

REVISION DATES: 1/23/2018; 10/01/2015 (EFFECTIVE 10/01/2015), 03/03/2015, 09/17/2014

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

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

Effective 10/1/2014 AHCCCS will determine Medicaid reimbursement for most acute care hospital inpatient services for the majority of Arizona hospitals, and out-of-state hospitals, using a Diagnosis Related Group (DRG) payment methodology. DRG pricing and pricing logic will be based on the date of discharge.

Acute care hospital inpatient stays with a date of discharge on or after 10/1/2014 will be priced using the DRG methodology.

DRG payment will be applied to all inpatient claims from acute care hospitals except the following:

- Claims from a free-standing rehabilitation facility
- Claims from a free-standing long term acute care facility
- Claims from a free-standing psychiatric facility
- Claims from an Indian Health Service facility or tribally operated 638 facility

Refer to FFS Chapter 11 Hospital Services Addendum APR-DRG for full details regarding billing instructions and reimbursement methodology.

Inpatient Hospital Services

Effective 10/1/2014 this section of this chapter is no longer valid for all hospital providers and is undergoing revision.

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 *those services that meet the federal Emergency Medical Condition criteria*. Some of the services described in this chapter are NOT covered for *FESP recipients*. 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 include:

- Maternity care unit

- 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

Covered ancillary services include:

- Labor, delivery, observation rooms, and birthing centers

- Surgery, operating, and recovery rooms

- Perfusion services

- Laboratory services

- Radiology and medical imaging services

- Anesthesiology services

- Rehabilitation services, including physical, occupational, and speech therapies

- Pharmaceutical services and prescribed drugs

- Respiratory therapy

Blood products are included in tier payments and are included in Outlier calculations.

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

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).

Blood administration is considered a nursing function and is not included in calculating whether a particular case qualifies as an Outlier nor is it a covered service paid for under the Outlier payment methodology if a case qualifies as an Outlier.

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.

Effective 10/1/2011 and ending 9/30/2014:

For members 21 years of age or older, coverage of in-state and out-of-state inpatient hospital services is limited to 25 days per benefit year. The benefit year is a one year time period of October 1st through September 30th. This limit applies for all inpatient hospital services with dates of service during the benefit year regardless of whether the member is enrolled in Fee for Service, is enrolled with one or more contractors, or both, during the benefit year.

For purposes of counting the annual 25 inpatient day limit:

1. Inpatient days are counted towards the limit if paid in whole or part by the Administration or a contractor;

2. Inpatient days will be counted toward the limit in the order of the adjudication date of a paid claim;
3. Paid inpatient days are allocated to the benefit year in which the date of service occurs;
4. Each 24 hours of paid observation services will count as one inpatient day if the patient is not admitted to the same hospital directly following the observation services;
5. Observation services, which are directly followed by an inpatient admission to the same hospital are not counted towards the inpatient limit; and
6. After 25 days of inpatient hospital services have been paid as provided for in this policy:
 - a. Outpatient services that are directly followed by an inpatient admission to the same hospital, including observation services, are not covered.
 - b. Continuous periods of observation service lasting less than 24 hours that are not directly followed by an inpatient admission to the same hospital are covered.
 - c. For continuous periods of observation services of more than 24 hours that are not directly followed by an inpatient admission to the same hospital, AHCCCS will only pay for the first 23 hours of observation services.

For purposes of counting the annual 25 inpatient day limit the following exclusions apply:

1. Transplants

Days reimbursed under specialty contracts between the Administration and a transplant facility that are included within the component pricing referred to in the contract.

Examples include the following:

- a. Evaluation (limited to inpatient days directly associated with the evaluation)
- b. Tissue harvesting for autologous bone marrow transplants and the related costs/inpatient days for live donors are part of the exclusion.
Note: If the donor is a Medicaid member, this will not be included as part of the donor's 25 day limit.
- c. Total Body Irradiation (limited to the inpatient days associated with the series of conditioning regimens prior to bone marrow or peripheral blood stem cell transplantation)
- d. Preparation and transplant (10 days post transplant care for kidney transplants)
- e. Post transplant care (up to 60 days for other covered transplants)
- f. Placement of Circulatory Assist Devices (CAD) also known as Ventricular Assistive Devices (VAD) and Total Artificial Hearts (TAH) limited to day of surgery. Inpatient days before and after the placement of the CADs are to be counted towards the annual 25 inpatient day limit.

