Military Hospital

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33.1 Enrollment
To enroll in the Texas Medicaid Program, a military hospital must be certified by Medicare, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process. Veterans Administration (VA) hospitals are eligible to receive Texas Medicaid payment only on claims that have crossed over from Medicare. Military hospital providers must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA) rules and regulations. Providers who do not comply with CLIA will not be reimbursed for laboratory services.

Important: All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

Refer to: “Provider Enrollment” on page 1-2 for more information about enrollment procedures.
“Clinical Laboratory Improvement Amendments (CLIA)” on page 26-2.

33.1.1 Medicaid Managed Care Enrollment
Medicaid Managed Care health plans must reimburse military hospital providers for emergency services.

Refer to: “Managed Care” on page 7-1 for more information.

33.2 Reimbursement
Reimbursement is limited to claims submitted for emergency inpatient care only.

Allowed inpatient hospital stays are reimbursed according to a prospective payment methodology based on diagnosis-related groups (DRGs). The reimbursement method itself does not affect inpatient benefits and limitations. The Texas Medicaid Program requires that one claim be submitted for each inpatient stay with appropriate diagnosis and procedure code sequencing. Providers should submit only one claim per inpatient stay to Medicaid, regardless of the diagnosis, to ensure accurate payment. The DRG reimbursement includes all facility services that were provided to the client while registered as an inpatient.

Reimbursement to hospitals for inpatient services is limited to $200,000 per client, per benefit year (November 1 through October 31). This limitation does not apply to services related to certain organ transplants, services to clients younger than 21 years of age and covered by the Comprehensive Care Program (CCP), or to services for certain clients enrolled in Medicaid Managed Care.

Military hospitals should keep a Medicaid client as an inpatient only for the length of time necessary to stabilize that client. The Medicaid client, once stabilized, should be transferred to the nearest Medicaid acute care hospital facility for further treatment.

When more than one hospital provides care for the same client, the hospital that furnishes the most significant amount of care receives consideration for a full DRG payment.

The other hospital is paid a per diem rate based on the lesser of the mean length of stay for the DRG or eligible days in the facility. The DRG modifier PT on the Remittance and Status (R&S) report indicates per diem pricing related to a client transfer.

Client transfers within the same facility are considered one continuous stay and receive only one DRG payment. Medicaid does not recognize specialty units as separate entities; therefore, these transfers should be billed as one admission under the provider identifier. Admissions billed inappropriately are identified and denied during the utilization review process and may result in intensified review.

After all hospital claims have been submitted, TMHP performs a post-payment review to determine if the hospital furnishing the most significant amount of care received the full DRG. If the review reveals that the hospital furnishing the most significant amount of care did not receive the full DRG, an adjustment is initiated.

The inpatient DRG reimbursement includes payment for all radiology and laboratory services, including those sent to referral laboratories.

Refer to: “Reimbursement” on page 2-2 for more information about reimbursement.
“THSteps-Comprehensive Care Program (CCP)” on page 43-33.

33.3 Benefits and Limitations

33.3.1 Inpatient Services
Inpatient hospital services include medically necessary items and services ordinarily furnished by a Medicaid hospital or by an approved out-of-state hospital under the direction of a physician for the care and treatment of inpatient clients. Reimbursement to hospitals for inpatient services is limited to the Medicaid “spell of illness.” The spell of illness is defined as “30 days of inpatient hospital care, which may accrue intermittently or consecutively.” After 30 days of inpatient care have been provided, reimbursement for additional inpatient care is
not considered until the client has been out of an acute care facility for 60 consecutive days. Exceptions are made in the following instances:

- Texas Health Steps (THSteps)-eligible clients do not have a 30-day spell of illness limitation, if medically necessary conditions exist (covered under THSteps-CCP).
- Some Medicaid Managed Care clients do not have a 30-day spell of illness limitation.

Refer to: “Managed Care” on page 7-1 for more information.

Hospitals may submit information only claims to TMHP when one of the following situations exists:

- The inpatient 30-day spell of illness benefit is exhausted.
- Payment that has been made by a third party resource/other insurance exceeds the Medicaid allowed amount.

For clients older than 21 years of age and not enrolled in Medicaid Managed Care, an inpatient expenditure cap of $200,000 per benefit year (November 1 through October 31) exists. Claims are reviewed retrospectively, and payments exceeding $200,000 will be recouped.

It is appropriate to submit information only claims using TOB 110.

The following hospital services must be medically necessary and are subject to the utilization review requirements of the Texas Medicaid Program. Medicaid reimbursement for services cannot exceed the limitations of the Texas Medicaid Program.

Inpatient hospital services include the following items and services:

- Bed and board in semiprivate accommodations or in an intensive care or coronary care unit, including meals, special diets, and general nursing services; or an allowance for bed and board in private accommodations, including meals, special diets, and general nursing services up to the hospital’s charge for its most prevalent semiprivate accommodations. Bed and board in private accommodations are provided in full if required for medical reasons, as certified by the physician. Additionally, the hospital must document the medical necessity for a private room, such as the existence of a critical or contagious illness or a condition that could result in disturbance to other patients. This type of information is included in Block 80 or attached to the claim.
- Whole blood and packed red cells that are reasonable and necessary for treatment of illness or injury, provided they are not available without cost.
- All medically necessary services or supplies ordered by a physician.

Medicaid benefits are not available for take-home or self-administered drugs or personal comfort items, except when received by prescription through the Vendor Drug Program.

Only inpatient claims that have an emergency diagnosis on the claim are considered for reimbursement.

33.3.2 Outpatient/Physician Services

Although Medicare reimburses for emergency outpatient and inpatient services, Medicaid does not reimburse for either outpatient or physician services. Military hospitals are not reimbursed for outpatient day surgery.

33.4 Utilization Review


33.5 Claims Information

If type of bill (TOB) 110 is used to submit a claim, all charges must be noncovered and the claim will finalize with Explanation of Benefit (EOB) 217, “Payment reduced through hospital action.”

It is appropriate to submit information only claims using TOB 110.

Military hospitals may submit total charges in one line with appropriate accommodation revenue codes. Emergency hospital services must be submitted to TMHP in an approved electronic format or on the UB-04 CMS-1450 claim form. Providers may purchase claim forms from the vendor of their choice. TMHP does not supply the forms.

Refer to: “TMHP Electronic Data Interchange (EDI)” on page 3-1 for information on electronic claims submissions.

“Claims Filing” on page 5-1 for general information about claims filing.

When completing a UB-04 CMS-1450 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claims supplements.

Instructions for completing paper claims are provided in “UB-04 CMS-1450 Claim Filing Instructions” on page 5-30. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Refer to: “Military Hospital (Emergency Inpatient)” on page D-23.
33.5.1 Claim Filing Resources

Refer to the following sections and/or forms when claims:

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