2024 Indian Health Service Partnership Conference

Medicare Expanded Services for 2024

August 2024

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Agenda

- Updates
- Requirements, Enrollment and Billing for Marriage and Family Therapists (MFT) and Mental Health Counselors (MHC)
- Stay of Enrollment
- Revalidation
- Medicare Secondary Payer (MSP)
- Requirements, Enrollment and Billing for IHS Rural Emergency Hospital (REH)
- Provider - Based Hospital Off-Campus Practice Location Address
- Fiscal Intermediary Shared System (FISS) Consistency Edit To Validate Attending Physician NPI
- Intensive Outpatient Program (IOP) for Tribal FQHCs, GFT FQHCs, and IHS

Acronym List

Acronym	Definition
277CA	277 Claims Acknowledgement
AIR	All-Inclusive Rate
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CWF	Common Working File
DDE	Direct Data Entry
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics and Supplies
FAQs	Frequently Asked Questions
FISS	Fiscal Intermediary Shared System
FQHC	Federally Qualified Health Centers
GFT FQHC	Grandfathered Tribal FQHC
HCPCS	Healthcare Common Procedure Coding System
IHS	Indian Health Services

Acronym List Two

Acronym	Definition
IOP	Intensive Outpatient Program
MAC	Medicare Administrative Contractor
MFT	Marriage and Family Therapists
MHCs	Mental Health Counselors
MSP	Medicare Secondary Payer
MUEs	Medically Unlikely Edits
NPI	National Provider Identifier
PECOS	Provider Enrollment, Chain and Ownership System
REH	Rural Emergency Hospital
SNF	Skilled Nursing Facility
UB-04	Uniform Billing Form

Updates

2024 IHS Hospital Payment Rates

Who

- Indian Health Service Facilities.

When

- Effective: January 1, 2024
- Implementation January 3, 2024

What

- Hospital Payment Rates for Calendar Year 2024

Lower 48 States	CY 2024
Outpatient AIR	$667
Inpatient Ancillary	$963

Alaska	CY 2024
Outpatient AIR	$961
Inpatient Ancillary	$1,341

- Change Request (CR) 13506 Indian Health Services (IHS) Hospital Payment Rates for Calendar Year 2024

Novitasphere?

- What is Novitasphere?
  - Novitasphere is a secure internet portal that provides easy and quick access to access to many time-saving features
  - Available to JH Part A and Part B providers, billing services and clearinghouses for FREE:
    - Enrollment is required for each Part A and Part B
  - Live Chat feature
- Access Reminders:
  - All users must log in at least once every 30 days, or their Novitasphere access will be removed
  - If your office is already enrolled, please share this reminder with users in your organization
  - If you are having trouble successfully logging in, please review our new Novitasphere Log In Help document
  - The Novitasphere Help Desk can assist with password issues, locked and adding Multi-Factor Authentication (MFA) devices:
    - 1-855-880-8424
- Novitasphere Redesigned:
  - COMING in Fall 2024 - Novitasphere is being redesigned to a more modern look and feel!
  - The redesigned Novitasphere will include the same current features and several feature enhancements

Coming Soon PECOS 2.0

- Internet-based PECOS:
  - PECOS is a CMS established Internet-based online enrollment process system
  - Allows physicians, non-physician practitioners, and provider and supplier organizations/facilities the option of enrolling, making a change in their Medicare enrollment information, or tracking the status of their Medicare enrollment applications throughout the Internet submission process
  - PECOS offers providers and supplier resources and tutorials to assist with using PECOS
  - In order for your application to be sent to Novitas, you should select Novitas as the Fee for Service contractor
- PECOS 2.0 will contain new features:
  - Consistent and accurate information across applications
  - Reduced errors and inconsistencies
  - Easier management of enrollments and associates
  - Faster enrollment process
  - One Application Creates Multiple Enrollments:
    - Feature a consolidated application so large health systems and chains can enroll or update information across multiple states or enrollments with a single application
    - Automatically send your submitted application to the appropriate MAC for processing
  - Pre-population of data and an application that's tailored to you:
    - Keep information like names, licenses, locations, ownership, and more for every individual and organization in a single national profile. You'll be able to easily view this information across enrollments, and it'll be pre-populated for new applications
  - Enhanced capability to add or delete group members
  - Re-validation reminders

Requirements, Enrollment and Billing for Marriage and Family Therapists (MFT) and Mental Health Counselors (MHC)

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Marriage and Family Therapists (MFTs)

- Section 4121 of Division FF of the Consolidated Appropriations Act, 2023 (CAA, 2023), establishes a new Medicare benefit category for MFT and MHC services furnished by and directly billed by MFTs and MHCs; payment for MFT and MHC services under Part B of the Medicare program will begin January 1, 2024
- MFT Requirements to enroll:
  - Possesses a master's or doctorate degree which qualifies for licensure or certification as a MFT under State law of the State in which such individual furnishes marriage and family therapist services
  - Is licensed or certified as an MFT by the State in which they furnish services
  - Has performed at least 2 years or 3,000 hours of clinical supervised experience in marriage and family therapy or mental health counseling after obtaining the degree referenced above
  - Meets other requirements as the Secretary of Health and Human Services (HHS) determines appropriate

Mental Health Counselors (MHCs)

- Section 4121 Division FF of the Consolidated Appropriations Act, 2023 (CAA 2023), defines MHC services as services for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital)
- An MHC is an individual who:
  - Possesses a master's or doctorate degree which qualifies for licensure or certification as a MHC, clinical professional counselor, or professional counselor under State law of the State in which such individual furnishes MHC service
  - Is licensed or certified as an MHC, clinical professional counselor, or professional counselor by the State in which they furnish services
  - Has performed at least two years or 3,000 hours of clinical supervised experience in marriage and family therapy or mental health counseling after obtaining the degree referenced above
  - Meets other requirements as the Secretary of Health and Human Services (HHS) determines appropriate
- Marriage and Family Therapists (MFT) and Mental Health Counselors (MHC) Provider Enrollment Frequently Asked Questions (FAQs)

