CHAPTER 19:

Hospital Services

Reviewed/Revised: 10/01/18, 08/05/19; 10/02/19, 1/1/20, 07/09/20, 1/1/21, 07/06/21, 12/1/21, 9/2/22, 9/1/23

19.0 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.

19.1 BILLING OF INPATIENT HOSPITAL CLAIMS

Inpatient hospital claims must be submitted to BCBSAZ Health Choice on a UB-04 billing form (see Chapter 9: *Billing on the UB Claim Form*, for specific billing requirements), electronic claims submission through Change Healthcare our EDI Clearinghouse vendor, (see Chapter 7: *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.

19.2 REIMBURSEMENT OF INPATIENT HOSPITAL CLAIMS

DRG Pricing Information Summary

AHCCCS determines 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. Specifically, All Patient Refined Diagnosis Related Groups (APR-DRGs) 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 from an Indian Health Service facility or tribally owned or operated 638 facility
- Claims paid by Tribal/Regional Behavioral Health Authorities (T/RBHAs) for behavioral health services
- 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

AHCCCS Contractors are not mandated to utilize AHCCCS' methodology or rates except in the absence of a contract. Contractors may enter into contracts with hospitals which specify alternative methodologies and/or rates.

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 and/or, effective with dates of discharge on and after October 1, 2016, a Differential Adjusted Payment (DAP) Multiplier. A DRG pricing flow chart is given below and details of the pricing calculation are shown in the following pages.

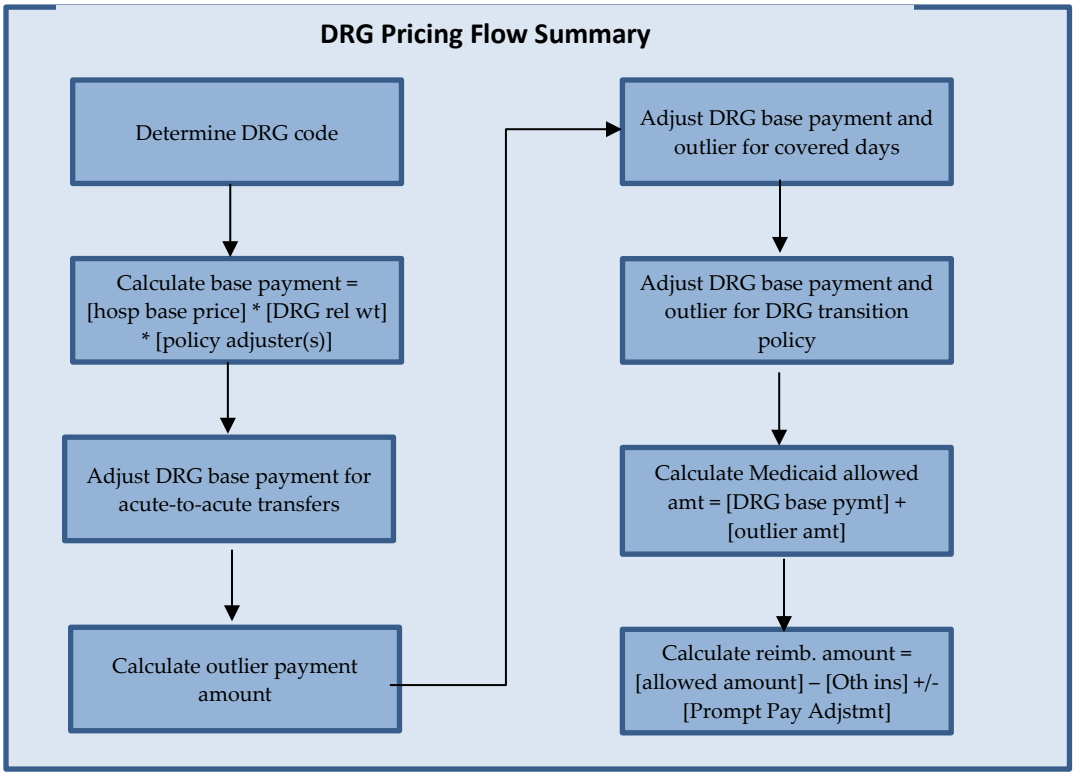
DRG Base Payment

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 through 9/30/2022, 1.700 beginning 10/1/2022
- 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 through 9/30/21, 2.400 beginning 10/1/21

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
82: Discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission
85: Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission
94: Discharged/transferred to a critical access hospital with a planned acute care hospital inpatient readmission

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 38 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 by AHCCCS. Some examples are:

- Recipient is enrolled in the Federal Emergency Services Program (FES)
- Recipient gains Medicaid eligibility after admission into the hospital
- Recipient loses Medicaid 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 = {[AHCCCS Covered Days] + 1}
/[DRG National Average Length of Stay]

If recipient gains Medicaid eligibility after admission then:

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

If recipient loses Medicaid eligibility prior to discharge then:

Covered Day Adjustment Factor Unadjusted = {[AHCCCS 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.

