Ratio (INR) testing is within a therapeutic range. Hospital/clinic-specific policies, protocols, etc., in and of themselves, cannot alone justify coverage. CMS has developed a NCD for prothrombin testing. The need to repeat this test is determined by changes in the underlying medical condition and/or the dosing of warfarin. In a patient on stable warfarin therapy, it is ordinarily not necessary to repeat testing more than every two to three weeks. When testing is performed to evaluate a patient with signs or symptoms of abnormal bleeding or thrombosis and the initial test result is normal, it is ordinarily not necessary to repeat testing unless there is a change in the patient's medical status. For Medicare to allow these services, the patient must meet the [NCD guidelines](#).

Ideally, once the patient's INR has been stabilized, he/she could be taught to use the home PT/INR monitoring. Effective for claims with dates of service on or after March 19, 2008, Medicare covers the use of home PT/INR monitoring for chronic, oral anticoagulation management for patients with:

- Mechanical heart valves.
- Chronic atrial fibrillation.
- Venous thromboembolism (inclusive of deep venous thrombosis and pulmonary embolism).

Medication therapy

Medication therapy management services are provided as components of a wide variety of services provided by hospitals and clinics. The cost for this service is included in the costs of other services furnished to the beneficiary on the same day.

Clinical pharmacist encounter

Medicare does not cover medical services performed or provided by a clinical pharmacist. These services cannot be billed as an IHS clinic visit (the AIR billed on the UB-04) when this was the only service rendered (e.g., there was no covered service that day, such as a physician visit).

A provider-based or freestanding clinic may bill for clinical pharmacist services if the "incident to" guidelines are met. If "incident to" guidelines are met, the physician/non-physician practitioner providing direct supervision may bill 99211, the 5-minute exam, on the Part B 1500 claim form.

Note: Clinical pharmacist cannot provide an evaluation and management service above the 99211 as “incident to” since E&M services are not within the scope of practice for clinical pharmacists, based on the E&M policy set by CMS.

Incident to services

“Incident to” services are defined as those services that are furnished incident to physician professional services in the physician’s office (whether located in a separate office suite or within an institution) or in a patient’s home. These services are billed as Part B services to your contractor as if you personally provided them and are paid under the physician fee schedule.

References

- [CMS IOM Publication 100-02, Benefit Policy Manual, Chapter 15](#)
- [SE0441- “Incident to” Services](#)

Evaluation and management service

Advise physicians to use CPT codes (level 1 of HCPCS) to code physician services, including evaluation and management services. Medicare will pay for E/M services for specific non-physician practitioners (i.e., NP, CNS and CNM) whose Medicare benefit permits them to bill these services. A PA may also provide a physician service, however, the physician collaboration and general supervision rules as well as all billing rules apply to all the above non-physician practitioners. The service provided must be medically necessary and the service must be within the scope of practice for a non-physician practitioner in the State in which he/she practices. Do not pay for CPT evaluation and management codes billed by physical therapists in independent practice or by occupational therapists in independent practice.

Reference

[CMS IOM Publication 100-04, Claims Processing Manual, Chapter 12](#)

Hospital outpatient billing procedures

All charges, except where otherwise indicated, are combined and reported on TOB 131 (Acute care hospital) or 851 (CAH) with revenue code 0510 (clinic visit).

HCPCS codes

HCPCS codes were developed in 1983 by CMS for the purpose of standardizing the coding systems used to process Medicare claims. HCPCS codes are primarily used to bill Medicare for supplies, materials, and injections and for certain services and procedures that are not defined in the CPT. Valid HCPCS and/or CPT codes are to be reported on all outpatient Part A and B claims.

Outpatient reimbursement

When outpatient services are provided in an acute care hospital or its provider-based clinics, reimbursement is made based on an AIR unless the services rendered are separately billable (e.g., therapy and vaccines) and paid based on fee schedules or reasonable costs. The AIR is established by CMS and IHS based upon a review of yearly cost reports prepared by IHS' 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 the OMB, the approved rate is published in the *Federal Register* and IHS systems can be updated with the new rate for billing. Medicare cannot pay the new rates until CMS issues a change request that provides the new rates and authorizes Medicare Part A to update claims processing systems to pay the new rate. If the rates increase, then mass adjustments will be made for claims that have processed under the old rate. The AIR is established for each calendar year and includes rates for outpatient and ancillary services rendered in acute care hospitals.

Services provided in the outpatient department of a CAH are reimbursed at 101% of the facility-specific daily rate established for the facility based on a cost report.

The AIR and the CAH facility daily rate are also defined as an encounter rate.

Services included in the encounter rate

Services provided by acute care hospitals and CAHs that are considered part of the encounter rate include:

- Medically necessary physician or NPP visits.
- Technical components of diagnostic tests (radiology and laboratory).
- Covered drugs and biologicals (including their administration) furnished incident to a physician service.
- DSMT services.
- MNT services.

Note: This is not an all-inclusive list.

Multiple visits on the same day

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 (acute care and CAH, including the hospital’s provider-based clinics) constitute a single visit.

IHS providers should not report more than one for the number of visits in the Units column (FL 46) of the UB-04 claim for this type of visit. The only exception to the “all-inclusive” encounter situation described above is when the patient is seen in the emergency room with an unrelated condition. Two clinic visits may be billed in this instance with one visit being an emergency room CPT code. The remarks section of the bill must include a narrative describing the situations and why two clinic visits are being billed.

When a medical visit and an emergency visit occur on the same day, condition code G0 (zero) (distinct medical visit) must be reported on the claim. All of the services provided for both of the covered encounter situations must be submitted on one bill with two detail lines: one detail line for the clinic visit using an office visit E/M code and the second detail line using the emergency room (ER) visit code. 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 in order to receive the appropriate payment. In the remarks field a statement must be submitted to justify two visits in one day.

Example

Revenue Code (FL 42)	HCPCS Code (FL 44)	Date of Service (FL 45)	Service Units (FL46)	Charge (FL 47)
0510	99212	03/10/	1	180.00
0510	99283	03/10/	1	180.00

Guidelines for FQHC multiple visits on the same day can be found in the “Federally Qualified Health Centers” section of this manual.

Outpatient services under arrangement

If an IHS provider is unable to provide all the services needed by a beneficiary who is a registered outpatient of the facility, 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 non-physician 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. Service unbundling is prohibited; only the provider can bill for services furnished to its inpatients and outpatients.

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.

ESRD bundling

Effective January 1, 2011, Section 153b of the Medicare Improvements for Patients and Providers Act (MIPPA) requires the implementation of an ESRD bundled PPS. On January 14, 2011, CMS issued CR7064 explaining the new ESRD PPS and bundled services.

ESRD consolidated billing

Certain lab services and limited drugs and supplies will be subject to Part B consolidated billing and will no longer be separately payable when provided to ESRD beneficiaries by providers other than the renal dialysis facility. Should these lab services and limited drugs be provided to a beneficiary but are not related to the treatment for ESRD, then the claim lines must be submitted with the new AY modifier to allow for separate payment outside of the ESRD PPS. Facilities billing for any labs or drugs will be part of the bundled PPS payment unless billed with modifier AY.

ESRD FAQs

Question: If non-ESRD-related services (e.g., primary care provider, ER physician, laboratory and/or pharmacy) were provided to an ESRD patient at an IHS or Tribal 638 facility, is this part of the monthly ESRD PPS payment the dialysis center receives?

Answer: No. If you render non-ESRD-related services to an ESRD patient, you would use the AY modifier on the hospital outpatient claim. Medicare will reject at the line level on incoming outpatient TOBs 13X, 14X and 85X billing for ESRD services subject to consolidated billing that do not contain modifier AY when overlapping the "from" and "through" dates of a covered 72X (ESRD facility) claim in history or incoming claim. Part B physician services are not subject to the ESRD bundled service guideline.

Question: If the facility codes a diagnosis that is ESRD-related will Medicare reject?

Answer: No. However, you are responsible for determining if the service rendered is ESRD-related or not.

Question: If the ESRD patient is admitted to a hospital for non-ESRD-related conditions and the patient needs to be transferred to the dialysis center for service three times a week (while still an inpatient), does the hospital recoup its costs from the dialysis center? If the ESRD patient is an inpatient for non-ESRD-related services but has ESRD-related labs drawn and meds from the IHS pharmacy administered, does the dialysis get reimbursed with a bundled rate from Medicare for these services?

Answer: The ESRD bundled service guideline pertains to Part B services. Inpatient services are Part A. If you have an ESRD patient admitted to the hospital, any service provided to the patient, including dialysis treatments, labs and meds, will be the responsibility of the IHS hospital. The inpatient guidelines are not affected by the ESRD bundled service rule.

Question: If a dialysis facility sends an ESRD patient to IHS to get labs drawn, is the dialysis reimbursed with the bundled rate?

Answer: Yes. IHS will need to look to the dialysis facility for payment.

Question: Are Aranesp® and Epoetin Alfa injections included in the ESRD bundled service guideline?

Answer: If ESRD-related, these drugs are included in the ESRD bundled payment.

Question: If a physician provides an E/M service to an ESRD patient either as an outpatient or inpatient, are these services billed to the ESRD facility for reimbursement?

Answer: No. Part B physician services are not included in the ESRD bundled provision.

References

- [CMS IOM Pub. 100-04, Claims Processing Manual, Chapter 8](#)
- [Novitas' ESRD Specialty Page](#)

Physician fee schedule

Medicare Part B pays for physician services based on the Medicare Physician Fee Schedule (MPFS), which lists services and their payment rates. Medicare-covered services are normally allowed at the fee schedule amount and reimbursed at 80%.

Physicians' services include:

- Office visits.
- Surgical procedures.
- A range of other diagnostic and therapeutic services.

Physicians' services are furnished in all settings including:

- Physicians' offices.
- Hospitals.
- ASCs.
- SNFs and other post-acute care settings.
- Hospices.
- Outpatient dialysis facilities.
- Clinical laboratories.
- Beneficiaries' homes.

Non-physician fee schedule services

Non-physician services are priced on individual fee schedules.

The non-physician services are:

- Ambulance.
- ASC fees.
- Anesthesia conversion factors.
- Clinical laboratory services.
- DME.
- Drugs (ASP/NOC) fee schedule.
- ESRD separately billable drugs.
- Radiopharmaceuticals.

The Part B fee schedule can be found on the Fee Schedule page.

IHS-specific types of bill

Type of bill	Revenue code
111 – Inpatient	0100 – All-inclusive inpatient 0180 – Leave of absence 0001 – Total charges
121 – Inpatient ancillary Part B	0240 – All-inclusive 0001 – Total charges
131 – Acute care outpatient 851 – CAH outpatient	0510 – All-inclusive outpatient 0540 – Ambulance 0636 – Vaccines 0771 – Administration of vaccines 0420 – Physical therapy 0430 – Occupational therapy 0440 – Speech-language pathology 0274 – Orthotic/prosthetic 0623 – Surgical dressings 0001 – Total charges
141 – Reference lab	030X – Clinical lab 031X – Pathology 0001 – Total charges
181 – Swing bed	0022 - Acute care hospitals itemize using HIPPS 0120 – Acute care room and board 0100 – CAHs only bill accommodation rate and no other revenue codes except total charges 0001 – Total charges
771 – FQHC	0519 – Clinic visit, supplemental 052X – Visit 0780 – Telehealth 0900 – Psychiatric 0001 – Total charges

Third digit

The third digit of the TOB is the bill frequency digit. This digit shows the nature or intent of the bill submitted. Below is a listing of the possible third digits available to a CAH.

Third digit	Definition
0	Non-payment/zero claim
1	Admit through discharge claim
7	Replacement of prior claim (adjustment)
8	Void/cancel of prior claim

Additional Part A claim requirements

Inpatient

In addition to providing patient and provider information, the requirements listed below are for inpatient claims. Additional information may be required depending on the inpatient stay (i.e., non-covered days would require value code 81 and occurrence span code M1 with date or MSP claims would require primary insurance information).

Refer to the UB-04 claim form requirements chart (in the previous section) for additional information.

