

10/1/2011 Benefit Limit Q &A's

Will the inpatient accumulation be on the ETI report? If not how will days be counted/communicated to the plans? - All the limits will be incorporated into the ETI reporting. And as noted this information will be available on the encounter limits tracking screen in PMMIS and reporting to the plans, although with an acknowledged lag.

How will we ensure that the member has received 25 inpatient days (not resulting in an inpatient stay) if the encounters have not yet been submitted to AHCCCS at the time a member is transitioned to our plan. - See above, should be included in ETI.

Can the hospital bill the member after the 25 inpatient days limits have been met? - Consistent with rule guidelines, yes. Would this apply to out of state? - Yes, out of state is not a noted exception to the limits.

Can a contracted hospital refuse an elective admission if the member is over their 25 day limit? - Yes.

Is PPC included in the 25 day inpatient? - Yes, PPC is not a noted exception to the limits.

How do the benefit limits affect TPL/Reinsurance? - Should not impact. Service is either covered or it is not. Please clarify if I've misunderstood the question.

If there was an overpayment of units (25 inpatient days) can the plan recoup? - If necessary yes, although preference is always to try to catch pre-payment if possible.

Does AHCCCS have a timeline for providing member/provider communication material to the plans? - Timing for these materials is TBD. However, an initial Fact Sheet and FAQ's will be posted to website next week.

Confirm understanding, Observation will have a max of 23 hours, anything greater should be paid IP per diem. - No, the inclusion of Observation hours in 24 hour increments towards the 24 day limit does not impact the OP Observation valuation or payment methodologies. Below are a few examples, let me know if they help. I'm working on specific examples for each of the benefit limits as well as the OPFS changes for us to walkthrough at the 7/19 meeting.

For purposes of the 25 Day Inpatient benefit limit, our processing rules say count each 24 hours of (paid not bundled) observation billed on an Outpatient claim as one unit. If an Outpatient claim has less than 24 units of observation it doesn't even get into this limit evaluation.

So if the following situations occurred here's what we would do -

Member A - has not met their 25 day limit

Outpatient claim for 30 units of paid Observation - Apply 24 of the billed hours as 1 day to limit and pay all hours under OPFS.

Outpatient claim for 10 units of Observation - Not considered under 25 day Inpatient Limit as claim criteria not met, paid under OPFS.

Member B - has met their 25 day limit

Outpatient claim for 30 units of Observation - Pay 23 hours of OBS under OPFS and disallow 7 hours

Outpatient claim for 10 units of Observation - Not considered under 25 day Inpatient Limit as claim criteria not met, pay under OPFS

Member C - has accumulated 24 days toward their 25 day limit

Outpatient claim for 30 units of Observation - Apply 24 of the billed hours as 1 day to limit and pay all hours under OPFS

Outpatient claim for 10 units of Observation - Not considered under 25 day Inpatient Limit as claim criteria not met, pay under OPFS

Outpatient claim for 52 units of Observation - Apply 24 hours of the billed hours as 1 day to limit, pay those 24 hours and 23 of the additional hours under OPFS, and disallow the remaining 5 hours.

IP day limit – will transplants be carved-out of the 25 day limit? – Transplant related days are listed as an exception in the matrix for this limit.

Would the limitation of 25 day IP be per type of admission? i.e. med/surg, maternity, icu – No this limit is 25 Inpatient days per adult member per benefit period (10/1 through 9/30 of each year) regardless of the type of Inpatient admission.

For the IP 25 days limit and contract year split, assume the days calculation starts over on 10/1, even if patient in the middle of a hospital stay? – Correct, days are allocated to the benefit year in which the dates of service fall.

What affect, if any does the limitations have on reinsurance? – No specific impacts to reinsurance, although the payment of less Inpatient days may result in less need for related reinsurance also.

