

19

Hospital Services

INPATIENT HOSPITAL SERVICES

Health Choice Arizona covers medically necessary inpatient hospital services provided by or under the direction of a physician which are ordinarily furnished in a hospital, except for services in an institution for tuberculosis or mental diseases. Inpatient services are covered for Health Choice Arizona recipients when the recipient's condition requires hospitalization because of the severity of illness.

Covered hospital accommodation services

- Maternity care.
- Routine care unit.
- Nursery and neonatal intensive care unit.
- Intensive care and coronary care unit.
- Nursing services necessary and appropriate for the recipient's condition.
- Dietary services.
- Medical supplies, appliances, and equipment ordinarily furnished to hospital inpatients that are billed as part of the daily room and board charge.

Covered ancillary services

- Labor, delivery, observation rooms, and birthing centers.
- Surgery, operating, and recovery rooms.
- Laboratory services.
- Radiology and medical imaging services.
- Anesthesiology services.
- Rehabilitation services, including physical, occupational, and speech therapies.
- Pharmaceutical services and prescribed drugs.
- Respiratory therapy.
- Services and supplies necessary to store, process, and administer blood and blood derivatives.
- Central supply items, appliances, and equipment ordinarily furnished to all patients and customarily reimbursed as ancillary services.
- Maternity services.
- Nursery and related services.
- Chemotherapy.
- Dialysis.
- Total parenteral nutrition services (TPN).
- Dental surgery for EPSDT recipients.

Exclusions and Limitations

- Routine inpatient hospital accommodations are limited to no more than a semi-private rate, except when patients must be isolated for medical reasons.
- Inpatient dialysis treatments are covered only when the hospitalization is for:
 - An acute medical condition requiring hemodialysis treatments.
 - A medical condition experienced by a recipient routinely maintained on an outpatient chronic dialysis program.
 - Placement, replacement, or repair of the chronic dialysis route (shunt or cannula).
 - Personal comfort items are not covered.
 - Inpatient hospital services are subject to the prior authorization, medical and concurrent review requirements for medical necessity for admission and continued stay.
 - Professional component for services rendered during an inpatient stay must be billed separately on a CMS 1500 claim form.

BILLING OF INPATIENT HOSPITAL CLAIMS

Inpatient hospital claims must be submitted to Health Choice Arizona on a UB-04 billing form (See Chapter 9: Billing on the UB Claim Form, for specific billing requirements.)

Health Choice Arizona will match inpatient and outpatient UB-04 claims for the same recipient for the same date of service. If a recipient is treated in the emergency room, observation area, or other outpatient department and is directly admitted to the same hospital, the emergency room, observation, or other outpatient charges must be billed on the inpatient claim.

Health Choice Arizona offers direct electronic claim submission. Refer to Chapter 7: General Billing Rules for more information.

REIMBURSEMENT OF INPATIENT HOSPITAL CLAIMS

DRG Pricing Information Summary

Effective October 1, 2014, Health Choice Arizona will determine Medicaid reimbursement for most acute care hospital inpatient services for the majority of Arizona hospitals, and out-of-state hospitals, using a Diagnosis Related Group (DRG) payment methodology. Specifically, All Patient Refined Diagnosis Related Groups (APR-DRGs) created by 3M Health Information Systems will be used to categorize each inpatient stay. 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 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

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 times 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.