Enrolling Physician/ Non-Physician Practitioners Applications

- Internet-based PECOS:
  - When using PECOS there is an application Questionnaire:
    - Select Individual Physician or Non-Physician Practitioner, this will populate the CMS-855I
    - Select the type of physician specialty hat you will be enrolling or updating
    - There is a drop-down box for you to select Novitas as the Fee for Service contractor
    - PECOS contains a tab for reassignments, this can be used for new, revisions to current, or termination of reassignment of Medicare benefits:
      - The reassignment only applies to group practices or Method II CAHs
- The paper CMS-855I Physician/ Non-Physician Practitioners application:
  - Section 1(A): check the box indicating the reason you are submitting the application and following the instructions on completing the required sections
  - Section 2(G): check the type of physician specialty that you will be enrolling or updating
  - Section 4 (F): New, revisions to current, or termination of reassignment of Medicare benefits can be submitting using the paper CMS-855I Physicians and Non-Physician Practitioners
  - CMS-855I Tutorial
- When enrolling via PECOS or the paper CMS-855 applications there is an application questionnaire asking if the application is an Indian Health Service (IHS) facility:
  - All Indian Health Service, Tribes and Urban Indian providers/suppliers should always select yes when enrolling with Novitas
  - This questions does not affect the laws that you go by, it just assures Novitas receives your application from PECOS and that we process your application into the correct processing system

Billing MFTs and MHCs Services

- Tribal and IHS hospitals:
  - Part A billing:
    - Can bill the AIR for services provided
    - Revenue Code 0510:
      - Appropriate HCPCS
  - Part B (Provider Based Clinic) billing:
    - Associated with a hospital
    - Can bill the professional l services
- IHS, Tribal or Urban not-provided-based (free-standing ambulatory) clinic billing:
  - Not Provider-based is not associated with a hospital
  - Part B: can bill the professional services
- Tribal FQHC and GFT FQHC billing:
  - Billed on UB-04
  - Revenue code:
    - 0900
  - G0469 or G0470
  - Appropriate qualifying HCPCS
  - Same as Clinical Psychologist, Clinical Social Worker bill under mental/behavior health services

Payment for Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) in a Method II Critical Access Hospital (CAH)

Who

- Physicians and non physicians in Method II CAHs

When

- Effective Date: January 1, 2024
- Implementation Date: February 26, 2024

What

- Payment methodology for MFTs and MHCs when performed by a Method II CAH provider

- Key information:
  - Physicians and/or non-physician practitioners have reassigned their benefits to the Method II CAH:
    - Revenue Codes (RC) 96X, 97X or 98X
    - Reimbursement for MFTs and MHCs will be 80 percent of the lesser of the actual charge or 75 percent of the Medicare Physician Schedule (MPFS)
- References:
  - Change Request (CR) 13502 - Payment for Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) in a Method II Critical Access Hospital (CAH)

Stay of Enrollment

Stay of Enrollment Overview

- Background:
  - The CY 2024 Physician Fee Schedule (PFS) Final Rule contains provisions about Medicare provider enrollment, including the creation of a new provider enrollment status "stay of enrollment"
- Definition:
  - Stay of enrollment is a CMS action that's less burdensome on providers and suppliers than a deactivation or revocation of your Medicare enrollment
  - A stay of enrollment (or "stay") is a preliminary, interim status representing a pause in enrollment
- Implementation date:
  - Effective May 30, 2024, providers and suppliers will begin to see notifications indicating stay of enrollment when a stay is implemented on their enrollment records
- Reference:
  - Medicare Learning Network (MLN) Matters Article: MM13449 "Stay of Enrollment"

Requirements for a Stay of Enrollment

- There are two steps for implementing a stay per 42 CFR 424.541:
  - Step one:
    - The provider is identified as non-compliant with at least one Medicare enrollment requirement
  - Step two:
    - The provider can remedy the non-compliance by submitting, as applicable, CMS enrollment form using the paper CMS-855, CMS-20134, or CMS-588 or submitting these form via PECOS
      - CMS refer to these forms as applicable CMS forms (ACFs)
  - If the type of non-compliance involved cannot be corrected by the submission of an ACF, a stay can't be imposed:
    - Normal enrollment processing guidelines will apply:
      - Deactivation or revocation will be implemented on the enrollment record

Examples of a Stay of Enrollment

- Examples of how this two-step works include:
  - A provider failed to report a change in its address from 10 Smith Street to 20 Smith Street
  - A supplier didn't respond to a revalidation request
  - A DMEPOS supplier didn't report the deletion of a managing employee
  - A physician didn't report a change in their practice location's ZIP code
  - A Medicare Diabetes Prevention Program supplier failed to report a change in the address of an organizational owner
- In these examples, the provider failed to adhere to a reporting, revalidation, or supplier standard requirement, but could resume compliance by submitting the necessary applicable CMS forms (ACFs)
- These are merely examples, there are many more scenarios in which a stay could apply

Key Points of a Stay of Enrollment

- Key Points:
  - You remain enrolled in Medicare during the stay
  - Claims will be rejected that are submitted with dates of service within the stay period and must be resubmitted once reinstated
  - Your stay of enrollment lasts no longer than 60 days
  - The MAC can impose a stay of less than 60 days
  - A stay ends on the earlier of the following dates:
    - The date your MAC decides you resume compliance with all Medicare enrollment requirements
    - The day after the imposed stay period expires
  - A stay isn't considered an adverse legal action of any kind
  - A stay may be imposed multiple times for separate instances of non-compliance:
    - Example: A stay in June 2024 and another stay in December 2025
- If there is no response to the stay of enrollment request, normal enrollment processing rules will apply:
  - A deactivation or revocation will be implemented on the enrollment record

