





Indian Health Services and Tribal 638 Facilities Billing Medicare Inpatient Facility

July 16, 2024

AHCCCS
Arizona Health Care Cost Containment System




IHS/638 Prior Authorization

Prior Authorization

No Prior Authorization is required for Title XIX members receiving services at an IHS or 638 Tribal facility.




IHS/638 Tribal Facility
All Inclusive Rate (AIR)

Medicaid IHS/638 Facility Inpatient Hospital

Reimbursement for IHS/638 facilities cover inpatient ancillary services and outpatient services based on the All-Inclusive Rate (AIR).

The AIR rate is published annually in the Federal Registry.

Resource:
https://www.azahcccs.gov/PlansProviders/OtherProviderProgramsAndInitiatives/qualifyingproviders.html

AIR and Differential Adjusted Payments

When submitting inpatient claims to AHCCCS FFS, it is important to calculate the billing amount correctly which will include the AIR and DAP. Each calendar year the AIR and DAP rates may change.

Calendar Year 2024

AIR Inpatient + DAP

Medicare Part B Inpatient Ancillary Per Diem Rate.

Calendar Year 2023

AIR - Inpatient + DAP

Medicare Part B Inpatient Ancillary Per Diem Rate.

Medicare - Medicaid Inpatient Reimbursement

AHCCCS Medicaid reimburses IHS/638 inpatient stays at the Inpatient AIR rate in effect for the service covered dates.

Payment for services rendered shall be per date of inpatient stay and is set in the Federal Register.

Medicare Part A reimburses IHS/638 inpatient stays at DRG, with Medicare cost-sharing:

- Copay,
- Inpatient deductible
- Coinsurance

Billers should familiarize themselves with Medicare billing guidelines.




Medicare Part A Requirements

How Does Medicare Part A Reimburse Charges

- Medicare reimburses IHS/638 facilities for covered inpatient stay at the inpatient prospective payment system (IPPS) based upon diagnosis-related groups (DRGs).
- If charges are combined and reported under **revenue code 0100 - 0101** (all-inclusive room and board plus ancillary) on **Type of Bill 11X** (hospital inpatient).
- **Inpatient services are billed from admission through discharge date.**

Medicare Part A Billing

There are some billing differences between Medicare and Medicaid billing for inpatient facility services.

- Medicare allows providers to bill under **revenue code 024X** (all-inclusive ancillary) on **bill type 12X** (hospital inpatient Part B) and **include the total number of days based on the inpatient stay**.
- 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.

Question #1

The member has Medicare Part B coverage only. If I submit a claim to Medicare with revenue code 0240, how does AHCCCS process this type of claim?

Answer:

1. Medicare will transmit the approved Medicare Part B claim to AHCCCS.
2. The claim will auto deny with the denial codes H225.3 “Medicare /TPL Only, Part B On File” and AD211 “Bill Medicare Part B Charges to Medicare Part A - EOB Required”.

Question #1 (continued)

3. The facility must bill Medicare Part A for the full charges (AHCCCS AIR + DAP if applicable) to obtain a copy of the Medicare Part A EOB denial for processing.

4. After you receive a copy of the denial from Part A, bill AHCCCS for the AIR + DAP and include a copy of the Medicare Part A and Part B explanation of benefits for processing.

Remember AHCCCS will need a copy of both EOBs to coordinate the payment.

Question #2

The member has Medicare Part A coverage, can we bill Medicare directly with revenue code 0100 or 0101?

Answer: Yes, Medicare will transmit the claim over to the medicaid payer and remember the only amount due by AHCCCS in this example, is the inpatient medicare deductible for members who have Medicare Part A coverage.




Inpatient Claims for Medicare Part B Coverage Only

Medicare Part B

Certain Medicaid/Medicare clients may only have Medicare Part B coverage.

