CHAPTER 18:

Hospital Services

Reviewed/Revised: 9/15/24, 01/01/24

18.0 INPATIENT HOSPITAL SERVICES

BCBSAZ Health Choice covers medically necessary inpatient hospital services. Inpatient services are subject to the prior authorization, notification, and concurrent review requirements of the health plan.

18.1 BILLING OF INPATIENT HOSPITAL CLAIMS

Inpatient hospital claims must be submitted to BCBSAZ Health Choice on a UB-04 billing form (see Chapter: *Billing on the UB Claim Form*, for specific billing requirements), electronic claims submission through Change Healthcare our EDI Clearinghouse vendor, (see Chapter: *General Billing Rules* for more information). BCBSAZ Health Choice follows standard billing guidelines and therefore 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 department, 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.

18.2 REIMBURSEMENT OF INPATIENT HOSPITAL CLAIMS

DRG Pricing Information Summary
Provider contracts will dictate the inpatient reimbursement methodology. However, most facilities will be reimbursed under the All Patient Refined Diagnosis Related Groups (APR-DRGs) methodology created by 3M Health Information Systems is used to categorize each inpatient stay based on the first 12 diagnosis codes billed.

Each inpatient hospital claim will be assigned an APR-DRG code and each DRG code is assigned a relative weight which is intended to indicate the average relative amount of hospital resources required to treat patients within that DRG category. The DRG relative weight is a key factor in determining payment to the hospital. Exceptions to APR-DRG payments are described below and elsewhere in this document. Modifications to components of the APR-DRG pricing for certain in-state and most out-of-state hospitals are also defined later in this document.

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 for administrative days only
- Claims for transplant services

- Claims in which admit and discharge are on the same day and the discharge status does not indicate member expired
- Claim is an interim bill

Payment under DRG pricing will be comprised of a DRG base payment and a DRG outlier add-on payment. Total payment will equal the sum of these two. DRG base payment is generally set to a hospital DRG base price multiplied by the DRG relative weight. In addition, a few payment factors referred to as "policy adjustors" will be applied under specific scenarios to affect the DRG base payment. The DRG outlier add-on payment will be cost-based and calculated based on a fixed-loss threshold.

The following are examples of the payment policy adjustors applied to the DRG base payment under specific scenarios:

- Provider specific policy adjustor
- Service specific policy adjustor – applied based on DRG assigned to the claim/encounter

DRG Pricing Formulas

With DRG pricing, claim payment is comprised of a DRG base payment and, when applicable, an outlier add-on payment. Final allowed amount is the sum of DRG base payment and the outlier add-on payment. In the pricing calculation, an unadjusted DRG base payment and an unadjusted outlier add-on payment are calculated. These values may then be adjusted based on covered days.. A DRG pricing flow chart is given below and details of the pricing calculation are shown in the following pages.