Final Payment Adjustment

The Provider DRG Transition Multiplier will be a combination of two payment adjustments – one for the DRG transition policy and the second for anticipated improvement in documentation and coding (DCI). The transition to APR-DRG is now complete, and the transition Multiplier is no longer applicable.

In its place, a Differential Adjusted Payment (DAP) Multiplier is applied as the last step in the DRG pricing logic. Where a hospital qualifies for DAP, the multiplier will increase the total DRG payment.

By applying this adjustment as the last step in the DRG pricing logic, final payment will be calculated as:

Final DRG Base Payment = [Covered Day Adjusted DRG Base Payment]
** [DAP Multiplier]*

Final DRG Outlier Add-on Payment =
*[Covered Day Adjusted DRG Outlier Add-on Payment] * [DAP Multiplier]*

Final Allowed Amount = Final DRG Base Payment + Final DRG Outlier Add-on Payment=

Final Reimbursement Amount = Final Allowed Amount – Other Insurance Payment
+/- Prompt Pay Adjustment

Note 1: The current prompt pay policy (slow pay penalties and quick pay discounts) will continue to apply. Refer to section *Slow Pay Penalties and Quick Pay Discounts* of this document for more information.

Note 2: A non-contracted urban hospital shall be reimbursed for inpatient services by an urban contractor at 95% of the final payment, unless otherwise negotiated by both parties.

Admit versus Discharge Date
DRG pricing, the DRG pricing logic, and per diem claims will be based on date of discharge. The Medicaid payer in effect on the date of discharge will always have responsibility for the full payment. The day of discharge is never paid unless the member expires on the date of discharge.

Recipient Enrolled in Federal Emergency Services Program (FES)
Inpatient hospital services provided to recipients enrolled in the Federal Emergency Services Program (FES) are paid by the AHCCCS Administration under the fee-for-service program. Payment is limited to those services that meet the Federal definition of an emergency service, as determined through the Administration's Medical Review process.

The emergency portion of an inpatient hospital service is determined on a claim-by-claim basis by determining the number of days of service for each inpatient hospital claim that meet the Federal definition of an emergency. Any portion of a day during which the FES member receives treatment for an emergency medical condition is counted as an AHCCCS covered day.

DRG payment is designed to be payment for a complete hospital stay. For claims paid via DRG pricing in which only emergency services are reimbursed, payment will be prorated based on the number of AHCCCS covered days. The proration factor, which is referred to as the Covered Day Adjustment Factor, is maximized at 1.0 so that the prorated payment does not exceed full DRG payment. The Covered Day Adjustment Factor is calculated as,

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

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]

Enrollment Change during Hospital Stay

A recipient may change payers during a single hospital stay, while maintaining Medicaid eligibility throughout the entire stay. This may occur under a variety of scenarios including,

- A recipient changing enrollment from fee-for-service into a managed care plan
- A recipient changing enrollment from a managed care plan into fee-for-service
- A recipient changing enrollment between managed care plans within the same program
- A recipient changing enrollment between managed care plans in different programs, for example, moving from an Acute MCO to the Arizona Long Term Care System (ALTCS)

In these scenarios, services paid via the DRG method and/or per diem will be paid by the payer with which the recipient is enrolled on date of discharge, except as noted below. This payer will be responsible for reimbursement for the entire hospital stay, including any applicable outlier payment. If the member is eligible but not enrolled with a contractor on the date of discharge, then the AHCCCS administration shall be responsible for reimbursing the hospital for the entire length of stay.

Unique to these enrollment change scenarios, providers are expected to submit a claim to the appropriate payer with the "From" date of service (form locator 6 on the UB-04 paper claim form and Loop 2300 Segment DTP on electronic Institutional claims/encounters) equal to the first day in which the recipient was enrolled with that payer. This will avoid denial based on eligibility/enrollment edits. Under these scenarios, the "From" date of service for the payer responsible on the Date of Discharge will be later than the Date of Admission. The "Through" date of service is the date of discharge. The claim may include all surgical procedures (form locator 74 on the UB-04 claim form and Loop 2400 Segment SV2) applicable for the hospital stay (admit through discharge), even if these procedures were performed prior to the recipient's enrollment with the payer responsible for reimbursement. However, each payer's claim(s) should only include revenue codes, service units, and charges applicable to services performed during the covered days included on the claim (e.g. days between the "From" and the discharge date).