Notification and Rebuttals

- Notification Letters:
  - MACs will send all stay notification letters by hard-copy mail to the correspondences address and e-mail if a valid email address is available
- Rebuttals:
  - You may file a rebuttal under a stay of enrollment
  - A rebuttal is an opportunity for you to show you met all applicable enrollment requirements and that the stay shouldn't have been imposed
  - You may submit only one rebuttal request per enrollment stay

Revalidation

Revalidation Requirements

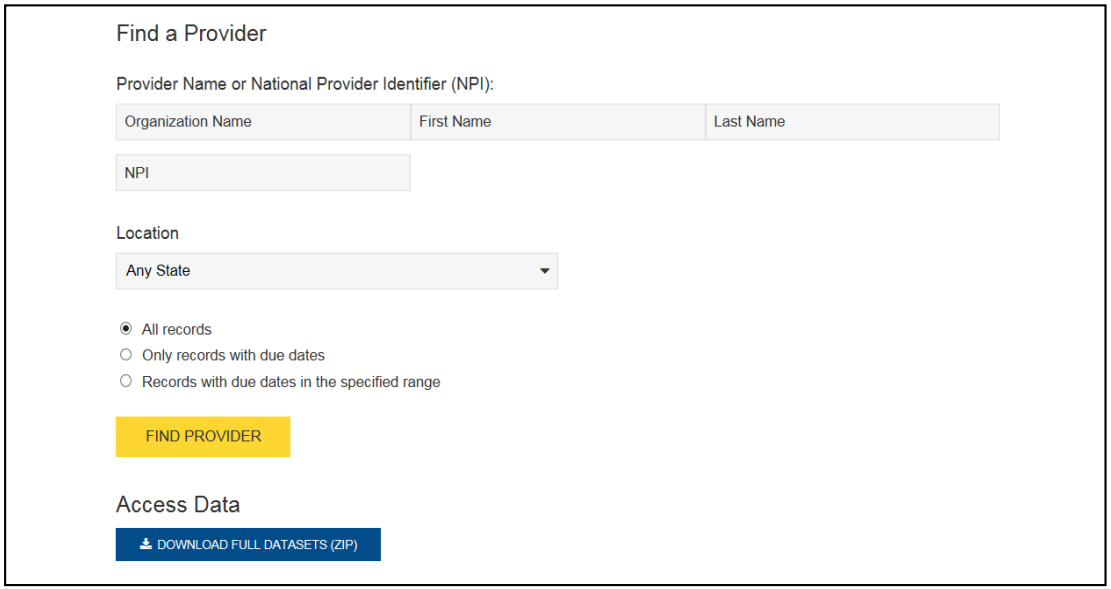
- All providers and suppliers are required to revalidate enrollment records every five years to maintain Medicare billing privileges:
  - To ensure compliance with these requirements, CMS is permitted to conduct off-cycle revalidations for certain program integrity purposes
- Due dates for revalidations are displayed on the Revalidation Lookup tool, if due within six months:
  - "TBD" (To Be Determined) displayed in the due date field for all other providers/suppliers:
    - Unsolicited revalidation submissions will be returned
- Revalidation notices:
  - MACs will send a revalidation notice three to four months prior to your revalidation due date to the correspondence and special payments address on file
- Failure to respond to revalidation request by the due date, will result in a stay of enrollment status and notification will be sent indicating the time frame we must receive the revalidation application:
  - The provider/supplier has 30 days to submit the revalidation application and during this timeframe, claims will reject

Revalidation Requirements

- Failure to respond to the stay of enrollment revalidation request by the due date or failure to respond to a development request within 30 days, will result in be deactivation
- Deactivated status:
  - May result in a gap in coverage (no payments) between the date of deactivation and the new Medicare effective date:
    - Reactivation date after period of deactivation will be based on the receipt date of the new, full, and complete application
    - Providers/suppliers will maintain their original Provider Transaction Access Number (PTAN) and/or CMS certification number (CCN)
    - Medicare will not reimburse you for any services during the period that you were deactivated

CMS Revalidation Lookup Tool

- Medicare Revalidation Lookup Tool:
  - Tool used to determine revalidation due dates



Medicare Secondary Payer (MSP)

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MSP Background and Provisions

- MSP Background:
  - Medicare was the primary payer for services except those covered by Workers Compensation (WC) under the Medicare law, as enacted in 1965
  - In 1980, a series of provisions were enacted by Congress, which resulted in Medicare becoming the secondary payer to other insurance plans
- MSP Purpose:
  - Shift costs from the Medicare program to private sources
  - Protect Medicare Trust Fund from improper reimbursement
  - Establish the order of payment
- MSP provisions are found in the Social Security Act section 1862 (b):
  - Federal law takes precedence over state law and private contracts
  - Prohibits Medicare from making payment if payment has been made, or can reasonably be expected to be made, by certain primary payers under certain conditions
  - Applies when Medicare is not the primary or first payer of claims
- Medicare Secondary Payer (MSP) Manual, Pub. 100-05