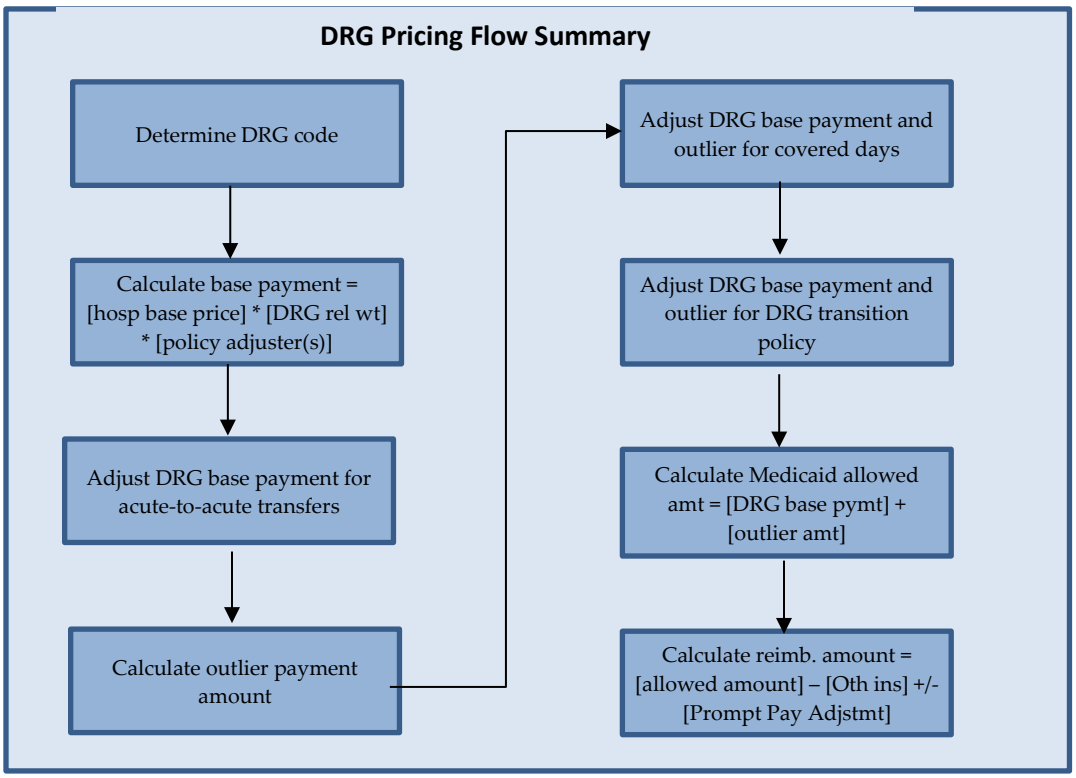
DRG Base Payment

Initial DRG Base Payment will be calculated as:

Initial DRG Base Payment = [Wage Adjusted Provider DRG Base Rate]
** [Post-Health Care Acquired Condition DRG Relative Weight]*
** [Provider Policy Adjustor]*
** [DRG Service Policy Adjustor]*

The DRG Service Policy Adjustor will be determined based on the category of the DRG code found on the claim. Listed below are the DRG code categories along with the applicable DRG Service Policy Adjustor.

- Normal newborn DRG codes: 1.550
- Neonates DRG codes: 1.100
- Obstetrics DRG codes: 1.550
- Psychiatric DRG codes: 1.650
- Rehabilitation DRG codes: 1.650
- Burn DRG codes: 2.700 through 9/30/19, 4.000 beginning 10/1/19



The applicable DRG Service Policy Adjustor for claims for members under the age of 19 for which the assigned DRG codes fall outside of the categories listed above are:

- Severity of Illness 1 or 2: 1.250
- Severity of Illness 3 or 4: 2.300

Where none of the DRG Service Policy Adjustors above apply to the claim, a DRG Service Policy Adjustor of 1.025 is applied the claim.

If the patient discharge status code is in the following list of codes for which the DRG transfer policy applies,

02: Discharged/transferred to a short-term general hospital for inpatient care
05: Discharged/transferred to a designated cancer center or children's hospital
66: Discharged/transferred to a critical access hospital

Then the Transfer DRG Base Payment will be calculated as:

Transfer DRG Base Payment = [Initial DRG Base Payment]
/ [DRG National Average Length of Stay]
** [Length of Stay + 1]*

Note: The "DRG National Average Length of Stay" means the national arithmetic mean length of stay published in version 34 of the All Patient Refined Diagnosis Related Group (APR - DRG) classification established by 3M Health Information Systems.

Note: The "Length of Stay" means the total number of days of an inpatient stay beginning with the date of admission through the date of transfer, but not including the date of transfer.

If the patient discharge status code is in the list of codes for which the DRG transfer policy applies, then:

Unadjusted DRG Base Payment = lesser of [Initial DRG Base Payment] and [Transfer DRG Base Payment]

Otherwise,

Unadjusted DRG Base Payment = [Initial DRG Base Payment]

DRG Outlier Add-On Payment

Not all claims will qualify for a DRG outlier add-on payment. For those that do, the DRG outlier add-on payment will be added to the DRG Base Payment to determine the final payment for the claim. The outlier add-on payment is equal to the Claim Cost minus the Outlier Threshold, multiplied by the DRG Marginal Cost Percentage.

To determine if a claim will qualify for an outlier add-on payment, first the Claim Cost must be calculated. The Claim Cost will be calculated as:

*Claim Cost = {[Claim Total Submitted Charges] – [Claim Non-Covered Charges]} * Hospital Cost-to-Charge Ratio*

The Claim Cost must then be compared to the Outlier Threshold. The Outlier Threshold is calculated as:

Outlier Threshold = Unadjusted DRG Base Payment + Fixed Loss Amount

The Cost-to-Charge (CCR) ratio necessary to determine the cost of the claim will vary depending on the hospital type as described below:

- For hospitals designated as type: hospital, subtype: children's in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services (ADHS) Division of Licensing Services for March of each year, the outlier CCR will be calculated by dividing the hospital total costs by the total charges using the most recent Medicare Cost Report available as of September 1st of that year.
- For Critical Access Hospitals the outlier CCR will be the sum of the statewide rural default operating cost-to-charge ratio and the statewide capital cost-to-charge ratio in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS.
- For all other hospitals the outlier CCR will be the sum of the operating cost-to-charge ratio and the capital cost-to-charge ratio established for each hospital in the impact file established as part of the Medicare IPPS by CMS.

