

REVISION DATES: 2/28/2019; 1/23/2018; 04/01/2017; 07/26/2016; 06/30/2016; 05/23/2016;
12/21/2015; 08/14/2014

General Information

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 The *AHCCCS Medical Policy Manual (AMPM)* is available on the AHCCCS website at:

<https://www.azahcccs.gov/shared/MedicalPolicyManual/>

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 at Indian Health Service (IHS) and 638 tribal hospitals are covered when the member's condition requires hospitalization because of the severity of illness and intensity of services required.

Coverage for Federal Emergency Services Program (FESP) members is limited to those services that meet the federal Emergency Medical Condition criteria. For additional information on FESP refer to AMPM 1100.

For detailed information on covered hospital accommodation services and ancillary services, refer to the AHCCCS Medical Policy Manual (AMPM), Chapter 310-K, Hospital Inpatient Services.

Exclusions and Limitations

Inpatient dialysis treatments are covered only when the hospitalization is for:

- An acute medical condition requiring hemodialysis treatments.
- A medical condition experienced by a member routinely maintained on an outpatient chronic dialysis program.
- Placement, replacement, or repair of the chronic dialysis route (shunt or cannula).

Personal comfort items are not covered.

Professional services rendered during an inpatient stay must be billed separately on a CMS 1500 claim form.

Health Care Acquired Conditions and Other Provider-Preventable Conditions

Section 2702 of the Patient Protection and Affordable Care Act (ACA) of 2010 prohibits Medicaid programs from reimbursing certain providers for services resulting from a “Provider-Preventable Condition” (PPC). Provider-Preventable Condition means a condition that meets the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC). These terms are defined as follows:

Health Care-Acquired Condition (HCAC) – means a Hospital Acquired Condition (HAC) which occurs in any inpatient hospital setting and is not present on admission. Refer to the current CMS list of Hospital-Acquired Conditions and the AHCCCS Medical Policy Manual (AMPM) Chapter 900, Policy 960 for additional information on HCAC.

Other Provider-Preventable Condition (OPPC) – means a condition occurring in the inpatient and outpatient health care setting which AHCCCS has limited to the following:

1. Surgery on the wrong member,
2. Wrong surgery on a member, and
3. Wrong site surgery.
- 4.

A member’s health status may be compromised by hospital conditions and/or medical personnel in ways that are sometimes diagnosed as a “complication”. If it is determined that the complication resulted from an HCAC or OPPC, any additional hospital days or other additional charges resulting from the HCAC or OPPC will not be reimbursed.

If it is determined that the HCAC or OPPC was a result of mistake or error by the hospital or medical professional, the AHCCCS Medical Review Department will report the occurrence to the AHCCCS Clinical Quality Management Unit.

Billing an Inpatient Claim

Inpatient hospital claims from IHS and 638 tribal facilities must be submitted to the AHCCCS Administration on UB-04 claim forms (See Chapter 5, Claim Form Requirements for UB-04 billing instructions).

Inpatient services for Title XIX (Medicaid) and Title XXI (KidsCare) members are billed with two revenue codes:

- 100 – All-inclusive Room and Board
- 001 – Total Charges

IHS/638 facilities approved for an NICU rate with AHCCCS must use NICU revenue codes to bill for NICU services.

All UB04 data fields must be completed as appropriate.

Effective with date of discharge 01/01/2016 the attending provider's NPI must be included on the UB-04 billing. The attending provider must be an active AHCCCS registered provider.

Reimbursement of Inpatient Hospital Claims

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. 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: 111 Patient status: 20

AHCCCS will reimburse six days because the patient status indicates expired.

Example 3:

Dates of service: 03/25 through 03/31 Accommodation days billed: 6

Bill type: 112 Patient status: 30

AHCCCS will reimburse six days. AHCCCS will pay the last accommodation day billed when the patient status is 30 (still a patient – first interim billing).

