Chapter 11

Hospital Services

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NOTE: The covered services, limitations, and exclusions described in this chapter are global in nature and are listed here to offer general guidance to acute care hospitals. Specific questions regarding covered services, limitations, and exclusions should be addressed to the AHCCCS Office of Special Programs at (602) 417-4053. The *AHCCCS Medical Policy Manual (AMPM)* also is available on the AHCCCS web site at www.ahcccs.state.az.us . See Chapter 8, Authorization/IHS Referrals, for prior authorization requirements for hospital services.

INPATIENT HOSPITAL SERVICES

AHCCCS covers medically necessary inpatient hospital services provided by or under the direction of a physician which are ordinarily furnished in a hospital, except for services in an institution for tuberculosis or mental diseases. Inpatient services are covered for AHCCCS/ALTCS recipients when the recipient's condition requires hospitalization because of the severity of illness and intensity of services required.

Coverage for Federal Emergency Services Program (FESP) recipients is limited to emergency services. Some of the services described in this chapter are NOT covered for these individuals. Pursuant to Laws of 2002, Third Special Session, Chapter 1, Section 3, effective for dates of service on and after March 1, 2002, AHCCCS does not cover hospitalization for State Emergency Services Program recipients.

☑ Covered hospital accommodation services

- ✓ Maternity care
- ✓ Routine care unit
- ✓ Nursery and neonatal intensive care unit
- ✓ Intensive care and coronary care unit
- ✓ Nursing services necessary and appropriate for the recipient's condition
- ✓ Dietary services
- ✓ Medical supplies, appliances, and equipment ordinarily furnished to hospital inpatients that are billed as part of the daily room and board charge
- ✓ Acute behavioral health care services, including up to 72 hours per episode of emergency hospitalization up to a maximum of 12 days per contract year (10/01 - 09/30)

INPATIENT HOSPITAL SERVICES (CONT.)

☑ Covered ancillary services

- ✓ Labor, delivery, observation rooms, and birthing centers
- ✓ Surgery, operating, and recovery rooms
- ✓ Laboratory services
- ✓ Radiology and medical imaging services
- ✓ Anesthesiology services
- ✓ Rehabilitation services, including physical, occupational, and speech therapies
- ✓ Pharmaceutical services and prescribed drugs
- ✓ Respiratory therapy
- ✓ Services and supplies necessary to store, process, and administer blood and blood derivatives
- ✓ Central supply items, appliances, and equipment ordinarily furnished to all patients and customarily reimbursed as ancillary services
- ✓ Maternity services
- ✓ Nursery and related services
- ✓ Chemotherapy
- ✓ Dialysis
- ✓ Total parenteral nutrition services (TPN)
- ✓ Dental surgery for EPSDT recipients
- ✓ Podiatry services ordered by a physician or PCP

☑ Exclusions and limitations

- ✓ Routine inpatient hospital accommodations are limited to no more than a semi-private rate, except when patients must be isolated for medical reasons.
- ✓ Inpatient dialysis treatments are covered only when the hospitalization is for:
  - ☒ An acute medical condition requiring hemodialysis treatments.
  - ☒ A medical condition experienced by a recipient routinely maintained on an outpatient chronic dialysis program.
  - ☒ Placement, replacement, or repair of the chronic dialysis route (shunt or cannula).

INPATIENT HOSPITAL SERVICES (CONT.)

☑ Exclusions and limitations (Cont.)

- ✓ Personal comfort items are not covered.
- ✓ Inpatient hospital services are subject to the prior authorization, medical and concurrent review requirements for medical necessity for admission and continued stay.
- ✓ Professional component for services rendered during an inpatient stay must be billed separately on a CMS 1500 claim form.

BILLING OF INPATIENT HOSPITAL CLAIMS

Inpatient hospital claims must be submitted to the AHCCCS Administration on UB billing forms (See Chapter 6, Billing on the UB Claim Form, for specific billing requirements.)

The claim form must be completed correctly with valid revenue, procedure, and diagnosis codes in order for the AHCCCS system to qualify the accommodation day(s) at the correct tier level(s). At least one accommodation revenue code must be billed with associated charges greater than zero for an inpatient claim to qualify for payment through the tiered per diem system. Any accommodation revenue code submitted without charges will not be considered for inpatient tier classification.

AHCCCS will match inpatient and outpatient UB claims for the same recipient for the same date of service. If a recipient is treated in the emergency room, observation area, or other outpatient department and is directly admitted to the same hospital, the emergency room, observation, or other outpatient charges must be billed on the inpatient claim.

REIMBURSEMENT OF INPATIENT HOSPITAL CLAIMS

AHCCCS reimburses acute general care hospital providers based upon the services rendered. The reimbursement methodologies are:

☑ Tiered per diem

- ✓ Used to reimburse instate, non-IHS, acute general care hospitals
- ✓ Defines seven tiers which are based on level and type of care
- ✓ Rates are set prospectively and adjusted annually

☑ Statewide inpatient cost-to-charge ratio

- ✓ Used to reimburse outlier claims and out-of-state inpatient hospital claims
- ✓ Computed based on average of all in-state, acute general care hospitals

REIMBURSEMENT OF INPATIENT HOSPITAL CLAIMS (CONT.)

☑ Contract/negotiated rates

- ✓ Used to reimburse providers for certain services, such as transplants, or for providers who have negotiated special rates for specific services

☑ IHS per diem rate

- ✓ Used to reimburse Indian Health Service (IHS) facility inpatient claims
- ✓ This rate is established by the federal Office of Management and Budget (OMB)

☑ Coinsurance and/or deductible

- ✓ Used to reimburse providers when Medicare is the primary payer and has made payment on the claim

The tiered per diem system consists of the following seven tiers:

1. Maternity
2. NICU
3. ICU
4. Surgery
5. Psychiatric
6. Nursery
7. Routine

The processing of the inpatient claim for payment is hierarchical. Each day is classified into only one tier, based on revenue, procedure, and/or diagnosis codes. An inpatient claim may split across no more than two tier levels. Some splits are either not allowed or are not logical.

The tiered per diem represents payment in full for both accommodation and ancillary services, regardless of the billed charges.

Exhibit 11-1 identifies the requirements for classification into each tier and the allowed tier splits.

REIMBURSEMENT OF INPATIENT HOSPITAL CLAIMS (CONT.)

The AHCCCS system will classify a fee-for-service acute hospital inpatient claim at the surgical tier for all applicable days under the following scenario:

☑ If the surgery occurs after the recipient becomes AHCCCS eligible and the recipient is fee-for-service eligible:

- ✓ A non-excluded ICD-9 surgical procedure must be billed, and the date of the procedure must be within the recipient's fee-for-service eligibility period.
- ✓ A 36X revenue code must be billed with charges greater than zero.

Reimbursement for the emergency room, observation, and other outpatient hospital services provided before the hospital admission are included in the tiered per diem payment. A UB outpatient claim will pend for review if the hospital has previously submitted an inpatient claim for the same recipient for the same date of service.

AHCCCS pays for the date of admission up to but not including date of discharge unless the patient expires.

Example 1:

Dates of service: 03/05 through 03/10 Accommodation days billed: 5

Bill type: 111 Patient status: 01

AHCCCS will reimburse five days at the appropriate tier(s). The date of discharge will not be paid when the patient status indicates a status other than expired.

Example 2:

Dates of service: 03/05 through 03/10 Accommodation days billed: 6

Bill type: 112 Patient status: 30

AHCCCS will reimburse six days at the appropriate tier(s). AHCCCS will pay the last accommodation day billed when the patient status is 30 (still a patient).