In the event the claim is expected to qualify as an outlier, the claim must include condition code 61 (Cost Outlier) indicating the provider's desire for special outlier consideration. A claim that includes condition code 61 may include all revenue codes (including accommodations), service units, charges, and surgical procedures applicable for the full enrolled eligible hospital stay (admit through discharge), even if performed prior to the recipient's enrollment with the payer responsible for reimbursement.

Interim claims submitted to a payer other than the one with which the recipient is enrolled on date of discharge shall be handled in the same manner as all other interim claims. See section below *Interim Claims*.

Medicare Dual Eligible

Throughout the duration of a single hospital stay, a recipient dually eligible for Medicare and Medicaid may exhaust the allowable Medicare Part A benefit.

In the event a recipient exhausts Medicare Part A benefits during a hospital stay, a separate claim should be filed for services performed after the date the maximum Medicare Part A benefit is exceeded. On the UB-04 paper claim form or the 837 institutional submission, providers shall report the "From" date of service as the first day Medicaid is the primary payer (i.e. the day after Medicare benefits have been exhausted). The "Through" date of service reported on the claim should be the date of the discharge. The provider will include on the claim only the charges associated with the Medicaid portion of the stay (i.e. the "From" date of service through the "Through" date of service reported on the claim). All diagnosis codes describing the patient's medical condition may be included on the claim. However, the payer's claim(s) should only include those revenue codes, surgical procedures, service units, and charges for services performed between the "From" and "Through" dates of service to ensure that Medicaid does not make a duplicate payment for services already covered for by Medicare. Since a separate claim is filed there is no proration of the claim; a full DRG payment will be paid for the Medicaid claim.

Administrative Days

For hospitals reimbursed under the DRG method for acute care services, BCBSAZ Health Choice may also offer reimbursement for Medicaid recipients 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
For dates of discharge on or after October 1, 2018, 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. Inpatient claims covered by a RBHA are not considered administrative days, regardless of the principal diagnosis on the hospital claim.

For patients qualifying for an administrative day due to a primary diagnosis of behavioral health, reimbursement will be through a daily rate found on the AHCCCS Inpatient Behavioral Health Capped Fee-for-Service Schedule meeting the criteria of "Service Description – Psychiatric Stay," regardless of revenue code.

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 Medicaid eligibility or changes in payer enrollment during the stay. The full claim will be paid under the DRG payment methodology.

Single Medicaid Payer for Entire Stay
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.

Multiple Medicaid Payers for Entire Stay
The initial Medicaid payer will recoup all interim payments at the time Medicaid enrollment changes to another Medicaid payer. To the extent interim bills are submitted to and paid by the Medicaid payer in effect on the date of discharge, hospitals will be required 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. The full claim should be submitted in accordance with the instructions in section as *Enrollment Change during Hospital Stay*, and paid by the Medicaid payer in effect on the date of discharge.

Medicaid Eligibility Changes During the Stay

A member may lose or gain Medicaid eligibility during an inpatient stay. To the extent there are interim bills submitted to and paid by the Medicaid payer, hospitals will be required to void all interim bills prior to submitting the full, admit through discharge claim for reimbursement.
The final claim will not be reimbursed until all interim claims associated with the patient stay are voided. The final claim should be submitted in accordance with the instructions under sections: *Recipient Gains Medicaid Eligibility after Admission* as well as *Recipient Loses Medicaid Eligibility to Discharge*, and paid by the Medicaid payer in effect on the date of discharge or the date that eligibility changes.

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
82: Discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission
85: Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission
94: Discharged/transferred to a critical access hospital with a planned acute care hospital inpatient readmission

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

Lesser of:

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

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.

Recipient Gains Medicaid Eligibility after Admission

A recipient may be ineligible for Medicaid upon admission, however, may become eligible for Medicaid during his/her stay in the hospital. Under this circumstance, the DRG payment which is designed to cover the full hospital stay will be prorated based on the number of AHCCCS covered days. The proration factor, which is referred to as the Covered Day Adjustment Factor, is maximized at 1.0 so that the prorated payment does not exceed full DRG payment. The Covered Day Adjustment is calculated as,

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

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

The covered day adjustment factor does not include one additional day to account for the first part of the stay when a disproportionate amount of costs are incurred since the recipient is not Medicaid eligible upon admission; rather the recipient gains eligibility at some point after admission.