If the Claim Cost exceeds the Outlier Threshold, then the claim qualifies for a DRG outlier add-on payment; if the Claim Cost does not exceed the Outlier Threshold, the claim receives $0 DRG outlier add-on payment.

For claims that qualify for a DRG outlier add-on payment, the Unadjusted DRG Outlier Add-on Payment will be calculated as:

Unadjusted DRG Outlier Add-on Payment = [Claim Cost – Outlier Threshold]
** DRG Marginal Cost Percentage*

The DRG Marginal Cost Percentage is 90% for burn DRGs and 80% for all other DRGs. The base DRG codes for burn DRGs are 841, 842, 843, and 844.

Covered Day Adjustment

There are scenarios for which payment will be adjusted because not all days of the inpatient stay are payable. Some examples are:

- Recipient gains eligibility after admission into the hospital
- Recipient loses eligibility after admission and before discharge

For each of these scenarios, a payment adjustment factor will be calculated in order to prorate the payment based on covered days. If the factor is greater than 1, it will be reduced to 1 so that the covered day adjustment never has the effect of increasing payment beyond the full DRG payment. The factor will be applied to both the Unadjusted DRG Base Payment and the Unadjusted DRG Outlier Add-on Payment.

The formulas for calculating the Covered Day Adjustment Factor are:
If recipient enrolled in the FES program:

Covered Day Adjustment Factor Unadjusted = {[Covered Days] + 1}
/[DRG National Average Length of Stay]

If recipient gains eligibility after admission then:

Covered Day Adjustment Factor Unadjusted = [Covered Days]
/[DRG National Average Length of Stay]

If recipient loses eligibility prior to discharge then:

Covered Day Adjustment Factor Unadjusted = {[Covered Days] + 1}
/[DRG National Average Length of Stay]

The final covered day adjustment factor is calculated as:

If [Covered Day Adjustment Factor Unadjusted] > 1.0 Then
Covered Day Adjustment Factor Final = 1.0
Else

Covered Day Adjustment Factor Final = [Covered Day Adjustment Factor Unadjusted]

The Covered Day Adjustment Factor Final gets applied to both the Unadjusted DRG Base Payment and the Unadjusted DRG Outlier Add-on Payment using the following formulas:

*Covered Day Adjusted DRG Base Payment = [Unadjusted DRG Base Payment] * [Covered Day Adjustment Factor Final]*

*Covered Day Adjusted DRG Outlier Add-on Payment = [Unadjusted DRG Outlier Add-on Payment] * [Covered Day Adjustment Factor Final]*

Note: The adjustment factors are applied separately to the DRG base payment and the outlier payment so that the percentage of total payment coming from outliers can be monitored.

Admit versus Discharge Date

DRG pricing and the DRG pricing logic will be based on date of discharge. The day of discharge is never paid unless the member expires on the date of discharge.

Administrative Days

For hospitals reimbursed under the DRG method for acute care services, BCBSAZ Health Choice may also offer reimbursement for members occupying a bed while not in need of acute care. For example, this may occur prior to an acute care episode when an expecting mother stays in a hospital awaiting birth of a baby. This may also occur at the end of an acute care episode in which a recipient is awaiting placement in a nursing home or other sub-acute or post-acute setting.

Those days in which a member does not meet the criteria for an acute inpatient stay but is not discharged because an appropriate placement outside the hospital is not available or the member cannot be safely discharged or transferred, are referred to as administrative days. Administrative days do not include days when the member is awaiting appropriate placement or services that are currently available, but the hospital has not transferred or discharged the member because of the hospital's administrative or operational delays. When prior authorized, administrative days will be reimbursed by BCBSAZ Health Choice using a negotiated per diem rate. Reimbursement for administrative days will be separate from DRG reimbursement for acute care services.

To enable separate payment, administrative days must be billed on a separate UB-04 claim from the acute care services. Administrative days are identified by the presence of a prior authorization for the member, the provider, and the dates of service that reflect an administrative rate.