Example 3:

Dates of service: 03/05 through 03/10 Accommodation days billed: 2

Bill type: 111 Patient status: 01

AHCCCS will reimburse two days at the appropriate tier(s). The provider billed only two accommodation days. AHCCCS will reimburse the number of accommodation days billed up to the maximum allowed for the dates of service.

REIMBURSEMENT OF INPATIENT HOSPITAL CLAIMS (CONT.)

When a patient is admitted and discharged on the same day, AHCCCS will reimburse the claim as follows:

☑ Same day admit/transfer

- ✓ For dates of service prior to 7/1/2005: AHCCCS reimburses the transferring hospital's claim by multiplying allowed ancillary charges by the hospital-specific outpatient cost-to-charge ratio.
- ✓ The receiving hospital would be paid the full per diem payment for the date of transfer, provided the hospital bills for at least one accommodation day.
- ✓ For dates of service on or after 7/1/2005: AHCCCS reimburses the transferring hospital's claim using the AHCCCS Outpatient Hospital Fee Schedule.
- ✓ The receiving hospital would be paid the full per diem payment for the date of transfer provided the hospital bills for at least one accommodation day.

☑ Same day admit/discharge

- ✓ For dates of service prior to 7/1/2005: AHCCCS reimburses same day admit/discharge claims by multiplying allowed ancillary charges (observation room, laboratory, X-rays, etc.) by the hospital-specific outpatient cost-to-charge ratio.
- ✓ If the hospital bills the claim as an inpatient admission and the AHCCCS system would qualify the claim at the Maternity or Nursery tier, reimbursement will be the *lesser* of:

  All covered charges, multiplied by the hospital-specific outpatient cost-to-charge ratio,

  or

  The per diem for the Maternity or Nursery classified tier.
- ✓ For dates of service on or after 7/1/2005: AHCCCS reimburses same day admit/discharge claims using the AHCCCS Outpatient Hospital Fee Schedule.
- ✓ If the hospital bills the claim as an inpatient admission and the AHCCCS system would qualify the claim as Maternity or Nursery tier, reimbursement will be the lesser of:

  All covered charges, using the AHCCCS Outpatient Hospital Fee Schedule,

  or

  The per diem for the Maternity or Nursery classified tier.

REIMBURSEMENT OF INPATIENT HOSPITAL CLAIMS (CONT.)

☑ Same day admit/patient expires

✓ AHCCCS will reimburse the facility the appropriate per diem payment for the date of death, provided the hospital bills for the accommodation day.

OUTLIERS

AHCCCS reimburses in-state, non-IHS hospitals for inpatient claims with extraordinary cost per day as *outliers*. A claim is defined as an outlier if its covered costs per day exceed the statewide average cost thresholds. (See the Outlier Calculation Worksheet, Exhibit 11-3.)

In order for claims to be paid at the outlier payment rate, hospitals must enter a Condition Code 61 in any Condition Code field (24-30) on the UB claim form. The entire claim for which AHCCCS is responsible must be submitted as one claim. If a claim has been paid and the provider decides to submit an adjustment for outlier consideration, the entire period of AHCCCS liability must be submitted on one claim form. The claim may not be split billed with a request for outlier reimbursement on the first claim and the remaining hospital stay billed on a subsequent claim. Claims that are identified as outlier with condition code 61 are subject to medical review.

A claim identified as an outlier with condition code 61 will be considered for outlier reimbursement if it is:

☑ An admit through discharge billing, identified by a bill type 111, or

☑ The last bill of interim billings which represents the total AHCCCS liability period of a confinement identified by bill type 114.

Example: Inpatient stay billed on two different claims

Dates of service	January 1 - 10
First claim submitted to AHCCCS	January 1 - 5
Bill Type: 112	Patient status: 30
Second claim submitted to AHCCCS	January 6 - 10
Bill Type: 114	Patient status: 01

After the initial claims have been reimbursed by AHCCCS, the provider decides to request outlier reimbursement. The provider must resubmit the entire stay on a single claim as a Replacement with a Condition Code 61 (See Chapter 4, General Billing Rules, for information on submitting Replacements to UB claims).

Replacement submitted to AHCCCS	January 1 - 10

Bill Type: 111 Patient status: 01

Condition Code: 61

AHCCCS will void the original claims and process the Replacement claim. If the Replacement claim qualifies for outlier payment, the outlier amount will be calculated. If the Replacement claim does not qualify for an outlier payment, the claim will be reimbursed using the tier per diem rates.

If a claim is identified as an outlier with Condition Code 61, but it does not qualify as an outlier, and the billed services are covered, that claim will be paid at the appropriate tiered per diem rate.

The hospital-specific fee-for-service rate sheets include hospital-specific billed charges per day (charge thresholds) as a guideline to assist hospitals in identifying claims to flag with the Condition Code 61.

Outlier Calculations:

The steps in the outlier process for claims classified at one tier are:

1. [Total charges (-) non-covered charges] (÷) allowed accommodation days (=) covered charges per day.
2. Covered charges per day (x) provider-specific cost-to-charge ratio (=) claim costs per day.
3. If the claim costs per day exceed the tier threshold amount, the claim will pend for outlier medical review. If the costs per day do not exceed the threshold, the claim will pay at the appropriate tier(s).
4. If the claim is forwarded for outlier medical review, it will be reprocessed through the outlier calculation to determine if any disallowed charges disqualify the claim as an outlier. Although the claim costs per day may have initially exceeded the outlier threshold, upon completion of medical review, the costs per day may no longer exceed the threshold.
5. If the claim is still an outlier, reimbursement is calculated by multiplying the covered claim charges by the statewide inpatient cost-to-charge ratio, subtracting other deductions and applying discounts or penalties.

OUTLIERS (CONT.)

Outlier example 1 (single tier):

Units (Days)	Revenue code	Description	Hospital charges
3	17X	Nursery	$ 3,000
		Ancillary 1	4,000
		Ancillary 2	1,500
		Ancillary 3	6,000
			$14,500

1. Compute the hospital charges per day:

   Total charges ÷ total days = Hospital charges per day

Total charges	$14,500.00
Total days	3
Hospital charges per day = 14,500 ÷ 3 =	$ 4,833.33

2. Determine the hospital cost per day:

   Charges per day x inpatient cost-to-charge ratio = Hospital cost per day

Hospital charges per day	$4,833.33
Hospital-specific Inpatient cost-to-charge ratio	.3282
Hospital cost per day = $4,833.33 X .3282 =	$1,586.30

3. Compare to the outlier threshold.

   Is the cost per day ($1,586.30) greater than the hospital-specific nursery tier threshold? If so, the claim qualifies as an outlier and will be forwarded for medical review. If not, the claim will pay at the appropriate tier.

Claims classified at more than one tier are processed with a weighted tier threshold amount:

Tier 1 threshold X number of accommodation days classified at Tier 1

Plus

Tier 2 threshold X number of accommodation days classified at Tier 2

Divided By

Total accommodation days

Equals

Weighted threshold amount

OUTLIERS (CONT.)

Outlier example 2 (two tiers):

An inpatient claim qualifies for five days at the ICU tier and two days at the Routine tier.