When submitting a claim under this scenario, providers are expected to report the "From" date of service as the first date the recipient is eligible for reimbursement. Assuming the recipient is enrolled with Medicaid through discharge, the "Through" date of service will be set to the date

of discharge. The number of AHCCCS covered days will be calculated as the "Through" date of service on claim less the "From" date of service. If the recipient expires in the hospital, the day of discharge is reimbursable and one day will be added to the number of AHCCCS covered days to account for date of discharge.

Only claims with dates of service where the recipient is enrolled with that payer will be accepted.

Recipient Loses Medicaid Eligibility Prior to Discharge
A recipient may be an eligible member upon admission, however, may lose eligibility during the duration of a single hospital stay. In this scenario, the DRG payment attributable to the entire stay will be prorated based on the number of AHCCCS covered days. The proration factor, which is referred to as the Covered Day Adjustment Factor, is maximized at 1.0 so that the prorated payment does not exceed full DRG payment.

The Covered Day Adjustment Factor is calculated as,

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

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]

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 since the costs of stabilization are generally higher than the remaining days of the patient stay.

When submitting a claim in this scenario, the date of admission and the first date of service should be the same. The "Through" date of service on the claim should be reported as the last date the recipient is enrolled with the Medicaid payer. The number of AHCCCS covered days will be calculated as the "Through" date of service less the date of admission.

Only claims with dates of service where the recipient is an enrolled member will be accepted.

Same Day Admit and Discharge
Inpatient claims with an admission date equal to the date of the discharge will be paid using the AHCCCS outpatient fee schedule methodology, including same day admission and discharge claims for maternity and nursery.

There is one exception to this methodology. Claims with a same date of admission and date of death will be reimbursed at full DRG payment.

Specialty Hospitals
Hospitals designated as type: hospital, subtype: short-term that have a license number beginning "SH" in the Provider & Facility Database for Arizona Medical Facilities posted by ADHS will be reimbursed under the DRG methodology, under a separate DRG base rate. Hospitals located in a city with a population greater than one million, which on average have at least 15 percent inpatient days for patients who reside outside of Arizona, and at least 50 percent of discharges as reported on the Medicare Cost Report are reimbursed by Medicare will also be reimbursed under a separate DRG base rate using DRG methodology. The DRG base rate for these providers will be reflected in the rate tables as with all other DRG providers.

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 published by AHCCCS. 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.

A new provider type (C4) is established to identify these providers and includes freestanding rehabilitation and LTAC providers.

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 consistent with ADHS reimbursement policy for this provider type (71). There is no outlier provision.

Inpatient Claims for Recipients with Medicare Part B Only
The treatment of Medicare Part B payments on inpatient claims is not changing with the implementation of DRG pricing. On inpatient claims in which the Medicaid recipient has Medicare Part B coverage, no Medicare Part A coverage, or Medicare Part A coverage has been exhausted, final Medicaid reimbursement is calculated by subtracting the Medicare Part B payment amount from the Final Allowed Amount.

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
The current billing policy regarding the recording of non-covered charges remains unchanged. 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. This is consistent with current AHCCCS policy applied to claims paid via per diem. 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.

Out-of-State Hospitals
Acute care services provided by out-of-state providers will be reimbursed under the DRG methodology. Out-of-state hospitals determined by the Administration to be high volume out-of-state hospitals will be reimbursed using hospital-specific Wage Adjusted Provider DRG Rates and hospital-specific Cost-to-Charge Ratios. All other out-of-state hospitals will be reimbursed using a uniform Wage Adjusted Provider DRG Rate and a uniform Cost-to-Charge Ratio. Out-of-state hospitals are not eligible for the Provider Policy Adjustor or the Differential Adjusted Payment Multiplier.

Slow Pay Penalties and Quick Pay Discounts
Slow Pay Penalties:

- For hospital Clean Claims, Health Choice shall pay slow payment penalties (interest) on payments made after 60 day of receipt of the Clean Claim.
- Health Choice shall pay interest on all claim disputes as appropriate based on the date of the receipt of the original Clean Claim submission (not the claim dispute).

In the event a claim is reprocessed as a result of an overturned claim dispute or State Fair Hearing, the claims shall be reprocessed within 15 days from the date of the decision, and interest shall be paid back to the date the clean claim was received.

