CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2075	**Date: October 28, 2010**
	Change Request 6908

SUBJECT: Implementation of Section 2902 of the Patient Protection and Affordable Care Act (the Affordable Care Act) for Indian Health Service (IHS) Part B Services and All Inclusive Rate (AIR) Billing for Return Visits

I. SUMMARY OF CHANGES: Section 630 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) allowed IHS facilities to bill for certain Part B services, which were not previously covered under Section 1848 of the Act, and expanded the scope of items and services for which payment would be made to IHS providers, suppliers, physicians, and other practitioners for a 5-year period beginning January 1, 2005. Section 2902 of the ACA indefinitely extends section 630 of the MMA, retroactive to January 1, 2010.

IHS providers are paid for covered Part B covered outpatient services based upon an AIR. Clarification is needed regarding billing for return visits under the AIR payment methodology

EFFECTIVE DATE: January 1, 2010
IMPLEMENTATION DATE: January 28, 2011

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	19/10/General
R	19/20.2/Overview of Medicare Part B Services
R	19/30/Medicare Part B Services
R	19/80.5/Carrier - Screening and Preventive Services
R	19/80.6/Carrier - Clinical Laboratory Services - Payment Policy
R	19/90/DME General Information
R	19/90.1/Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Payment Policy
R	19/100.1/FI - Medicare Part B Services Paid Under Various Fee Schedules
R	19/100.5.1/FI - Outpatient - Medicare Part B - Claims Processing
R	19/100.12/FI - Ambulance Services
R	19/100.13/FI - Other Screening and Preventive Services - Payment Policy

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2075	Date: October 28, 2010	Change Request: 6908

SUBJECT: Implementation of Section 2902 of the Patient Protection and Affordable Care Act (the Affordable Care Act) for Indian Health Service (IHS) Part B Services and All Inclusive Rate (AIR) Billing for Return Visits

Effective Date: January 1, 2010

Implementation Date: January 28, 2011

I. GENERAL INFORMATION

A. Background: Section 630 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) allowed IHS facilities to bill for certain Part B services, which were not previously covered under Section 1848 of the Act, and expanded the scope of items and services for which payment would be made to IHS providers, suppliers, physicians, and other practitioners for a 5-year period beginning January 1, 2005. Section 2902 of the Affordable Care Act indefinitely extends section 630 of the MMA, retroactive to January 1, 2010.

IHS providers are paid for covered Part B covered outpatient services based upon an AIR. Clarification is needed regarding billing for return visits under the AIR payment methodology.

B. Policy:

Section 2902 of the Affordable Care Act indefinitely extends section 630 of the MMA, retroactive to January 1, 2010. The specific Part B services are:

- Ambulance services;
- Clinical laboratory services;
- Part B drugs processed by the J4 Part A and Part B Medicare Administrative Contractors (A/B MACs) and the Durable Medical Equipment (DME) MACs;
- Influenza and pneumonia vaccinations;
- DME;
- Therapeutic shoes;
- Prosthetics and orthotics;
- Surgical dressings, splints, and casts; and
- Screening and preventive services not covered prior to the implementation of section 630 of the MMA.

CMS updated the Medicare Claims Processing Manual, Pub. 100-04, Chapter 19 to reflect the indefinite extension of section 630 of the MMA.

In addition, CMS updated the Medicare Claims Processing Manual, Pub. 100-04, Chapter 19, §100.5.1 to clarify that while a face-to-face encounter with a physician or non-physician practitioner is required for an initial visit to count as a billable AIR encounter, the same is not always true of return visits to obtain follow-up care ordered by the physician or non-physician practitioner during the initial visit. If a physician or non-physician practitioner orders a specific procedure or test which cannot be furnished until a later date after the date of the initial visit with the physician or non-physician practitioner, and the procedures or tests are medically necessary, then it is appropriate for the return encounter to be billed on the date the procedure or test

is furnished and for the provider to receive an additional AIR payment even if the beneficiary did not interact with a physician or non-physician practitioner during the return visit.

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

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
6908.1	Contractors shall be in compliance with the instructions found in Publication 100-04, Medicare Claims Processing Manual, Chapter 19. Contractors need not search their files for previously denied claims affected by this legislative change. However, contractors shall adjust any claims brought to their attention.		x								Trail-Blazer Health Enter-prises, LLC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
6908.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters		x								Trail-Blazer Health Enter-prises, LLC

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

X-Ref Requirement Number	Recommendations or other supporting information:
	None

Section B: All other recommendations and supporting information: None

V. CONTACTS

Pre-Implementation Contact(s): Carrie Bullock at carrie.bullock@cms.hhs.gov for policy questions and Susan Guerin at susan.guerin@cms.hhs.gov for claims processing questions.