Units	Revenue Code	Description	Charges
5	203	ICU	$12,500
2	110	Routine	2,000
		Ancillary 1	20,000
		Ancillary 2	18,500
		Ancillary 3	15,000
		Ancillary 4	10,000
			$78,000

1. Compute the hospital charges per day:

Total charges	$78,000.00
Total days	7

   Charges per day = 78,000 ÷ 7 = $11,142.86

2. Determine the hospital cost per day:

Hospital charges per day	$11,142.86
Inpatient cost to charge ratio	.3484

   Hospital cost per day = $11,142.86 X .3484 = $3,882.17

3. Since the claim has split across tiers, compute a weighted tier threshold:

Tier	Threshold	Number of Days
ICU	$4,500	5
ROUTINE	$2,000	2

   [(Tier 1 threshold X days at Tier 1) + (Tier 2 threshold X days at Tier 2)] ÷ total days

   [($4,500 X 5) + ($2,000 X 2)] ÷ 7 = [$22,500 + $4,000] ÷ 7 = $26,500 ÷ 7 = $3,785.71

4. The cost per day ($3,882.17) is greater than the weighted threshold ($3,785.71), and the claim will go to medical review.

5. After medical review, the claim is processed through the outlier calculation again to determine if it still qualifies as an outlier.

6. If it is an outlier, reimbursement is calculated by multiplying covered charges by the statewide inpatient cost-to-charge ratio, subtracting other deductions and applying discounts or penalties.

DISCOUNTS AND PENALTIES

AHCCCS calculates quick pay discounts and slow pay penalties on the AHCCCS allowed amount for in-state, non-IHS general acute hospital inpatient and outpatient claims billed on the UB claim form. Quick pay discounts and slow pay penalties are applied to:

- ☑ Inpatient claims reimbursed at the tier level
- ☑ Transplant claims reimbursed at the statewide inpatient cost-to-charge ratio
- ☑ Outlier claims reimbursed at the statewide inpatient cost-to-charge ratio
- ☑ Outpatient claims for dates of service prior to 7/1/2005, reimbursed at the provider-specific outpatient cost-to-charge ratio
- ☑ Outpatient claims for dates of service on or after 7/1/2005, reimbursed using the Outpatient Hospital Fee Schedule.

Effective October 1, 2001, a 1% quick pay discount is applied to claims paid within 30 days of the clean claim date.

The slow pay penalty is based on a 30 calendar day month, as illustrated below:

Claim paid within 31-60 days of clean claim date:	0% discount/penalty
Claim paid within 61-90 days of clean claim date:	1% penalty
Claim paid within 91-120 days of clean claim date:	2% penalty

etc.

The penalty continues to accrue at a rate of 1 per cent per month or partial month until the claim is paid by AHCCCS.

Discount/Penalty Example 1:

A claim is paid within 30 days of the clean claim date, and the quick pay discount is applied.

AHCCCS allowed amount (tier per diem)	$10,000.00	
1% discount applied to AHCCCS allowed amount	-100.00	($10,000.00 X .01)
AHCCCS payment	$ 9,900.00	

Discounts and penalties are applied on the net balance to claims with other insurance.

Discount/Penalty Example 2:

A claim for a recipient with other insurance is paid within 30 days of the clean claim date.

AHCCCS allowed amount (tier per diem)	$10,000.00
Other insurance payment	- 2,000.00

DISCOUNTS AND PENALTIES (CONT.)

Balance	$ 8,000.00	
1% discount applied to balance	- 80.00	($8,000.00 X .01)
AHCCCS payment	$ 7,920.00	

Discount/Penalty Example 3:

Claim is paid 69 days after the clean claim date, and a slow pay penalty is applied.

AHCCCS allowed (tier per diem)	$10,000.00	
1% penalty applied to AHCCCS allowed amount	+ 100.00	($10,000.00 X .01)
AHCCCS payment	$10,100.00	

Discount/Penalty Example 4:

A claim for a recipient with other insurance is paid 69 days after the clean claim date, and a slow pay penalty is applied.

AHCCCS allowed (tiered per diem)	$10,000.00	
Other insurance payment	- 2,000.00	
Balance	$ 8,000.00	
1% penalty applied to balance	+ 80.00	($8,000 X .01)
AHCCCS payment	$ 8,080.00	

Adjustment claims are subject to discounts and penalties with consideration to the original claim. The only adjustments that affect payment of an inpatient claim are an increase in the number of days billed or billing a revenue code, procedure code, or diagnosis code that impacts the tiers.

If an adjustment is submitted for additional accommodation days where additional payment is due from AHCCCS, a new clean claim date is established.

If the adjustment allowed amount is more than the AHCCCS allowed amount of the original claim, a new discount or penalty will be calculated only on the amount of the increase. The original discount or penalty will remain as applied to the initial claim amount.

If the adjustment allowed amount is less than the allowed amount of the original claim, the same discount or penalty percentage applied to the original claim will be applied to the adjusted amount, regardless of the processing time.

DISCOUNTS AND PENALTIES (CONT.)

Discount/Penalty Example 5:

A claim was originally paid within 30 days of the clean claim date, and a 1% discount was applied. The hospital submits an adjustment that increases the AHCCCS allowed amount. The adjusted claim is paid 67 days after the new clean claim date. A 1% penalty is applied to the difference between the original and adjusted allowed amounts.

Original claim paid within 30 days:

AHCCCS allowed amount (tier per diem)	$8,000.00	
1% discount	- 80.00	($8,000.00 X .01)
AHCCCS payment	$7,920.00	

Adjustment reimbursed 67 days after the new clean claim date:

New AHCCCS allowed amount (tier per diem)	$12,500.00	
Original AHCCCS allowed amount	- 8,000.00	
Difference between original/new allowed amounts	4,500.00	
1% penalty on difference	+ 45.00	($4,500 X .01)
	$ 4,545.00	
	+7,920.00	(original payment)
New AHCCCS total payment	$12,465.00	

Discount/Penalty Example 6:

A claim was originally paid 95 days after the clean claim date, and a 2% penalty was applied. The hospital submits an adjustment that increases the AHCCCS allowed amount. The adjusted claim is paid within 30 days of the new clean claim date. A 1% discount is applied to the difference between the original and adjusted allowed amounts.

Original claim paid within 91-120 days of clean claim date:

AHCCCS allowed (tier per diem)	$8,000.00	
2% penalty	+ 160.00	
AHCCCS payment	$8,160.00	

Adjusted claim reimbursed within 30 days of the clean claim date:

New AHCCCS allowed amount	$12,500.00	
Original AHCCCS allowed amount	- 8,000.00	
Difference original/new	$ 4,500.00	
1% discount on difference	- 45.00	($4,500 X .01)
	$ 4,455.00	
	+ 8,160.00	
New AHCCCS total payment	$12,615.00	

DISCOUNTS AND PENALTIES (CONT.)

Discount/Penalty Example 7:

A claim was originally paid within 30 days of the clean claim date, and a 1% discount was applied. The hospital submits an adjustment that decreases the AHCCCS allowed amount. The same discount percentage that was applied to the original claim will be applied to the adjusted amount, regardless of the processing time.

Original claim paid within 30 days:

AHCCCS allowed	$8,000.00	
1% discount	- 80.00	($8,000.00 X .01)
AHCCCS payment	$7,920.00	

Adjusted claim with decrease in AHCCCS allowed amount**:**

New AHCCCS allowed amount	$7,000.00	
Original 1% discount reapplied	- 70.00	($7.000.00 X .01)
New AHCCCS total payment	$6,930.00	
Original AHCCCS payment	- 7,920.00	
Recoup difference	<$ 990.00>	

Discount/Penalty Example 8:

A claim was originally paid 97 days after the clean claim date, and a 2% penalty was applied. The hospital submits an adjustment that decreases the AHCCCS allowed amount. The same penalty percentage that was applied to the original claim will be applied to the adjusted amount, regardless of the processing time.