- TOB – 111, acute and CAH
- Appropriate revenue codes:
 - 0100 – Inpatient accommodation
 - 0001 – Total charge
- Value code:
 - Use value codes 80, 81 and 82 as appropriate to available benefit days and report number of covered days
- Date range
- Units
- Present on admission (POA) indicator (excluding CAH)
- Point of origin (source of admission)
- Type of admission (visit type)
- Patient discharge status
- Admitting diagnosis
- ICD-10-CM procedure codes
- Total charge

Outpatient

Outpatient encounters should be billed with the information listed below. All charges, except therapies, pneumococcal pneumonia vaccine, influenza virus and hepatitis B vaccines, surgical dressings, prosthetic/orthotics and hospital-based ambulance services are combined and reported under revenue code 0510 (clinic visit) on TOB 131 or 851 (hospital outpatient) with the appropriate HCPCS code(s).

- TOB:
 - 131 – Acute care
 - 851 – CAH
- Appropriate revenue codes:
 - 0510 – Outpatient clinic visit
 - 0001 – Total charge
- Date of service
- Units
- Point of origin (source of admission)
- Type of admission (visit type)
- Patient discharge status
- Diagnosis
- ICD-10-CM procedure codes (if applicable)
- Total charge

POA Indicator

CMS must capture a POA indicator for all inpatient admissions to general acute hospitals in order to group diagnoses into the proper DRG. The *UB-04 Data Specifications Manual* and the *ICD-9-CM Official Guidelines for Coding and Reporting* should be used to facilitate the assignment of the POA indicator for each “principal” diagnosis and “other” diagnoses codes reported on the UB-04 and 837 institutional claim forms.

CAHs are exempt from this reporting.

If hospitals do not report a valid POA indicator for each diagnosis on the claim, the claim will be returned to the hospital for correction. The valid POA indicators are:

- 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
- W (Clinically Undetermined) – The provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not.

Point of origin (source of admission)

The hospital's registration process must determine the appropriate source of admission or point of origin (where the patient came from before they were seen at the hospital). This can be done by internal processes or asking the patient. The source of admission pertains to both outpatient and inpatient claims and to all Part A submitters and is reported in Form Locator 15.

The following chart explains the most commonly used codes. For a complete list, please refer to the [National Uniform Billing Committee \(NUBC\)](#) website.

Code and description	Inpatient and Outpatient
1 – Non-health care Example: Patient coming from home or work.	Inpatient: The patient was admitted to this facility. Outpatient: The patient presented to this facility for outpatient services.
2 – Clinic or physician's office	Inpatient: The patient was admitted to this facility. Outpatient: The patient presented to this facility for outpatient services.
4 – Transfer from a hospital (different hospital). Excludes transfers from hospital inpatient in the same facility.	Inpatient: The patient was admitted after transfer from acute care facility where he was inpatient or outpatient. Outpatient: The patient was transferred to this facility as an outpatient from an acute care facility.

Type of admission (visit type)

The type of admission code indicates the priority of the admission. This code is reported in Form Locator 14 for both inpatient and outpatient claims for all Part A submitters.

Code	Description
1	Emergency – Patient required immediate medical intervention. Usually admitted through emergency room.
2	Urgent – Patient required immediate attention for care and treatment of a physical or mental disorder.
3	Elective – Patient's condition permitted adequate time to schedule visit.
9	Information not available.

Split your Medicare Part A services

Provider types	Provider's Fiscal Year	Federal Fiscal Year (09/30 & 10/01)	Calendar Year (12/31 & 01/01)
Acute care hospital	Not required	Not required	Not required
CAH	X	N/A	N/A
CAH swing bed	X	N/A	X
Acute care swing bed	N/A	X	N/A
Outpatient services	X	N/A	X
FQHC	X	N/A	X

[Part B CMS-1500 claim form](#)

View our resources for completion of the 1500 claim form available in the Claims Center of our website.

Outpatient services

Section 630 of the Medicare Modernization Act (MMA) of 2003 expanded coverage to IHS facilities to allow payment consideration on all Part B items or services. The following services were included in this regulation and are payable outside of the encounter rate:

- Preventive services (including influenza, pneumonia and hepatitis B vaccines and their administration).
- Clinical laboratory services.
- Therapy.
- Ambulance.
- Durable medical equipment.

The following guidelines pertain to both Part A (UB-04) and B (CMS-1500) claim submissions.

Vaccines

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 will be paid in addition to the AIR or facility-specific rate for CAHs when administered on the same day as a medically necessary patient encounter.

Note: These vaccines and their administration, when rendered during a medically necessary visit for a medical condition, should be included on the same claim. No clinic visit shall be billed if the vaccine and its administration are the only services received.

Vaccines are reimbursed based on the average wholesale price (AWP) except when furnished in a FQHC (paid based on reasonable cost). Administration of the vaccine is reimbursed based on the national allowance by state.

Influenza vaccines

Typically, this vaccine is 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.

Pneumococcal pneumonia vaccine (PPV)

Typically, PPV is administered once in a lifetime. Claims are paid for beneficiaries who are at high risk of pneumococcal disease and have not received the PPV within the last five years or are revaccinated because they are unsure of their vaccination status. Individuals considered at high risk for PPV, for whom an initial vaccine may be administered, include:

- All people age 65 and older.
- Immunocompetent adults who are at increased risk of pneumococcal disease or its complications because of chronic illness (e.g., cardiovascular disease, pulmonary disease, diabetes mellitus, alcoholism, cirrhosis or cerebrospinal fluid leaks).
- Individuals with compromised immune systems (e.g., splenic dysfunction or anatomic asplenia, Hodgkin's disease, lymphoma, multiple myeloma, chronic renal failure, HIV infection, nephrotic syndrome, sickle cell disease or organ transplantation).

Hepatitis B vaccine

The hepatitis B vaccine and its administration are available to Medicare beneficiaries who are at high or intermediate risk of contracting hepatitis B. The vaccine may be administered upon order by a doctor of medicine or osteopathy, or by home health agencies, (SNFs, ESRD facilities, hospital outpatient departments or persons recognized under the "incident to" physicians' services provisions of law.

High-risk groups include:

- ESRD patients.
- Hemophiliacs who receive Factor VIII or IX concentrates.
- Clients of institutions for the mentally retarded.
- Persons who live in the same household as a hepatitis B virus (HBV) carrier.
- Homosexual men.
- Illicit injectable drug users.

Intermediate risk groups include:

- Staff in institutions for the mentally retarded.
- Workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work.

Exception: Individuals in either of the above-listed intermediate and high-risk groups would not be considered at high or intermediate risk for contracting HBV if there is laboratory evidence positive for antibodies to hepatitis B.

Claims for hepatitis B vaccinations must report the identification number of the referring physician.

Billing requirements

For guidelines on billing of preventive services, please review [Preventive Services](#) available on our website.

Part A claims

TOB:

- 131 – Acute care outpatient.
- 851 – CAH outpatient.
- 771 – FQHC.

Revenue codes:

- 0636 – Pharmacy, drugs requiring detailed coding.
- 0771 – Preventive care services, vaccine administration.

Condition code A6

Condition code A6 is required on the hospital's Part A claim for the PPV and influenza vaccine.

FQHC

Administration of seasonal influenza virus vaccine and PPV does not count as a visit when the only service performed is the administration of the vaccine. The charges for the vaccines and administrations must be carved out and reported on separate detail lines. FQHCs will continue to be reimbursed through the cost report.

Payment for the hepatitis B virus vaccine is included in the clinic visit payment. The charges for the vaccine and its administration must be carved out and included on separate detail lines. However, FQHCs do not bill for a visit when the only service involved is the administration of the hepatitis B vaccine.

Part B claims

Vaccines administered in a hospital, FQHC or provider-based clinic are not separately reported on a Part B (CMS-1500) claim form. Only freestanding clinics report vaccines and their administration on the Part B claim form using POS code 11.

Roster billing

IHS/tribal hospitals and their provider-based clinics that provide mass immunization services, whether in the hospital/clinic or at local sites (e.g., chapter house, schools), can submit a roster bill to Part A.

Freestanding clinics (no hospital affiliation) that provide these same services must submit the roster bill to Part B.

Filing roster bills to Part A using DDE

The roster bill entry screen (MAP1681) in DDE allows quick and convenient online entry of the immunization of the influenza vaccine and PPV. The simplified process will provide basic beneficiary data on a roster, and a list of beneficiaries will be filed along with a single preprinted UB-04 claim form containing standardized information in lieu of preparing individual bills for each beneficiary.

In order to submit a roster bill through the roster bill entry option, the same type of vaccination must have been given to multiple beneficiaries on the same date of service. Each type of vaccination must be billed on a separate roster bill. In other words, pneumonia and flu shots cannot be listed on the same roster bill.

For instructions on completing the roster bill via FISS, please refer to the [FISS Training Manual](#) located in the Claims Center of our website.

[Filing roster claims to Part B](#)

We have created standard roster billing forms for the COVID-19, monoclonal antibody, influenza, and pneumococcal services, along with examples of the modified CMS-1500.

Outpatient observation services

Observation care is a well-defined set of specific, clinically appropriate services, including ongoing short-term treatment, assessment and reassessment, which are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they can be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. All hospital observation services that are medically reasonable and necessary, regardless of the duration of the observation care, are covered by Medicare. Observation services must be ordered by a physician or another individual authorized by state licensure law and hospital staff by-laws to admit patients to the hospital or to order outpatient tests.

When a physician orders that a patient be placed under observation, the patient's status is that of an outpatient. The purpose of observation is to determine the need for further treatment or for inpatient admission. Thus, a patient in observation may improve and be released, or be admitted as an inpatient.

Most observation services do not exceed 48 hours. If a hospital intends to retain a patient in observation status for more than 48 hours and an exception does not exist, the hospital must give the beneficiary proper written advance notice of non-coverage under the limitation of liability procedures. This applies only to non-AI/AN beneficiaries.

Reporting observation hours

Time begins at the time documented in the patient's medical record that coincides with the time that observation care is initiated in accordance with a physician's order.

Time ends when all medically necessary services related to observation care are completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient to be released or admitted as an inpatient.

The hours must equal or exceed eight hours.

Documentation

The medical record must include a provider's order for observation status, a detailed admission note indicating the reason for observation, diagnosis, a treatment plan and a clear definition of the end point for patient disposition.

Orders should be clear for the level of care intended, such as "admit to inpatient" or "admit for observation."

The medical record should include documentation that the physician assessed the patient risk to determine if the patient would benefit from observation care.

Documentation must show examinations, diagnostic test orders and results, medical decision-making, progress notes and patient status during observation.

Medical record documentation for observation services must show one of the following services rendered:

- Emergency room
- Clinic visit
- Critical care

If this was a direct admit from another location, documentation must show the referring provider, medical necessity for the observation admission and where the patient was seen by the referring provider.

Discharge instructions

Observation services end when the physician or other qualified licensed practitioner orders an inpatient admission, a transfer to another health care facility or discharge.

Admission following medical observation

When a patient is admitted to an observation unit for a medical condition, which either worsens or does not improve, and is subsequently admitted as an inpatient of the same hospital for this same medical condition, the principal diagnosis would be the medical condition which led to the hospital admission.

Non-coverage

The following services are not covered as observation services:

- Services not reasonable or necessary for the diagnosis or treatment of the patient.
- Services provided for the convenience of the patient, the patient's family or a physician.
- Services covered under Part A, such as a medically appropriate inpatient admission.
- Services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., four to six hours), which should be billed as recovery room services. Similarly, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished before the testing and during recovery are included in the payment for those diagnostic services. Observation should not be billed concurrently with therapeutic services such as chemotherapy.
- Standing orders for observation services are not acceptable since it is not necessary to employ observation services for every patient in a given category to reach a clinical decision about the appropriate next step in the patient's care.

Billing requirements**Part A**

Observation services are part of the outpatient visit and should be billed on the UB-04 as follows:

- Date of service = the date patient was placed in observation status and the date of discharge from observation.
- TOB:
 - 131, acute care hospitals
 - 851, CAHs
- Revenue code = 0510
- Units = number of days patient was in observation.
- HCPCS = use the equivalent E/M code that best describes the services provided.

Reimbursement

Payment for outpatient observation services is included in the AIR or CAH facility-specific outpatient rate per day of observation.

Part B

Payment for initial observation may only be made to the physician who ordered hospital outpatient observation services and was responsible for the patient during his observation care.