When an acute care stay is followed by an administrative day stay, hospitals shall use patient discharge status 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list) on the acute care claim. Likewise, when the opposite occurs – an

administrative day stay is followed by an acute care stay –hospitals shall use patient discharge status 70 on the administrative day claim.

Administrative Days-Behavioral Health
Administrative days include situations in which a member is admitted as an inpatient to an acute care hospital, meets the criteria for an acute inpatient stay, and has a primary diagnosis of behavioral health.

For patients qualifying for an administrative day due to a primary diagnosis of behavioral health, reimbursement will be through a daily rate as specified per provider contract.

Interim Claims
A recipient may be in the hospital for an extended period of time. If a patient stay exceeds a 29 day period, hospitals may submit interim claims related to the patient stay in increments of 30 days. Interim claims will be reimbursed under a per diem rate of $500 per day.

Hospitals must submit a full, admit through discharge claim associated with the patient stay upon the patient's discharge. The final claim should reflect all procedures performed and all charges incurred during the entire patient stay – admit through discharge unless dates of service on the claim must be limited due to changes in eligibility or changes in payer enrollment during the stay. The full claim will be paid under the DRG payment methodology.
Hospitals should submit a claim to void all interim bills prior to submitting the full, admit through discharge claim for reimbursement. The full claim will not be reimbursed until all interim claims associated with the patient stay are voided.

Transfer Policy
In the event a recipient is transferred from one acute care facility to another, payment to the "transferring" hospital will be subject to reduction. The "transferring" and "receiving" hospitals will file separate claims and may result in different DRG assignments. Payment to the receiving acute care facility will follow standard DRG pricing rules and is not subject to transfer payment reduction unless the recipient is transferred again out of the receiving hospital.

The transfer payment methodology is applicable when a patient is transferred from one acute care facility to another, as identified by the following discharge status codes:

02: Discharged/transferred to a short-term general hospital for inpatient care
05: Discharged/transferred to a designated cancer center or children's hospital
66: Discharged/transferred to a critical access hospital

Under this transfer payment policy, DRG base payment for the transferring hospital will be calculated as follows:

Lesser of:

$$\textit{Transfer DRG Base Payment} = \left[\left(\frac{\textit{Initial DRG Base Payment}}{\textit{DRG National Average Length of Stay}} \right) * (\textit{Length of Stay + 1 Day}) \right]$$

Or:

Initial DRG Base Payment

The base DRG payment reimbursed to the "transferring" hospital will be the lesser of the Transfer DRG Base Payment, as calculated above, or the calculated Initial DRG Base Payment for the full hospital stay. The base payment is a prorated per diem amount for each day the recipient is in the hospital prior to the transfer.

One additional day is added to the length of stay to account for the disproportionate amount of costs related to the stabilization of the recipient prior to the transfer since the costs of stabilization are generally higher than the remaining days of the patient stay. In calculating the length of stay, the date of the discharge will not be included. The date of discharge is only payable by BCBSAZ Health Choice when the recipient expires in the hospital, which is not a scenario in which the transfer payment policy applies.

BCBSAZ Health Choice will allow outlier payments for the "transferring" hospital if the claim meets the outlier criteria. The outlier payment will be added to the base payment (i.e. the Transfer DRG Base Payment or the Initial DRG Base Payment as appropriate) to determine the final DRG payment.

Clarification Regarding Transfers for Sub-Acute Services: A recipient who no longer meets medical inpatient criteria may be discharged/transferred to another acute care facility without triggering a reduction to the transferring hospital via the 70 Discharge Status Code (Discharged/transferred to another type of health care institution not defined elsewhere in code list) for the provision of sub-acute services. Dates of service for sub-acute services shall be considered administrative days. See *Administrative Days* above.

Same Day Admit and Discharge

Inpatient claims with an admission date equal to the date of the discharge will be paid using the terms specified in the Provider Contract.

Rehabilitation and LTAC Hospitals

Hospitals designated as rehabilitation and long term acute care (LTAC) hospitals will not be reimbursed under the DRG methodology. These facilities will be reimbursed under a separate per diem rate, including provisions for outlier payments, with provider designation of condition code 61 for consideration, where rates and outlier thresholds will be included in the capped fee schedule. If the covered costs per day on a claim exceed the published threshold for a day, the claim is considered an outlier. Outliers will be paid by multiplying the covered charges by the outlier CCR. The resulting amount will be the total reimbursement for the claim.