Original claim paid within 91-120 days of clean claim date:

AHCCCS allowed	$8,000.00	
2% penalty	+ 160.00	($8,000.00 X .02)
AHCCCS payment	$8,160.00	

Adjusted claim with decrease in AHCCCS allowed amount**:**

New AHCCCS allowed amount	$7,000.00	
Original 2% penalty reapplied	+ 140.00	($7,000.00 X .02)
New AHCCCS total payment	$7,140.00	
Original AHCCCS payment	- 8,160.00	
Recoup difference	<$1,020.00>	

MEDICAL REVIEW OF INPATIENT HOSPITAL CLAIMS

An inpatient claim is considered to be a clean claim, for medical review purposes only, upon initial receipt of the legible, error-free UB claim form by AHCCCS if the claim includes the following error-free documentation in legible form:

- ☑ An admission face sheet
- ☑ An itemized statement
- ☑ An admission history and physical
- ☑ A discharge summary or an interim summary if the claim is split
- ☑ An emergency record, if admission was through the emergency room
- ☑ Operative report(s), if applicable
- ☑ A labor and delivery room report, if applicable

Periodically, retrospective review will be conducted by AHCCCS based upon a variety of criteria.

OBSERVATION SERVICES

Observation services are those reasonable and necessary services provided on a hospital's premises for evaluation until criteria for inpatient hospital admission or discharge/transfer have been met. Covered observation services include:

- ☑ Use of a bed
- ☑ Periodic monitoring by a hospital's nursing staff or, if appropriate, other staff necessary to evaluate, stabilize, or treat medical conditions of a significant degree of instability and/or disability on an outpatient basis

Observation stays must be provided in a designated "observation area" of the hospital unless such an area does not exist.

It is not an observation stay when a recipient with a known diagnosis enters a hospital for a scheduled procedure/treatment that is expected to keep the recipient in the hospital for less than 24 hours. This is an outpatient procedure, regardless of the hour in which the recipient presented to the hospital, whether a bed was utilized, or whether services were rendered after midnight.

Extended stays after outpatient surgery must be billed as recovery room extensions.

OBSERVATION SERVICES (CONT.)

Observation status *must* be ordered in writing by a physician or another individual authorized to admit patients to the hospital or to order outpatient diagnostic tests or treatments. The following factors must be taken into consideration by the physician or authorized individual in ordering observations status:

- ☑ Severity of the signs and symptoms of the recipient
- ☑ Degree of medical uncertainty that the recipient may experience an adverse occurrence
- ☑ Need for diagnostic studies that appropriately are outpatient stays (i.e., they do not ordinarily require the recipient to remain at the hospital for 24 hours or more) to assist in assessing whether the recipient should be admitted
- ☑ The availability of diagnostic procedures at the time and location where the recipient presents for medical treatment

The following services are ***not*** AHCCCS-covered observation services:

- ☑ Substitution of outpatient services provided in lieu of observation status for physician ordered inpatient services
- ☑ Services that are not reasonable, cost-effective, and necessary for diagnosis or treatment
- ☑ Services provided for the convenience of the recipient or physician
- ☑ Excessive time and/or amount of services medically required by the condition of the recipient
- ☑ Services customarily provided in a hospital-based outpatient surgery center and not supported by medical documentation of the need for observation status

In general, observation status should not exceed 24 hours. This time limit may be exceeded, if medically necessary, to evaluate the medical condition and/or treatment of a recipient. Extensions to the 24-hour limit must be prior authorized.

Observation services, without labor, billed on the UB claim form must be billed with a 762 revenue code (Treatment/Observation Room - Observation Room) and the appropriate observation HCPCS procedure code 99218, 99219 or 99220 (note that 99217 is not appropriate for hospital billing). Each hour or portion of an hour that a recipient is in observation status must be billed as one unit of service.

Observation services, with labor, billed on the UB claim form must be billed with a 721 revenue code (Labor Room Delivery – Labor) and the appropriate HCPCS procedure codes. Each hour or portion of an hour that a recipient is in observation status must be billed as one unit of service.

OBSERVATION SERVICES (CONT.)

Example: Billing observation services

A recipient is placed in observation status at 2:25 p.m. and sent home at 7:45 p.m. The hospital would submit a UB claim to AHCCCS as follows:

Revenue Code 762

Units 6

Each unit of observation services equals one hour or portion of an hour. The recipient was in observation status for five hours and 20 minutes, which equals six units.

Observation services that directly precede an inpatient admission to the same hospital must not be billed separately. These charges must be billed on the inpatient claim. The inpatient claim is priced at the tiered per diem rate based on the number of allowed accommodation days. Reimbursement for the observation services provided before the hospital admission is included in the tiered per diem payment.

All observation services are subject to medical review of records to determine if:

- ☑ Observation status was reasonable, cost-effective, medically necessary to evaluate an outpatient condition or determine the need for inpatient status
- ☑ Length/type/amount of observation status was medically necessary for the recipient's condition
- ☑ Reimbursement is warranted

AHCCCS will review the immediate and continuing observation status by assessing the severity of illness and intensity of services. Medical review for continued observation status will consider each case on an individual basis and include, at a minimum, the following documentation:

- ☑ Emergency room record, if applicable
- ☑ Progress notes
- ☑ Operative report, if applicable
- ☑ Diagnostic test results, if applicable
- ☑ Nursing notes, if applicable
- ☑ Labor and delivery records, if applicable
- ☑ Physician orders

OBSERVATION SERVICES (CONT.)

The following are required for documenting medical records:

- ☑ Orders for observation status must be written on the physician's order sheet, not the emergency room record, and must specify "admit to observation."
  - ✓ Rubber stamped orders are not acceptable.
- ☑ Follow-up orders must be written at least every 24 hours.
- ☑ Changes from "observation status to inpatient" or "inpatient to observation status" must be made by a physician or authorized individual.
- ☑ Inpatient to observation status must be made by a physician or authorized individual and occur within 12 hours after admission as an inpatient.
- ☑ Inpatient/outpatient status change must be supported by medical documentation.

OUTPATIENT HOSPITAL SERVICES

AHCCCS covers preventive, diagnostic, rehabilitative, and palliative items or services ordinarily provided in hospitals on an outpatient basis for all recipients within certain limits based on recipient age and eligibility.

- ☑ Covered hospital outpatient services include:
  - ✓ Routine care unit
  - ✓ Physician services (including ambulatory surgery, specialty care physician, and home physician visits)
  - ✓ Dialysis
  - ✓ Emergency room services
  - ✓ Laboratory services
  - ✓ Medical supplies and equipment ordinarily furnished to persons receiving outpatient services to the extent that they are covered services and ordered by a physician
  - ✓ Nurse midwife services
  - ✓ Dental surgery for EPSDT eligible recipients
  - ✓ Outpatient podiatry services performed by a licensed podiatrist when ordered by a primary care physician
  - ✓ Pharmaceutical services and prescribed drugs

OUTPATIENT HOSPITAL SERVICES (CONT.)

- ✓ Rehabilitation services, excluding occupational therapy and speech therapy for recipients 21 years of age or older
- ✓ Services of allied health professionals when referred by or under the supervision of a physician
- ✓ Total parenteral nutrition (TPN) services
- ✓ Radiology and medical imaging services

If a recipient is treated in the emergency room, observation area, or other outpatient department and is directly admitted to the same hospital, the emergency room, observation, or other outpatient charges must be billed on the inpatient claim.