Payment for an initial observation care code is for all the care rendered by the ordering physician on the date the patient's observation services began. All other physicians who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient observation services must bill the appropriate outpatient service codes.

Physician services for observation are submitted on the CMS-1500 claim form using a POS 19 Off campus-Outpatient hospital or POS 22 On campus - Outpatient hospital.

Outpatient therapy services

Effective January 1, 2006, IHS providers are paid separately from the encounter rate for PT, OT, SLP and diagnostic audiology services. 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.

Coverage under Part B

Coverage under Part B includes services furnished by or under arrangements made by a participating provider of services. For the purpose of this coverage, the term "provider of services" includes approved clinics, rehabilitation agencies and public health agencies as well as participating hospitals, SNFs and home health agencies.

Therapy services rendered in an outpatient hospital or one of the hospital's provider-based clinics will be submitted on the UB-04 claim form or electronic equivalent. Therapy services rendered in a freestanding clinic will be submitted on the CMS-1500 claim form or electronic equivalent.

Enrollment of therapists Not sure we will want this either just go to the therapy pages

Therapists providing services in an outpatient hospital or a hospital's provider-based clinic are not required to enroll in the Medicare program. However, hospitals must ensure that guidelines for rehabilitation services and providers that perform these services follow the CMS Conditions of Participation Title 42, Section 482.56 and state laws.

Therapists providing services in a freestanding facility must enroll with Medicare Part B and obtain a PTAN before services can be billed. Enrollment applications are on the [Enrollment Center](#) of our website.

Conditions of coverage and payment

Outpatient therapy services furnished to a beneficiary by a provider or supplier are payable only when furnished in accordance with certain conditions. The following conditions of coverage apply:

- The services are required because the individual needed therapy services.
- The services are furnished while the individual is under the care of a physician and the physician has written an order for therapy services.
- A plan of care for furnishing the services has been established by a physician/ NPP or by the therapist providing the services and is periodically reviewed by a physician/NPP.
- The ordering physician has certified the plan of care. The services must be furnished on an outpatient basis.

Orders/Referrals and need for care

An order (or referral) for therapy service, if documented in the medical record, provides evidence of both the need for care and that the patient is under the care of a physician.

The certification requirements are met when the physician certifies the plan of care. Payment is dependent on the certification of the plan of care rather than the order, but the order shows that a physician is involved in care and available to certify the plan.

Plan of care

Therapy must relate directly and specifically to a written treatment plan, or plan of care (POC), which must be established before treatment is begun. The signature and professional identity of the person who established the plan and the date it was established must be recorded with the plan. A physician, NPP or therapist can establish a plan of care. The POC must contain at least a diagnosis, long-term treatment goals and the type, amount, duration and frequency of therapy services. Any changes to the plan must be signed by a professional responsible for the patient's care. The therapist may not significantly alter a POC established or certified by a physician or NPP without his documented written approval.

Certification and recertification

Certification requires a dated signature on the POC or some other document that indicates approval of the POC. Acceptable documentation of certification may be a physician's progress note, a physician/NPP order, or a POC that is signed and dated by a physician/NPP. The documentation must indicate the physician/NPP is aware that therapy service is or was in progress; no record of disagreement with the plan, and evidence the plan is available for review. Initial certification should be obtained as soon as possible after the POC has been established. "As soon as possible" means the physician/NPP shall certify the initial plan as soon as it is obtained or within 30 days of the initial therapy treatment. Timely certification of the initial plan is met when physician/NPP certification of the plan is documented, by signature or verbal order, and dated in the 30 days following the first day of treatment (including evaluation). If the order to certify is verbal, it must be followed within 14 days by a signature to be timely. A dated notation of the order to certify the plan should be made in the patient's medical record. Certifications are required for each interval of treatment based on the patient's needs, not to exceed 90 calendar days from the initial therapy treatment. Recertification is timely when dated during the duration of the initial plan of care or within 90 calendar days of the initial treatment under that plan, whichever is less.

Physical therapy assistant (PTA)

A PTA is a person who is licensed as a PTA, is registered or certified, if applicable, as a PTA by the state in which practicing, has graduated from an approved curriculum for PTAs and has passed a national examination for PTAs.

The services of PTAs used when providing covered therapy benefits are included as part of the covered service. These services are billed by the supervising physical therapist. PTAs may not provide evaluation services, make clinical judgments or decisions, or take responsibility for the service. They act at the direction and under the supervision of the treating physical therapist and in accordance with state laws.

A physical therapist must supervise PTAs. The level and frequency of supervision differs by setting (and state or local law). General supervision is required for PTAs in all settings except private practice, unless state practice requirements are more stringent, in which case state or local requirements must be followed.

Outpatient therapy coding requirements

Occurrence code

If more than one discipline (e.g., PT and OT) is billed, occurrence code 11 (onset of symptoms/illness) does not have to be reported when the date of the onset is the same for each individual therapy billed.

The following table lists the applicable codes required when billing Medicare Part A outpatient therapy services.

Revenue codes	Modifiers	HCPCS codes	Occurrence codes/Dates
0420 – PT	GP	Required	11 – Onset of symptoms/illness. 29 – The date the PT plan was established or last reviewed. 35 – Date treatment began for PT.
0430 – OT	GO	Required	11 – Onset of symptoms/illness. 17 – The date the OT plan was established or last reviewed. 44 – Date treatment began for OT.
0440 – SLP	GN	Required	11 – Onset of symptoms/illness. 30 – The date the SLP plan was established or last reviewed. 45 – Date treatment began for SLP.
0470 – Audiological function test		Required	Not applicable

Therapy rendered in freestanding clinic

Therapy services rendered in a freestanding clinic are submitted on the CMS-1500 claim form, or electronic equivalent, with POS 11 and the appropriate therapy HCPCS and modifier. The same coverage guidelines apply in freestanding clinics.

Repetitive services

Repetitive services furnished to a single individual by providers that bill Medicare Part A are required to be billed monthly (or at the conclusion of treatment). When there is an inpatient stay during a month when repetitive outpatient services are rendered, one bill for repetitive services should be submitted for the entire month as long as the provider uses occurrence span code 74 on the monthly repetitive bill.

References

- Therapy specialty page ([Part A](#)) ([Part B](#)) ([Part A](#)) ([Part B](#))

Audiology services

Diagnostic testing, including hearing and balance assessment services, performed by a qualified audiologist is covered as “other diagnostic tests” under Section 1861(s) (3) of the Social Security Act when a physician orders such testing for the purpose of obtaining information necessary for the physician’s diagnostic evaluation or to determine the appropriate medical or surgical treatment of a hearing deficit or related medical problem. Services are excluded by virtue of Section 1862(a)(7) of the Act when the diagnostic information required to determine the appropriate medical or surgical treatment is already known to the physician, or the diagnostic services are performed only to determine the need for or the appropriate type of hearing aid.

Diagnostic services performed by a qualified audiologist and meeting the above requirements are payable as “other diagnostic tests.” The payment for these services is determined by the reason the tests were performed, rather than the diagnosis or the patient’s condition.

If a physician refers a beneficiary to an audiologist for evaluation of signs or symptoms associated with hearing loss or ear injury, the audiologist’s diagnostic services should be covered even if the only outcome is the prescription of a hearing aid. If a beneficiary undergoes diagnostic testing performed by an audiologist without a physician referral, the tests are not covered even if the audiologist discovers a pathologic condition.

Diagnostic testing:

- Audio logical diagnostic testing refers to tests of the audio logical and vestibular systems, e.g., hearing, balance, auditory processing, tinnitus and diagnostic programming of certain prosthetic devices, performed by qualified audiologists.
- Audio logical tests require the skills of an audiologist and must be furnished by qualified audiologists or, in states where it is allowed by state and local laws, by a physician or NPP.

Medicare is not authorized to pay for these services when performed by audio logical aides, assistants, technicians or others who do not meet the qualifications.

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 used due to congenital malformations, chronic disease, severe sensorineural hearing loss or surgery.

CPT code 92591© (hearing aid exam, both ears) is non-covered due to Medicare exclusion.

Please refer to the LCD, [L3507- Vestibular and Audiologic Function Studies](#) and [A57434 Article Billing and Coding: Vestibular and Audiologic Function Studies](#) located on the LCD page of our website.

Note: If the patient has a medically necessary clinic visit in addition to the audiology services on the same day, add revenue code 0510 with the appropriate HCPCS code to the claim.

Billing requirements for therapy and audiology

Part A:

- TOB 12X, 13X or 85X.
- Appropriate revenue code.
- Appropriate HCPCS code.
- These services may be billed with or without a clinic visit.
- One claim should be submitted with all services rendered for the date of service.
- 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.

Part B:

- Audiology and therapy services rendered in a freestanding facility are submitted on the CMS-1500 claim form, or electronic equivalent, using POS code 11. All coverage guidelines apply.

Screening and preventive services

Effective January 1, 2005, payment is made based on the AIR to IHS providers, excluding CAHs for screening and preventive services covered under Section 630 of the Medicare Modernization Act (MMA).

Payment is made to CAHs based on cost.

Screening and preventive services covered under Section 630 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 (Must have a copy of the DSMT certification prior to payment being made.)
- MNT
- Initial Preventive Physical Exam (IPPE)
- Smoking and tobacco use cessation (counseling and screening)

Note: This is not an all-inclusive list as CMS is continually implementing new services.

References

- [Preventive Services Preventive Services](#)
- [CMS Prevention Website](#)
- [CMS IOM Pub. 100-04, Claims Processing Manual, Chapter 19](#)

Ambulance services

An ambulance is any vehicle designed and equipped to respond to medical emergencies and, in non-emergency situations, is capable of transporting beneficiaries with acute medical conditions. The vehicle must comply with state or local laws governing the licensing and certification of an emergency medical transportation vehicle.

Medicare coverage for ambulance transportation is limited by CMS national policy in accordance with federal law.

Billing instructions

Part A

Hospital based ambulances (hospital owns ambulance) submit claims to Part A on a UB-04 claim form, billed under the hospital PTAN with:

- TOB:
 - 131 – Acute care hospital
 - 851 – CAH
- Revenue code - 0540 – Ambulance.
- HCPCS code - Report the appropriate code based on transportation and mileage.
- Diagnosis code:
 - Report the diagnosis code based on chief complaint and observation. Refer to our Ambulance LCD for coverage policy.
- Value code:
 - The value code is defined as ZIP code of the location from which the beneficiary is initially placed on board the ambulance; it is required on all Part A ambulance claims. Value code A0 should be reported in Form Locators (FLs) 39–41 (value codes). Only one ZIP code may be reported per claim.
 - Providers should report the five-digit ZIP code in the dollar portion of the FL, right justified to the left of the dollar/cents delimiter.

The attending physician's NPI number should be reported on the claim. Only non-emergency trips (i.e., HCPCS codes A0426 and A0428) require an NPI in the attending physician field. Entry of an NPI in the attending physician field is not required for emergency trips (i.e., HCPCS codes A0427, A0429, A0430, A0431, A0432, A0433 and A0434).

Part B

Part B ambulance companies (not owned by hospital) submit claims to Part B on the CMS-1500 claim form under their own Medicare number, using a POS code 41 (ambulance), and the appropriate HCPCS for the transportation and mileage. The ZIP code for the POP and drop-off will be entered in Item 23.

Prosthetics, orthotics and surgical dressings

For dates of service on or after July 1, 2005, IHS providers, including CAHs, must bill the designated IHS MAC for prosthetics and orthotics. Medicare Part B payment may be made to IHS providers who furnish prosthetic devices that 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 MAC by IHS providers.

Splints and casts

Medicare Part B covers splints and casts and other devices used for reductions of fractures and dislocations. This includes dental splints. Splints and casts are included in the AIR for hospitals and hospital-based facilities.

Surgical dressings

Surgical dressings are limited to primary and secondary dressings required for the treatment of a wound caused by or treated by a surgical procedure that has been performed by a physician or other health care professional to the extent permissible under state law. In addition, surgical dressings required after debridement of a wound are also covered, irrespective of the type of debridement, as long as the debridement was reasonable and necessary and was performed by a health care professional acting within the scope of his legal authority when performing this function. Surgical dressings are covered for as long as they are medically necessary.