NOTE: Inpatient days while “wait listed” are to be counted towards the 25 day limit. This is the period of time after a member has been determined to be a candidate for transplant, by the transplant facility, and is waiting for an available organ.

2. Behavioral Health

- a. Inpatient days that qualify for the Psychiatric Tier under R9-22-712.09 and reimbursed by the Administration or its contractors.
- b. Inpatient days with a primary psychiatric diagnosis code reimbursed by the Administration or its contractors.
- c. Inpatient days paid by the Arizona Department of Health Services Division of Behavioral Health Services or a RBHA or TRBHA.

3. Days related to treatment of conditions with diagnoses of burns or burn late effect at a governmentally-operated hospital located in an Arizona county with a population of more than 500,000 persons with a specialized burn unit in existence prior to 10/1/2011; and

4. Same Day Admit Discharge services are excluded from the 25 day limit.

Health Care Acquired Conditions and Other Provider-Preventable Conditions

Section 2702 of the Affordable Care Act (ACA) 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) under the Medicare program which occurs in any inpatient setting and which is not present on admission. Refer to the AHCCCS Medical Policy Manual (AMPM) Chapter 900, Policy 960.

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

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 Department.

Billing Inpatient Hospital Claims

Effective 10/1/2014 this section of this chapter is no longer valid for all hospital providers and is undergoing revision.

Acute care hospital inpatient stays with a date of discharge on or after 10/1/2014 will be priced using the DRG methodology. Refer to FFS Chapter 11 Hospital Services Addendum APR-DRG for billing instructions.

Inpatient hospital claims must be submitted to the AHCCCS Administration on UB-04 billing forms (See Chapter 6, Billing on the UB-04 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-04 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.

Same day admit/discharge services are considered outpatient except:

- When AHCCCS would qualify the claim as Maternity or Nursery; or
- When the patient expires, provided the hospital bills for the accommodation day

Reimbursement of Inpatient Hospital Claims

Effective 10/1/2014 this section of this chapter is no longer valid for all hospital providers and is undergoing revision.

Acute care hospital inpatient stays with a date of discharge on or after 10/1/2014 will be priced using the DRG methodology. Refer to FFS Chapter 11 Hospital Services Addendum APR-DRG for reimbursement details.

AHCCCS reimburses acute general care hospital providers based upon the services rendered.

The tiered per diem methodology is used to reimburse in-state, non-IHS, acute general care hospitals. Rates are set prospectively and adjusted annually. The tiered per diem system consists of seven tiers which are based on level and type of care:

Maternity	NICU	ICU	Surgery
Psychiatric	Nursery	Routine	

The AHCCCS system will classify a fee-for-service acute hospital inpatient claim at the surgical tier for all applicable days if the surgery occurs after the recipient becomes AHCCCS eligible and the recipient is fee-for-service eligible. A non-excluded ICD surgical procedure must be billed, and the date of the procedure must be within the recipient's fee-for-service eligibility period. Revenue code 036X must be billed with charges greater than zero.

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 and includes emergency room, observation, and other outpatient hospital services provided before the hospital admission.

Exhibit 202-1 identifies the requirements for classification into each tier and the allowed tier splits.

The statewide inpatient cost-to-charge ratio is used to reimburse outlier claims and out-of-state inpatient hospital claims and is computed based on average of all in-state, acute general care hospitals.

Contract/negotiated rates are used to reimburse providers for certain services, such as transplants, or for providers who have negotiated special rates for specific services.

The current published Federal Register per diem rate is used to reimburse Indian Health Service (IHS)/638 facility inpatient claims. This rate is established by the federal Office of Management and Budget (OMB).

When Medicare is the primary payer and has made payment on the inpatient hospital claim, Medicare's coinsurance and/or deductible may be reimbursed (see Chapter 9).

Inpatient Hospital claims shall be paid according to inpatient methodology. Outpatient payment methodology *does not apply* to inpatient 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 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 for the emergency room, observation and other outpatient hospital services provided before the hospital admission are included in the admission and will be paid using inpatient methodology only. A UB-04 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, or vice versa.

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

Same day admit/transfer

AHCCCS reimburses the transferring hospital's claim by valuing allowed ancillary charges using the AHCCCS Outpatient Hospital Fee Schedule Methodology.

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

AHCCCS reimburses same day admit/discharge claims by valuing allowed ancillary charges using the AHCCCS Outpatient Hospital Fee Schedule Methodology.