Two of the most common reasons to bill Part B are shown below, but are not limited to these examples:

- The patient is ***not entitled*** to Medicare Part A.
- No Part A payment is made at all for the inpatient stay because the patient's benefits ***were exhausted before admission.***

Medicare Inpatient Part B Crossover Claims

- A crossover claim is a claim for a recipient who is eligible for both Medicare and AHCCCS.
- A inpatient claim for an individual with Part A and or Part B coverage, the claim must always be submitted to Medicare first for formal determination.
- Medicare pays their responsibility and transmits the claim directly to AHCCCS for the balance or medicare cost sharing portion.




Medicare Billing Examples

Member With Medicare Part B Coverage Only

Bill Medicare Part A to receive the appropriate denial. Medicare will issue a denial for the services which will normally state PR" member cannot be identified".

Bill Medicare Part B, Medicare will crossover the part B claim to AHCCCS.

After the Part A denial is received, bill the full inpatient stay charges to AHCCCS with a copy of the MEOB from Part A and Part B for processing.

Remember you must bill AHCCCS the daily Medicaid AIR + DAP to receive the correct payment.

Medicare Ancillary Part B Per Diem

Calendar year 2024 the Medicare Part B ancillary per diem rate is $963.00 per day. This may change each year.

Members with Part B only, the biller will calculate the ancillary per diem rate multiplied by the total number of inpatient days and submit the claim to Medicare Part B for consideration.

- Example: The member is admitted on 6/1/2024 and discharged on 6/10/2024, total of 9 inpatient days.

Please note the date of discharge is not reimbursed by FFS but must be included in the covered date span field.

Medicaid Members with Part B Coverage Only

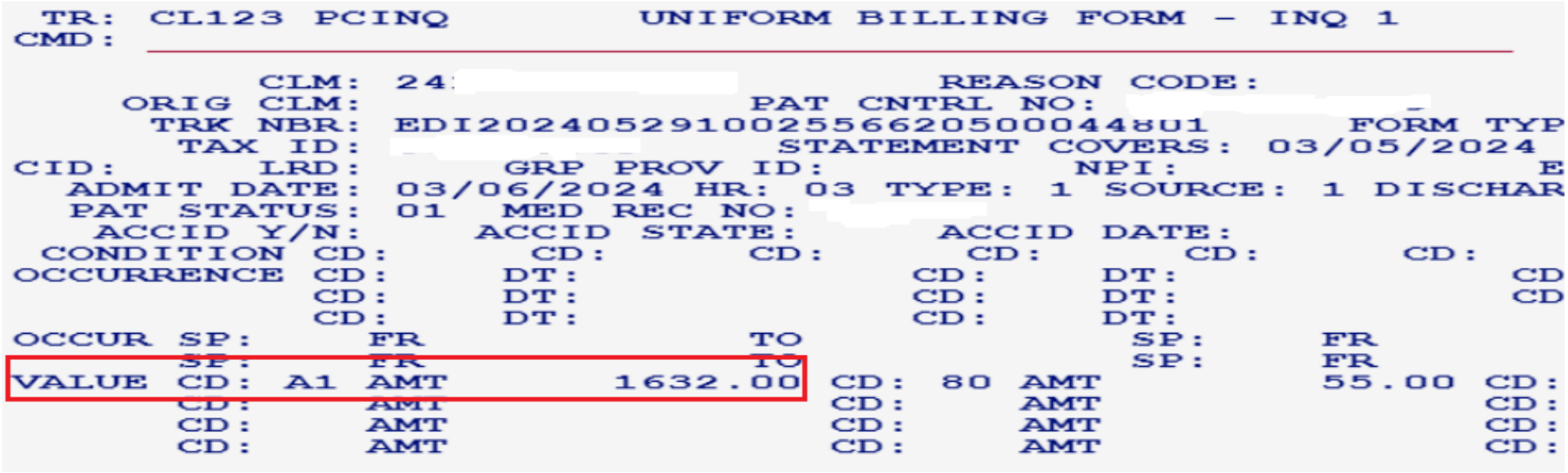
- In order for AHCCCS to properly consider the full inpatient charges for reimbursement, IHS/638 providers must bill AHCCCS the current inpatient AIR rate again to include the DAP if applicable.