Post-Implementation Contact(s): Appropriate regional office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

10 - General

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

The Indian Health Service (IHS) is the primary health care provider to the American Indian/Alaska Native (AI/AN) Medicare population. The Indian health care system, consisting of tribal, urban, and federally operated IHS health programs, delivers a spectrum of clinical and preventive health services to its beneficiaries, via a network of hospitals, clinics, and other entities. While §§1814(c) and 1835(d) of the Social Security Act (the Act), as amended, generally prohibit payment to any Federal agency, an exception is provided for IHS/Tribally owned and operated facilities under §1880. The enactment of Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (BIPA), expanded payment for Medicare services provided in IHS/tribally owned and operated facilities beyond services provided in hospitals, skilled nursing facilities (SNFs) and swing-bed facilities.

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

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

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

- IHS provider refers to all hospital or hospital based-facilities, including outpatient clinics, unless otherwise noted.

- IHS supplier refers to a freestanding (non-hospital based) entity that furnishes durable medical equipment, prosthetics, orthotics, supplies (DMEPOS), and parenteral and enteral nutrition, unless otherwise noted.

- IHS physician or practitioners refers to physician and non-physician practitioners billing for services under Medicare Part B.

- **NOTE:** The ISDEA promotes maximum Indian participation in the government and education of the Indian people; provides for the full participation of Indian tribes in certain programs and services conducted by the Federal Government for Indians and encourages the development of the human resources of the Indian people; established and carries out a national Indian education program; to encourage the establishment of local Indian school control; to train professionals in Indian education; and establishes an Indian youth intern program.

20.2 - Overview of Medicare Part B Services

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

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

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

- DME;
- Prosthetics and orthotics;
- Prosthetic devices;
- Surgical dressings, splints and casts;
- Therapeutic shoes;
- Drugs (*A/B MAC and* DME MAC drugs);
- Clinical laboratory services;
- Ambulance services; and

- Screening and preventive services not already covered.

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

- The Medicare Physician Fee Schedule (MPFS);
- The Clinical Diagnostic Laboratory Fee Schedule;
- The Ambulance Fee Schedule;
- The DMEPOS Fee Schedule;
- The Anesthesia Fee Schedule; or
- DME MAC Drugs – based on the average sales price (ASP).

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

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

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

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

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

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

30 - Medicare Part B Services

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

Effective July 1, 2001, §432 BIPA extended payment for the services of physician and non-physician practitioners furnished in hospitals and ambulatory care clinics (services paid under the MPFS, §1848 of the Act). Clinics associated with hospitals or which are freestanding that are owned and operated by IHS or tribally owned and IHS operated are considered to be IHS and are authorized to bill only the designated carrier for Medicare Part B (medical insurance) services identified in §432 of BIPA 2000. Other clinics associated with hospitals or which are freestanding that are not considered to be IHS (i.e., IHS owned but tribally operated or tribally owned and operated) can continue to bill the

local Medicare Part B carrier for the full range of covered Medicare services, not restricted to the limitations of the BIPA provision.

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

80.5 - Carrier - Screening and Preventive Services

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

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

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

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

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

80.6 - Carrier - Clinical Laboratory Services - Payment Policy

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

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

90 - DME General Information

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

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

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

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

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

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

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

100.1 - FI - Medicare Part B Services Paid Under Various Fee Schedules
(Rev.2075, Issued: 10-28-10, Effective: 01-01-10, Implementation: 01-28-11)

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

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

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

100.5.1 - FI - Outpatient - Medicare Part B - Claims Processing
(Rev.2075, Issued: 10-28-10, Effective: 01-01-10, Implementation: 01-28-11)

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

Regardless of the number of times a patient is seen in a given day at a particular IHS provider, the outpatient services should be billed only once (i.e., all-inclusive). An exception is when a patient is seen for a clinic visit, then returns to the emergency room later on the same day, at the same provider, for an unrelated condition (or vice versa). Two clinic visits may be billed in this instance. The remarks section of the bill shall include a narrative describing the situation and why two clinic visits are being billed. When a medical visit and an emergency visit occur on the same day, condition code G0 (distinct medical visit) shall be reported on the claim.

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

additional AIR payment even if the beneficiary did not interact with a physician or non-physician practitioner during the return visit.

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

See Chapter18, §10 of Pub. 100-04, Medicare Claims Processing Manual, for detailed billing instructions for vaccines. Chapter 12 of Pub. 100-04 contains detailed billing instructions for outpatient therapy services provided by an occupational or physical therapist. See Chapter15 of Pub. 100-04 for detailed billing instructions for ambulance services.

The MSN is suppressed.

100.12 - FI - Ambulance Services

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

Section 630 of the MMA*, indefinitely extended by §2902 of the ACA,* allows for the reimbursement of ambulance services provided by hospital-based ambulance providers, including CAHs, which operate hospital-based ambulances. Effective January 1, 2005, claims for ambulance services submitted by hospital-based ambulance providers (including CAHs) shall be processed by the designated FI.

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

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

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

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

- Pelvic exam;
- Glaucoma screening;
- Bone mass measurements;
- Prostate cancer screening;
- Colorectal cancer screening;

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

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