

Outpatient Rebase 2011 Public Comments/AHCCCS Responses

<u>Numb:</u>	<u>Date/ Commentor:</u>	<u>Comment:</u>	<u>Response:</u>
1.	03/22/11 Steve Bush TMC	R9-22-712.35 (B)(5) or (D) The measures exclude both Southern Arizona children's medical centers, including the region's largest pediatric program that cares for nearly 50 percent of the Southern Arizona children. Given the current language in the outlier fee structure, TMC would be excluded from the outpatient fee schedule adjustments provided to hospitals in Maricopa County.	AHCCCS' aim was to recognize the significant expense realized by a hospital that dedicates a large percentage of its business to pediatric care. We determined that this would be approximately 20% pediatric licensed beds. Twenty percent is not a proper delimiter since a hospital with 20 beds could have 4 pediatric beds and qualify. AHCCCS determined that 100 pediatric beds would have the effect of covering these additional expenses for hospitals that serve a large portion of our population.
2.	03/22/11 Steve Bush TMC	R9-22-712.35 (D) The proposed schedule calls for a rate adjustment for hospitals with more than 100 pediatric beds. That number may be appropriate for a metropolitan area such as Maricopa County, but does not match the demand for beds in Pima County. Keep in mind, of course, that Diamond Children's Medical Center at University Medical Center and TMC for Children serve the same role and function in terms of carrying for the pediatric population in Pima County as the children's hospitals and medical centers in Maricopa County. However, with the exclusion of NICU beds, neither of the two Southern Arizona children's medical centers meet the criteria outlined in the proposed schedule.	See answer above. TMC's pediatric beds comprise 9-10% of its total licensed beds. This does not show that TMC has dedicated a large portion of its business to pediatric care. AHCCCS chose inpatient beds as a proxy for outpatient costs since the data has no lag and capital expenditures are a good indicator of a hospital's emphasis. NICU beds are more a function of obstetric care than pediatric care.
3.	03/22/11 Steve Bush TMC	TMC recommends an approach that combines inpatient and emergency department (outpatient) volumes that would be inclusive of children's medical centers throughout the state. We recommend that AHCCCS Administration consider	Number of inpatient beds was chosen as a proxy to identify hospitals with high pediatric volume and correspondingly high pediatric costs. In addition, the number of inpatient beds is a more stable measure than the number of outpatient visits that

Outpatient Rebase 2011 Public Comments/AHCCCS Responses

<u>Numb:</u>	<u>Date/ Commentor:</u>	<u>Comment:</u>	<u>Response:</u>
		<p>adjusting the qualifying numbers to be 50 beds and/or more than 20,000 annual pediatric emergency department visits. This combination recognizes the importance of opening the appropriate number of beds based on community size and need. It also recognizes the important role emergency departments play in caring for the pediatric patient population.</p>	<p>may vary from year to year. Outpatient visit data is difficult to collect on a timely basis and doesn't allow for adequate reimbursement to new hospitals that intend to serve a significant number of children.</p> <p>Lowering the threshold to include hospitals with 50 or more pediatric beds would not achieve AHCCCS' objective of targeting hospitals with a pediatric emphasis. A lower threshold of pediatric beds would include several more hospitals and require a reduction or elimination of the adjustment.</p>
4.	03/22/11 Susan Watchman, Gammage and Burnham	<p>Other than complexity, the most frequent frustrations that hospital business office staff express about the outpatient system is the timing and manner of "Table updates" to conform to Medicare coding (procedure and APC changes) or implement AHCCCS-specific coding and the inability to research historic information reliably. Our experience has been that although existing R9-22-712.40(A) states that AHCCCS <i>shall</i> add new procedure codes for covered outpatient procedures to its system, AHCCCS has been slow to update the fee schedules and reference extracts (together referred to herein as "Tables"). Moreover, it has been unclear whether AHCCCS follows Medicare with regard to when changes are effective – some Medicare changes are based on date of service, while others are effective based on bill date. Medicare coding guidelines are considered the default for</p>	<p>Consistent with the current rule the updates and their effective dates are published on our website. The information provided on the website indicates whether the effective date relates to the date of service or the bill date.</p> <p>Consistent with A.R.S. § 36-2903.01(B)(6) changes are published at least 30 days in advance of the effective date of the change and are also posted to the AHCCCS website.</p> <p>AHCCCS does not follow Medicare provisions unless statute, rule or policy explicitly adopts Medicare standards or procedures. Providers should not assume that AHCCCS follows Medicare billing standards.</p> <p>The current web address is:</p>