BILLING OUTPATIENT HOSPITAL SERVICES

When billing outpatient services, the following information must be included on the UB outpatient claim:

- ☑ Bill Type must be 13X, 7XX or 85X for Critical Access Hospitals (appropriate second and third digits as listed in UB manual).
- ☑ Service begin date and start of care date should be the same date.
- ☑ Revenue code(s), HCPCS code(s) and units must be appropriate and reflect all services provided.
  - ✓ Revenue codes which are valid only for inpatient services cannot be used for services reimbursed on an outpatient basis.
- ☑ If the service is an emergency, the Admit Type (field 19) must be a "1."

REIMBURSEMENT OF OUTPATIENT HOSPITAL CLAIMS

For dates of service prior to 7/1/2005: AHCCCS reimburses in-state, non-IHS hospitals for outpatient services billed on a UB claim form by multiplying covered charges by the hospital-specific outpatient cost-to-charge ratio.

For dates of service on or after 7/1/2005: AHCCCS reimburses in-state, non-IHS hospitals for outpatient services billed on a UB claim form using the AHCCCS Outpatient Hospital Fee Schedule. The Outpatient Hospital Fee Schedule will provide rates at the procedure code level, and Surgery/Emergency Department (ED) services will be bundled similar to Medicare for payment purposes.

REIMBURSEMENT OF OUTPATIENT HOSPITAL CLAIMS (CONT.)

The listing of revenue codes that are bundled with Surgery and ED can be referenced as Exhibit 11-4 at the end of this chapter. Multiple surgeries will pay the higher rate surgery at 100% of the fee schedule and secondary surgeries at 50% of the fee schedule (exceptions will be noted for those procedures that are intended to be paid at 100%/100%).

☑ Quick pay discounts and slow pay penalties

✓Quick pay discounts and slow pay penalties are applied to in-state, non-IHS general acute hospital outpatient UB claims according to AHCCCS policy.

☑ Late Charges

✓For dates of service prior to 7/1/2005: Services billed as late charges will affect the provider payment amount. A late charge claim will be processed through the system at the hospital-specific cost-to-charge ratio and will be reflected on the remittance as a late charge claim.

✓For dates of service on or after 7/1/2005: Late charge bills will no longer be accepted. When billing changes to the claim (including late charges), Hospitals must rebill the entire corrected claim. (Refer to Chapter 4, page 3).

☑ Denial/disallowance at line level

✓For dates of service on or after 7/1/2005: If one line of the claim is billed incorrectly, the entire claim will be denied. Incorrectly submitted claims will not deny/disallow at the line level.

☑ Out-of-state outpatient hospital claims

✓For dates of service prior to 7/1/2005: Out-of-state outpatient hospital claims are reimbursed using the statewide outpatient cost-to-charge ratio or a negotiated rate.

✓For dates of service on or after 7/1/2005: Out-of-state outpatient hospital claims are reimbursed using the AHCCCS Outpatient Hospital Fee Schedule or a negotiated rate.

Note: The Medicare Outpatient Prospective Payment System (OPPS) reimburses outpatient hospital services using Ambulatory Payment Classification (APC) rates and requires Hospitals to provide more detailed billing on outpatient UB claims. AHCCCS recognizes that hospitals are billing in accordance with the OPPS regulations. However, AHCCCS does not cover the identical services or pay under the same methodology as Medicare. Irrespective of the change in Medicare billing practices, AHCCCS will continue to calculate reimbursement using only those billed charges that represent medically necessary, reasonable, and customary items of expense of AHCCCS-covered services that meet the medical review criteria of the AHCCCS Administration or the contractor.

Refer to Exhibit 11-5 at the end of this chapter for a complete process flow outlining the AHCCCS Outpatient Hospital Fee schedule pricing logic.

BILLING CPT/HCPCS CODES WITH REVENUE CODES

AHCCCS requires that outpatient services be billed with an appropriate CPT or HCPCS code that further defines the services described by the revenue code listed on the UB claim form.

For example, Hospitals must indicate the appropriate revenue code and CPT/HCPCS code for the covered therapy, surgery, Emergency Department, clinic, etc . . . . services.

Units must be consistent with CPT/HCPCS code definitions. For example, if a hospital bills revenue code 421 (PT/Visit) with CPT code 97116 (Therapeutic procedure, one or more areas, each 15 minutes; gait training), each 15-minute increment represents one unit. If services were provided for 30 minutes, the hospital would bill two units, and so on.

BILLING OTHER SERVICES

☑ Hospital outpatient standalone pharmacy

- ✓ All fee-for-service pharmacy providers, including hospital pharmacies, are required to submit claims through RxAmerica, the AHCCCS-contracted pharmacy benefits manager.
- ✓ Outpatient hospital pharmacies must enter into a contract with RxAmerica to become part of the network. (See Chapter 12, Pharmacy Services)

☑ Durable medical equipment

- ✓ DME revenue codes are not reimbursable to hospitals on the UB claim form.
- ✓ Items must be correctly coded as medical/surgical supplies, or if DME, billed on the CMS 1500 claim form. (See Chapter 13, DME and Supplies)

☑ Transportation

- ✓ Transportation services provided by hospitals must be billed on a CMS 1500 claim form using HCPCS codes. (See Chapter 14, Transportation Services)
  - ☒ Transportation revenue codes are not covered on a hospital UB claim form.
- ✓ Transportation services provided by hospitals are reimbursed based on current AHCCCS policy for transportation providers.

☑ Professional services

- ✓ AHCCCS requires that physician and professional services provided in a hospital setting be billed on a CMS 1500 claim form.
  - ☒ Claims are reimbursed using the AHCCCS capped fee schedule.
  - ☒ Revenue codes for professional services are not covered on a UB claim form.
- ✓ Physician and mid-level practitioner services must be billed under the individual service provider's AHCCCS provider ID number.
  - ☒ AHCCCS does not allow hospitals and/or clinics to bill AHCCCS or any AHCCCS-contracted plans for physician/mid-level practitioner services using the hospital and/or clinic AHCCCS ID number.
- ✓ Hospitals and clinics may register as group billers and bill as an agent for physicians and mid-level practitioners.
- ✓ In these cases, the claim will carry both the physician/mid-level practitioner ID as the service provider and the hospital group biller ID.

BILLING OTHER SERVICES (CONT.)

☑ Residents and interns

- ✓ See Chapter 10, Professional and Technical Services, for information on billing for services provided by teaching physicians.

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Exhibit 11-1

HIERARCHY FOR DETERMINING INPATIENT HOSPITAL TIER LEVELS

Tier	Identification Criteria	Allowed Splits
MATERNITY	A primary diagnosis defined as maternity **640.X - 643.X, 644.2 -676.X, V22.X - V24.X or V27.X.**	**None**
NICU	Revenue Code = 174 **AND** the provider has a certified Level II or III NICU. NICU revenue codes should only be billed for the period immediately following the infant's birth. Infants that are discharged home but return to the hospital and require ICU care should be billed using ICU revenue codes.	**Nursery**
ICU	Revenue code **equal** to **200 - 204, 207 - 212, or 219**.	**Surgery** **Psychiatric** **Routine**
SURGERY	Surgery is identified by a revenue code of **36X**. To qualify in this tier, there must be a valid surgical procedure code that is not on the excluded procedure list (Exhibit 11-2). The Surgery tier can only split with the ICU tier. All claim accommodation days that do not qualify at the ICU tier will be classified at the Surgery tier.	**ICU**
PSYCHIATRIC	Psychiatric Revenue Codes - **114, 124, 134, 144, or 154 AND Psychiatric Diagnosis = 290.XX - 316**. If a routine revenue code is present and all diagnoses codes on the claim are equal to **290.XX – 316**, classify as a psychiatric claim.	**ICU**
NURSERY	Revenue Code of **17X (excluding 174)**.	**NICU**
ROUTINE	Revenue Codes of **100 - 101, 110 - 113, 116 - 123, 126 - 133, 136 - 143, 146 - 153, 156 - 159, 16X, 206, 213, or 214**.	**ICU**

Note: The order of the hierarchy does not denote level of payment.