Example 4:

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

Bill type: 111 Patient status: 01

AHCCCS will reimburse two days. 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.

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

1. Same day admit/transfer:

If the transferring hospital is an IHS/638 facility the reimbursement will be at the outpatient All Inclusive Rate (AIR).

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.

2. Same day admit/discharge:

The IHS/638 facility will be reimbursed at the outpatient All Inclusive Rate (AIR) If the hospital bills as an inpatient admission and the AHCCCS system would qualify the claim as Maternity or Nursery tier, reimbursement will be at the inpatient All Inclusive Rate (AIR).

3. Same day admit/patient expires:

The IHS/638 facility will be reimbursed at the inpatient All Inclusive Rate (AIR).

AHCCCS reimburses inpatient claims from IHS and 638 tribal facilities as follows:

Federally published All Inclusive Rate as established by the federal Office of Management and Budget (OMB)

When Medicare is the primary payer and has made payment on the claim AHCCCS will reimburse the Medicare coinsurance and/or deductible when appropriate. Please refer to Chapter 7, Medicare/Other Insurance Liability, of the IHS/Tribal Provider Billing Manual for further information.

Outpatient Facility Services

AHCCCS covers preventive, diagnostic, rehabilitative, and palliative services or items ordinarily provided on an outpatient basis for all members within certain limits based on member age and eligibility. Refer to the AHCCCS Medical Policy Manual (AMPM) for additional information on covered services.

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

Billing and Reimbursement of Outpatient Services for Title XIX (Medicaid)

IHS/638 tribal **hospital outpatient surgery claims** for **Title XIX (Medicaid)** members are billed on the 1500 claim form (837P for electronic claims).

Use the appropriate surgical CPT code(s).

- The AHCCCS Claims System will price the procedure at the appropriate AHCCCS ASC Fee Schedule amount accordingly.
- The surgeon and anesthesiologist may bill for services on the CMS 1500 claim form. (837P for electronic claims). (See Chapter 8, Individual Practitioner Services). These claims are reimbursed at the lesser of billed charges or the AHCCCS capped fee.

Outpatient Pharmacy

IHS/638 facility Pharmacy outpatient services for **Title XIX (Medicaid)** members are billed on a UB-04 claim form (837I for electronic claims) using the appropriate pharmacy clinic revenue code 0519.

Effective with date of service 01/01/2016 the facility's NPI must be billed as the attending provider on the UB-04, as AHCCCS does not register pharmacists.

Effective with date of service 07/01/2016 all pharmacy claims billed on a UB-04 with revenue code 0519 must be billed with the National Drug Code (NDC) for each medication and vaccine. For detailed billing information refer to Chapter 5 Claim Form Requirements and the NDC resource documents available on the AHCCCS website at:

<https://www.azahcccs.gov/AmericanIndians/Providers>

The outpatient IHS/638 all-inclusive rate is billable for a pharmacy clinic consult visit when the pharmacist, or an intern under the supervision of a pharmacist, counsels the patient at the point of picking up the medication(s).

Each clinic pharmacy consultation visit billed to AHCCCS must be supported by pharmacy records including, but not limited to, the patient's dated signature and their prescription profile to support the date of consultation at the pharmacy.

The Initial Pharmacy Consultation service includes the cost of medication. Reimbursement for pharmacy consultation services is only available on a day when medication is dispensed. Refills at the facility for prescribed medications after the initial Pharmacy Consultation are reimbursable as a pharmacy encounter under this same methodology when the pharmacist, or an intern under the supervision of a pharmacist, counsels the member at the point of medication pick up at the pharmacy.

For members eligible for Medicare Part D coverage, the pharmacy service cannot be billed to AHCCCS for any medications covered by the Part D plan, including Part D copays. (refer to Chapter 7 Medicare for further details and the AHCCCS Pharmacy web page <https://www.azahcccs.gov/Resources/Downloads/PharmacyUpdates/AHCCCSDualFormulary.pdf> for the AHCCCS Drug List [ADL] for Duals)

Adult (age 21 and older) seasonal flu and pneumococcal vaccines administered by the facility's pharmacist are also considered a pharmacy outpatient service when administered by a pharmacist who is licensed and certified by the Arizona State Board of Pharmacy consistent with the limitations of this policy and state law ARS §32-1974.