Quick Pay Discount:
BCBSAZ Health Choice shall apply a quick pay discount of 1% on hospital claims paid within 30 days of the date the Clean Claim was received (A.R.S. §36-2903.01(G)). Quick pay discounts are applied to any acute hospital inpatient, outpatient and freestanding emergency department claims billed on a UB-04 claim form.

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.**

Specific criteria for identifying preventable readmissions by a hospital during the medical review process will be developed. The criteria will be the same for FFS as well as MCO claims.

The AHCCCS Administration and BCBSAZ Health Choice may consider monitoring readmission rates across providers and may consider future rate adjustments for providers with potentially preventable rates in excess of their peers or some established standard.

Non-covered Services
Charges associated with use of robotic technology or other non-covered services will be disallowed when claims are reviewed for outlier consideration. For non-outlier claims, robotic technology does not impact the DRG payment.

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.

Long Acting Reversible Contraceptives (LARC)
Effective for dates of discharge on and after 10/01/2016, Long Acting Reversible Contraceptive (LARC) devices as defined eligible by AHCCCS are permitted to be separately reimbursed outside of the DRG payment when billed by the hospital on a professional form 1500 or on and after 10/01/2017 on an Outpatient UB04 form with the appropriate HCPCS procedure code and will be reimbursed at the appropriate AHCCCS fee schedule rate for that code. Source: https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFS_Chap10.pdf

AHCCCS-identified LARC procedure codes are as follows:

- J7297 Levonorgestrel-Releasing Intrauterine Contraceptive System, 52mg, 3 Year Duration
- J7298 Levonorgestrel-Releasing Intrauterine Contraceptive System, 52 Mg, 5 Year Duration
- J7300 Intrauterine Copper Contraceptive
- J7301 Levonorgestrel-Releasing Intrauterine Contraceptive System, 13.5 Mg
- J7307 Etonogestrel (Contraceptive) Implant System, Including Implant and Supplies

19.3 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 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.

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

19.4 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.

Covered hospital outpatient services include:

- Routine care unit
- Physician services (including ambulatory surgery, specialty care physician, and home physician visits)
- Dialysis
- Emergency department services
- ECT (see Chapter 18: Behavioral Health Services for additional details)
- 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
- Dental surgery for EPSDT eligible recipients
- Outpatient podiatry services performed by a licensed podiatrist when ordered by a primary care physician
- Pharmaceutical services and prescribed drugs
- Rehabilitation services, excluding occupational therapy and speech therapy for recipients 21 years of age or older
- Outpatient therapy visits cannot exceed 15 visits per contract year
- 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. All outpatient elective MR, CT, Outcomes Focused Cardiology, PET scan, and Ultrasound studies not associated with emergency room or urgent care services require prior authorization through eviCore Health Solutions (eviCore). See the BCBSAZ Health Choice website OR the eviCore website for details and complete CPT code list at https://www.evicore.com

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.

19.5 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"

19.6 REIMBURSEMENT OF OUTPATIENT HOSPITAL CLAIMS

BCBSAZ Health Choice reimburses in-state, non-IHS hospitals for outpatient services billed on a UB-04 claim form using the AHCCCS Outpatient Hospital Fee Schedule Methodology (OPFS). 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.

Out-of-state outpatient hospital claims: Out-of-state outpatient hospital claims are reimbursed using the AHCCCS Outpatient Hospital Fee Schedule or a negotiated rate.

Note:
The Medicare Outpatient Prospective Payment System (OPPS) reimburses outpatient hospital services using Ambulatory Payment Classification (APC) rates and requires hospitals to provide more detailed billing on outpatient UB-04 claims. AHCCCS recognizes that hospitals are billing in accordance with the OPPS regulations.

However, BCBSAZ Health Choice does not cover the identical services or pay under the same methodology as Medicare. Irrespective of the change in Medicare billing practices, BCBSAZ Health Choice 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 Health Choice Arizona.

19.7 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.

19.8 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.

Transportation

- Transportation services provided by hospitals must be billed on a CMS 1500 claim form or Professional electronic claim format using HCPCS codes (Transportation revenue codes are not covered on a hospital UB-04 claim form or Institutional electronic claim submission)
- Transportation services provided by hospitals are reimbursed based on current BCBSAZ Health Choice policy for transportation providers

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. For non-contracted providers, Professional Claims are reimbursed using AHCCCS Fee for Service 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.