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Exhibit 11-2

EXCLUDED SURGICAL PROCEDURES

The following procedures, while not necessarily excluded from AHCCCS coverage, will not classify an inpatient hospital claim at the surgery tier.

00.01-00.09 -- Therapeutic ultrasound

00.10 -- Implantation of chemotherapeutic agent

00.11 -- Infusion of drotrecogin alfa

00.12 -- Administration of inhaled nitric oxide

00.13 -- Injection or infusion of nesiritide

00.14 -- Injection or infusion of oxazolidinone class of antibiotics

00.15 -- High-dose infusion interleukin-2 [IL-2],

00.50-00.54 -- Implantation of cardiac resynchronization defibrillator

00.55 -- Insertion of drug-eluting non-coronary artery stent(s)

01.01 -- Cisternal Puncture

01.02 -- Ventriculopuncture through previously implanted catheter

02.41 -- Irrigation of ventricular shunt

02.95 -- Removal of skull tongs or halo traction device

03.31 -- Spinal tap

03.90 -- Insertion of catheter in spinal canal for infusion

03.91 -- Injection of anesthetic into spinal canal for analgesia

03.92 -- Injection of other agent into spinal canal

03.95 -- Spinal blood patch

04.11 -- Closed [percutaneous] [needle] biopsy of cranial or peripheral nerve or ganglion

04.2 -- Destruction of cranial and peripheral nerves

EXCLUDED SURGICAL PROCEDURES (CONT.)

04.80 -- Peripheral nerve injection, not otherwise specified

04.81 -- Injection of anesthetic into peripheral nerve for analgesia

04.89 -- Injection of other agent, except neurolytic

05.31 -- Injection of anesthetic into sympathetic nerve for analgesia

05.32 -- Injection of neurolytic agent into sympathetic nerve

05.39 -- Other injection into sympathetic nerve or ganglion

06.11 -- Closed [percutaneous] [needle] biopsy of thyroid gland

07.11 -- Closed [percutaneous] [needle] biopsy of adrenal gland

08.01 -- Incision of lid margin

08.02 -- Severing of blepharorrhaphy

08.09 -- Other incision of eyelid

08.11 -- Biopsy of eyelid

08.19 -- Other diagnostic procedures on eyelid

08.20 -- Removal of lesion of eyelid, not otherwise specified

08.21 -- Excision of chalazion

08.22 -- Excision of other minor lesion of eyelid

08.25 -- Destruction of lesion of eyelid

08.81 -- Linear repair of laceration of eyelid or eyebrow

08.91 -- Electrosurgical epilation of eyelid

08.92 -- Cryosurgical epilation of eyelid

08.93 -- Other epilation of eyelid

11.21 -- Scraping of cornea for smear or culture

Exhibit 11-2 (Cont.)

EXCLUDED SURGICAL PROCEDURES (CONT.)

14.21 -- Destruction of chorioretinal lesion by diathermy

14.22 -- Destruction of chorioretinal lesion by cryotherapy

14.23 -- Destruction of chorioretinal lesion by xenon arc photocoagulation

14.24 -- Destruction of chorioretinal lesion by laser photocoagulation

14.25 -- Destruction of chorioretinal lesion by photocoagulation of unspecified type

14.26 -- Destruction of chorioretinal lesion by radiation therapy

14.27 -- Destruction of chorioretinal lesion by implantation of radiation source

14.29 -- Other destruction of chorioretinal lesion

16.21 -- Ophthalmoscopy

18.01 -- Piercing of ear lobe

18.02 -- Incision of external auditory canal

18.09 -- Other incision of external ear

18.11 -- Otoscopy

18.12 -- Biopsy of external ear

18.19 -- Other diagnostic procedures on external ear

18.4 -- Suture of laceration of external ear

20.31 -- Electrocochleography

21.00 -- Control of epistaxis

21.01 -- Control of epistaxis by anterior nasal packing

21.02 -- Control of epistaxis by posterior (and anterior) packing

21.03 -- Control of epistaxis by cauterization (and packing)

21.21 -- Rhinoscopy

EXCLUDED SURGICAL PROCEDURES (CONT.)

21.22 -- Biopsy of nose

21.29 -- Other diagnostic procedures on nose

21.3 -- Local excision or destruction of lesion of nose

21.30 -- Excision or destruction of lesion of nose

21.31 -- Local excision or destruction of intranasal lesion

21.71 -- Closed reduction of nasal fracture

21.81 -- Suture of laceration of nose

22.0 -- Aspiration and lavage of nasal sinus

22.00 -- Aspiration and lavage of nasal sinus, not otherwise specified

22.02 -- Aspiration or lavage of nasal sinus through natural ostium

23.01 -- Extraction of deciduous tooth

23.09 -- Extraction of other tooth

23.2 -- Restoration of tooth by filling

23.3 -- Restoration of tooth by inlay

23.41 -- Application of crown

23.42 -- Insertion of fixed bridge

23.43 -- Insertion of removable bridge

23.49 -- Other (dental restoration)

23.70 -- Root canal, not otherwise specified

23.71 -- Root canal therapy with irrigation

23.72 -- Root canal therapy with apicoectomy

23.73 -- Apicoectomy

EXCLUDED SURGICAL PROCEDURES (CONT.)

24.11 -- Biopsy of gum

24.12 -- Biopsy of alveoli

24.19 -- Other diagnostic procedures on teeth, gums and alveoli

24.6 -- Exposure of tooth

24.7 -- Application of orthodontic appliance

24.8 -- Other orthodontic operation

24.91 -- Extension or deepening of buccolabial or lingual sulcus

24.99 -- Other operations on teeth, gums, and alveoli

25.01 -- Closed [needle] biopsy of tongue

25.51 -- Suture of laceration of tongue

25.91 -- Lingual frenotomy

26.11 -- Closed [needle] biopsy of salivary gland or duct

27.23 -- Biopsy of lip

27.24 -- Biopsy of mouth, unspecified structure

27.29 -- Other diagnostic procedures on oral cavity

27.31 -- Local excision or destruction of lesion or tissue of bony palate

27.51 -- Suture of laceration of lip

27.52 -- Suture of laceration of other part of mouth

27.91 -- Labial frenotomy

31.0 -- Injection of larynx

31.1 -- Temporary tracheostomy

31.94 -- Injection of locally-acting therapeutic substance into trachea

Exhibit 11-2 (Cont.)

EXCLUDED SURGICAL PROCEDURES (CONT.)