If the hospital bills the claim as an inpatient admission and the AHCCCS system would qualify the claim as Maternity or Nursery, reimbursement will be the per diem rate for the Maternity or Nursery classified tier.

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

Effective 10/1/2014 this section of this chapter is no longer valid for all hospital providers and is undergoing revision.

Acute care hospital inpatient stays with a date of discharge on or after 10/1/2014 will be priced using the DRG methodology. Refer to FFS Chapter 11 Hospital Services Addendum APR-DRG for outlier billing and reimbursement details.

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.

In order for claims to be paid at the outlier payment rate, hospitals must enter a Condition Code 61 in any Condition Code field (18 - 28) on the UB-04 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 if it is

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 an adjustment with a Condition Code 61 (See Chapter 4, General Billing Rules, for information on submitting adjustments to UB-04 claims).

Adjustment submitted to AHCCCS	January 1 - 10
Bill Type: 111	Patient status: 01
Condition Code: 61	

AHCCCS will void the original claims and process the adjustment. If the adjustment claim qualifies for outlier payment, the outlier amount will be calculated. If the adjustment 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 qualified 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.
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.

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	<u>6,000</u>
			\$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.

The steps in the outlier process for claims **classified at more than one tier** are processed with a weighted tier threshold amount:

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.

Tier 1 threshold number of accommodation days classified at Tier 1 x tier threshold amount

+

Tier 2 threshold number of accommodation days classified at Tier 2 x tier threshold amount

÷

3. If the claim costs per day exceed the qualified tier threshold amount (calculated below), 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.
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.

Total accommodation days = Weighted threshold amount

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	<u>10,000</u>
			\$78,000

1. Compute the hospital charges per day:

Total charges	\$78,000.00
Total days	7

Charges per day = $78,000 \div 7 =$ \$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 = $\$11,142.86 \times .3484 = \$3,882.17$

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

$[(\text{Tier 1 threshold} \times \text{days at Tier 1}) + (\text{Tier 2 threshold} \times \text{days at Tier 2})] \div \text{total days}$
 $[(\$4,500 \times 5) + (\$2,000 \times 2)] \div 7 = [\$22,500 + \$4,000] \div 7 = \$26,500 \div 7 = \$3,785.71$

- The cost per day (\$3,882.17) is greater than the weighted threshold (\$3,785.71), and the claim will go to medical review.
- After medical review, the claim is processed through the outlier calculation again to determine if it still qualifies as an outlier.
- 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

Acute care hospital inpatient stays with a date of discharge on or after 10/1/2014 will be priced using the DRG methodology. Refer to FFS Chapter 11 Hospital Services Addendum APR-DRG for discount/penalty details.

AHCCCS calculates quick pay discounts and slow pay penalties on the AHCCCS allowed amount for any in-state, non-IHS/638 general acute hospital inpatient and outpatient claims (including secondary claims) billed on the UB-04 claim form. Quick pay discounts and slow pay penalties are applied to:

- Inpatient claims
- 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 Methodology

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

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	<u>-100.00</u>	(\$10,000.00 x .01)
AHCCCS payment	\$ 9,900.00	

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

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	<u>- 2,000.00</u>	
Balance	\$ 8,000.00	
1% discount applied to balance	<u>- 80.00</u>	(\$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	<u>+ 100.00</u>	(\$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	<u>- 2,000.00</u>	
Balance	\$ 8,000.00	
1% penalty applied to balance	<u>+ 80.00</u>	(\$8,000 x .01)
AHCCCS payment	\$ 8,080.00	

Replacement claims are subject to discounts and penalties with consideration to the original claim. The only replacements 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 a replacement is submitted for additional accommodation days where additional payment is due from AHCCCS, a new clean claim date is established.

If the replacement 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 replacement 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.

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 internal adjustment or replacement 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	<u>- 80.00</u>	(\$8,000.00 x .01)
AHCCCS payment	\$7,920.00	

Replacement reimbursed 67 days after the new clean claim date:

New AHCCCS allowed amount (tier per diem)	\$12,500.00	
Original AHCCCS allowed amount	<u>- 8,000.00</u>	
Difference between original/new allowed amounts	4,500.00	
1% penalty on difference	<u>+ 45.00</u>	(\$4,500 x .01)

	\$ 4,545.00
original AHCCCS payment	<u>+7,920.00</u>
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	<u>+ 160.00</u>
AHCCCS payment	\$8,160.00

Internal adjustment or replaced claim reimbursed within 30 days of the clean claim date:

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

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 internal adjustment or replacement 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	<u>- 80.00</u> (\$8,000.00 x .01)
AHCCCS payment	\$7,920.00

Replaced claim with decrease in AHCCCS allowed amount:

New AHCCCS allowed amount	\$7,000.00
Original 1% discount reapplied	<u>- 70.00</u> (\$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 internal adjustment or replacement 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

Replaced 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

Effective 10/1/2014 this section of this chapter is no longer valid for all hospital providers and is undergoing revision.