Psychiatric Hospitals
Hospitals designated as freestanding psychiatric facilities will not be reimbursed under the DRG methodology. These facilities will be reimbursed under a separate per diem rate. There is no outlier provision.

Carved-out Services within Claims Paid under DRG Methodology
DRG payment when applied to an inpatient hospital claim will cover all inpatient services related to that stay. No services or supplies will be carved out or separately reimbursed.

Non-covered Charges
Hospitals shall report non-covered charges and BCBSAZ Health Choice shall consider them where appropriate.

Transplants
Transplant cases are exempted from DRG payment, and will continue to be reimbursed under the current methodology of contracted rates. The current methodology for identifying claims as transplants will remain the same. Days in the hospital beyond day 60 will be reimbursed via a per diem when primary payment for the hospital stay is covered under the transplant contract.

Detox / Behavioral Health versus Physical Health Diagnosis
A recipient admitted to a hospital may require both physical health treatment as well as psychiatric/behavioral health treatment. Only one claim will be submitted and reimbursed for a single hospital stay in which both physical and behavioral health treatment are necessary.

- The principle diagnosis for the recipient for the hospital stay will determine which payment methodology the claim will be reimbursed under.

Health Care Acquired Conditions (HCAC) and POA
BCBSAZ Health Choice follows Centers for Medicare and Medicaid (CMS) policy on reporting Present on Admission (POA) indicators on inpatient hospital claims and non-payment for HCACs. These rules include a finite list of diagnosis codes and surgical procedure codes.

In some cases, the surgical procedure codes are considered to be a HCAC only if billed in conjunction with a specific diagnosis code, and only in the absence of a present on admission (POA) indicator. Claims submitted without the required POA indicators will be denied. For claims containing secondary diagnoses that are included on Medicare's most recent list of HCACs and for which the condition was not present on admission, the HCAC secondary diagnosis is not used for DRG grouping. That is, the claim is paid as though any secondary diagnoses (HCAC) were not present on the claim.

POA is defined as "present" at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered Present on Admission. A POA indicator must be assigned to principal, secondary diagnoses External Cause codes.

To implement this policy, POA indicators will continue to be required on all acute inpatient claims. This is because the HCAC payment reduction policy only applies if the HCAC condition(s) were acquired in the hospital (after admission). POA indicators associated with each diagnosis code on the claim (except the admit diagnosis code) will be edited to ensure they are valid. Claims with invalid POA indicators will be denied. Diagnosis codes defined as exempt from POA reporting will not require a POA code. CMS publishes a list of diagnoses exempt from POA reporting annually.

The following values are valid for the POA indicator:

Y	Diagnosis was present at time of inpatient admission
N	Diagnosis was not present at time of inpatient admission
U	Documentation insufficient to determine if condition was present at the time of inpatient admission
W	Clinically undetermined; Provider unable to clinically determine whether the condition was present at the time of inpatient admission
Blank	Diagnosis is exempt from POA reporting

Under the DRG pricing methodology, values of "N," "U," and "W" will all be interpreted as indicating the diagnosis was not present at the time of admission. Blank is a valid value only for diagnoses included on CMS' list of codes exempt from POA reporting.

Under the DRG payment methodology, two DRGs will be assigned to every claim, one referred to as a "pre-HCAC" DRG and a second referred to as a "post-HCAC" DRG. The "pre-HCAC" DRG is assigned using all diagnosis codes on the claim whether or not they were present on admission. The "post-HCAC" DRG is assigned after removing any diagnosis and/or procedure codes identified as HCACs.

On the rare cases where the pre-HCAC and post-HCAC DRGs are different, the DRG with the lower relative weight will be used to price the claim. This will almost always be the post-HCAC DRG, but logic will be implemented to compare both relative weights and select the DRG with the lower relative weight to price the claim.

Same Day Admit and Date of Death

Claims with a same date of admission and date of death will be reimbursed a full DRG payment. Providers must report the discharge status code of 20 on the claim indicating death.

Interest

Interest terms follow state statutes; ARS 44-1201 and ARS 20-3102. Which state interest, all Form Types, should be applied at 10% per annum (Days of interest owed * 0.000273973 * Payment owed) for any clean claims not paid within 30 days of receipt. Interest calculation begins on day 31 from the date of clean claim receipt.