Outpatient Rebase 2011 Public Comments/AHCCCS Responses

<u>Numb:</u>	<u>Date/ Commentor:</u>	<u>Comment:</u>	<u>Response:</u>
		legally compliant billing in the absence of published instructions from the AHCCCS Administration as the single state agency.	www.azahcccs.gov
5.	03/22/11 Susan Watchman, Gammage and Burnham	<p>We recognize that the dollars involved in individual lines may be small. But that is precisely why hospitals should not be “nickeled and dimed” or forced to go through cost-ineffective methods to get paid. We therefore request that AHCCCS, preferably in regulation, protect hospitals from timeliness denials due to coding discrepancies when AHCCCS has not issued explicit instructions that AHCCCS specific coding not be used, or has published conflicting information in its material and systems. We would suggest something along the lines of the following changes to R9-22-712.40:</p> <p style="padding-left: 40px;">A. Procedure codes. When procedure codes are issued by CMS and added to <u>or deleted from</u> the Current Procedural Terminology published by the American Medical Association, AHCCCS shall add the new procedure codes for covered outpatient services and shall either assign the default CCR, the Medicare rate, or calculate an appropriate fee. <u>AHCCCS shall additionally revise or delete codes as revised or deleted by CMS.</u></p> <p style="padding-left: 40px;">C. <u>If a hospital bills a claim in accordance with codes issued by CMS and the claim is inconsistent with coding information posted on the AHCCCS web-site or</u></p>	The AHCCCS Administration does not have statutory authority to change the timeliness requirements described in A.R.S. § 36-2904 (G).

Outpatient Rebase 2011 Public Comments/AHCCCS Responses

<u>Numb:</u>	<u>Date/ Commentor:</u>	<u>Comment:</u>	<u>Response:</u>
		<p><u>provided to Contractors but not made publically available to providers, the claim shall not be considered an “unclean” based solely on the coding inconsistency. The Contractor or Administration when acting as payer shall be required to notify the hospital of the specific coding inconsistency that is causing the claim or a line of a claim to deny or pay less than expected. The hospital shall have sixty (60) days from notification or one year from date of service, whichever is later, to submit a revised claim. If the hospital files a claim dispute based on the code inconsistency or for any other reason, the Contractor or Administration shall allow the hospital to revise its claim as part of the dispute resolution process, including any case in which coding inconsistency was not the basis for the dispute but subsequently causes the claim to deny or pay less than expected after the dispute is upheld.</u></p>	
6.		<p>We have had discussions with AHCCCS staff in which we are told that changes are prospective, but which appear on the published Tables or in system information accessible only to plans with dates suggesting retrospective application. We would urge AHCCCS to make the following administrative changes:</p> <ol style="list-style-type: none"> 1. Archive prior versions of Tables in a publically accessible portion of the AHCCCS web-site for at least five years. This will allow providers and plans to see code history during a claim processing or dispute process. 	<p>This suggestion will be considered for future policy clarification, however, it is beyond the scope of this rulemaking.</p>

Outpatient Rebase 2011 Public Comments/AHCCCS Responses

<u>Numb:</u>	<u>Date/ Commentor:</u>	<u>Comment:</u>	<u>Response:</u>
		<ol style="list-style-type: none"> 2. Integrate code change information currently published in both Claims Clues and Encounter Keys. 3. Neither Claims Clues or Encounter Keys are indexed or searchable, which limits their use for research. AHCCCS should all annual or semiannual indexes to these publication. 4. AHCCCS should publish notices in written material (e.g. Claims Clues or written notices to hospitals) identifying code changes that will be applied retroactively any earlier than a specified period (e.g. identify any change retroactive more than three months prior to the announced change). 5. Impose strict oversight on plan claims projects related to adjusting OP claims that based solely on coding issues. 	
7.	03/01/11 Merrick Morgan	<p>Pursuant to section B-1 of above referenced section “When clinic services are billed using 51X revenue codes, the reimbursement is the difference between the facility and non-facility rates”</p> <p>Does this mean that if the clinic is a hospital based clinic the hospital receives the non-facility rate plus the difference between the facility and non-facility rate? Can you explain the reimbursement please.</p>	<p>When clinic services are billed using 51X revenue codes, the reimbursement is the difference between the facility and non-facility rates from the physician fee schedule.</p> <p>Here is an example: Patient goes to physician office, physician is paid the non-facility rate, which reimburses for the procedure/service plus a bump for overhead office costs: \$44.00. Patient goes to a clinic, physician is paid the facility rate, which is only the rate for the procedure/service and no bump for overhead costs: \$32.00</p>

Outpatient Rebase 2011 Public Comments/AHCCCS Responses

<u>Numb:</u>	<u>Date/ Commentor:</u>	<u>Comment:</u>	<u>Response:</u>
			<p>In this second case, the facility (hospital based clinic or otherwise) would receive the difference between these two rates: \$12.00 as the overhead office cost for the visit. If this is a hospital-based clinic and the hospital has a PGM, that would apply to the \$12.00. R9-22-712.20(B)(1) has been clarified.</p>