Primary dressings are therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin. Secondary dressing materials that serve a therapeutic or protective function and that are needed to secure a primary dressing are also covered. Items such as adhesive tape, roll gauze, bandages and disposable compression material are examples of secondary dressings. Elastic stockings, support hose, foot coverings, leotards, knee supports, surgical leggings, gauntlets and pressure garments for the arms and hands are examples of items that are not ordinarily covered as surgical dressings. Some items, such as transparent film, may be used as a primary or secondary dressing.

Billing requirements

When billing for surgical dressings, report revenue code 0623.

The appropriate HCPCS code that defines the surgical dressing:

- A6010-A6011
- A6021-A6024
- A6154
- A6196-A6197
- A6199
- A6203-A6204
- A6207
- A6209-A6212\
- A6214
- A6219-A6220
- A6222-A6224
- A6229
- A6231-A6238
- A6240-A6248
- A6251-A6255
- A6257-A6259
- A6266
- A6402-A6403
- A6408
- A6410
- A6412
- A6441-A6457

Note: Revenue codes 0274 and 0623 should be billed on a separate claim from a qualified clinic visit for the same date of service.

Reimbursement

Prosthetics, orthotics and surgical dressings are payable under the [Durable Medical Equipment, Prosthetics, Orthotics and Supplies \(DMEPOS\) fee schedule](#). If provided by an IHS/tribally owned and/or operated hospital or hospital-based facility, they are billed to the designated MAC; if provided by another entity, these items must be billed to the DME MAC.

Telemedicine services

Telemedicine (also known as telehealth) is the ability to provide medical services via telecommunications in an approved originating site that is located in a rural Health Professional Shortage Area (HPSA) or other medically underserved area. The use of an interactive telecommunications system may substitute for a face-to-face, “hands-on” encounter.

Telemedicine services fall into two categories:

1. Originating site facility service in which the beneficiary is presented to the distant site practitioner; and
2. Distant site service that is generally some type of professional consultation.

“Originating site” is defined as the location of an eligible Medicare beneficiary at the time the service being furnished, via a telecommunications system, occurs. This may be the physician/practitioner office, hospital, CAH, RHC, FQHC, hospital-based dialysis center, SNF or community mental health center.

“Distant site” is defined as a site where the physician/practitioner providing the professional service is located at the time the service is provided via a telecommunications system.

For Medicare payment to occur, interactive audio and video telecommunications must be used, permitting real-time communication between the distant site physician or practitioner and the Medicare beneficiary. As a condition of payment, the patient must be present and participating in the telemedicine visit.

Effective January 1, 2009, IHS hospitals, including CAHs, are paid separately from the AIR for the telemedicine originating site facility fee. HCPCS code Q3014 (telemedicine originating site facility fee) is a Part B benefit. IHS providers are paid for HCPCS code Q3014 according to the fee schedule. For CAHs, the payment amount is 80 percent of the fee schedule.

Billing instructions

Part A

When a patient is seen at a hospital and telemedicine services begin at this location, the originating site HCPCS code will be submitted on the Part A claim.

- TOB:
 - 131 – Acute care hospital
 - 851 – CAH
- Revenue code – 0780, Telemedicine.
- HCPCS code - Q3014, Originating site.

Part B

When a patient is seen at a provider-based clinic of a hospital and the telemedicine services begin at this location, the originating site HCPCS code will be submitted on the Part B CMS-1500 claim form using a POS code 19 or 22.

If telemedicine services begin at a freestanding clinic, the originating site HCPCS code will be submitted using POS code 11 on the CMS-1500 claim form.

Distant site services performed at a provider-based or freestanding clinic are submitted with modifier GT (via interactive audio and video telecommunication system) or GQ (via asynchronous telecommunications system) modifier indicating telemedicine services.

Note: Modifier GT is no longer required effective January 1, 2018.

Effective for claims with dates of service on and after January 1, 2019, MACs will accept new informational HCPCS modifier G0 to be used to identify Telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke. Modifier G0 is valid for all:

Telehealth distant site codes billed with POS code 02 or CAH method II (revenue codes 096X, 097X, or 098X); or

Telehealth originating site facility fee, billed with HCPCS code Q3014.

- References [MLN Matters Article, MM10883-New Modifier for Expanding the Use of Telehealth for Individuals with Stroke](#)
- [Telehealth Services Fact Sheet](#)
- [Telehealth Services Specialty Page](#)

Other Part B services

ASCs

General background for IHS and Tribal ASC

Effective January 1, 2008, CMS implemented a new ASC payment system based on Section 626 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. IHS and tribal hospital ASCs were directly affected by this new requirement.

In order to continue paying IHS and tribal hospitals for the ASC service, they were required to enroll with Medicare Part B and obtain a Part B ASC PTAN. In order to ease the process of converting from the Part A fiscal intermediary to the Part B carrier, CMS determined that IHS and tribal hospital ASCs were not required to be individually surveyed for compliance to ASC conditions of participation since the hospitals already met compliance based on the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or CMS certification. The conversion was not mandatory but, to continue receiving the ASC payment rate, it must be made through Part B.

Effective with date of service January 1, 2008, Part A claims submitted as ASC services will be denied. If a hospital elected not to enroll as an ASC with Part B, then the AIR could be billed to Part A using revenue code 0510.

Definition of ASC

For Medicare purposes an ASC is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients.

The Medicare definition of covered ASC facility services for a covered surgical procedure includes services that would be covered if furnished on an inpatient or outpatient basis in connection with a covered surgical procedure. This includes operating and recovery rooms, patient preparation areas, waiting rooms and other areas used by the patient or offered for use to patients needing surgical procedures. It includes all services and procedures provided in connection with covered surgical procedures furnished by nurses, technical personnel and others involved in patient care. These do not include physician services or medical and other health services for which payment may be made under other Medicare provisions.

ASC services on ASC list

Covered ASC services are those surgical procedures that are identified by CMS on an annually updated ASC listing. Some surgical procedures covered by Medicare are not on the ASC list of covered surgical procedures. These may be billed by the rendering provider as Part B services but not as ASC services.

Under the ASC payment system, Medicare will make facility payments to ASCs only for the specific ASC-covered surgical procedures on the ASC list of covered surgical procedures. In addition, Medicare will make separate payment to ASCs for certain covered ancillary services that are provided integral to a covered ASC surgical procedure. All other non-ASC services such as physician services and prosthetic devices may be covered and separately billable under other provisions of Medicare Part B.

Facility and physician allowance

Generally, there are two primary elements in the total cost of performing a surgical procedure:

- Cost of the physician's (surgeon) professional services for performing the procedure.
- Cost of services furnished by the facility where the procedure is performed (for example, surgical supplies, equipment and nursing services).

The professional fee is paid to the surgeon; the facility fee is paid to the ASC.

Physician coding and ASC coding of the procedures performed should match.

In addition to the surgeon's claim, a separate claim can be submitted for the anesthesiologist using anesthesia CPT codes.

The POS code for services rendered in an ASC is 24.

References

[CMS' ASC website](#)

[Novitas Provider Specialty website Ambulatory surgery center \(ASC\)](#)

Anesthesia services

Anesthesia is the administration of a drug or gas to induce partial or complete loss of consciousness. Services involving administration of anesthesia should be reported by the use of the CPT anesthesia five-digit procedure code plus modifier codes. Surgery codes are not appropriate unless the anesthesiologist or certified registered nurse anesthetist (CRNA) is performing the surgical procedure.

An anesthesiologist, CRNA or an anesthesia assistant (AA) can provide anesthesia services. The anesthesiologist and the CRNA can bill separately for anesthesia services they personally perform. In cases of medical direction, both the anesthesiologist and the CRNA would bill Medicare for their component of the procedure. Each provider should use the appropriate anesthesia modifier.

Note: If the surgery is non-covered, the anesthesia is also non-covered.

Modifiers

Modifiers are two-digit indicators used to modify payment of a procedure code, assist in determining appropriate coverage or otherwise identify the detail on the claim.

Every anesthesia procedure billed to Medicare must include one of the following anesthesia modifiers: AA, QY, QK, AD, QX or QZ. Other modifiers listed below may be used to identify specific situations in addition to the required modifiers.

Do not use the following modifiers if the provider of service is a CRNA or AA.

Modifier	Description
AA	Anesthesia services personally performed by the anesthesiologist
QY	Medical direction of one CRNA by an anesthesiologist
QK	Medical direction of two, three or four concurrent anesthesia procedures
AD	Supervision, more than four procedures

CRNA

Do not use the following modifiers if the provider of service is an anesthesiologist.

Modifier	Description
QX	Anesthesia, CRNA medically directed
QZ	Anesthesia, CRNA not medically directed

Monitored anesthesia care

Modifier	Description
QS	Monitored anesthesia care (MAC) services (can be billed by a CRNA, AA or physician)

Time

Anesthesia time begins when the anesthesiologist starts to prepare the patient for the procedure. Normally, this service takes place in the operating room, but in some cases, preparation may begin in another location (e.g., holding area). Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service.

Anesthesia time is reported in total minutes in Item 24G of the CMS-1500 claim form. The allowance for anesthesia services is based on the following formula:

Time units + base units x conversion factor = allowance.

One time unit will be allowed for each 15-minute interval or fraction thereof, starting from the time the physician begins to prepare the patient for induction and ending when the patient may safely be placed under postoperative supervision and the physician is no longer in personal attendance.

Example: 95 minutes total anesthesia time divided by 15-minute interval equals 6.3 time units.

Anesthesia base unit values have been assigned to each anesthesia procedure code and reflect the difficulty of the anesthesia services, including the usual preoperative and postoperative care and evaluation. The base unit is used to determine a portion of the reimbursement amount of the anesthesia procedure.

Note: Base units are automatically calculated and should not be reported on the claim form.

The anesthesia conversion factor is used to compute allowable amounts for anesthesia services. Conversion factors (CF) are determined based on a formula consisting of work, practice and malpractice expense; therefore, each state or locality may have a different CF.

For more information, please visit the [Anesthesia specialty page](#) of our website.

Dental services

The Medicare program does not cover most routine dental services. The Medicare law clearly excludes coverage “for services in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting teeth.”

Medicare will not pay for most routine dental care, such as fillings, cleanings, X-rays and dentures, even if those services are performed in a hospital.

A narrow exception permits coverage of certain dental services that are necessary to the provision of certain Medicare covered medical services. For example, Medicare may cover the following services:

- Extraction of a tooth as part of a repair of a fractured jaw.
- Maxillofacial surgery for pathological or traumatic medical conditions (for example, in case of a serious injury).
- Prosthetic rehabilitation to replace or treat certain oral and/or facial structures related to covered medical and surgical interventions (for example, cancer surgery).
- Extraction of teeth prior to radiation treatment of the jaw.

- Oral examination prior to kidney transplantation.

Medicare may also cover certain medical procedures that dentists are licensed to perform (e.g., biopsy for oral cancer).

A claim for the Part A all-inclusive rate cannot be submitted for Medicare program exclusions, including routine dental services provided in an emergency room (e.g., removal of tooth due to infection) unless there are other signs or symptoms that warrant medical necessity (e.g., removal of teeth to repair a fractured jaw).

If a patient's supplemental insurance will cover the Medicare excluded service and a remit is required, submit a no-pay claim (TOB 130, condition code 21) for Part A and/or the non-covered dental diagnosis and procedure for Part B.

Reference

[CMS IOM Pub. 100-02, Benefit Policy Manual, Chapter 16, Section 140](#)

Diagnostic tests

A “diagnostic test” includes all diagnostic X-ray tests, all diagnostic laboratory tests and other diagnostic tests furnished to a beneficiary.

A “treating physician” is a physician who furnishes a consultation or treats a beneficiary for a specific medical problem, and who uses the results of a diagnostic test in the management of the beneficiary’s specific medical problem.

A “treating practitioner” is a nurse practitioner, clinical nurse specialist or physician assistant who furnishes, pursuant to state law, a consultation or treats a beneficiary for a specific medical problem, and who uses the result of a diagnostic test in the management of the beneficiary’s specific medical problem.

An “order” is a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary. The order may conditionally request an additional diagnostic test for a particular beneficiary if the result of the initial diagnostic test ordered yields to a certain value determined by the treating physician/practitioner (e.g., if test X is negative, then perform test Y).