33.26 -- Closed [percutaneous] [needle] biopsy of lung

33.33 -- Pneumoperitoneum for collapse of lung

34.04 -- Insertion of intercostal catheter for drainage

34.25 -- Closed [percutaneous] [needle] biopsy of mediastinum

34.91 -- Thoracentesis

34.92 -- Injection into thoracic cavity

36.04 -- Intracoronary artery thrombolytic infusion

36.07 -- Insertion of drug-eluting coronary artery stents(s)

37.0 -- Pericardiocentesis

37.21 -- Right heart cardiac catheterization

37.22 -- Left heart cardiac catheterization

37.23 -- Combined left and right heart cardiac catheterization

37.26 -- Cardiac electrophysiologic stimulation and recording studies

37.27 -- Cardiac mapping

37.71 -- Initial insertion of transvenous lead [electrode] into ventricle

37.72 -- Initial insertion of transvenous leads [electrodes] into atrium and ventricle

37.73 -- Initial insertion of transvenous lead [electrode] into atrium

37.75 -- Revision of lead [electrode]

37.76 -- Replacement of transvenous atrial and/or ventricular lead (s) [electrode]

37.77 -- Removal of lead (s) [electrode] without replacement

37.78 -- Insertion of temporary transvenous pacemaker system

38.91 -- Arterial catheterization

EXCLUDED SURGICAL PROCEDURES (CONT.)

38.93 -- Venous catheterization, not elsewhere classified

38.94 -- Venous cutdown

38.95 -- Venous catheterization for renal dialysis

38.98 -- Other puncture of artery

38.99 -- Other puncture of vein

39.72 -- Endovascular repair or occlusion of head and neck vessels

39.92 -- Injection of sclerosing agent into vein

39.95 -- Hemodialysis

39.96 -- Total body perfusion

39.97 -- Other perfusion

41.31 -- Biopsy of bone marrow

41.32 -- Closed [aspiration] [percutaneous] biopsy of spleen

41.92 -- Injection into bone marrow

42.22 -- Esophagoscopy through artificial stoma

42.23 -- Other esophagoscopy

42.24 -- Closed [endoscopic] biopsy of esophagus

44.12 -- Gastroscopy through artificial stoma

44.13 -- Other gastroscopy

44.14 -- Closed [endoscopic] biopsy of stomach

44.22 -- Endoscopic dilation of pylorus

44.93 -- Insertion of gastric bubble [balloon]

44.94 -- Removal of gastric bubble [balloon]

Exhibit 11-2 (Cont.)

EXCLUDED SURGICAL PROCEDURES (CONT.)

45.12 -- Endoscopy of small intestine through artificial stoma

45.13 -- Other endoscopy of small intestine

45.14 -- Closed [endoscopic] biopsy of small intestine

45.16 -- Esophagogastroduodenoscopy [EGD] with closed biopsy

45.22 -- Endoscopy of large intestine through artificial stoma

45.23 -- Colonoscopy

45.24 -- Flexible sigmoidoscopy

45.25 -- Closed [endoscopic] biopsy of large intestine

45.30 -- Endoscopic excision or destruction of lesion of duodenum

45.42 -- Endoscopic polypectomy of large intestine

45.43 -- Endoscopic destruction of other lesion or tissue of large intestine

46.85 -- Dilation of intestine

46.95 -- Local perfusion of small intestine

46.96 -- Local perfusion of large intestine

48.22 -- Proctosigmoidoscopy through artificial stoma

48.23 -- Rigid proctosigmoidoscopy

48.24 -- Closed [endoscopic] biopsy of rectum

48.31 -- Radical electrocoagulation of rectal lesion or tissue

48.32 -- Other electrocoagulation of rectal lesion or tissue

48.33 -- Destruction of rectal lesion or tissue by laser

48.34 -- Destruction of rectal lesion or tissue by cryosurgery

48.35 -- Local excision of rectal lesion or tissue

EXCLUDED SURGICAL PROCEDURES (CONT.)

49.21 -- Anoscopy

49.22 -- Biopsy of perianal tissue

49.23 -- Biopsy of anus

49.29 -- Other diagnostic procedures on anus and perianal tissue

49.31 -- Endoscopic excision or destruction of lesion or tissue of anus

49.39 -- Other local excision or destruction of lesion or tissue of anus

49.41 -- Reduction of hemorrhoids

49.42 -- Injection of hemorrhoids

49.92 -- Insertion of subcutaneous electrical anal stimulator

50.11 -- Closed (percutaneous) [needle] biopsy of liver

50.91 -- Percutaneous aspiration of liver

50.93 -- Localized perfusion of liver

50.94 -- Other injection of therapeutic substance into liver

51.10 -- Endoscopic retrograde cholangiopancreatography [ERCP]

51.11 -- Endoscopic retrograde cholangiography [ERC]

51.12 -- Percutaneous biopsy of gallbladder or bile ducts

51.14 -- Other closed [endoscopic] biopsy of biliary duct or sphincter of Oddi

51.15 -- Pressure measurement of sphincter of Oddi

52.11 -- Closed [aspiration] [needle] [percutaneous] biopsy of pancreas

52.13 -- Endoscopic retrograde pancreatography [EPR]

52.14 -- Closed [endoscopic] biopsy of pancreatic duct

54.24 -- Closed [percutaneous] [needle] biopsy of intra-abdominal mass

Exhibit 11-2 (Cont.)

EXCLUDED SURGICAL PROCEDURES (CONT.)

54.25 -- Peritoneal lavage

54.91 -- Percutaneous abdominal drainage

54.97 -- Injection of locally-acting therapeutic substance into peritoneal cavity

54.98 -- Peritoneal dialysis

55.29 -- Other diagnostic procedures on kidney

55.92 -- Percutaneous aspiration of kidney (pelvis)

55.95 -- Local perfusion of kidney

55.96 -- Other injection of therapeutic substance into kidney

56.32 -- Closed percutaneous biopsy of ureter

57.0 -- Transurethral clearance of bladder

57.11 -- Percutaneous aspiration of bladder

57.94 -- Insertion of indwelling urinary catheter

57.95 -- Replacement of indwelling urinary catheter

60.96 -- Transurethral destruction of prostate tissue by microwave therapy

60.97 -- Other transurethral destruction of prostate tissue by microwave therapy

61.91 -- Percutaneous aspiration of tunica vaginalis

62.11 -- Closed [percutaneous] [needle] biopsy of testis

62.91 -- Aspiration of testis

62.92 -- Injection of therapeutic substance into testis

63.91 -- Aspiration of spermatocele

64.0 -- Circumcision

64.11 -- Biopsy of penis

EXCLUDED SURGICAL PROCEDURES (CONT.)

66.8 -- Insufflation of fallopian tube

67.11 -- Endocervical biopsy

67.12 -- Other cervical biopsy

68.11 -- Digital examination of uterus

69.6 -- Menstrual extraction or regulation

69.7 -- Insertion of intrauterine contraceptive device

69.91 -- Insertion of therapeutic device into uterus

69.92 -- Artificial insemination

69.93 -- Insertion of laminaria

69.94 -- Manual replacement of inverted uterus

69.96 -- Removal of cerclage material from cervix

70.0 -- Culdocentesis

70.11 -- Hymenotomy

70.12 -- Culdotomy

70.21 -- Vaginoscopy

70.24 -- Vaginal biopsy

71.11 -- Biopsy of vulva

71.21 -- Percutaneous aspiration of Bartholin's gland (cyst)

71.22 -- Incision of Bartholin's gland (cyst)

71.3 -- Other local excision or destruction of vulva and perineum

75.38 -- Fetal Pulse Oximetry

76.93 -- Closed reduction of temporomandibular dislocation

EXCLUDED SURGICAL PROCEDURES (CONT.)