AHCCCS allows one outpatient pharmacy clinic encounter per member, per date of service regardless of the number of pharmacy services during the encounter. (Note: the number of clinic visits per member, per date of service is limited to 5, one of which can be the outpatient pharmacy clinic visit.)

Date of service for a pharmacy outpatient clinic visit is defined as:

- the date of the face-to-face encounter for the medication counseling as supported by the member's dated signature;
- the date the pharmacist administered the adult vaccine(s);
- the date of the face-to-face encounter for anti-coagulant therapy management

The date of service must be supported in the pharmacy records by the member's dated signature at the time of the consultation in the pharmacy.

The AHCCCS Claims System will reimburse the service at the outpatient all inclusive rate (AIR) as established annually by the federal Office of Management and Budget (OMB). A pharmacy outpatient clinic visit is eligible for reimbursement at the AIR so long as an AHCCCS covered service has been provided during the visit and all other criteria is met.

Effective with date of service 04/01/2017 the All Inclusive Rate (AIR) shall be reimbursed for federally reimbursable drugs rather than pharmacy clinic consult services.

IHS/638 facility Pharmacy outpatient services for Title XIX (Medicaid) members are required to be billed using revenue code 0519, the National Drug Code (NDC) of the medication and the facility's NPI billed as the attending provider on the UB-04 claim form (837I for electronic claims)

1. The Indian Health Services and 638 Tribal facility pharmacies shall bill AHCCCS the AIR using the date of service, also known as the fill date. AHCCCS allows one outpatient pharmacy clinic encounter per member, per date of service regardless of the number of pharmacy services during the encounter. (Note: the number of clinic visits per member, per date of service is limited to 5, one of which can be the outpatient pharmacy clinic visit.)
2. The AIR shall be reimbursed for claims submitted with a valid/covered NDC code on Line 1, when a claim is submitted for multiple drugs on the same date of service/fill date. Note: Anticoagulants do not have an NDC, therefore must be submitted with a valid corresponding diagnosis code for that NDC.
3. The AIR shall be reimbursed for only one pharmacy visit per date of service, when claims are submitted on separate claims forms for drugs billed on the same date of service/fill date.
4. Three-month supplies of medication dispensed to the member shall be billed and reimbursed as one AIR for the first federally reimbursable drug whether submitted as individual claims or three separate claims on the same date of service/ fill date.
5. The pharmacy must provide verification, upon request, that the member received the prescribed drug within 10 days of the date of service/fill date, as evidenced by, at a minimum, acknowledging receipt of the prescribed drug when the drug is dispensed to the member or the member's representative at the pharmacy or other methodology if the drug(s) are mailed to the member.
6. If prescribed drugs are "returned to stock" and the facility has been reimbursed the AIR, the facility shall submit a void to AHCCCS for the AIR when the member did not receive the service.
7. When a non-IHS/638 pharmacy is used to provide mail order or centralized pharmacy services, the Mail Order or Centralized Pharmacy must be an AHCCCS registered provider and must comply with all regulations as stated in the Provider Participation Agreement (PPA).