An order may include the following forms of communication:

- A written document signed by the treating physician/practitioner that is hand-delivered, mailed or faxed to the testing facility.
 - **Note:** No signature is required on orders for clinical diagnostic tests paid on the basis of the clinical laboratory fee schedule, the physician fee schedule or for physician pathology services.
- A telephone call by the treating physician/practitioner or his office to the testing facility.
 - **Note:** If the order is communicated via telephone, both the treating physician/practitioner or his office and the testing facility must document the telephone call in their respective copies of the beneficiary’s medical records.
- An e-mail by the treating physician/practitioner or his office to the testing facility.

A physician’s signature is not required on orders for clinical diagnostic tests (including X-ray, laboratory and other diagnostic tests) that are paid on the basis of the clinical laboratory fee schedule or the MPFS, or for physician pathology services. While a physician order is not required to be signed, the physician must clearly document in the medical record his intent that the test be performed.

Standing orders

The Medicare program considers payment for services performed based on medical necessity of the patient. Diagnostic services, including lab services, are not exempt from this requirement. Patient records must support the medical necessity for performing the ordered lab service. Many facilities have “standing orders” for testing and other services for all residents of their facility. The problem with this type of standing order is the lack of patient-specific signs/symptoms/medical needs prompting the laundry list of tests. This type of standing order does not meet the requirement of documented medical necessity required by Medicare for reimbursement.

The term “standing order” is sometimes used for anticipated scheduled testing required for some drug therapies. Some drug therapies require monitoring of therapeutic levels. This type of standing order is patient-specific and medically necessary to monitor patient-specific conditions. The physician has to evaluate the patient and then authorize the order for the service or procedure and subsequent ones. The patient’s medical record must support the continued monitoring of the patient based on the lab findings that prompt drug therapy dose and frequency adjustments along with lab frequency adjustments to meet the changing needs of the patient. The medical necessity and the nature of each service or procedure must be clearly documented by a physician and the physician’s authorization must be in the patient’s medical records.

Ordering provider

Medicare will only pay for items or services for Medicare beneficiaries that have been ordered by a physician or eligible professional who is enrolled in Medicare and their individual NPI has been provided on the claim. The ordering provider or supplier (physician or eligible professional) must also be enrolled with a specialty type that is eligible (per Medicare statute and regulation) to order and refer those particular items or services (e.g., chiropractors enroll and provide services to beneficiaries but their specialty type is not eligible to order services).

Claims submitted for services that require an ordering provider (e.g., diagnostic tests and (DME supplies) must show the ordering provider’s name and NPI in Items 17 and 17b of the CMS-1500 claim form. This must be an individual’s name and NPI, not an organization.

Until further notice from CMS, claims will reject if the ordering provider’s name and NPI are not located in the PECOS or if this information is not provided on the claim form. In the future, edits will be in place to deny claims whenever the ordering provider’s name and NPI are not in PECOS.

For information on PECOS enrollment, please visit [Internet-based PECOS](#) on the CMS website.

Electrocardiogram (ECG or EKG)

Medicare Part B covers an electrocardiogram if the test is prescribed to diagnose a condition, not merely for general cardiac screening. Medicare covers electrocardiogram services as diagnostic tests when there are documented signs and symptoms or other clinical indications for providing the service. Medicare will cover a screening EKG when it is provided as a component of the "Welcome to Medicare" exam.

Coverage includes the review and interpretation of an EKG/ECG by a qualified physician or NPP who is licensed by his state to perform these services. The recording and interpretation should be part of the patient's medical record.

The report of the professional component (the interpretation) for the ECG/EKG must be a complete written report that includes relevant findings and appropriate comparisons. The interpretation may appear on the actual tracing or with a progress note or other report of an E/M service when the ECG/EKG is performed in conjunction with performance of an E/M service. An interpretation reported in the latter fashion, when billed as a separate service from the E/M service, should contain the same information as a report made upon the tracing itself. A simple notation of "ECG/EKG normal," without accompanying tracing, will **not**, in this circumstance, suffice as documentation of a separately payable interpretation.

Interpretation of an ECG/EKG is submitted under the appropriate CPT code, not with modifier 26. If the interpretation was provided at a hospital or provider-based clinic and the POS code would be 19, 21, 22 or 23; then CPT code 93010 should be submitted on the CMS-1500 claim form. The technical component is included in payment of the outpatient encounter through Part A. For electrocardiogram services rendered in a freestanding clinic (POS 11), the complete procedure can be submitted if both the technical and interpretation were performed at the clinic. Otherwise, the technical component is billed as 93005 or the interpretation as 93010, depending on which procedure was performed.

Laboratory services

Medicare covers medically necessary diagnostic lab services that are ordered by a treating physician or non-physician practitioner when they are performed by a provider or lab that is a Clinical Laboratory Improvement Amendments (CLIA)-certified laboratory. CLIA regulations apply to laboratory testing all settings including commercial, hospitals and physician clinics.

The CLIA number must be submitted on all claims for laboratory services, including tests granted a “waived” status under CLIA and tests covered under the provider performed microscopy procedures certificates.

CLIA certification is not required when the only service the clinic provides is a blood draw. However, CLIA certification is required even on a simple urinalysis.

Under Part B clinical laboratory tests are reimbursed on the basis of fee schedules. The type of lab service provided determines the type of fee schedule used in payment:

- Clinical laboratory fee schedule
- Physician fee schedule

Clinical laboratory tests

Clinical laboratory services are microbiological, serological, chemical, hematological, radio bioassay, cytological, immunohematology or pathological examinations performed on material derived from the human body to provide information for the diagnosis, prevention or treatment of a disease or assessment of a medical condition. Clinical laboratory tests are paid at 100 percent of the clinical lab fee schedule or the actual billed amount; whichever is less.

Diagnostic laboratory tests

Diagnostic laboratory and pathology services are surgical pathology, specific cytopathology, hematology and blood banking services, which require performance by a physician or other certified professionals. Payment is 80 percent of the physician fee schedule.

Diagnosis coding requirements

Diagnoses documented as probable, suspected, questionable, rule-out or working should not be coded as though they exist. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as signs, symptoms, abnormal test results, exposure to communicable disease or other reasons for the visit.

The use of the term “screening” or “screen” in a CPT code descriptor does not necessarily describe a test performed in the absence of signs and symptoms of illness, disease or condition.

Tests that are performed in the absence of signs, symptoms, complaints, and personal history of disease or injury are not covered except when there is a statutory provision that explicitly covers a test for screening as described.

If a person is tested to rule out or to confirm a suspected diagnosis because the patient has a sign and/or symptom, this is considered a diagnostic test, not a screening test.

Modifier 90

Part B claims for referred laboratory services may be made only by suppliers having specialty code 69, i.e., independent clinical laboratories. Independent laboratories shall use modifier 90 to identify all referred laboratory services. This modifier is not used by IHS providers.

If a specimen is obtained by an IHS location and sent to a laboratory for interpretation, the only billable procedure by the IHS location would be the specimen collection. This is not considered a reference lab service where modifier 90 would be used.

Claim requirements

Part A claims for diagnostic tests performed on days when there is no face-to-face visit with a provider are submitted as an encounter if the service meets the guidelines for medical necessity and “incident to” (refer to the appendix for Q&As). The exception to this rule is when billing for reference labs using TOB 141.

When billing for the interpretation of diagnostic tests or tests performed in a freestanding facility, Part B claims will require the following additional information:

- Items 17 and 17b – Name and NPI of ordering provider (even if it is the same as the attending).
- Item 23 – 10-digit CLIA certification number (clinical lab claims only). Claims will reject if this information is missing from the claim.

For more information, please review the [Laboratory Specialty](#) page located on our website.

Foot care

Medicare generally does not cover routine foot care. However, foot care services may be billed if treated by a physician for a medical condition affecting circulation of the legs or feet.

Medicare Part B covers the services of a podiatrist for medically necessary treatment of injuries or diseases of the foot (such as hammer toe, bunion deformities, heel spurs and routine foot care for patients with a qualifying systemic condition).

For services to qualify for covered routine foot care, the patient must have been seen by that provider for the specified condition within six months prior to or shortly after (within six weeks) the routine foot care service.

Report the NPI and the date last seen (MM/DD/YYYY) of the attending provider in Item 19 or the electronic equivalent of the CMS-1500 claim form.

Before Medicare will consider coverage of these services, medical documentation must support the medical necessity based on the appropriate LCD and be made available to Medicare upon request.

For more information, please visit the [Podiatry specialty page](#) of our Novitas website.

Maternity services

Most surgeons and obstetricians bill patients an all-inclusive package charge intended to cover all services associated with the surgical procedure or delivery of a child. All expenses for surgical and obstetrical care, including preoperative/prenatal examinations and tests and postoperative/postnatal services, are considered incurred on the date of surgery or delivery, as appropriate. This policy applies whether the physician bills on a package charge basis or itemizes the bill separately for these items.

Occasionally, a physician's bill may include charges for additional services not directly related to the surgical procedure or the delivery. Such charges are considered incurred on the date the additional services are furnished.

The above policy applies only where the charges are imposed by one physician or by a clinic on behalf of a group of physicians. Where more than one physician imposes charges for surgical or obstetrical services, all preoperative/prenatal and postoperative/postnatal services performed by the physician who performed the surgery or delivery is considered incurred on the date of the surgery or delivery. Expenses for services rendered by other physicians are considered incurred on the date they were performed.

Modifiers

Modifiers are used to modify payment of a procedure code, assist in determining appropriate coverage or otherwise identify the detail on the claim. The use of modifiers becomes more important every day when reporting services to ensure appropriate reimbursement from Medicare.

For additional information on modifiers, please visit the [Modifiers](#) page of our website.

Medically Unlikely Edits (MUEs)

To lower the Medicare fee-for-service paid claims error rate, CMS established units of service edits referred to as (MUEs. The National Correct Coding Initiative (NCCI) contractor develops and maintains MUEs. This set of edits is based on anatomical considerations and addresses approximately 2,800 codes.

An MUE is defined as an edit that tests claim lines for the same beneficiary, HCPCS code, date of service and billing provider against a criteria number of units of service. These MUEs will auto-deny claim line items containing units of service billed in excess of the MUE criteria.

Additional information on MUEs can be found on the CMS [NCCI](#) web page.

Ophthalmology

Routine eye examinations and refractions for the purpose of prescribing, fitting or changing eyeglasses are Medicare exclusions. The exclusion does not apply to a physician's services (and services incident to a physician's service) performed in conjunction with an eye disease (e.g., glaucoma and cataracts).

The determination of refractive state will always be denied by Medicare. Non-covered services are sometimes billed to Medicare for the purpose of a claim denial. The denial is then forwarded to the patient's secondary insurance for payment consideration.

Non-covered services such as "determination of refractive state" must be billed with the **GY** modifier. The GY modifier indicates the provider is aware the service is non-covered and the patient is financially responsible for the service (used for IHS/tribal patients that have a supplemental insurance policy that will consider payment).

Provider qualifications

Ophthalmologist/Physician

A "physician" is defined as a Doctor of Medicine or doctor of osteopathy. The issuance by a state of a license to practice medicine constitutes legal authorization. The services performed by a physician within these definitions are subject to any limitations imposed by the state on the scope of practice. If state licensing law limits the scope of practice of a particular type of medical practitioner, only the services within those limitations are covered.

Optometrist

A Doctor of Optometry is considered a physician with respect to all services the optometrist is authorized to perform under state law or regulation. To be covered under Medicare, the services must be medically reasonable and necessary for the diagnosis or treatment of an illness or injury and must meet all applicable coverage requirements.

E/M

An ophthalmologist or optometrist may bill either an E/M service (99202–99215) or an ophthalmologic examination (92002–92014), whichever is more appropriate. The patient's medical documentation must support the code billed to Medicare.

Diabetic retinopathy services

Coverage is allowed for general and diagnostic ophthalmological services provided to diabetic patients at risk for retinopathy. Such tests and evaluations are not considered routine screening services as they are ordered to assess the presence or extent of diabetic retinopathy as part of the appropriate management of a patient with diabetes.

POS

Claims submitted to Medicare Part B on the CMS-1500 claim form require a POS code to indicate where the service was rendered or where the patient was located at the time a service was performed.