MSP Type Codes

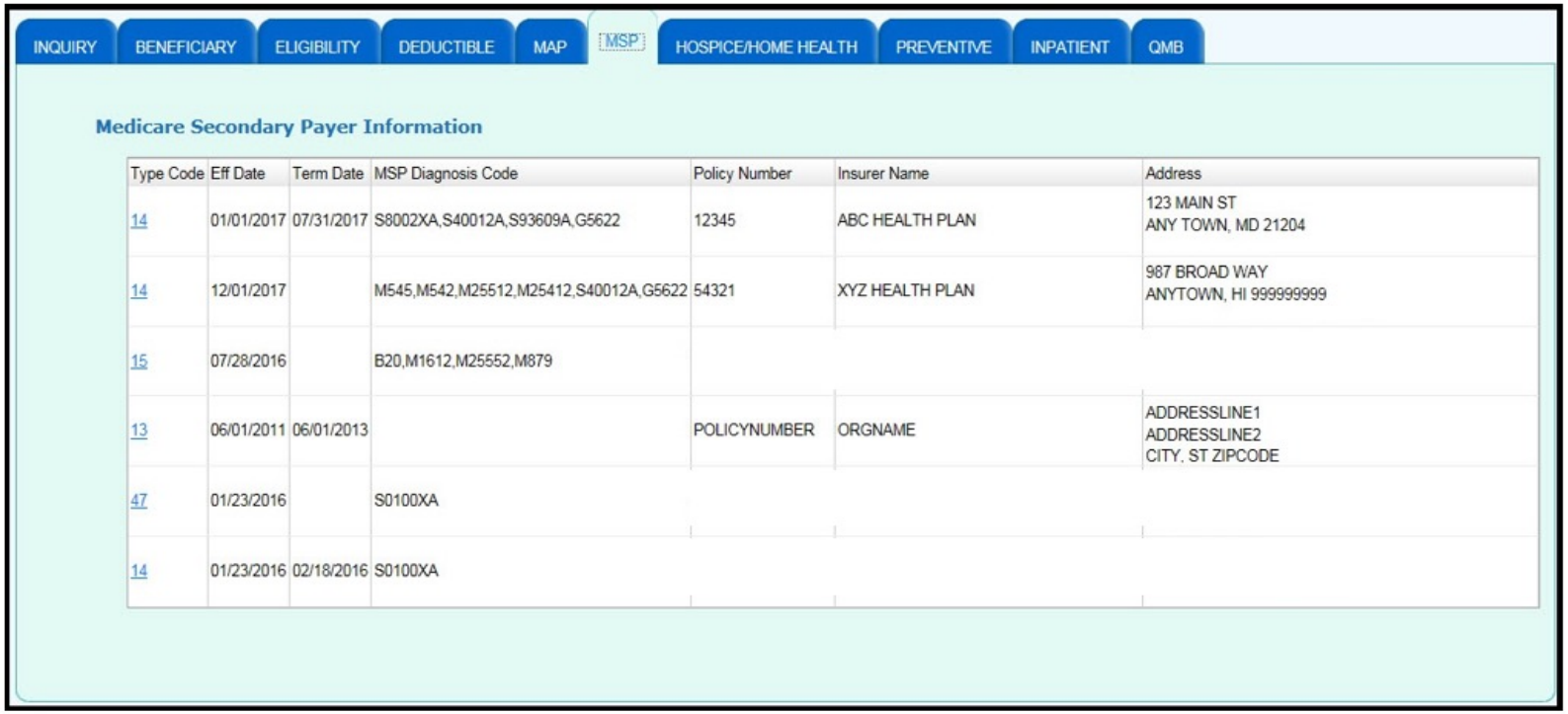
- The following codes are required when submitting the claim to Medicare and must match the codes on file with Novitas
- The MSP type code can be verified via the Novitsphere
- MSP Type Codes:
  - 12 – Working Aged
  - 13 – End Stage Renal Disease (ESRD)
  - 14 – Automobile/No Fault
  - 15 – Worker's Compensation
  - 16 – Federal
  - 41 – Black Lung
  - 43 – Disability
  - 47 – Liability

MSP Type Code

- Correct Reporting of MSP Type Code on Electronic Claim
- Report the MSP Insurance Type Code in Loop/Segment 2000B/SBR05 of the electronic claim

MSP Insurance Type	GHP or NGHP	MSP Provision
12	GHP	**Working Aged** – Beneficiaries age 65 or older who are insured through their own or their spouse's current employment. The beneficiary must be aged 65 or older. There must be at least 20 or more employees.
43	GHP	**Disability** – This coverage is for beneficiaries who are under age 65 and disabled. Insurance is based on their own current employment or through the current employment of a family member. There must be 100 or more employees.
13	GHP	**End Stage Renal Disease** – This coverage is for beneficiaries enrolled with Medicare solely due to renal failure and are insured their own, or through a family member's current or former employment. Medicare is secondary payer for the first 30 months. There is no age restriction on this type of coverage. The beneficiary may be under or over age 65.
14	NGHP	**Automobile/no-fault** – No-Fault insurance that pays for medical expenses for injuries sustained from a motor vehicle accident. This coverage is not based on employment.
15	NGHP	**Workers' Compensation** – This is insurance that employers are required to provide employees that become ill or injured on the job.
47	NGHP	**Liability** – Insurance (including a self-insured plan) that provides payment based on the policyholder's alleged legal liability for injury, illness or damage to property. Some examples of this coverage could be product liability, malpractice, and homeowner's coverage.

Novitasphere MSP Information



MSP Contractor

- The MSP Contractor (formerly Benefits Coordination and Recovery Center (BCRC)) consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries
- The purpose of the coordination of benefits (COB) program is to identify the health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent mistaken Medicare payment
- MSP claims process using data stored in CWF:
  - Primary insurance file, maintained by the MSP Contractor, contains the name, address, and effective/termination dates of the patient's primary insurance company
- Denials occur when a claim is submitted as primary and CWF indicates other insurance primary to Medicare

MSP Contractor (cont.)