8. Seasonal flu and pneumococcal vaccines for ages 18 and older, administered by the facility's pharmacist are also considered a pharmacy outpatient service when administered by a pharmacist who has obtained the Immunizer Certificate from the American Pharmacists Association or the Arizona State Board of Pharmacy.
9. Refer to AMPM Policy 310-V Prescription Medication/Pharmacy Services for program guidelines, limitations and exclusions.
10. The AIR shall not be reimbursed when:
 - a. More than one federally reimbursable drug claim per day is submitted.
 - b. The pharmacy is out-of-stock of a medication. The AIR shall only be billed and reimbursed when the member is dispensed the initial available quantity. The pharmacy shall not bill a second AIR when the remaining quantity of the prescription is dispensed.
 - c. The member receives a maintenance medication for an ongoing or chronic condition and the quantity dispensed is less than a 30-day supply unless:
 - i. The medication is new to the members drug regimen; or
 - ii. The previous drug dosage has changed in the frequency ordered or the dosage strength of the medication; or
 - iii. The member's medication is lost or stolen as documented in the member's pharmacy profile.
 - d. The prescribing clinician has ordered a 30-day supply of medication to be dispensed in smaller quantities. Only one AIR rate may be billed to AHCCCS.
 - e. Controlled substance prescriptions dispensed to a member are written by a prescribing clinician with an invalid DEA number.
 - f. Prescription drugs dispensed to a member were written by a prescribing clinician whose license has expired or is prescribing outside the restricted limitations of their license.

Prescription Drug Coverage Limitations

IHS and Tribal 638 pharmacists and pharmacies are not required to be licensed in the State of Arizona. However, all pharmacists and pharmacies providing prescription medications, to AHCCCS members and Non-Title XIX SMI members, must adhere to all Arizona State Board of Pharmacy and Federal rules and regulations.

AHCCCS covers the following for AHCCCS members and non-Title XIX SMI members who are eligible to receive Medicare:

1. An Over-the-Counter (OTC) medication that is not covered as part of the Medicare Part D prescription drug program and is prescribed in place of a covered prescription medication that is clinically appropriate, equally safe and effective, and more cost effective than the covered prescription medication.
2. A drug that is excluded from coverage under Medicare Part D by CMS and the drug is medically necessary and federally reimbursable.

Refer to the AHCCCS Pharmacy webpage for the AHCCCS Duals Formulary at <https://www.azahcccs.gov/Resources/Downloads/PharmacyUpdates/AHCCCSDualFormulary.pdf>

AHCCCS Pharmacy Benefit Exclusions

1. Medication prescribed for the treatment of a sexual or erectile dysfunction, unless prescribed to treat a condition other than a sexual or erectile dysfunction and the Food and Drug Administration (FDA) has approved the medication for the specific condition.
2. Medications that are personally dispensed by a physician, dentist or other provider except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.
3. Drugs classified as Drug Efficacy Study Implementation (DESI) drugs by the FDA.
4. Outpatient medications for individuals under the Federal Emergency Services Program (FESP).
5. Medical marijuana. Refer to AMPM Policy 3120-M Medical Marijuana.
6. Drugs eligible for coverage under Medicare Part D for AHCCCS members eligible for Medicare whether or not the member obtains Medicare Part D coverage.
7. Pharmacies are prohibited from auto-filling prescription medications.
8. Repackaged medications are not federally reimbursable.

Other Outpatient Hospital and Clinic Services

All **other hospital** and **clinic outpatient services** for **Title XIX (Medicaid)** members are billed on a UB-04 claim form (837I for electronic claims) using the appropriate clinic revenue code (0510 for medical; 0512 for dental; 0516 for ER).

Effective with date of service 01/01/2016 the attending provider's NPI must be billed on the UB-04. The attending provider must be an active AHCCCS registered provider on the date of service.

An outpatient clinic service (revenue code 0510, 0512, 0516) is eligible for reimbursement at the All Inclusive Rate (AIR) so long as an AHCCCS covered service has been provided during the visit and all other criteria are met.

Effective with date of service 01/01/2016, the IHS/Tribal facility has the option to breakout Emergency Department services by billing with revenue code 0516 and must include the ED attending provider's NPI. Billing the ED services with revenue code 0516 (rather than using the clinic code 0510) will allow for more accurate data reporting to help inform care coordination efforts for the members. There will be no edits placed to deny for incorrect place of service for revenue code 0516.