The POS code used by the physician and other supplier will be assigned as the same setting in which the beneficiary received the face-to-face service. Because a face-to-face encounter with a physician/practitioner is required for nearly all services paid under the MPFS and anesthesia services, this rule applies to the overwhelming majority of MPFS services.

In cases where the face-to-face requirement is obviated, such as those when a physician/practitioner provides the professional component (PC)/interpretation of a diagnostic test from a distant site, the POS code assigned by the physician/practitioner will be the setting in which the beneficiary received the technical component (TC) of the service. For example: A beneficiary receives an MRI at an outpatient hospital near his home. The hospital submits a claim that would correspond to the TC portion of the MRI. The physician furnishes the PC portion of the beneficiary's MRI from his office location. POS code 19 or 22 will be used on the physician's claim for the PC to indicate that the beneficiary received the face-to-face portion of the MRI – the TC – at the outpatient hospital.

The two exceptions to this face-to-face provision/rule in which the physician always uses the POS code are when the beneficiary is receiving care as a hospital inpatient or an outpatient of a hospital, regardless of where the beneficiary encounters the face-to-face service. Report the POS code for the setting in which the beneficiary is receiving inpatient or outpatient care from a hospital, including inpatient hospital (POS 21) or outpatient hospital (POS 19 or 22).

POS codes 05, 06, 07 and 08

As a covered entity, Medicare must use the POS codes from the national POS code set for processing its electronically submitted claims. Medicare must also recognize as valid POS codes from the POS code set when these codes appear on such a claim.

Medicare must recognize and accept POS codes from the national POS code set in terms of HIPAA compliance.

POS codes 05, 06, 07 and 08 are on the national POS code set and Medicare is required to accept these codes when submitted electronically; however, they are not applicable for adjudication by Medicare. Part B claims submitted with these POS codes will be returned as unprocessable. IHS and tribal facilities should continue to use POS 19 or 22 (outpatient provider-based) or 11 (freestanding).

For more information on POS codes, please visit the CMS [Place of Service Codes](#) web page.

Incentive programs

Providers may receive bonus payments in addition to their Medicare reimbursement through various CMS-sponsored incentive programs. Participation in any of the initiative programs is voluntary and would certainly provide an increase to the Medicare reimbursement.

Reference

[CMS IOM Pub. 100-22, Medicare Quality Reporting Incentive Programs Manual](#)

Hospital value-based reporting

Under this Program, CMS will make value-based incentive payments to acute care hospitals, based either on how well the hospitals perform on certain quality measures or how much the hospitals' performance improves on certain quality measures from their performance during a baseline period.

For more information, please visit the [CMS hospital quality initiative](#) web page.

ASC quality measures

To be eligible for the full ASC annual payment update, ASCs are required to submit complete data on individual quality measures by submitting appropriate quality-data codes on claims. For data collected from October 1, 2012, through December 31, 2012, appropriate quality-data codes will be submitted on claims for the 2014 payment determination measures.

The penalty for failing to report the required data will be a 2% reduction of future Medicare ASC payment updates.

References

- [Ambulatory Surgical Center \(ASC\) Payment](#)
- [Ambulatory Surgical Center Specialty Page](#)

Partners in compliance

Definition of compliance

Compliance is a state of being in accordance with established guidelines, specifications, or legislation or the process of becoming so.

Overview

With increasing expenditures, expanding federal benefits and a growing beneficiary population, the importance and challenges of safeguarding the Medicare Trust Fund are greater than ever. CMS stays committed to identifying program weaknesses and vulnerabilities to help prevent fraud, waste, and abuse and to improve quality of care in the Medicare program. These actions protect the taxpayers and future Medicare beneficiaries.

We educate the provider community on CMS programs and develop initiatives that complement CMS' efforts. All efforts sustain the commitment to "pay it right the first time, every time."

Providers may receive requests for documentation from several national safeguard programs:

- [Comprehensive Error Rate Testing](#)
- [Recovery Auditor](#)
- [Unified Program Integrity Contractors](#)

Providers may also receive record requests from us, your Medicare contractor. We have the authority to review any claim at any time. Our medical review staff may decide to focus their review on problem areas that demonstrate significant risk to the Medicare program as a result of inappropriate or potentially inappropriate payments.

Importance of documentation

Medical record documentation is required to record pertinent facts, findings and observations about an individual's health history, including past and present illnesses, examinations, tests, treatments and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high-quality care. The medical record facilitates:

- The ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment and to monitor his health care over time.
- Communication and continuity of care between physicians and other health care professionals involved in the patient's care.
- Accurate and timely claims review and payment.
- Appropriate utilization review and quality of care evaluations. Collection of data that may be useful for research and education.

An appropriately documented medical record can reduce many of the challenges associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

General principles of documentation

The medical record should be complete and legible. The documentation of each patient encounter should include:

- Date.
- Reason for the encounter.
- Appropriate history and physical exam.
- Review of lab, X-ray data and other ancillary services and, when appropriate, assessment.
- A plan of care (including discharge plan, if appropriate).
- Past and present diagnoses should be accessible to the treating and/or consulting physician.
- The reasons for and results of X-rays, lab tests and other ancillary services should be documented or included in the medical record.
- Relevant health risk factors should be identified.
- The patient's progress, including:
 - response to treatment,
 - change in treatment,
 - change in diagnosis and patient non-compliance should be documented.
- The written plan of care should include, when appropriate:
 - Treatments and medications, specifying frequency and dosage.
 - Any referrals.
 - Patient/family education.
 - Specific instructions for follow-up.
- The documentation should support the intensity of the patient evaluation and/or treatment, including thought processes and the complexity of medical decision-making.

- All entries to the medical record should be dated and authenticated by physician/provider signature. See [signature requirements](#) located on our website.
- The CPT/ICD-9-CM codes reported on the Medicare claim should reflect the documentation in the medical record.

Appeals

An appeal is a written request to Medicare to reconsider a claim.

The purpose of the appeals process is to give dissatisfied providers and beneficiaries a vehicle to request an independent re-evaluation of Medicare's claim decision. Through this process, Medicare seeks to ensure that the correct payment is made, and a clear and adequate explanation is given supporting non-payment.

The appeals process uses the pertinent Medicare laws, provider documentation and patient record regarding the claim. Each level of appeal must be completed before proceeding to the next level. For example, an administrative law judge review may not be requested until after the claim has completed redetermination and reconsideration reviews.

For comprehensive information on the forms, process, timeframes, and requirements for the appeal of a claim determination, please visit the [Appeals](#) page of our website.

Overpayments

Overpayments are Medicare payments a provider or beneficiary has received in excess of amounts due and payable under the statute and regulations. Once a determination of an overpayment has been made, the amount is a debt owed by the debtor to the United States government.

Under the Federal Claims Collection Act of 1966, as amended, each agency of the federal government (pursuant to regulations jointly promulgated by the Attorney General and the Comptroller General of the United States) must attempt collection of claims of the federal government for money arising out of the activities of the agency.

When an overpayment is determined and established by a Medicare contractor, an overpayment demand letter is sent to the provider who received the incorrect Medicare payment. This letter will include the reason for the overpayment, the amount of the overpayment, the current interest rate, and instructions on refunding the overpayment and appeal rights. The overpayment demand letter may include a request for one claim regarding one beneficiary or may include a request regarding multiple claims for multiple beneficiaries. In either case, a listing will be enclosed with the demand letter that includes the names, Medicare numbers, internal control numbers and specific overpayment amounts for each claim.

Interest rate charged on overpayments

Medicare contractors are required to charge interest on overpayments not refunded within 30 days of the demand letter date. Interest accrues from the date of the initial request for refund and is assessed for each full 30-day period that payment is delayed. Any payments received are credited to interest first, then to the outstanding principal balance.

Both Medicare Parts A and B offer the opportunity to request immediate recoupment of overpayments.

For additional information on overpayments, please review the [Overpayments](#) article on our website.

Indian Health has the option to refund the overpayment by requesting an automatic recoupment from future payments or refund by check. If a facility elects to send a check and that check will be sent from the U.S. Treasury, complete the [Return of Monies Form](#) available on our website.

FISS claims processing

Reason Code File

The reason code file is the heart of claims processing within the Fiscal Intermediary Standard System (FISS).

The reason code is a five-digit alphanumeric code. It is used to communicate errors, actions or conditions associated with a claim as it processes through FISS. Several reason codes can be listed to describe one error.

Reason codes appear on the following online screens:

- ADR, and
- Return to provider (RTP) report

Changes/updates are made to the reason code file daily. Providers can view the reason code file online.

Reason codes are used for both informational and instructional purposes:

Status/Location information sheet

FISS processing is driven by the type of bill. The claim path or processing path is defined for each type of bill.

A claim is routed through the system based on a predefined path of locations. The location of a claim indicates the processing step in which the claim has completed or currently resides. FISS has automated and manual locations defined. Manual processing locations are unique to the functional needs to internal processing.

The status of a claim reflects the condition of the claim as it resides in the claim path location. The following are valid pending and finalized FISS statuses.

Claim status pending location

- S (suspense) – The claim is placed in this location to research and make any updated corrections before processing can continue.
- M (manual) – Clerical intervention required. Claims moved manually to another department, employee desk, etc., as reflected by the location.
- B (batch processing) – A series of systematic batch cycles must be run to continue claims processing.

Finalized locations

- D (medical denial) – Final disposition of a claim due to a medically reviewed denial with no reimbursement.
- P (processed) – Final disposition of a claim that has been approved for processing.
- R (non-medical reject) – Final disposition for a claim that has been rejected due to a duplicate claim, benefits exhausted.
- T (RTP) – Final disposition for a claim that requires further billing information from the provider to complete the claims processing. If the correction is not received regarding the RTP, the claims will be inactivated in the system.
- I (inactive) – Final disposition for a claim that was inactivated. Provider will have to resubmit the claim for processing.

RTP process

If an initial Part A bill has been returned to the provider, the provider may have information that will allow completion of the bill for processing to payment. The RTP process is a mechanism to eliminate rekeying of the bill by both the provider and the MAC.

All RTP bills are considered inactive in the system; therefore, only a correction of the error(s) will reactivate the claim for processing. For this reason, an RTP bill cannot be adjusted or voided.

Novitas does not generate RTP reports.

DDE

DDE was designed as an integral part of FISS to make a direct access mechanism of information for answering questions regarding claim processing, beneficiary information, and the ability to enter claims electronically available to providers.

Claims correction

RTP bills appear in the system location with a “T” status. On the claims correction screen, using the F6 key to scroll forward, providers can view all claims that have been returned for correction.

The system will display five claims per screen page with the primary reason code displayed to identify the reason the claim was returned. RTP claims can receive multiple reason codes. All reason codes can be viewed after the claim is selected. Correcting one reason code at a time may also correct multiple reason codes associated with the same error.

RTPs are only available online for corrections for 120 days. The claim then becomes inactive and a new claim will need to be submitted.

CWF

The CWF reorganizes certain claims processing functions to simplify and improve overall Medicare claims processing by creating localized databases containing total beneficiary histories.

Advantages include:

- Creates a beneficiary data set that contains all entitlement and utilization information in one location.
- Increases program savings by detecting additional duplicate and inappropriate payments.
- Enhances utilization review opportunities because all beneficiary history is in one file.
- Avoids costly adjustment processing and overpayment recovery activities with prepayment edits and performs prepayment A/B data exchange edits within the claims process.

Remittance advice

Medicare contractors send a notice of payment, referred to as the Remittance Advice (RA), to providers, physicians and suppliers as a companion to claim payments. RAs explain the payment and any adjustment(s) made. For each claim or line item payment, reduction or denial, there is an associated RA item. Payment for multiple claims can be reported on one transmission of the RA. RA notices can be produced and transferred in either paper or electronic format.

Medicare standard electronic PC-Print software

PC-Print software enables providers to print remittance data transmitted by Medicare. Medicare contractors are required to make PC-Print software available to providers at no charge. This software must be able to operate on Windows 95, 98, 2000/Me, and Windows NT platforms and include self-explanatory loading and use information for providers. It should not be necessary to furnish providers training for use of PC-Print software. Medicare will supply providers with PC-Print software within three weeks of the request.

PC-Print software for Part A

The PC-Print software enables providers to:

- Receive, over a wire connection, an 835 ERA transmission on a personal computer and write the 835 file in American National Standard Code for Information Interchange (ASCII) to the provider's "A" drive.
- Print 835 claims and provider payment summary information. View and print remittance information for a single claim.
- View and print a subtotal by bill type.

