Update: Division of Fee-for-Service

Tribal Consultation Meeting

March 6, 2009

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AHCCCS Medical Director
Assistant Director, Division of Fee-for-Service Management
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

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<tr>
<th>Service</th>
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<tr>
<td>IHS/638 Inpatient Per Diem (Medicaid)</td>
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<td>IHS/638 Outpatient All Inclusive Rate (Medicaid)</td>
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<td>IHS/638 Inpatient Professional Services (Medicaid)</td>
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<td>IHS/638 Services to KidsCare members</td>
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<tr>
<td>IHS Ambulatory Surgery Centers</td>
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<tr>
<td>Non-IHS/638 Hospital Inpatient Services</td>
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<tr>
<td>Non-IHS/638 Hospital Outpatient Services</td>
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<td>Non-IHS/638 Dental Services</td>
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<tr>
<td>Nursing Facility Services</td>
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### 2/1/2009 5% Reduction

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<th>Service</th>
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<tbody>
<tr>
<td>Pharmacy Services</td>
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<td>Free-Standing Dialysis Clinics</td>
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<td>Non-Emergency Transportation</td>
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<td>ALTCS HCBS</td>
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<td>ALTCS Professional Services</td>
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<td>TRBHA Services</td>
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<tr>
<td>Urban Indian Clinic Services</td>
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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