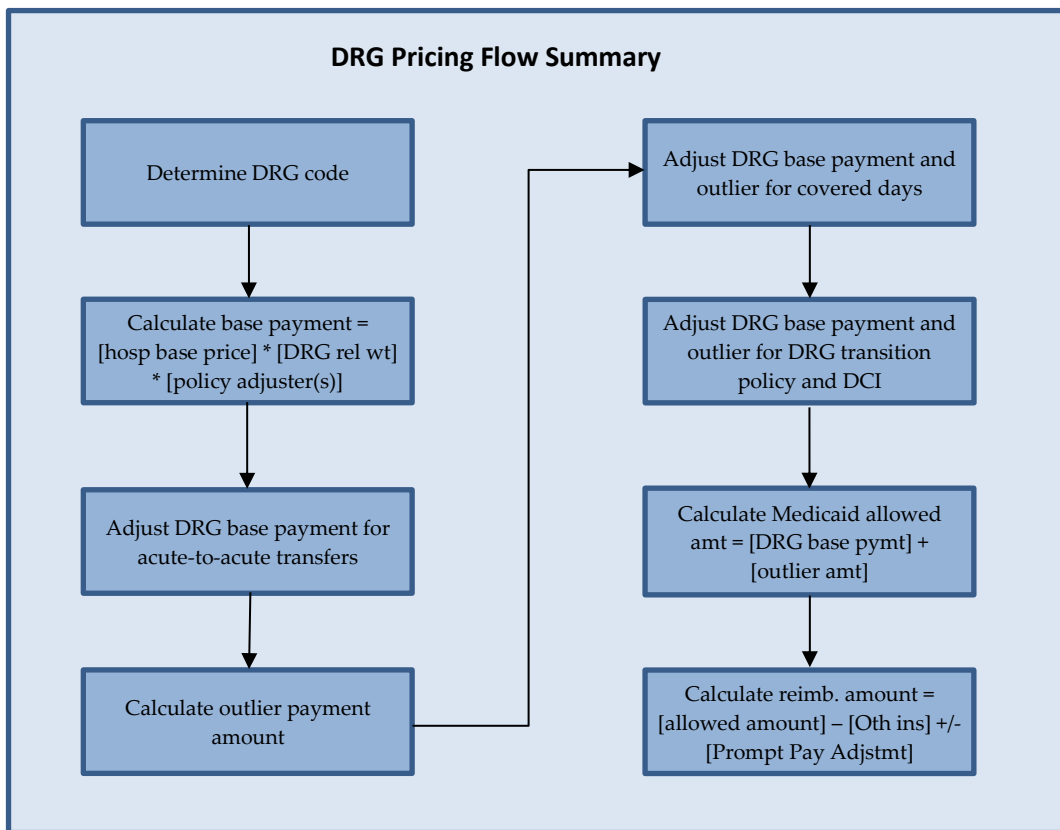
The following are examples of the payment policy adjustors applied to the DRG base payment under specific scenarios,

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

All policies and numerical parameters identified in this document are applicable for initial implementation of DRG pricing on October 1, 2014. The payment policies and, in particular, the numerical pricing parameters are subject to change in future years.

DRG Pricing Formulas

With DRG pricing, claim payment is made up 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 a transitional adjustor which will be in place for the first three years of DRG pricing. A DRG pricing flow chart is listed below and details of the pricing calculation are shown in the following pages.



DRG Base Payment

Initial DRG Base Payment will be calculated as:

$$\begin{aligned}
 \text{Initial DRG Base Payment} &= [\text{Wage Adjusted Provider DRG Base Rate}] \\
 &\quad * [\text{Post-Health Care Acquired Condition DRG Relative Weight}] \\
 &\quad * [\text{Provider Policy Adjustor}] \\
 &\quad * [\text{DRG Service Policy Adjustor}]
 \end{aligned}$$

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.

1. Normal newborn DRG codes: 1.55
2. Neonates DRG codes: 1.10
3. Obstetrics DRG codes: 1.55
4. Psychiatric DRG codes: 1.65
5. Rehabilitation DRG codes: 1.65

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 is 1.25.

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:

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

Note: The "DRG National Average Length of Stay" means the national arithmetic mean length of stay published in version 31 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:

$$\text{Unadjusted DRG Base Payment} = \text{lesser of } [\text{Initial DRG Base Payment}] \text{ and } [\text{Transfer DRG Base Payment}]$$

Otherwise,

$$\text{Unadjusted DRG Base Payment} = [\text{Initial DRG Base Payment}]$$

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.