An inpatient claim is considered to be a clean claim, for medical review purposes only, upon initial receipt of the legible, error-free UB-04 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
- Medication Administration Record (MAR)
- 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.

Freestanding Emergency Departments (FrEDs)

Effective with dates of service on and after March 1, 2017, Hospital-based Freestanding Emergency Departments (FrEDs) will be reimbursed by AHCCCS and its Contractors in accordance with the unique reimbursement methodology and rate schedule delineated in A.A.C. R9-22-712.90. A Hospital-Based FrED is an outpatient treatment center that provides emergency department services, is subject to the requirements of 42 CFR § 489.24 (EMTALA), and shares an ownership interest with a hospital.

The new Hospital-based FrED fee schedule requires that AHCCCS and its Contractors be able to differentiate FrEDs from the hospitals with which the FrEDs are licensed. To that end, AHCCCS has established a new, distinct provider type specifically for Hospital-based FrEDs and all Hospital based FrEDs are required to submit separate provider registration.

Reimbursement using the new Hospital-based FrED fee schedule will be tied directly to the use of FrED NPIs for claims with dates of service on and after March 1, 2017. The rendering provider on the claim must be the FrED as indicated by the NPI. Therefore each Hospital-based FrED is required to have a distinct NPI not already associated with an active AHCCCS Provider Identification Number.

Billing FrED Claims

Claims must be submitted to the AHCCCS Administration on UB-04 billing forms (See Chapter 6, Billing on the UB-04 Claim Form, for specific billing requirements.) Bills should include all detail for the services including the correct Revenue Code-to-Procedure Code combinations.

Reimbursement of FrED Claims

For dates of service on and after March 1, 2017, hospital-based FrEDs shall be reimbursed a percentage of the total amount otherwise reimbursable under the AHCCCS Outpatient Capped Fee-For-Service Schedule, depending on the level of service provided:

1. 60% for a level 1 emergency department visit.
2. 80% for a level 2 emergency department visit.
3. 90% for a level 3 emergency department visit.
4. 100% for a level 4 or 5 emergency department visit.

Peer Group Multipliers will not be applied except under specific circumstances.

Hospital-based FrEDs located in a city or town in a county with less than 500,000 residents where the only hospital in the city or town operating an emergency department closed on or after January 1, 2015, shall be reimbursed using the *Outpatient Hospital Reimbursement*:

Adjustment to Fees associated with the nearest hospital with which the freestanding emergency department shares an ownership interest.

Services provided by an outpatient treatment center that does not meet the FrED criteria shall be reimbursed based on the non-hospital AHCCCS capped fee-for-service schedule. If the member is admitted directly from a hospital-based FrED to a hospital with an ownership interest in the hospital-based FrED, AHCCCS will not reimburse for the services provided at the hospital-based FrED. The sole reimbursement to the hospital shall be payment for the inpatient stay using the DRG methodology.

Discounts and Penalties

AHCCCS calculates quick pay discounts and slow pay penalties on the AHCCCS allowed amount for any in-state, non-IHS/638 general acute hospital inpatient, outpatient, and freestanding emergency department claims (including secondary claims) billed on the UB-04 claim form. Quick pay discounts and slow pay penalties are applied to:

- Inpatient claims
- 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 Methodology
- Freestanding Emergency Department claims for dates of service 03/01/2017, reimbursed using a percentage of the total amount otherwise reimbursable under the AHCCCS Outpatient Capped Fee-For-Service Schedule

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

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

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
- Pharmaceutical services and prescribed drugs
- 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, then the emergency room, observation, or other outpatient charges must be billed on the inpatient claim.

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

Refer to the Inpatient Hospital Services Exclusions and Limitations section of this chapter for further guidance regarding observation services for members who have received greater than 25 inpatient days.

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.