- Patients are responsible for ensuring that CWF has current information:
  - Overpayments may occur when the CWF is not current
- If corrections are needed to the CWF contact the MSP Contractor:
  - MSP data may be updated, as necessary, based on additional information received from external parties such as, beneficiaries, providers, attorneys, third party payers:
    - Development to confirm information may be required
- Contact information:
  - Medicare – MSP General Correspondence
  - P.O. Box 138897
  - Oklahoma City, OK 73113-8897
  - 1-855-798-2627 (8 AM to 8 PM ET)
  - 1-405-869-3307 (Fax to Medicare-MSP General Correspondence)

Primary and Secondary Claim Submission

- Part A claims:
  - Inpatient hospital or inpatient skilled nursing facility claims that report span dates of service, the “Through” date on the claim is used to determine timely filing:
    - Claims received after 12 months from the date of discharge will be rejected or returned to provider
- Part B claims must be filed within one calendar year after the date of service
- Claim filing extensions will not be granted because of incorrect insurance information filed on a claim
- Verify benefits and submit timely claims to the appropriate insurance
- When Medicare is not the primary payer, submit claim to the appropriate insurance first
- Required to submit to Medicare as a secondary payer, even if primary pays if full:
  - May fulfill beneficiary’s deductible and co-insurances
  - Maintain the beneficiary’s benefit period
- Never submit claims to more than one insurer at the same time

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

Tribal Self-Funded Insurance (cont.)

- Medicare's systems cannot distinguish self-insurance from third-party insurance:
  - When verifying eligibly the Tribal Self-Funded reflects as a MPS insurance in the Medicare system
- This does not affect claims processing or payment; however, the MSP contractor may later include IHS provider claims in a demand for repayment
- If a demand/recoupment is received from Novitas, the provider will need to submit a redetermination following the redetermination process:
  - Part A
  - Part B
- The tribe's self-insurance is a valid defense against the inclusion of such claims; to assert this reason:
  - The tribe must provide the MSP contractor with documented proof that it was self-insured at the time the IHS facility provided the relevant services
- Upon receiving the appropriate documentation, the MSP contractor will remove the IHS provider claims from the debt

Tribal Self-Funded Insurance Tips

- Claim must be filed to Novitas:
  - Part A claim submission for tribal self-funded insurance
  - Part B Indian Health Tribal Self-Funded Electronic Claims Filing Requirements
- Claim must be submitted as a secondary claim:
  - Can be submitted via Novitasphere, ABILITY | PC-ACE (Free Medicare Billing Software) or DDE (Part A only):
    - Can be processed initially:
      - No denial would be required
- If a denial is received, submit the appropriate adjustment form:
  - Part A UB-04 can be adjusted electronically or use the Part A - Request for tribal self-funded adjustments
  - Part B 1500 can be corrected via Novitasphere or IVR or use the Part B - Request for tribal self-funded adjustments

Tribal Self-Funded Part A UB-04 Submission

- The following slides have the criteria to submit a successful claim for reimbursement:
  - Initial claim step by step instructions by electronic submission, DDE and/or paper
  - Adjustments:
    - Adjust claim as a normal adjustment with the appropriate information as an initial claim
    - If unable to submit an electronic adjustment, then you would need to complete a Hardcopy Adjustment Cancel Request Form and attach a UB-04 CMS-1450 claim form
    - D9 condition code would be used for the adjustment with the appropriate “remarks” “Tribal self-funded insurance”

UB-04 Tribal Self-Funded Claim

Part A claim submission for tribal self-funded insurance

An initial Part A claim submission for tribal self-funded insurance can be sent electronically, via Direct Data Entry (DDE) or by paper claim submission. The following information is required in order for a **tribal self-funded insurance** claim to process. These instructions are only applicable to the IHS providers.

The process for providers using electronic submissions is not changing.

Data	Entry description	5010 Electronic file loop	Direct Data Entry (Page)	UB04 paper claim form locator
Occurrence code **24**	Enter the Occurrence Code 24 and the date after the last date of service on the claim	2300 Segment HI	Claim Page 1 (MAP1711)	31
Value code and amount	Enter the value code that is applicable to the type of **tribal self-funded insurance** 12= Working-aged 43= Disability The amount field is for paid amounts. Since the **tribal self-funded insurance** has not paid, enter zeroes	2300 Segment HI Qualifier BE	Claim Page 1 (MAP1711)	39
Payer code	For payer code In 50A enter: 'C' and the name of the **tribal self-funded insurance** In 50B enter: 'Z' and Medicare	2000B Segment SBR	Claim Page 3 (MAP1713)	50A-B
Patient / Insurance information	Enter the name of the person that 'owns' the insurance Enter the beneficiary's name Both fields are required	2010BA Segment NM1 Qualifier IL	Claim Page 05 (MAP1715)	58A-B
	Enter the insured's employee ID Enter the beneficiary's Medicare Beneficiary ID Number	2010BA Segment REF	Claim Page 05 (MAP1715)	60A-B

UB-04 Tribal Self-Funded Claim (cont.)