Readmission Policy
A recipient may be readmitted to a hospital after receiving a service or treatment. For claims paid via the DRG methodology, BCBSAZ Health Choice will identify certain readmission cases and conduct a medical review prior to finalizing payment associated with the readmission claim.

The following criteria will prompt a medical review:

- Recipient must be readmitted to the same hospital within 72 hours, and
- The base DRG assignment on the readmission claim must match the base DRG assignment on the initial claim (the base DRG assignment is identified by the first three digits of the DRG code), and
- The readmission claim has not been prior authorized. If prior authorized, the readmission claim will be considered to have already gone through medical review.

If the claim associated with the readmission meets the criteria above, the claim will be pended for medical review. The payment associated with the readmission claim will be held until the completion of the medical review process. Upon the medical review, if the readmission is determined to have been preventable by the hospital, the payment associated with the readmission claim will be disallowed. Alternatively, if upon the medical review it is determined the hospital would not have been able to prevent the readmission, the claim will be paid under DRG methodology. **It is incumbent upon the acute hospital to notify BCBSAZ Health Choice within one day of a readmission to the same hospital occurring 72 hours after discharge.**

Newborn Birth Weight Reporting
For claims submitted related to newborns, providers should include the birth weight of the newborn on all claims in which the age of the newborn is fourteen (14) days or less. Birth weight should be communicated in a value amount field with associated value code equal to 54. Birth weight should be billed as a number of grams.

For claims submitted related to newborns under the following additional circumstances, the provider should include the birth weight of the newborn:

- Age at admission = 15-28 days and principal diagnosis of a specific perinatal complication with certain operating room or non-operating room procedures.
- Age at admission = 15-28 days with a secondary diagnosis of a specific perinatal complication with certain operating room or non-operating room procedures.

Hemophilia HCPCS / NDC Reporting
For claims which include hemophilia drugs, providers should include the appropriate HCPCS, NDC code and units, on the corresponding pharmacy revenue code.

18.3 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.

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.

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 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** BCBSAZ Health Choice 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

Observation services, without labor, billed on the UB-04 claim form must be billed with the appropriate revenue code (Treatment/Observation Room - Observation Room) 0762 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 the UB-04 claim form must be billed with the appropriate revenue code (Labor Room Delivery - Labor) 0721 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 3:25 p.m. and sent home at 8:45 p.m. The hospital would submit a UB-04 claim 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.

BCBSAZ Health Choice will review the immediate and continuing observation status by assessing the medical necessity criteria for that level of care. Medical review for continued observation status will consider each case on an individual basis.

Clinical documentation must include, at a minimum:

- 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 and Physician orders
- 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 is not acceptable
- Follow-up orders must be written at least every 24 hours

- Changes Item "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

18.4 OUTPATIENT HOSPITAL SERVICES

BCBSAZ Health Choice 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.

If a recipient is treated in the emergency department, 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.

18.5 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 code(s), Modifier 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 14) must be a "1"

18.6 REIMBURSEMENT OF OUTPATIENT HOSPITAL CLAIMS

BCBSAZ Health Choice reimburses outpatient hospital claims per provider contract. 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

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.

18.7 BILLING CPT/HCPCS CODES WITH REVENUE CODES

BCBSAZ Health Choice requires outpatient services be billed with an appropriate CPT/HCPCS code and appropriate modifier (s) that further defines the services described by the revenue code listed on the UB-04 claim form or Institutional electronic claim submission.

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

Units must be consistent with CPT or HCPCS code definitions. For example, if a hospital bills revenue code 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.

18.8 BILLING OTHER SERVICES

Durable medical equipment

- DME revenue codes are not reimbursable to hospitals on the UB-04 claim form or Institutional electronic claim submissions
- Items must be correctly coded as medical/surgical supplies, or if DME, billed on the CMS 1500 claim form or Professional electronic claim format.

Professional services

- BCBSAZ Health Choice requires that physician and professional services provided in a hospital setting be billed on a CMS 1500 claim form or Professional electronic claim submission
- For contracted providers, Professional Claims are reimbursed using BCBSAZ Health Choice contracted rates.
- Revenue codes for professional services are not covered on a UB-04 claim form
- All provider services must be billed under the individual service provider's National Provider Identifier (NPI) number
- BCBSAZ Health Choice does not allow hospitals and/or clinics to bill BCBSAZ Health Choice for individual provider services using the hospital and/or clinic NPI 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/rendering provider and the hospital group biller ID as the billing provider.