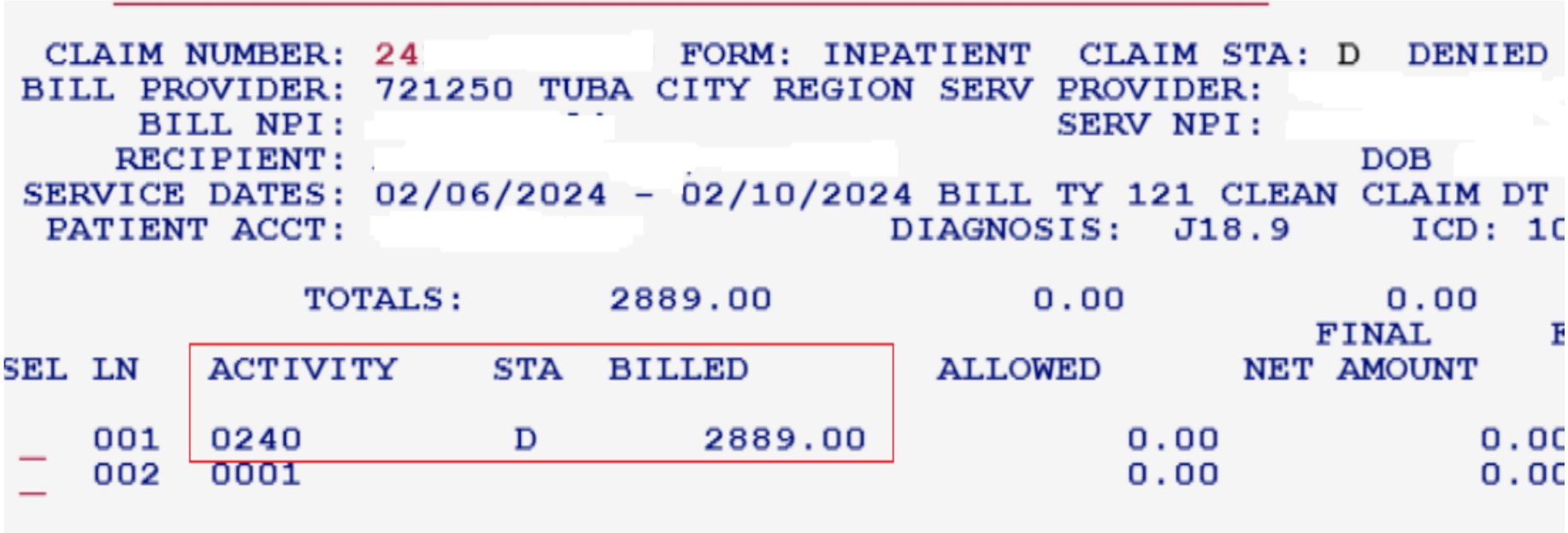

Part A Payments

Part A Crossover Claims and Deductible

The Part A deductible details are entered in the Value Code and Amount (Box 39 thru 41 A thru D) fields on the UB-04 claim with code “A1” or “B1.” This information is included on the crossover claim.



This is a example of a Medicare Part B crossover claim, billed with revenue code 0240 and the ancillary amount only.