	Enter the employer group name	2000B Segment SBR	Claim Page 05 (MAP1715)	61
	Enter the employer group number	2000B Segment SBR	Claim Page 05 (MAP1715)	62
	Enter the Employer name	2320 Segment SBR	Claim Page 05 (MAP1715)	65
Remarks	Enter remarks stating the patient has tribal self-funded insurance	2300 Segment NTE	Claim Page 04 (MAP1714)	80
Date of the denial / payment from the primary payer	Enter the date of the denial by the primary payer. If no remittance is available, enter day after the last date of service on the claim	2330B DTP03 or 2430 DTP03 (one or the other not both)	Claim Page 3 (MAP1719)- Press F11 to access	If available, send a copy of the remittance with the paper claim submission
Amount paid by the primary payer	For **tribal self-funded insurance** claims, this should be $0.00	2320 AMT02 D qualifier	Claim Page 3 (MAP1719)- Press F11 to access	If available, send a copy of the remittance with the paper claim submission
Adjustment group code	Enter the adjustment group code. Enter the group code received on the **tribal self-funded insurance** remittance if available. If no remittance is available, enter 'CO'	2320 CAS01 or 2430 CAS01	Claim Page 3 (MAP1719) - Press F11 to access	If available, send a copy of the remittance with the paper claim submission
Claim adjustment reason code	Enter the Claim adjustment reason code identifying the detailed reason the adjustment was made. If a remittance is available from the **tribal self- funded insurance**, enter the appropriate code on the remittance. If no remittance is available from the tribal self-funded insurance use '45'	2320 CAS02 or 2430 CAS02	Claim Page 3 (MAP1719) - Press F11 to access	If available, send a copy of the remittance with the paper claim submission
Monetary amount	Enter the monetary amount associated with the adjustment reason code. Enter the dollar amount from the **tribal self-funded insurance** remittance if available. If no remittance is available, enter the total billed amount of the claim	2320 CAS03 or 2430 CAS03	Claim Page 3 (MAP1719) - Press F11 to accesss	If available, send a copy of the remittance with the paper claim submission

Requirements, Enrollment and Billing for IHS Rural Emergency Hospital (REH)

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IHS REH

- Background:
  - Beginning January 1, 2024:
    - A tribal or IHS operated hospital (as defined in 42 Code of Federal Regulations (C.F.R) § 413.65(m)) that converts to an REH (IHS-REH) that provides hospital outpatient services to a Medicare beneficiary may be paid for such services under the outpatient hospital All-Inclusive Rate (AIR) that is established and published annually by the IHS, rather than the rates for REH services described at 42 CFR § 419.92(a)(1)
- Who is eligible to convert to an REH?
  - A facility is eligible to convert to an REH if it was a Critical Access hospital (CAH) or rural hospital with 50 beds or less as of December 27, 2020
  - Including a hospital that closed after December 27, 2020
- References:
  - Provider specialty: Rural emergency hospital (REH)
  - Medicare Program Integrity Manual, Pub. 100-08, Chapter 10 - Medicare Enrollment, Section 10.2.1.8.1.1, “Indian Health Service (IHS) Rural Emergency Hospital (REH)”
  - 42 CFR Chapter IV, Subchapter G, Part 485, "CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS“
  - REH FAQs
  - Change Request (CR) 13312 - Indian Health Service (IHS) Rural Emergency Hospital (REH) Provider Enrollment

REH Enrollment

- PECOS:
  - Select the Institutional provider Application
  - Selecting the **Create Initial Enrollment Application** button on the My Associates page or My Enrollment page:
    - To enroll as a REH via PECOS, you must create an Initial Enrollment application for provider type REH
  - Select "Rural Emergency Hospital" under the Part A Provider Services dropdown box
  - Complete all applicable sections
  - Upload all required state licenses/certifications for operation as an REH (if available)
  - Submit application through PECOS

- Paper CMS-855A Institutional Providers Application:
  - Follow the instructions for changing your Medicare information
  - Sections to be completed:
    - Section 1(A): check the "You are changing your Medicare information" box
    - Section 2(A)(1): check the type of provider, "Rural emergency hospital"
    - Complete Sections 2(B): with REH information
    - Compete Section 3: Final Adverse Legal Actions
    - Compete Section 15: Certification Statement
  - When submitting paper applications, the IHS cover sheet should be submitted:
    - IHS Part A coversheet
  - Once completed:
    - Upload the application using the Provider Enrollment Gateway; this portal allows for paper applications to be uploaded and submitted online
    - Or the application can be mailed

IHS REH Billing

- Claims submitted on the UB-04 and/or 837I equivalent
- Outpatient bill:
  - TOB will always be a 13X or 14X:
    - Revenue Code 0510:
      - Appropriate HCPCS
  - Inpatient claims are not billable as an REH
- Reimbursement is under the All-Inclusive Rate (AIR) as IHS REH services:
  - Services that are not under the definition of an IHS REH service, such as the following:
    - Ambulance services if REH owned and operated would be reimbursed under the ambulance fee schedule
    - Post-hospital care SNF services are reimbursed under the SNF PPS

IHS REH Monthly Facility Payment

- IHS REH facilities will receive an additional facility payment:
  - Payments received in twelve monthly installments
  - Must keep detailed information of how payments are used:
    - Be available if CMS asked for information
  - Monthly facility payment is updated annually
  - Sequestration applies
- References:
  - 2024 updates:
    - Change Request (CR) 13457 - January 2024 Annual Rural Emergency Hospital (REH) Monthly Facility Payment
  - 2023 updates:
    - Change Request (CR) 12820 - Implementation of Rural Emergency Hospital (REH) Provider Type

Provider - Based Hospital Off-Campus Practice Location Address

Provider - Based Hospital Off-Campus Practice Location Address Requirements

- Hospital Location Requirements:
  - Medicare allows hospitals to have additional locations, on or off campus, outside of the main hospital as part of the hospital for billing purposes:
    - Includes clinics, departments, remote locations, and satellite locations not separately enrolled or certified under Medicare
    - These locations should be listed in the enrollment records
  - Requirements for correct provider practice location reporting was effective back in 2017, however, systematic edits were not put in place until August 1, 2023
- Systematic Validation Edits:
  - CMS implemented systematic validation edits to enforce requirements in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 1, section 170, for hospitals with multiple locations to include off-campus provider-based departments location
- Hospital Provider Requirements:
  - Providers should ensure that their enrollment information is up to date, and any claim submissions reflect the practice locations exactly as it appears from the practice location address screen which is received from PECOS viewed in FISS under Short Cut 1D provider practice address
  - Providers should ensure that the practice locations are linked to the NPI that is being reported on the claim submission