Is the accrual of bed days based on approved/paid days paid? Should days be denied for not meeting medical necessity, delay in care or treatment, etc. not be applied to the accrual of hospital days for the member? – As noted in the matrix, only paid days should be evaluated towards the limit.

Do admissions that do not meet IP criteria, are denied and then negotiated with an observation rate to the facility, count as an IP day? – Lets discuss further and if possible please provide me with an example or two, so I can verify my response.

Health plan negotiated with provider to pay IP claims at OBS rate. No codes are changed on the claim, only the amount paid-out will be different. Since this will look like an IP day to AHCCCS, but the health plan only paid OBS, anyway to have those not-counted towards the limit? - Will you non-cover/cutback these days on the Inpatient claim? If not or without some other designation, it will not be possible for AHCCCS to recognize this type of payment arrangement.

Could be a possibility – will consider marking the days noncovered. - If you are unable to reflect this day as non-covered, regardless of contracting it will be counted.

Since there is no limit on SNF days, can health plans negotiate a lower level of care in acute facilities (SNF, ICF/ECF)? Would days at this level contribute to the member's hospital limit? – Lets discuss further and if possible please provide me with an example or two, so I can verify my response.

As an example, a member is admitted to the hospital for cellulitis. Blood cultures are done and the member is found to have osteoarthritis. The member has a PICC line, requires IV antibiotics and has a history of drug use. No SNF bed is available or a SNF will not accept the member. The member cannot be discharged home with a drug history and a PICC line. If the hospital agrees to continue skilled not acute care in the hospital, can they be paid at a

lower level of care (SNF rate, RC 191-193) and will it not count against acute IP days? Or fail thru encounters? - At this time this scenario is not identified as an exception. Policy committee determined that this situation will not be considered as an exception at this time for this benefit limitation.

If hospital days that are denied do not contribute to the member's bed day limitation, what happens if they are overturned in claim's disputes, appeals or State Hearing process? How will those days be reconciled? – As outlined in the matrix, claims are applied to towards the limit in the order in which they adjudicated as paid/approved. In the event a denial is overturned any days in excess of the limit for that member and benefit period would be disallowed.

RE: Adult Recipients age 21 and >. Will there be any additional criteria (beyond QMB) applied to adults? i.e. transplants, maternity, SOBRA, TWG, DD adults, etc? – No additional criteria or exceptions have been defined for this type of limit at this time.

Does observation limit include maternity observation (rev code 762)? - Observation is identified by HCPCS/CPT procedure code G0378 or G0379, there is currently no criteria that looks at the revenue code in this situation.

We are figuring that AHCCCS will be adding space for inpatient days to ETI Form. What do you think the timing of the updated form will be? - In progress. Will be distributed as soon as possible.

Regarding the requirement that Non QMB claims/encounters should count and allow entire stay in which 25th day occurs regardless of length of that stay – I want to confirm that this requirement applies to NonQMB duals only, not regular AHCCCS adults that are not duals? - This criteria applies to Medicare Non-QMB Dual claims only.

It's anal of us but it would be helpful if in the next update of the grid if AHCCCS could add confirmation that the 25th limit does not apply to QMB duals and that the standard guidance applies to QMB duals regarding coinsurance and deductible regardless of # days. - Documentation updated to further emphasize this.

What do you see/estimate is the timeline for ETA on office visit and transportation benefit reductions? And is the office visit reduction related to copays or no show penalty or both? - At this time Office Visits are not being addressed, any future evaluation will provide for appropriate timeframes. Transportation is still under evaluation, but if addressed will not be prior to 1/1/2012.

Potential exists for outliers to increase as a result of the 25 day inpatient limit. A stay that hits the limit with some days covered and some not covered b/c of hitting the limit could end up in outlier status as a result of noncovered days on the end of the stay (majority of expense on front end of stay). Was this discussed? - Yes, this was discussed and noted a possible concern. I will again share this concern with the policy group for any additional feedback. In general disallowance of days should also result in the disallowance for ancillary charges associated with those days prior to outlier consideration.