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 observation 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-04 claim form must be billed with a 0762 revenue code (Treatment/Observation Room - Observation Room) and the appropriate observation HCPCS procedure code G0378. 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 a UB-04 claim form must be billed with 0721 revenue code (Labor Room Delivery – Labor) and the appropriate observation HCPCS procedure code G0378. Each hour or portion of an hour that a recipient is in observation status must be billed as one unit of service.

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-04 claim to AHCCCS as follows:

Revenue Code	0762
CPT Code	G0378
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. Reimbursement for the observation services provided before the hospital admission is included in the inpatient payment methodology.

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

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."

Orders must be signed and dated by a physician within 24 hours if ordered by non-physician staff.

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 prior to the recipient's discharge from the facility.
- 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.

Billing Outpatient Hospital Services

When billing outpatient services, the following information must be included on the UB-04 outpatient claim:

- Bill Type must be 13X, 14X or 85X for Critical Access Hospitals (appropriate third digit as listed in UB-04 manual).
- Service begin date and start of care date should be the same date.
- Revenue code(s), CPT/HCPCs, Modifiers 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

AHCCCS reimburses in-state, non-IHS/638 hospitals for outpatient services billed on a UB-04 claim form using the AHCCCS Outpatient Hospital Fee Schedule Methodology. The Outpatient Hospital Fee Schedule Methodology will provide rates at the HCPCS/CPT procedure code level, and Surgery/Emergency Department (ED) services will be bundled similar to Medicare for payment purposes.

The listing of revenue codes that are bundled with Surgery and ED can be referenced via the AHCCCS website/Outpatient Fee Schedule as Extract RF796.

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%) and do not require indication of a 51 modifier.

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 charge bills are not accepted. When billing changes to the claim (including late charges), hospitals **must** rebill the entire corrected claim. (Refer to Chapter 4 General Billing Rules).

If one line of the claim is billed incorrectly, that line will be disallowed/denied as a payment of \$0.00.

Out-of-state outpatient hospital claims are reimbursed using the AHCCCS Outpatient Hospital Fee Schedule Methodology 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-04 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.

Billing CPT/HCPCS Codes with Revenue Codes

AHCCCS requires that outpatient services be billed with an appropriate CPT or HCPCS code and appropriate modifier(s) that further define the services described by the revenue code listed on the UB-04 claim form.

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

Units must be consistent with CPT/HCPCS code definitions. For example, if a hospital bills revenue codes 0421 (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 pharmacy

All fee-for-service pharmacy providers, including hospital pharmacies, are required to submit claims through the AHCCCS-contracted pharmacy benefits manager, OptumRx*.

Outpatient hospital pharmacies must enter into a contract with OptumRx* to become part of the network. (See Chapter 12, Pharmacy Services)

*Prior to 10/01/2015, PBM is MedImpact. Effective 10/01/2015 new PBM is OptumRx

Durable medical equipment

DME revenue codes are not reimbursable to hospitals on the UB-04 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-04 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-04 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.

For information on billing for professional services provided by residents, interns and teaching physicians, refer to Chapter 10 Professional and Technical Services.

The following Per Diem Tier Table is **NO LONGER** valid:

Effective discharge date = 10/1/2014 for DRG facilities

OR

Effective admit date 10/1/2014 for facilities excluded from DRG reimbursement

Tier	Identification Criteria	Allowed Splits
MATERNITY	A primary diagnosis defined as maternity 640.xx – 643.x, 644.2x -676.xx, V22.22 – V24.xx or V27.xx.	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 codes 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. The Surgery tier can only split with the ICU tier. All claim accommodation days that do not qualify at the ICU tier will be	ICU

	classified at the Surgery tier.	
PSYCHIATRIC	Psychiatric Revenue Codes – 114, 124, 134, 144, or 154 AND Psychiatric Diagnosis = 290.xx – 316.xx . If a routine revenue code is present and all diagnoses codes on the claim are equal to 290.xx – 316.xx , classify as a psychiatric claim.	ICU
NURSERY	Revenue Code of 17x , but not equal to 174 or 175..	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

Revision History

Date	Description of changes	Page(s)
1/23/2018	Formatting	All
03/01/2017	Added Freestanding Emergency Departments (FrEDs) language	18-19
10/01/2015	“ICD-9” replaced with “ICD” New PBM contractor OptumRx replaces MedImpact effective 10/1/2015	multiple 25
03/03/2015	Correction: same day admit/discharge services	6
09/17/2014	APR-DRG language, effective 10/01/2014	multiple