Hospital Location Address Systematic Validation Edits

- If a hospital submits a claims with a location not listed in the enrollment records or does not match exactly the claim will be reject as a return to provider (RTP) with:
  - Reason code 34977- Claim service facility address does not match provider practice file address:
    - Location submitted was not listed in the enrollment records
    - Location submitted does not exactly match the information from the enrollment records
    - Must match, word for word, including abbreviations and punctuation:
      - For example: Road vs. Rd, Suite vs. Ste., etc.
      - Include special characters if listed in the address:
        - For example, &, (),+, *, -, etc.
  - Applies to Type of Bill (TOB) 13x and 14x
- Resolving Reason Code 34977:
  - Ensure the service facility address reported in DDE MAP 171F matches provider enrollment information in PECOS:
    - Compare to the Provider Practice Address Query menu selection 1D from the Inquiry Menu available in DDE:
      - This is the practice location screen received from the PECOS
- Indian Health Service hospital off-campus outpatient department reporting requirements

Verifying Practice Location Address

- Verifying location information:
  - PECOS:
    - You can verify the location information in PECOS, if you have access to the system
  - The practice location screen is available in Direct Data Entry (DDE):
    - Provider Practice Address Query- Option 1D
    - Providers with outpatient practice locations may use this screen to verify the information available for the FISS to edit against
    - This screen will also provide the practice effective date in the field “PRAC EFF DT”
    - Refer to Indian Health Service hospital off-campus outpatient department reporting requirements for additional information
  - Contact the Novitas enrollment contact center:
    - We will only be able to release enrollment information to the provider/supplier, authorized/delegated official or contact person

Updating Practice Locations

- The PECOS Institutional provider or the paper CMS-855A Institutional Providers application is required in order to update practice locations or add locations:
  - When using the paper application, the IHS Part A coversheet should be submitted:
    - Upload the paper application using the Provider Enrollment Gateway; this portal allows for paper applications to be uploaded and submitted online
    - Or the application can be mailed
- The enrollment application fee is required when adding a practice location
- Enrollment Application Fee:
  - 2024 Application Fee of $709.00 must be paid prior to submitting the application dependent on your supplier provider/supplier type:
    - IHS hospitals, Tribal FQHCs, GFT FQHCs, ambulance, Ambulatory Surgical Center (ASCs) and Durable Medical Equipment(DME) suppliers
  - Fee can be paid using PECOS or Pay.gov

Fiscal Intermediary Shared System (FISS) Consistency Edit To Validate Attending Physician NPI

FISS Edit To Validate Attending Physician NPI

- CMS implemented a new consistency system edit in April 2023 that validates the attending provider NPI on institutional claims
- Institutional providers must indicate the attending provider name and NPI for the patient's medical care and treatment on institutional claims for any services other than nonscheduled transportation claims:
  - Refer to MLN Matter Article (MM) 12889 New Fiscal Intermediary Shared System Edit to Validate Attending Provider NPI – Phase 2 for a list of physician and non-physician practitioner (NPP) specialties eligible as an attending physician and who must be enrolled in PECOS in an approved status
- Claims will return with reason code 34963: Attending Physician is Invalid, for one of the following reasons:
  - The attending physician on claim page 03 is invalid
  - The attending physician NPI is present, but the first four digits of the last name do not match PECOS
  - The claim has a through date of service equal or greater than the termination date of the physician

Resolving Reason Code 34963

- To resolve reason code 34963, follow the steps below:
  - Confirm the attending provider's name is the physician or non-physician practitioner (NPP) who certified the plan of care for the services on the claim and then validate the provider's name and NPI in PECOS
  - If you don't have PECOS access, you can use the order and referring data set at data.cms.gov to verify the physician's name and spelling as seen in PECOS:
    - It is recommended to search by the provider's NPI to correctly display the information
    - Use PECOS or data.cms.gov only for validation to obtain the correct information for editing
  - Correct the reported physician information and resubmit your institutional claim
- Example 1:
  - Provider's NPI: XXXXXXXXX
  - Provider's name: John Smith
  - System editing: J Smit
- Example 2:
  - Provider's NPI: XXXXXXXXX
  - Provider's name: John Smith Jones or Smith-Jones
  - System editing: J Smit
- References:
  - New Fiscal Intermediary Shared System (FISS) consistency edit to validate attending physician NPI
  - Reason code 34963
  - Resolve claim return reason code 34963 for outpatient therapy services

Intensive Outpatient Program (IOP) for Tribal FQHCs, GFT FQHCs, and IHS

Tribal FQHC IOP Services

Who

- Tribal Federally Qualified Health Centers (FQHCs) and Grandfather Tribal Federally Qualified Health Centers (GFT FQHCs)

When

- Effective: January 1, 2024
- Implementation January 2, 2024

What

- Medicare coverage and payment for IOP services for individuals with mental health needs when furnished by Tribal FQHCs

- Key information:
  - Items and services available under the IOP benefit include the following:
    - Individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law)
    - Occupational therapy with a qualified occupational therapist provided by an occupational therapist, or under appropriate supervision of a qualified occupational therapist by an occupational therapy assistant
    - Services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients
    - Drugs and biologicals furnished for therapeutic purposes, which cannot be self-administered
    - Individualized activity therapies that are not primarily recreational or diversionary
    - Family counseling (the primary purpose of which is treatment of the individual's condition)
    - Patient training and beneficiary education (to the extent that training and educational activities are closely and clearly related to individual's care and treatment)
    - Diagnostic services
- References:
  - Change Request (CR): CR13264 "Enforcing Billing Requirements for Intensive Outpatient Program (IOP) Services with Revenue Code 0905 for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)"
  - For a list of IOP services, see Attachment A for both List A Primary Services and List B Services