76.95 -- Other manipulation of temporomandibular joint

76.96 -- Injection of therapeutic substance into temporomandibular joint

79.0 -- Closed reduction of fracture without internal fixation

79.7 -- Closed reduction of dislocation

79.70 -- Closed reduction of dislocation of unspecified site

79.71 -- Closed reduction of dislocation of shoulder

79.72 -- Closed reduction of dislocation of elbow

79.73 -- Closed reduction of dislocation of wrist

79.74 -- Closed reduction of dislocation of hand and finger

79.75 -- Closed reduction of dislocation of hip

79.76 -- Closed reduction of dislocation of knee

79.77 -- Closed reduction of dislocation of ankle

79.78 -- Closed reduction of dislocation of foot and toe

79.79 -- Closed reduction of dislocation of other specified sites

80.3 -- Biopsy of joint structure

81.91 -- Arthrocentesis

81.92 -- Injection of therapeutic substance into joint or ligament

82.04 -- Incision and drainage of palmar or thenar space

82.46 -- Suture of muscle or fascia of hand

82.92 -- Aspiration of bursa of hand

82.93 -- Aspiration of other soft tissue of hand

82.94 -- Injection of therapeutic substance into bursa of hand

EXCLUDED SURGICAL PROCEDURES (CONT.)

82.95 -- Injection of therapeutic substance into tendon of hand

82.96 -- Other injection of locally-acting therapeutic substance into soft tissue of hand

83.21 -- Biopsy of soft tissue

83.94 -- Aspiration of bursa

83.95 -- Aspiration of other soft tissue

83.96 -- Injection of therapeutic substance into bursa

83.97 -- Injection of therapeutic substance into tendon

83.98 -- Injection of locally-acting theapeutic substance into other soft tissue

84.41 -- Fitting of prosthesis of upper arm and shoulder

84.42 -- Fitting of prosthesis of lower arm and hand

84.43 -- Fitting of prosthesis of arm, not otherwise specified

84.45 -- Fitting of prosthesis above knee

84.46 -- Fitting of prosthesis below knee

84.47 -- Fitting of prosthesis of leg, not otherwise specified

85.11 -- Closed [percutaneous] [needle] biopsy of breast

85.91 -- Aspiration of breast

85.92 -- Injection of therapeutic agent into breast

86.01 -- Aspiration of skin and subcutaneous tissue

86.02 -- Injection or tattooing of skin lesion or defect

86.03 -- Incision of pilonidal sinus or cyst

86.04 -- Other incision with drainage of skin and subcutaneous tissue

86.07 -- Insertion of totally implantable vascular access device (VAD)

EXCLUDED SURGICAL PROCEDURES (CONT.)

86.09 -- Other incision of skin and subcutaneous tissue

86.11 -- Biopsy of skin and subcutaneous tissue

86.24 -- Chemosurgery of skin

86.25 -- Dermabrasion

86.26 -- Ligation of dermal appendage

86.27 -- Debridement of nail, nail bed, or nail fold

86.28 -- Nonexisional debridement of wound, infection, or burn

86.59 -- Suture of skin and subcutaneous tissue of other sites

86.92 -- Electrolysis and epilation of skin

88.96 -- Other intraoperative magnetic resonance imaging

89.60 -- Continuous intra-arterial blood gas monitoring

87-99.99 -- Miscellaneous diagnostic and therapeutic procedures

Exhibit 11-3

OUTLIER CALCULATION WORKSHEET

To determine if a claim is a potential outlier:

Step 1: Compute the hospital *charges* per day:

_____	÷	_____	=	_____
Total Covered Charges		Allowed Accommodation Days		Covered Charges Per Day

Step 2: Determine the hospital *cost* per day:

_____	X	_____	=	_____
Covered Charges per Day		Hospital Specific I/P Cost-to-Charge Ratio		Claim Costs per Day

Step 3: Do the claim costs per day exceed the tier threshold amount? (Statewide cost thresholds are updated and distributed to each facility annually.) If "yes," the claim will pend for outlier medical review.

Once medical review has been completed, the claim will be reprocessed through the outlier calculation to determine if any disallowed charges disqualify the claim as an outlier. Although the claim costs per day may have initially exceeded the outlier threshold, upon completion of medical review, the costs per day may no longer exceed the threshold.

If the claim costs per day do not exceed the tier threshold, the claim will be priced at the appropriate tier.

Claims classified at more than one tier level are processed with a weighted tier threshold amount. to determine the weighted threshold:

[(_____	X	_____)	+	(_____	X	_____)]	÷	_____
Tier 1 Threshold		Accommodation Days Classified at Tier 1		Tier 2 Threshold		Accommodation Days Classified at Tier 2		Total Accommodation Days

Equals

_____
Weighted threshold amount

Follow Step 3 above, comparing the claim costs per day to the weighted threshold amount.

Exhibit 11-4

REVENUE CODES BUNDLED FOR SURGERY AND EMERGENCY DEPARTMENT

Revenue Code	Description
250	Pharmacy, General Classification
251	Pharmacy, Generic Drugs
252	Pharmacy, Non-generic Drugs
254	Pharmacy, Drugs Incident to Other Diagnostic Services
255	Pharmacy, Drugs Incident to Radiology
257	Pharmacy, Non-prescription
258	Pharmacy, IV Solutions
259	Pharmacy, Other Pharmacy
260	IV Therapy, General Classification
262	IV Therapy/Pharmacy Svcs
263	IV Therapy/Drug/Supply Delivery
264	IV Therapy/Supplies
269	IV Therapy, Other IV Therapy
270	Medical/Surgical Supplies and Devices, General Classification
271	Medical/Surgical Supplies and Devices, Non Sterile Suppy
272	Medical/Surgical Supplies and Devices, Sterile Supply
275	Medical/Surgical Supplies and Devices, Pacemaker
276	Medical/Surgical Supplies and Devices, Intraocular Lens
278	Medical/Surgical Supplies and Devices, Other Implant
279	Medical/Surgical Supplies and Devices, Other Supplies/Devices
280	Oncology, General Classification
289	Oncology, Other Oncology
343	Nuclear Medicine, Diagnostic Radiopharmaceuticals
344	Nuclear Medicine, Therapeutic Radiopharmaceuticals
370	Anesthesia, General Classification
371	Anesthesia, Incident to Radiology
372	Anesthesia, Incident to Other Diagnostic Services
379	Anesthesia, Other Anesthesia
390	Blood and Blood Component Administration, Processing and Storage, General Classification
399	Blood and Blood Component Administration, Processing and Storage, Other Processing and Storage
560	Medical Social Services, General Classification
569	Medical Social Services, Other Med. Social Service
621	Medical/Surgical Supplies, Supplies Incident to Radiology
622	Medical/Surgical Supplies, Supplies Incident to Other Diagnostic Services
624	Medical/Surgical Supplies, FDA Investigational Devices
630	Pharmacy, Drugs Requiring Specific Identification, General Classification
631	Pharmacy, Single Source Drug
632	Pharmacy, Multiple Source Drug
633	Pharmacy, Restrictive Prescription
637	Pharmacy, Self-administrable Drugs
681	Trauma Response, Level I
682	Trauma Response, Level II

683	Trauma Response, Level III
684	Trauma Response, Level IV
689	Trauma Response, Level V
700	Cast Room, General Classification
709	Cast Room, Other Cast Room
710	Recovery Room, General Classification
719	Recovery Room, Other Recovery Room
720	Labor Room, General Classification
721	Labor Room, Labor
762	Treatment Observation Room, Observation Room
942	Other Therapeutic Services, Education/Training

Exhibit 11-5

OUTPATIENT HOSPITAL FEE SCHEDULE PRICING FLOW

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