The receiving personal computer always writes an 835 file in ASCII. The providers may choose one or more print options (e.g., the entire transmission, a single claim, a summary by bill type or a provider payment summary).

For additional information, please review the [Standard Paper Remittances and Medicare Summary Notices](#) article on our website.

Medicare Remit Easy Print software for Part B

Medicare Remit Easy Print (MREP) software is free and available for viewing and printing the HIPAA-compliant ERA. The MREP software enables providers and suppliers to:

- View MREP RAs
- Search MREP RAs
- Print MREP RAs
- Print reports about MREP RAs

MREP software can be installed on a personal computer or on a network. Utilize the MREP software. Providers will need to receive a HIPAA-compliant ERA.

Detailed information about [MREP](#) can be found on the CMS website.

Reason and remark codes

Claim adjustment reason codes (CARCs)

[CARCs](#) are used on the Medicare electronic and paper RAs. A new code may not be added, and the indicated wording may not be modified without approval of the Health Care Code Maintenance Committee. These codes were developed for use by all U.S. health payers. As a result, they are generic, and a number of the codes do not apply to Medicare. These codes report the reasons for any claim financial adjustments, such as denials, reductions or increases in payment.

This list is updated every four months based on the outcome of each Health Care Code Maintenance Committee meeting held before ANSI X12N trimester meetings in February, June and October. The updated list is published in March, July, and November.

Remittance advice remark codes (RARCs)

RARCs are used in an RA to further explain an adjustment or relay informational messages that cannot be expressed with a claim adjustment reason code. CMS maintains remark codes.

ANSI codes

ANSI adjustment reason and remarks codes listed on the RA are available to providers on the [WPC Website](#) site. These files are updated frequently so providers may want to check them often.

Group codes

A group code identifies the general category of payment adjustment. A group code will always be used in conjunction with a claim adjustment reason code to show liability for amounts not covered by Medicare or to identify a correction or reversal of a prior decision.

Valid group codes for use on Medicare claims are:

- PR (patient responsibility adjustment) – Any adjustment where the patient will be assuming or has assumed financial responsibility.
- CR (correction) – Change to a previously processed claim.
- OA (other adjustment) – Any other adjustment. Do not include any adjustment for which the patient or provider has financial liability.
- CO (contractual obligation) – Payment adjustment where the provider did not meet a program requirement and is financially liable.

Negative reimbursement remit

During the first few months of a new year, CAHs may see a few Part A outpatient remits showing a negative reimbursement. This occurs because the patient's Part B deductible for the New Year has not yet been met. When outpatient charges are applied to a patient's Part B deductible, the resulting payment amount may show as a negative amount.

To figure these types of remits use the following formula:

Covered charges – coinsurance (product of covered charge times 20%) – deductible.

Example:

\$165.00 covered charges
- 33.00 (coinsurance)
\$132.00
- 140.00 (deductible)
\$ 8.00-

This amount is deducted from the total remit payment.

Requesting duplicate remits

Follow the steps below when requesting a duplicate remit.

1. Electronic remits can be reloaded by the ERA department if it is not more than 60 days old.
2. Part B remits older than 60 days can be reordered through the IVR system.
3. If the ERA or IVR system cannot resend a duplicate remit, contact Provider Customer Service at 855-252-8782.

Part A adjustments and voids (cancels)

Adjustment procedures

Adjustment bills are the most common mechanism for changing a previously accepted bill. They are required to reflect the results of the Quality Improvement Organization (QIO). Adjustments may also be requested by CMS via the CWF if it discovers that bills have been accepted and posted in error to a particular record. Providers will submit adjustment requests if an error other than the omission of a charge is discovered.

When an error has been discovered after a claim has been submitted to Medicare and the claim is finalized on a RA, an adjustment can be submitted to correct the claim.

Note: If the original claim has a “T” (RTP) status, the provider can resubmit a new bill, indicating the additional or corrected information on the new bill.

Use the original TOB frequency. Electronic adjustments cannot be made on the following:

- R Status - Rejected (must send written request)
- D Status - Medically denied (must send an appeals request)
- Type of bill - XXP (QIO adjustment, must send appeal to QIO)

Third-Digit Frequency Adjustment Identification

Bill type	Adjustment type
XX7	Provider (debit)
XX8	Provider (cancel)
XXF	Beneficiary
XXG	CWF
XXH	CMS
XXI	MAC
XXM	MSP
XXP	QIO
XXJ	Other
XXK	OIG

Hard copy claim instructions

Hard copy submitters must report:

- TOB XX7 –FL 4
- Claim change reason code - FLs 18–28 (**Note:** do not submit more than one claim change reason code per adjustment request.)
- Document control number (DCN) of the original claim that needs to be corrected – FL 64 of the claim being adjusted (14-digit number plus add TXA at the end making a 17-digit DCN indicated on the RA)
- Alpha adjustment reason code and brief narrative for the adjustment request –FL 80 (Remarks)

Note: When submitting by hard copy, the 14-digit DCN (plus add TXA at the end) that appears on the RA, must be indicated on the adjustment claim copy. Omitting this number could prevent the adjustment from being processed.

Condition codes

Listed below are the adjustment condition codes that must be present indicating why the claim is being adjusted.

Adjustment condition code	Definition
D0	Changes to service dates
D1	Changes to charges
D2	Changes to revenue codes/HCPSC codes
D3	Second or subsequent interim PPS bill
D4	Change in Grouper input
D8	Change to make Medicare the primary payer
D9	Any other change (must include a brief explanation in remarks)
E0	Change in patient status

Adjustment reason codes

Listed below are the adjustment reason codes that must be present to indicate why the claim is being adjusted.

Adjustment reason code	Definition
DS	Discharge status change
IB	PPS interim bill
IC	Invalid/incorrect revenue code
OC	Procedure code change
DC	Diagnosis code change
CC	Charge change
UT	Affects beneficiary utilization
HC	HCPCS (invalid HCPCS code)
DT	Changes in dates of service
AS	Ambulatory surgical center
WC	Workers' compensation
VA	Veterans Affairs
BL	Black lung
ES	End stage renal disease
AU	Automobile
OT	Other not listed above (must provide a narrative description in COND/DES or remarks field)
WE	Working aged
DB	Disabled

Adjustment bills inholding time limitation for filing claims

If a provider fails to include an item or service on its initial bill, an adjustment bill to include such an item or service is not permitted after the expiration of the time limitation for filing a claim.

Void (cancel) procedures**Hard copy claim instruction**

Hard copy submitters must report:

- TOB XX8 – FL 4
- DCN – FL 64
- Claim change reason code – Condition code FLs 18–28
- Alpha adjustment reason code and brief explanation for the void - FL 80 (remarks)

Condition codes

Condition codes for submitting cancel requests are:

- D5 – Incorrect provider identification numbers, incorrect HIC/MBI numbers
- D6 – Duplicate payments

Adjustments and cancels performed in DDE

For instructions on how to adjust or cancel claims using DDE, please refer to the [FISS Manual/User Guide](#).

Appendix A: Part A AIR when no face-to-face encounter on same day

CMS issued instructions regarding the billing of the AIR when no face-to-face encounter was with a physician or non-physician practitioner. The following questions and answers have been reviewed by CMS.

Question: The beneficiary sees a doctor at facility number one. Facility number one's X-ray machine is broken. Beneficiary makes an appointment at facility number two for the X-ray three days later. Is this considered an AIR for facility number two?

Answer: 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.

Question: The beneficiary sees the doctor at 4:30 p.m. and the doctor orders lab work. The lab is closed for the afternoon and the beneficiary must come back the next day or even next week to receive the ordered labs. Is the return visit for labs payable as an AIR?

Answer: 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.

Question: The beneficiary sees the doctor at clinic number one and he orders an X-ray. The hospital with the X-ray machine is two hours away and the beneficiary cannot get there the day it was ordered. The beneficiary goes the following day (or later) for the X-ray. Is this billable as the AIR?

Answer: 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.

Question: The doctor orders the beneficiary to come in for labs two times a week for two months to follow up on a new medication. Is each of the three visits billable as an AIR?

Answer: Since the order is for monitoring, each visit would be payable on the AIR, presuming that the frequency of the monitoring is considered reasonable and necessary.

Question: The beneficiary has a visit with a physician, during which the physician orders a comprehensive panel of lab tests. The panel of lab tests requires eight hours of fasting prior to collecting the specimen. Is the return visit for the fasting blood draw payable as an AIR?

Answer: The return visit is a payable AIR, as the requirement that the beneficiary fast prior to specimen collection is an issue of medical necessity.

Question: The beneficiary has an encounter with a physician who orders an X-ray of the colon. Required preparation for the X-ray must begin 24 hours prior to the X-ray. Is the return visit for the X-ray a payable AIR? What if the beneficiary doesn't see the physician when he returns for the X-ray?

Answer: The return visit for the X-ray is a payable AIR regardless of whether the beneficiary saw the physician on the return visit because the preparation for the X-ray was medically necessary.

Question: The beneficiary has an encounter with a physician. The physician writes a prescription for Coumadin®. The physician also orders daily Coumadin® testing, which is performed by the pharmacist. Is the daily Coumadin® tests payable on the AIR? For how long are these daily tests payable?

Answer: CMS has developed an NCD for prothrombin testing. The need to repeat this test is determined by changes in the underlying medical condition and/or the dosing of warfarin. In a patient on stable warfarin therapy, it is ordinarily not necessary to repeat testing more than every two to three weeks. When testing is performed to evaluate a patient with signs or symptoms of abnormal bleeding or thrombosis and the initial test result is normal, it is ordinarily not necessary to repeat testing unless there is a change in the patient's medical status. For Medicare to allow these services, they must meet the [NCD guidelines](#).

Ideally, once the patient's international normalized ratio (INR) has been stabilized, he could be taught to use the [home Prothrombin Time \(PT\)/INR monitoring](#). Effective for claims with dates of service on or after March 19, 2008, Medicare covers the use of home PT/INR monitoring for chronic oral anticoagulation management for patients with:

- Mechanical heart valves
- Chronic atrial fibrillation
- Venous thromboembolism (inclusive of deep venous thrombosis and pulmonary embolism) on warfarin

Question: The beneficiary sees a physician at the hospital for a wound on her leg. The physician orders twice weekly dressing changes. Are the visits for the dressing changes covered under the AIR?

Answer: Novitas established an LCD for wound care treatment. The LCD must be followed regarding medical necessity for dressing changes. If documentation supports the LCD and it is medically necessary for the patient to return for wound care treatment, the visits will be covered under the AIR.

Question: The beneficiary is receiving a course of allergy immunizations from the clinic at the hospital. There is no encounter with the physician during the allergy shot visits. Are these visits payable under the AIR?

Answer: Allergen immunotherapy is the repeated administration of specific allergenic antigen(s) to patients with IgE-mediated conditions. The purpose of allergen immunotherapy is to provide protection against the allergic symptoms and inflammatory reactions associated with natural exposure to these allergens. The allergenic antigen is administered in increasing doses over periodic intervals. A noticeable tolerance to the antigens is expected, with the patient achieving and maintaining a therapeutic dosage. CMS has established an NCD and Novitas expanded the NCD with an additional LCD, [L36240 - Allergen Immunotherapy](#). If the procedure was ordered by the physician during an initial visit and the NCD/LCD guidelines are followed, the medically necessary return visits would qualify for the AIR.

Appendix B: Part B Tribal self-insurance and MSP

Question: An AI/AN Medicare beneficiary receives services at an IHS facility and has tribal self-insurance GHP coverage based on his current employment status. Who pays primary?

Answer: Medicare will pay primary. IHS is the residual payer, and the tribal self-insurance GHP coverage does not pay since IHS is prohibited from billing the tribal self-insurance GHP. (See note below)

Question: An AI/AN Medicare beneficiary receives services at a non-IHS facility and has tribal self-insurance GHP coverage based on his current employment status. Who is primary?

Answer: The tribal self-insurance GHP coverage pays primary (assuming the GHP meets the MSP rules, e.g., the 20 or more current employees' rule, etc.), Medicare pays secondary, and IHS is the residual payer.