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:

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

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

$$\text{Outlier Threshold} = \text{Unadjusted DRG Base Payment} + \text{Fixed Loss Amount}$$

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.

The Fixed Loss Amount is \$5,000 for Critical Access Hospitals (CAH) and \$65,000 for all other providers.

If the Claim Cost exceeds the Outlier Threshold, then the claim qualifies for a DRG outlier add-on payment; else 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:

$$\text{Unadjusted DRG Outlier Add-on Payment} = \frac{[\text{Claim Cost} - \text{Outlier Threshold}]}{\text{DRG Marginal Cost Percentage}}$$

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:

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

Else if recipient gains Medicaid eligibility after admission then:

$$\text{Covered Day Adjustment Factor Unadjusted} = \frac{[\text{AHCCCS Covered Days}]}{[\text{DRG National Average Length of Stay}]}$$

Else if recipient loses Medicaid eligibility prior to discharge then:

$$\text{Covered Day Adjustment Factor Unadjusted} = \frac{\{[\text{AHCCCS Covered Days}] + 1\}}{[\text{DRG National Length of Stay}]}$$

The final covered day adjustment factor is calculated as:

$$\begin{aligned} &\text{If } [\text{Covered Day Adjustment Factor Unadjusted}] > 1.0 \text{ Then} \\ &\quad \text{Covered Day Adjustment Factor Final} = 1.0 \\ &\text{Else} \\ &\quad \text{Covered Day Adjustment Factor Final} = [\text{Covered Day Adjustment Factor Unadjusted}] \end{aligned}$$

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:

$$\text{Covered Day Adjusted DRG Base Payment} = [\text{Unadjusted DRG Base Payment}] * [\text{Covered Day Adjustment Factor Final}]$$

$$\begin{aligned} \text{Covered Day Adjusted DRG Outlier Add-on Payment} &= [\text{Unadjusted DRG Outlier Add-on Payment}] \\ &* [\text{Covered Day Adjustment Factor Final}] \end{aligned}$$

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

DRG payment methodology will be transitioned over two years (FFY 2015 through FFY 2016). For FFY 2015 and 2016 of DRG pricing, there will be a provider-specific payment adjustment applied to every claim paid via the DRG pricing method. This payment adjustment will be made using a numeric multiplier that will be applied to both the DRG base payment and the DRG outlier payment. The multiplier will be loaded into a provider specific DRG pricing table.

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).

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

$$\text{Final DRG Base Payment} = [\text{Covered Day Adjusted DRG Base Payment}] * [\text{Provider DRG Transition Multiplier}]$$

$$\begin{aligned} \text{Final DRG Outlier Add-on Payment} &= [\text{Covered Day Adjusted DRG Outlier Add-on Payment}] \\ &* [\text{Provider DRG Transition Multiplier}] \end{aligned}$$

$$\text{Final Allowed Amount Payment} = \text{Final DRG Base Payment} + \text{Final DRG Outlier Add-on Payment}$$

$$\text{Final Reimbursement Amount} = \text{Final Allowed Amount} - \text{Other Insurance Payment}$$

+/- Prompt Pay Adjustment

Note 1: The current prompt pay policy (slow pay penalties and quick pay discounts) will continue to apply. Refer to section 25 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 and the DRG pricing logic will be based on date of discharge. All hospital stays with a date of discharge on or after 10/1/2014 will be priced using the DRG methodology. 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,

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

If [Covered Day Adjustment Factor Unadjusted] > 1.0 Then

$$\text{Covered Day Adjustment Factor Final} = 1.0$$

Else

$$\text{Covered Day Adjustment Factor Final} = [\text{Covered Day Adjustment Factor Unadjusted}]$$

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 will be paid by the payer with which the recipient is enrolled on date of discharge. 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 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) 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) 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).

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 Issue Number 8.