Use bill type 131 (Hospital outpatient, admit through discharge) or 711 (Clinic, rural health, admit through discharge).

Enter the outpatient all inclusive rate (AIR) rate in the Total Charges field.

The AHCCCS Claims System will reimburse the service at the outpatient all inclusive rate (AIR) as established annually by the federal Office of Management and Budget (OMB).

The federal OMB **all inclusive rate (AIR)** encompasses all services performed and/or ordered during the clinic visit including labs, x-ray and imaging. The technical component (-TC) cannot be billed separately. (A "Stand Alone Visit" is a visit (encounter) that occurs in conjunction with a clinic visit, either before or after that clinic visit, but on a separate day. As a matter of policy AHCCCS does not reimburse Stand Alone Visits for lab services.)

A clinic visit is inclusive of all services provided in conjunction with the visit and includes any laboratory service that may be performed on the same day, before, or after the clinic visit. The AIR that is paid for the clinic visit (encounter) includes the laboratory services done on the same day or any other day.

A lab test that is ordered during a clinic visit but is done on another day is not considered an "Orphan Visit" and cannot be billed separately. For example: during a billable clinic visit a lab test is ordered for that day's assessment. For whatever reason, the lab work is not done the same day as the clinic visit. Documentation should reflect one single visit for the clinic and ordered lab work and therefore one billable All Inclusive Rate (AIR) encounter.

An "Orphan Visit" is a planned laboratory visit based on the provider's care plan, i.e. a new medication and a laboratory assessment is required after treatment initiation. Since this Orphan Visit is a planned laboratory visit, the patient is checked in, a visit is created and the labs are performed. Documentation must reflect this is an Orphan Visit and must be supported in the provider's care plan. The Orphan Visit can be billed separately as an outpatient claim, reimbursable at the AIR and is counted as one of the allowable visits per day.

AHCCCS does reimburse for Stand Alone Visits for radiology and medical imaging professional services. AHCCCS registered radiologists may bill for their interpretation services on a CMS 1500 claim form with HCPCS/CPT codes and modifier -26.

Billing and Reimbursement of Outpatient Services for Title XXI (KidsCare)

Claims for KidsCare must be submitted to the member's **enrolled health plan**. If the KidsCare member is enrolled in a managed care plan, submit the claim to that plan. If the KidsCare member is enrolled as FFS or AIHP, then submit the claim to AHCCCS.

IHS/638 tribal **hospital outpatient surgery claims** for **Title XXI (KidsCare)** members are billed on the 1500 claim form (837P for electronic claims) with appropriate CPT/HCPCS codes. Claims are reimbursed at the AHCCCS ASC Fee Schedule amount accordingly.

The surgeon and anesthesiologist may bill for services on the CMS 1500 claim form. (837P for electronic claims). (Refer to Chapter 8, Individual Practitioner Services). These claims are reimbursed at the lesser of billed charges or the AHCCCS capped fee schedule.

All **other hospital outpatient services** for **Title XXI (KidsCare)** members are billed on the UB-04 claim form (837I for electronic claims) with appropriate revenue codes. **Effective with date of service 01/01/2016** the attending provider's NPI must be billed on the UB-04. The attending provider must be an active AHCCCS registered provider on the date of service.

Claims are reimbursed at the Outpatient Fee Schedule (OPFS) rate.

All **other clinic outpatient services** for **Title XXI (KidsCare)** members are billed by the individual practitioner (physician, nurse practitioner, etc.) on the CMS 1500 with HCPCS/CPT codes. Claims are reimbursed at the lesser of billed charges or the AHCCCS capped fee.

Outpatient **dental services** for **Title XXI (KidsCare)** members are billed by the individual practitioner dentist on the ADA 2012 claim form with CDT-4 codes. Claims are reimbursed at the lesser of billed charges or the AHCCCS capped fee.

Billing for 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 the 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.