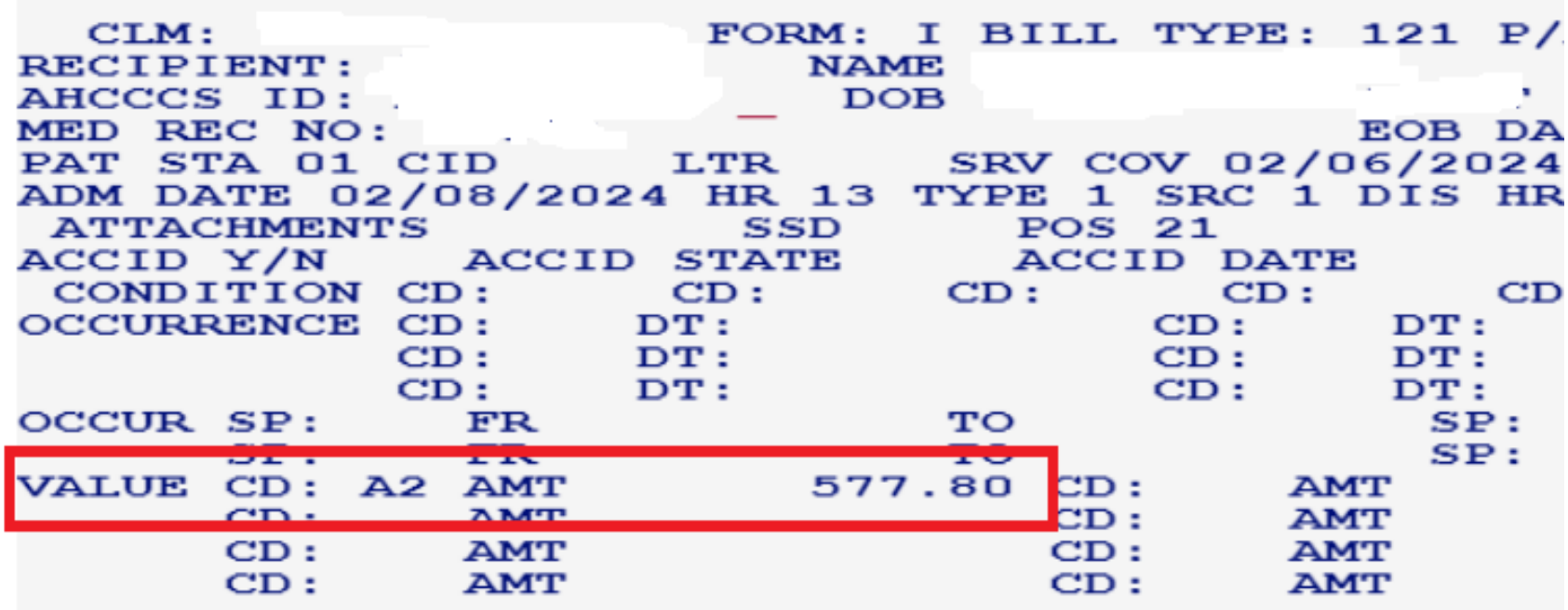


CLAIM NUMBER: 24 FORM: INPATIENT CLAIM STA: D DENIED
BILL PROVIDER: 721250 TUBA CITY REGION SERV PROVIDER:
BILL NPI: SERV NPI:
RECIPIENT: DOB
SERVICE DATES: 02/06/2024 - 02/10/2024 BILL TY 121 CLEAN CLAIM DT
PATIENT ACCT: DIAGNOSIS: J18.9 ICD: 10

TOTALS: 2889.00 0.00 0.00

SEL	LN	ACTIVITY	STA	BILLED	ALLOWED	FINAL NET AMOUNT	
_	001	0240	D	2889.00	0.00	0.00	
_	002	0001			0.00	0.00	

Page 2 shows the value code fields on a ancillary crossover claim.






Billing Medicare For A Non-Pay Claim

Medicare Inpatient No-Pay Billing

- A no-pay inpatient claim is submitted to Medicare to track benefit periods and to receive a EOB for processing.
- Once the inpatient “no-pay” claim has been submitted to Medicare and the provider receives a MEOB, providers may then bill the ancillary **charges to Part B claim (121 TOB).**
- Medicare does not crossover denied and or adjusted claims to AHCCCS.




Medicare Part B Requirements

Billing Revenue Code 0240

IHS/638 facilities will submit an ancillary claim to Medicare 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.
- The ancillary claim can be submitted after the denied inpatient claim has posted to a remittance notice.




Division of Fee-for-Service Management (DFSM) Provider Education and Training Unit

Thank You.