Update: Division of Fee-for-Service

Tribal Consultation Meeting

March 6, 2009

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Updates

- Division of Fee-for-Service Management
- 5% fee-for-service rate reduction
- Orphan lab visits
- Claims Submission
  - Red Forms
  - Electronic Claims Submission

Division of Fee-for-Service Management (DFSM)

DFSM serves the following populations:

- American Indian members who choose not to enroll in an AHCCCS capitated health plan and enroll in the American Indian Health Program (AIHP)
- American Indian ALTCS members enrolled with a tribe with an IGA with AHCCCS
- Members eligible only for Federal Emergency Services

5% fee-for-service rate reduction

- The proposed 5% reduction in fee-for-service payments is expected to have minimal impact on IHS facilities and tribally-operated 638 facilities and programs
- Services provided by IHS/638 facilities to AIHP Title XIX (Medicaid) members are reimbursed at the IHS inpatient per diem or the all-inclusive outpatient rate
- This reimbursement consists of 100% federal funds and is ***not*** affected by the 5% fee-for-service rate reduction

5% fee-for-service rate reduction

- Services provided by IHS/638 facilities to AIHP Title XXI (KidsCare) members are reimbursed at the AHCCCS fee-for-service rate
- Pro fees for inpatient services in IHS/638 facilities also are reimbursed at the fee-for-service rate.
- These rates ***are*** subject to the 5% reduction

2/1/2009 5% Reduction

Service	Yes	No
IHS/638 Inpatient Per Diem (Medicaid)		X
IHS/638 Outpatient All Inclusive Rate (Medicaid)		X
IHS/638 Inpatient Professional Services (Medicaid)	X	
IHS/638 Services to KidsCare members	X	
IHS Ambulatory Surgery Centers		X
Non-IHS/638 Hospital Inpatient Services		X
Non-IHS/638 Hospital Outpatient Services		X
Non-IHS/638 Dental Services		X
Nursing Facility Services		X

2/1/2009 5% Reduction

Service	Yes	No
Pharmacy Services		X
Free-Standing Dialysis Clinics	X	
Non-Emergency Transportation	X	
ALTCS HCBS		X
ALTCS Professional Services	X	
TRBHA Services		X
Urban Indian Clinic Services	X	

Orphan lab visits

- August 12, 2008 Memo to not cover Orphan lab visits
- IHS/AHCCCS Work group established to set guidelines
- February 2, 2009 Memo to cover Orphan lab visits
- Claims can now be submitted and retrospectively to August 2, 2008,

Orphan lab visits

- Not Orphan visit: During a billable provider visit, a lab test is ordered for that day's assessment. The patient decides to get the lab work on another day
- Orphan visit: the provider makes a care plan that includes a laboratory test for another time, i.e., a new medicine is started and a laboratory assessment is required after initiation of therapy

Orphan lab visits

- Since this Orphan lab visit is a planned laboratory visit, the patient is checked in, a visit is created, and the lab service is performed.
- Documentation should reflect this planned lab visit as an Orphan lab visit that can be billed separately as an outpatient claim at the AIR.
- The Orphan lab visit is counted as one of the three allowable visits per day for payment.

Claims Submission

- Red Forms
  - Plan to implement by 06/01/09
  - Categorical exclusions
- Electronic Claims Submission
  - Plan to mandate by 10/01/09
  - Claims Attachment Project
  - Categorical Exclusions

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Questions


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