Medicare Dual Eligibles

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, Health Choice Arizona 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 Health Choice Arizona 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 different claim from 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.

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 final 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 final claim will be paid under the DRG payment methodology.

Single Medicaid Payer for Entire Stay

Hospitals will be required to void all interim bills prior to submitting the final claim for reimbursement.

The final 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 that 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 final 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 in Issue Number 5, 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 final 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 in Issues Number 10 and 11, 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

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 Health Choice Arizona when the recipient expires in the hospital, which is not a scenario in which the transfer payment policy applies.

Health Choice Arizona 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.

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,

$$\text{Covered Day Adjustment Factor Unadjusted} = \frac{[\text{AHCCCS Covered Days}]}{[\text{DRG National Average Length of Stay}]}$$

If $[\text{Covered Day Adjustment Factor Unadjusted}] > 1.0$ Then

$$\text{Covered Day Adjustment Factor Final} = 1.0$$

Else

$$\text{Covered Day Adjustment Factor Final} = [\text{Covered Day Reduction Factor Unadjusted}]$$

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 the admission of the stay. 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,

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

If $[\text{Covered Day Adjustment Factor Unadjusted}] > 1.0$ Then

$$\text{Covered Day Adjustment Factor Final} = 1.0$$

Else

$$\text{Covered Day Adjustment Factor Final} = [\text{Covered Day Adjustment Factor Unadjusted}]$$

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 a 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 2011 Medicare Cost Report are reimbursed by Medicare will also be reimbursed under a separate DRG base rate that will also be reimbursed under the 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, where rates and outlier thresholds will be included in the capped fee schedule published by the Administration. 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 outlier CCR will be the sum of the urban or rural default operating cost-to-charge ratio appropriate to the location of the hospital and the statewide capital cost-to-charge ratio in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS. 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 Health Choice Arizona 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.

Negotiated Settlements

Health Choice Arizona will continue to support the current claim dispute and settlement process. The grievance settlement process will be conducted after initial adjudication of the claim and providers will be expected to follow the current claim dispute process independent of whether claim payment is calculated using a per diem, DRG, or other payment methodology.

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 primary diagnosis for the recipient for the hospital stay will determine if the claim will be submitted to the MCO under which the member is eligible or to the Tribal/Regional Behavioral Health Authority (T/RBHA) assigned to the member.

If upon admission into the facility, the primary diagnosis of the recipient is a physical health diagnosis, the claim should be submitted to the associated MCO and will be reimbursed under DRG methodology, if DRG pricing applies. If upon admission into the facility, the primary diagnosis of the recipient is a behavioral diagnosis, the claim should be submitted to the appropriate MCO (for dual members) or T/RBHA (for all others) and will be reimbursed under a per diem rate consistent with ADHS reimbursement policy.

Health Care Acquired Conditions (HCAC) and POA

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 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

Value	Definition	Coding Guidelines
Y	Yes	Present at time of inpatient admission
N	No	Not present at time of inpatient admission
U	No information in the record	Documentation is insufficient to determine if the condition is present on admission
W	Clinically Undetermined	Provider is unable to clinically determine whether condition is present on admission
[blank]	Unreported/not used	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.

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.

For out-of-state hospitals determined by the Administration to be high volume out-of-state hospitals, which are located in counties bordering the State of Arizona and have 500 or more AHCCCS covered inpatient days for the fiscal year beginning October 1, 2010, payments for services will be determined using the same methods used for payment of services to in-state hospitals, except that out-of-state hospitals will not be eligible for the Provider Policy Adjustor. Wage Adjusted Provider DRG Rates and Hospital Cost-to-Charge Ratios will be determined using the same methods as those used to determine such values for in-state hospitals.