Tribal FQHC and GFT FQHCs IOP Services Certification and Plan of Care

- Tribal FQHC and GFT FQHC IOP Certification and Plan of Care Requirements
- Pursuant to an individualized patient written plan of treatment established:
  - Periodically reviewed by a physician
  - Diagnosis
  - Type
  - Amount
  - Frequency
  - Duration of the items and services provided under the plan
  - Goals for treatment under the plan
- Physician certification and plan of care requirements required for IOP furnished in the Tribal FQHC and GFT FQHC settings require physicians to certify that an individual needs IOP services for a minimum of 9 hours per week of therapeutic services as evidenced in their plan of care
- Certification would require documentation to include that the patient requires such services for a minimum of 9 hours per week
- This determination must occur no less frequently than every other month

Tribal FQHC Billing Requirements for IOP Services

- Tribal FQHC IOP Payment Rate:
  - IOP payment rate is based on the 3-services per day hospital-based per diem payment amount which is $259.13
  - IOP services furnished in Tribal FQHCs, the payment is based on the lesser of a Tribal FQHC's actual charges or the 3-services per day payment amount
- Billing IOP services furnished in Tribal FQHCs:
  - Type of bill (TOB) 77X
  - Condition code 92
  - Revenue code 0905
  - HCPCS codes describing IOP services are listed in Appendix A as List A Primary Services and List B Services
- Tribal FQHCs must report charges on the primary service line for all IOP services furnished that day to be included in the calculation for coinsurance
- At least one IOP service from List A Primary Services must be included on the claim for payment:
  - Additional IOP services from List B Services listed on the claim will be bundled for that specific day
- Tribal FQHC Supplemental Payments for Medicare Advantage (MA):
  - Condition code 92
  - Revenue code 0519
  - HCPCS code from the Primary List A and any services from List B
- For a list of IOP services, see Attachment A for both List A Primary Services and List B Services

Tribal FQHC Multiple Visits Billing for IOP Services

- Multiple Visits:
  - Medical visit and a mental health visit on the same day
  - Initial preventive physical exam and a separate medical or mental health visit on the same day
  - IOP services are behavioral health services, payment for a mental health visit and IOP services on the same day is not allowed
  - In the case of a medical visit, an encounter can include a medical visit and a mental health visit or a medical visit and IOP services on the same day:
    - An encounter cannot include two mental health visits on the same day
  - Mental health services should continue to be reported with revenue code 0900
  - Do not report IOP services with revenue code 0900
- For a list of IOP services, see Attachment A for both List A Primary Services and List B Services

GFT FQHC Billing Requirements for IOP Services

- GFT FQHC IOP Payment Rate:
  - Reimbursed at GFT FQHC PPS rate not the IOP rate
  - IOP services furnished in a GFT FQHCs, the payment is based on the lesser of an GFT FQHC's actual charges or the GFT FQHC PPS rate per day payment amount
- Billing IOP services furnished in GFT FQHCs:
  - Type of bill (TOB) 77X
  - Condition code 92
  - Revenue code 0905
  - HCPCS codes describing IOP services are listed in Appendix A as List A Primary Services and List B Services
- GFT FQHCs must report charges on the primary service line for all IOP services furnished that day to be included in the calculation for coinsurance
- At least one IOP service from List A Primary Services must be included on the claim for payment:
  - Additional IOP services from List B Services listed on the claim will be bundled for that specific day
- For a list of IOP services, see Attachment A for both List A Primary Services and List B Services

GFT FQHC Multiple Visits Billing for IOP Services

- Multiple Visits:
  - IOP services are behavioral health services, payment for a mental health visit and IOP services on the same day is not allowed
- Mental health services should continue to be reported with revenue code 0900
- Do not report IOP services with revenue code 0900
- For a list of IOP services, see Attachment A for both List A Primary Services and List B Services

IHS Billing Requirements for IOP Services

- IHS will follow all IOP guidelines set forth in MM 13222 and CR 13496, reimbursement is the difference and one encounter per day
- IHS IOP Payment Rate:
  - IOP services furnished by IHS hospital based, reimbursement is the All-inclusive Rate (AIR) per day
- Billing IOP services furnished by IHS acute hospitals and critical access hospitals (CAH):
  - Type of bill (TOB); 13X and 85X
  - Revenue code 0510
  - HCPCS codes describing IOP services are listed in Appendix A as List A Primary Services and List B Services:
    - For a list of IOP services, see Attachment A for both List A Primary Services and List B Services
- At least one IOP service from List A Primary Services must be included on the claim for payment:
- Multiple Visits:
  - Visits with more than one health professional and multiple visits with the same health professional that take place during the same day at a single location within the hospital (including the hospital-based satellite) constitute a single visit
  - The only exception to the "all-inclusive" encounter is when the patient has an emergency room visit on the same day with an unrelated condition
- References:
  - Medicare Learning Network (MLN) Matters Article: MM13222: New Condition Code 92: Billing Requirements for Intensive Outpatient Program Services
  - Change Request (CR) 13496 - Enforcing Billing Requirements for Intensive Outpatient Program (IOP) Services with New Condition Code 92 - Additional Publication Update

Key Takeaways

- Discussed updates
- Reviewed the requirements, enrollment and billing for MFT and MHC
- Reviewed the new Stay of Enrollment guidelines
- Discussed the Revalidation policy
- Reviewed MSP requirements
- Discussed the requirements, enrollment and billing for IHS REH
- Covered the provider - based hospital off-campus practice location address edit
- Discussed the FISS edit to validate attending physician NPI
- Covered the IOP information for Tribal FQHCs, GFT FQHCs, and IHS facilities

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