Question: An AI/AN Medicare beneficiary receives services at an IHS facility and has GHP coverage (e.g., BlueCross BlueShield) through his employer, Burger King (not through a tribal self-insurance GHP), based on his current employment status. Who pays primary?

Answer: The GHP coverage (BlueCross BlueShield) pays primary (assuming the GHP coverage meets the MSP rules, e.g., the 20 or more employees' rule, etc.), Medicare pays secondary, and IHS is the residual payer.

Question: An AI/AN Medicare beneficiary receives services at a non-IHS facility and has GHP coverage (BlueCross BlueShield) through his employer, Burger King (not through a tribal self-insurance GHP), based on his current employment status. Who pays primary?

Answer: The GHP coverage (BlueCross BlueShield) pays primary (assuming the GHP meets the MSP rules, the 20 or more employees' rules, etc.), Medicare pays secondary, and IHS is the residual payer.

Question: An AI/AN Medicare beneficiary is referred from an IHS facility to a non-IHS facility where the services are performed. The individual has tribal self-insurance GHP coverage based on his current employment status and the non-IHS facility bills for services. Who pays primary?

Answer: The tribal self-insurance GHP coverage pays primary (assuming the GHP meets the MSP rules, e.g., the 20 or more employees' rules, etc.), Medicare pays secondary, and IHS is the residual payer.

Question: An AI/AN Medicare beneficiary receives services for a work-related injury at a non- IHS facility and has tribal self-insurance Workers' Compensation (WC) coverage. Who pays primary?

Answer: The tribal self-insurance coverage pays primary for the work-related injury services, Medicare pays secondary to the tribal self-insurance coverage, and IHS is the residual payer.

Question: An AIAN beneficiary receives services for a work-related injury at an IHS facility and has tribal self-insurance WC coverage. Who pays primary?

Answer: Medicare will pay primary, IHS is the residual payer, and the tribal self-insurance does not pay since the IHS facility is prohibited from billing the tribal self-insurance WC plan.

Notes:

Medicare's systems cannot distinguish self-insurance from third-party insurance. This does not affect claims processing or payment; however, CMS' MSPRC may later include IHS provider claims in a demand for repayment. The tribe's self-insurance is a valid defense against the inclusion of such claims; to assert this defense, the tribe must provide the MSPRC with documented proof that it was self-insured at the time the IHS facility provided the relevant services. Upon receiving the appropriate documentation, the MSPRC will remove the IHS provider claims from the debt.

In all cases, Medicare pays secondary to liability claims.

Appendix C: Traditional healers

American Indian/Alaska Native traditional healers are not eligible to enroll in the Medicare program because there is no recognized provider type. For services to be considered for payment by Medicare, the performing provider must meet the definition of a physician or non-physician practitioner found in the CMS [Pub.100-02, Benefits Policy Manual, Chapter 15, Section 40.4](#).

Additionally, the service the healer provides does not meet the definition of reasonable and necessary under the (SSA. Medical necessity is defined as services that are reasonable and necessary for the diagnosis and treatment of any illness or injury or to improve the functioning of a malformed body member (Section 1862(a) (1) of the SSA). While Medicare recognizes that when a patient is treated at an IHS or tribal hospital, they may opt for both Western medicine as well as a traditional healer, the services of a traditional healer are non-covered by Medicare and would not be billable to the Medicare program.

Appendix D: “Grandfathering” provisions for certain Indian Health Service Tribal facilities

In 2003, CMS clarified the application of provider-based criteria in the Medicare regulations at 42 CFR 413.65(m) that established a special “grandfather” provision for certain IHS and Tribal facilities. Under the provision, clinics and other facilities which do not meet provider-based criteria but were billing as components of IHS or Tribal hospitals when the regulations were first published in final form on April 7, 2000 may continue to be provider-based.

In some cases, there have been changes in the status or alignment of hospitals and facilities since the provider-based rules were first published in final form. For example, some hospitals or facilities that were operated by the IHS on April 7, 2000 are now operated by a Tribe. In other situations, realignment of the clinics or facilities previously associated with the hospital to another IHS or Tribal hospital has been necessary due to closure of an IHS or Tribal hospital, or for other administrative reasons. In these cases, questions have arisen as to whether facilities involved in changes of this kind continue to be considered provider-based under the grandfather provision in 42 CFR 413.65(m).

After review of these issues, CMS concluded that changes in the status of a hospital or facility from IHS to Tribal operation, or vice versa, or the realignment of a facility from one IHS or Tribal hospital to another IHS or Tribal hospital, will not cause a loss of grandfathered status for the facility if the resulting configuration is one which would have qualified for grandfathering under section 413.65(m) if it had been in effect on April 7, 2000.

This policy is explained in greater detail in the following FAQs:

Question: Do the provider-based regulations at 42 CFR 413.65 include any special provisions for IHS or Tribal facilities?

Answer: Yes. In section 413.65(m) there is a special “grandfather” provision for certain IHS and Tribal facilities. Under that provision, clinics and other facilities which do not meet provider-based criteria but were billing as components of IHS or Tribal hospitals when the regulations were first published in final form (on April 7, 2000) may continue to be treated as provider-based.

Question: What requirements does a facility or organization have to meet to qualify for this “grandfather” provision?

Answer: Under section 413.65(m), facilities or organizations operated by the IHS or Tribes to be departments of hospitals operated by the IHS or Tribes, if, on or before April 7, 2000, furnished only services that were billed as if they had been furnished by a department of a hospital operated by the IHS or a Tribe and they are owned and operated by the IHS, owned but leased from the Tribe by the IHS under the Indian Self-Determination Act (Pub. L. 93-638) in accordance with applicable regulations and policies of the IHS in consultation with Tribes; or owned by the HIS, but leased and operated by the Tribe under the Indian Self-Determination Act (Pub. L93-638), in accordance with applicable regulations and policies of the IHS in consultation with Tribes.

Question: In some cases, there have been changes in the status or alignment of hospitals and facilities. For example, some hospitals or facilities that were operated by the IHS on April 7, 2000 are now operated by a Tribe. In other situations, realignment of the clinics or facilities previously associated with the hospital to another IHS or Tribal hospital is necessary due to closure of an IHS or Tribal hospital, or for other administrative reasons. Will facilities involved in changes of this kind continue to be considered provider-based under the grandfather provision in section 412.65(m), or will they have to comply with the provider-based criteria in order to retain their status as hospital departments?

Answer: Changes in the status of a hospital or facility from IHS to Tribal operation, or vice versa, or the realignment of a facility from one IHS or Tribal hospital to another IHS or Tribal hospital, will not cause a loss of grandfathered status for the facility if the resulting configuration is one which would have qualified for grandfathering under section 413.65(m) if it had been in effect on April 7, 2000.

Question: Can you give some examples of changes that would not affect grandfathering?

Answer: Yes. For example, on April 7, 2000 a particular hospital and a clinic aligned with it may both have been operated by the IHS, but since that date the operational responsibility for the hospital may have been assumed by the Tribe under the Indian Self-Determination Act (Pub. L 93-638), in accordance with applicable regulations and policies of the IHS in consultation with Tribes. Since section 413.65(m) would have extended grandfathering to such a facility if this arrangement had been in place on April 7, 2000, a change of this kind would not prevent the clinic from retaining its grandfathered status, since section 413.65(m) would have extended grandfathering to such a facility if this arrangement had been in place on April 7, 2000.

Question: Are there any changes that would cause IHS or Tribal facilities to lose their grandfathered status?

Answer: Yes. Section 413.65(m) did not extend provider-based status to any facility owned and operated by a Tribe, if on April 7, 2000 the hospital with which the facility was affiliated was also owned and operated by a Tribe. Therefore, if any changes occur which result in a previously grandfathered facility becoming a Tribally owned and operated facility which claims affiliation with a Tribally owned and operated hospital, the facility would no longer qualify for provider-based status under the grandfathered provision. Such a facility may qualify for provider-based status only by showing actual compliance with the requirements in section 413.65.

Question: Have the CMS Regional Office and the Fiscal Intermediary been made aware of the policy clarification in these FAQs?

Answer: The clarifications have been discussed informally with them and formal notice was sent.

Review/Revision history

Date	Section	Revision
October 2014	Introduction to Medicare	Section updated to include Change Request (CR) 8527, CR 8982, updated CMS and Novitas Website links.
	Medical Necessity Provider Enrollment	Section updated CMS and Novitas Website links. Section updated CMS and Novitas Website links and the enrollment application fee; Updated 2015 application fee.
	Electronic Data Interchange (EDI) Patient Screening Medicare Secondary Payer (MSP)	Section updated CMS and Novitas Website links and removed the Version 5010 information. Section updated Novitas Website link. Section updated with CMS and Novitas Website links; removed basic MSP information and referred to Novitas Website and updated Benefits Coordination & Recovery Center (BCRC) per Special Edition (SE) 1416.
	Medicare Part A Hospital	Section updated with CMS 1599 IPPS Final Rule/2Midnight Guidelines updated M1 per SE1333; added new example for Pre-Entitlement, updated information and resources for Discharge Status Codes per SE0801; updated SNF co-insurance per CR 8527; Updated CMS and Novitas Website links; Updated SNF Coinsurance per CR 8982.
	Critical Access Hospitals (CAHs)	Section updated with CMS 1599 IPPS Final Rule/2Midnight Guidelines and CMS and Novitas Website links.
	Credit Balance Report Cost Reports	Added link to Novitas Credit Balance Tool. Updated to instruct IHS to complete Full Method A reports.
	Part B Outpatient Services	Updated incident to per CR 8533, multiple visits to include remarks when submitting claims; added additional ESRD resources; updated all CMS and Novitas Website links.
	Physician Fee Schedule UB-04 Claims Form Requirements	Updated Novitas Website links. Removed information and added link to UB-04 at a Glance
	Additional Part A Claim Requirements	Updated M1 per SE 1333; updated CMS and Novitas Website links.
	Part B CMS-1500 Claim Form	Removed information and provided a link to the Novitas Website.
	Part B (CMS-1500) Unprocessable Claims	Removed section.
	Outpatient Services	Updated CMS and Novitas Website links; added therapy reporting requirements based on SE1307.
	Ambulance Services	Removed most of the information and referred to Novitas Ambulance Specialty Manual.

	Other Part B Services	Updated Novitas and CMS Website links.
	Diagnostic Tests	Updated Novitas and CMS Website links.
	Laboratory Services	Updated Novitas Website link.
	Foot Care	Update Novitas Website links.
	Modifiers	Removed most of the modifiers and referred the Novitas Website.
	Ophthalmology	Updated Novitas Website links.
	Incentive Programs	Removed most of the information and linked to the Novitas Reference Manual.
	Partners in Compliance	Removed information and linked to the Novitas Reference Manual and Website.
	National Correct Coding Initiative (NCCI)	Moved information to the modifier section.
	Medically Unlikely Edits (MUES)	Moved information to the modifier section.
	Importance of Documentation	Updated Novitas Website link.
	Appeals	Removed most of the information and referred to Novitas Appeals Website.
	Overpayments	Updated Novitas Website link.
	FISS Claims Processing	Updated Paper RTPs.
	Remittance Advice	Updated Novitas and CMS Website links.
	Pat A Adjustments and Voids	Updated Website links
January 2015	Whole Document	Updated format
September 2015	Billing Requirements	Updated PC-ACE Pro-32 to Ability/PC-ACE
December 2015	Whole Document	Updated document due to CR 9410
June 2016	Whole Document	Updates Links
September 2017	Whole Document	Developed Anesthesia Specialty Page, Therapy Page, Updated CR 9902, Updated SE1411,
June 2018	Most of document	Updated to add 2018 deductibles/coinsurance amounts and Medicare Beneficiary Identifier (MBI).
January 2019	Most of document	Updated to add 2019 deductibles/coinsurance amounts and premium information; Updated ambulance LCD link; Added Incident-To information and link; Updated Clinical Pharmacist Encounter, per discussion with CMS Division of Tribal Affairs, CAHPG, CMCS, Kitty Marx, Director, CAPT Susan V. Karol, MD, FACS
January 2021	Most of document	Added links to deductibles/coinsurance amounts and premium information; updated all LCD links to the LCD home page.
October 2023	Most of document	Updated hyperlinks, removed 855R information, added hyperlinks to provider specialty pages