All other out-of-state hospitals will be assigned Wage Adjusted Provider DRG Rates that will be equal to the simple average of the Wage Adjusted Provider DRG Rates for in-state hospitals. They will also be assigned Cost-to-Charge ratios equal to the sum of the Arizona statewide urban default operating cost-to-charge ratio and the Arizona statewide capital cost-to-charge ratio in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS. As with designated border hospitals described above, these hospitals will not be eligible for the Provider Policy Adjustor. Further, for purposes of determining the Provider DRG Transition Multiplier for these providers, the DRG transition policy component will not be applied.

Slow Pay Penalties and Quick Pay Discounts

Health Choice Arizona will continue to support the current slow pay penalty and quick pay discount policies. Health Choice Arizona will calculate the quick pay discounts and slow pay penalties on the Final Allowed Amount for providers classified as types 02 and C4, excluding IHS and 638 providers, billed on the UB-04 claim form.

A quick pay discount of 1 percent will continue to be applied to claims paid within 30 days. The slow pay penalty will continue to be based on a 30 calendar day month, as illustrated below:

Claim paid within 31-60 days of clean claim date: 0% discount/penalty

Claim paid within 61-90 days of clean claim date: 1% penalty
Claim paid within 91-120 days of clean claim date: 2% penalty

The slow pay penalty will continue to accrue at a rate of 1 percent per month or partial month until the claim is paid by Health Choice Arizona.

Readmission Policy

A recipient may be readmitted to a hospital after receiving a service or treatment. For claims paid via the DRG methodology, Health Choice Arizona 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:

1. Recipient must be readmitted to the same hospital within 72 hours, and
2. 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
3. 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 HCA of a readmission to the same hospital within 72 hours.**

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 Administration 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.

Reinsurance

Any final claims which cross over contract years will not be eligible for reinsurance.

The Administration will not pay reinsurance on interim claims. The final claim submitted by a hospital associated with the full length of the patient stay will be eligible for reinsurance consideration as long as the days of the hospital stay do not cross contract years.

AHCCCS will not pay reinsurance on claims containing any Prior Period Coverage (PPC) for regular and catastrophic reinsurance types. Splitting claims for the purpose of separating PPC from prospective enrollment is not permitted.

Non-covered Services

Charges associated with use of robotic technology will be disallowed when claims are reviewed for outlier consideration.

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.

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.

Additional details regarding the transition to the new payment methodology may be found online at the following address:

<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ManagedCare/DRGbasedpayments.htm>
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MEDICAL REVIEW OF INPATIENT HOSPITAL CLAIMS

An inpatient claim is considered to be a clean claim, for medical review purposes only, upon initial receipt of the legible, error-free UB-04 claim form by Health Choice Arizona if the claim includes the following error-free documentation in legible form:

- An admission face sheet.
- An itemized statement.
- An admission history and physical.
- A discharge summary, death summary or an interim summary if the claim is split.
- An emergency record, if admission was through the emergency room 0 Operative report(s), if applicable.
- Operative report(s), if applicable.
- Consultations
- A labor and delivery room report, if applicable.

Periodically, retrospective review will be conducted by Health Choice Arizona based upon a variety of criteria.

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. Observation status is used to determine medical necessity and identify the appropriate level of care. Observation status should not exceed 24 hours.

If medically indicated for diagnostic testing or stabilization, observation status can be extended to 48 hours with a physician's order and prior authorization. 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 observation status:

- Severity of the signs and symptoms of the recipient.
- Degree of medical uncertainty that the recipient may experience an adverse occurrence.
- Need for diagnostic studies that appropriately are outpatient stays (i.e., they do not ordinarily require the recipient to remain at the hospital for 24 hours or more) to assist in assessing whether the recipient should be admitted.
- The availability of diagnostic procedures at the time and location where the recipient presents for medical treatment.

The following services are not Health Choice Arizona-covered observation services:

- Substitution of outpatient services provided in lieu of observation status for physician ordered inpatient services.
- Services that are not reasonable, cost-effective, and necessary for diagnosis or treatment.
- Services provided for the convenience of the recipient or physician.
- Excessive time and/or amount of services medically required by the condition of the recipient.
- Services customarily provided in a hospital-based outpatient surgery center and not supported by medical documentation of the need for observation status.