IHS and 638 tribal hospitals must bill for observation services for **Title XIX (Medicaid)** members on the UB-04 claim form (837I for electronic claims) following the instructions for other outpatient services above. AHCCCS will reimburse the observation services at the outpatient AIR rate.

IHS and 638 tribal hospitals must bill for observation services for **Title XXI (KidsCare)** members on the UB-04 claim form and must bill with 762 revenue code (Treatment/Observation Room - Observation Room).

Effective with date of discharge 01/01/2016 the attending provider's NPI must be included on the UB-04. The attending provider must be an active AHCCCS registered provider.

AHCCCS defines a "unit" of observation service as each hour or portion of an hour that a member is in observation status.

For example:

A member is placed in observation status at 2:25 p.m. and sent home at 7:45 p.m. The hospital would submit a UB-04 claim to AHCCCS as follows:

Revenue Code 762

Units to bill: 6

Each unit of observation services equals one hour or portion of an hour. The member 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 inpatient All Inclusive Rate based on the number of allowed accommodation days. Reimbursement for the observation services provided before the hospital admission is included in the inpatient AIR payment.

Group Billing

IHS and 638 tribal 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 or clinic group biller ID.

See Chapter 3, Provider Records and Registration, for information on registering as a group biller, or the AHCCCS website for Provider Registration at:

<https://www.azahcccs.gov/PlansProviders/NewProviders/registration.html>

Revision/Update History

Date	Description of changes	Page(s)
2/28/19	References added in lieu of listing all services: “Coverage for Federal Emergency Services Program (FESP) members is limited to <u>those services that meet the federal Emergency Medical Condition criteria</u> . For additional information on FESP refer to AMPM 1100.	1
	For detailed information on covered hospital accommodation services and ancillary services, refer to the AHCCCS Medical Policy Manual (AMPM), Chapter 310-K, Hospital Inpatient Services.”	
	Exclusions and limitations section updated.	1
	Health Care Acquired Conditions and Other Provider-Preventable Conditions section updated.	2
	Reference to AMPM added to Outpatient Facility Services section in lieu of listing all covered services.	5
	Reference to 25 inpatient day limit removed from observation services section.	11
1/23/2018	Formatting Phone number removed	All 1
04/01/2017	Inserted changes to Outpatient Pharmacy section effective 04/01/2017	10-13
07/26/2016	Added clarification for where to submit KidsCare claims	12
06/30/2016	Added web link to NDC references and resources for billing information	9
05/23/2016	Added clarification: pharmacy clinic visit attending provider must be facility’s NPI,	9
	not the pharmacist’s as initially advised	9
	Added NDC required beginning with date of service 07/01/2016	10
	Updated web address for AHCCCS Duals Drug list	10
	Added clarification: pharmacist must be licensed and certified in AZ for adult immunizations to administer without a prescription order on file	10 14

	Clarification language added re: AIR eligible reimbursement for covered service Updated web address for Group Billing information	
12/21/2015	<p>“Attending Provider” language added as UB-04 billing requirement effective with date of service or date of discharge 01/01/2016 attending provider NPI required</p> <p>Added new section header for Title XIX; Language clarified “<u>eligible</u> for Part D”; Clarified pharmacy encounter visit limit Removed language for adult seasonal flu/pneumo vaccines re: physician order must be on file Added optional breakout billing for ED services effective with service date 01/01/2016 Language clarified for pharmacy encounter “date of service”. Added new section header for KidsCare; Corrected the KidsCare outpatient hospital reimbursement language</p> <p>New document layout/formatting</p>	<p>6, 9, 11, multiple</p> <p>9</p> <p>9</p> <p>9</p> <p>10</p> <p>10</p> <p>11</p> <p>11</p> <p>11</p> <p>all</p>
8/14/2014	Added clarification for adult seasonal flu and pneumococcal vaccines administered by the pharmacist, physician order must be on file	9
1/24/2014	Added “perfusion services” to list of covered inpatient ancillary services to align with Medicare payment policy	1