In general, observation status should not exceed 24 hours. This time limit may be exceeded, if medically necessary, to evaluate the medical condition and/or treatment of a recipient. Extensions to the 24-hour limit must be prior authorized.

Observation services, without labor, billed on the UB-04 claim form must be billed with the appropriate revenue code (Treatment/Observation Room - Observation Room) and the appropriate observation HCPCS procedure code. Each hour or portion of an hour that a recipient is in observation status must be billed as one unit of service.

Observation services without labor, billed on the UB-04 claim form must be billed with the appropriate revenue code (Treatment/Observation Room – Observation Room) and the appropriate

observation HCPCS procedure code.

Each hour or portion of an hour that a recipient is in observation status must be billed as one unit of service.

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

Health Choice Arizona will review the immediate and continuing observation status by assessing the severity of illness and intensity of services. Medical review for continued observation status will consider each case on an individual basis and include, at a minimum, the following documentation:

- Emergency room record, if applicable.
- Progress notes.
- Operative report, if applicable.
- Diagnostic test results, if applicable.
- Nursing notes, if applicable.
- Labor and delivery records, if applicable 0 Physician orders.

The following are required for documenting medical records:

- Orders for observation status must be written on the physician's order sheet, not the emergency room record, and must specify "admit to observation." 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.

OUTPATIENT HOSPITAL SERVICES

Health Choice Arizona covers preventive, diagnostic, rehabilitative, and palliative items or services ordinarily provided in hospitals on an outpatient basis for all recipients within certain limits based on recipient age and eligibility. Covered hospital outpatient services include:

- Routine care unit.
- Physician services (including ambulatory surgery, specialty care physician, and home physician visits).
- Dialysis.
- Emergency room services.
- Laboratory services.
- Medical supplies and equipment ordinarily furnished to persons receiving outpatient services to the extent that they are covered services and ordered by a physician.
- 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 Health Choice Arizona 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 room, observation area, or other outpatient department and is directly admitted to the same hospital, the emergency room, observation, or other outpatient charges must be billed on the inpatient claim.

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, 7XX or 85X for Critical Access Hospitals (appropriate second and third digits 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."

REIMBURSEMENT OF OUTPATIENT HOSPITAL CLAIMS

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

The listing of revenue codes that are bundled with Surgery and ED can be referenced via the AHCCCS website/Outpatient Fee Schedule as Extract RF796. Multiple surgeries will pay the higher rate surgery at 100% of the fee schedule and secondary surgeries at 50% of the fee schedule (exceptions will be noted for those procedures that are intended to be paid at 100%/100% and do not require indication of a 51 modifier

Late Charges: Late charge bills will no longer be accepted. When billing changes to the claim (including late charges), Hospitals must rebill the entire corrected claim.

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

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

BILLING CPT/HCPCS CODES WITH REVENUE CODES

Health Choice Arizona requires that outpatient services be billed with an appropriate CPT/HCPCS code that further defines the services described by the revenue code listed on the UB-04 claim form. 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 421 (PT Visit) with CPT code 97116 (Therapeutic procedure, one or more areas, each 15 minutes; gait training), each 15-minute increment represents one unit. If services were provided for 30 minutes, the hospital would bill two units, and so on.

BILLING OTHER SERVICES

Durable medical equipment

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

Transportation

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

Professional services

- Health Choice Arizona requires that physician and professional services provided in a hospital setting be billed on a CMS 1500 claim form. Claims are reimbursed using the Health Choice Arizona contracted rates.
- Revenue codes for professional services are not covered on a UB-04 claim form.
- Physician and mid-level practitioner services must be billed under the individual service provider's National Provider Identifier (NPI) number.
- Health Choice Arizona does not allow hospitals and/or clinics to bill Health Choice Arizona for physician/mid-level practitioner 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 provider and the hospital group biller.