Regarding the I/P limit, the proposed rules (R9-22-204(C)(1)(f)) state that after 25 days of I/P hospital services have been paid, outpatient services that are directly followed by an inpatient admission to the same hospital, including observation services, are not covered. - Correct, as all OP services that result in an admission are only billed as components of the Inpatient stay. Per the FFS Provider Billing Manual - Reimbursement for the emergency room, observation, and other outpatient hospital services provided before the hospital admission are included in the tiered per diem payment.

Continuous periods of observation services of less than 24 hours that are not directly followed by an inpatient admission to the same hospital are not covered. - [Actually the Rule states the opposite, see below "ii" \(R9-22-204\(C\)\(1\)\(f\) States:](#)

[After 25 days of inpatient hospital services have been paid as provided for in this rule:](#)

[i. Outpatient services that are directly followed by an inpatient admission to the same hospital, including observation services, are not covered.](#)

[ii. Continuous periods of observation services of less than 24 hours that are not directly followed by an inpatient admission to the same hospital are covered](#)

[iii. For continuous periods of observation services of 24 hours or more that are not directly followed by an inpatient admission to the same hospital, 23 hours of observation are covered](#)

What happens when a hospital exhausts the observation time and then moves the member to another hospital in their system for further observation or admission? In this scenario, since the admission was to a different hospital, the observation would be covered. Should this be covered in this case? - [Technically there is no "exhaustion of observation time", however the number of observation hours paid may be impacted as outlined above in the Rule.](#)

[Contractor should continue to authorize the appropriate use observation and monitor and address the aforementioned situation should it occur inappropriately. Incidence of this should be rare and may sometimes be appropriate for other reasons. Should this occur basic rules of thumb after a member has exhausted their 25 day Inpatient benefit are \(as outlined above\) -](#)

- [a\) If the observation at the first hospital is 23 hours or less, it is covered.](#)
- [b\) If the observation at the second hospital is 23 hours less without admission it is covered.](#)
- [c\) If the observation at the second hospital results in an admission it is not covered as those charges roll up into the admission.](#)
- [d\) For continuous periods of observation services of 24 hours or more that are not directly followed by an inpatient admission to the same hospital, 23 hours of observations services are covered.](#)

What happens if a pregnant member exhausts her I/P coverage (for any reason) prior to a delivery or c-section? Federal law requires that the health plan cover 2 or 4 I/P days following a birth. In this scenario, the proposed rules would not allow payment. Is the plan responsible for payment in these scenarios? - [This situation is not defined as an exception to this benefit limit. Per legal council the federal law does not apply to Medicaid.](#)

The following is in the current FAQ on line:

Will benefit changes affect adult AHCCCS members who are also on Medicare?	
A6.	AHCCCS will continue to pay Medicare co-pays and deductibles for Qualified Medicare Beneficiaries (QMB) who are duals also enrolled in AHCCCS, with income at or under 100% FPL, even after the benefit limit is reached. For people with Medicare who don't have QMB, members will be responsible for co-pays after the benefit limit is reached. Members should contact their Contractors for more information.
Q7.	How will the provider know that the member is QMB dual?
A7.	PMMIS identifies QMB duals as Medicare Type C and/or with a Rate code of 2 in the 3rd digit.

[- We will be updating the Fact Sheet with a footnote re QMB and the document will also be posted to the web with the medical provider memo.](#)

Hospitals are asking about usage of Medicare lifetime reserve days. What is the AHCCCS policy on use of lifetime reserve days for members who have same? Can a provider mandate health plans use those days without written patient permission? Does AHCCCS house a member's lifetime reserve days somewhere for health plan access? Understand today, only the hospitals can view thru the CMS CWF? - [I will refer this question to Katrina Cope our internal Medicare Specialist for a response.](#)

From prior auth: The transportation benefit limit will impact the letter writing team the most. If MTBA gets a request for transportation from a member and the benefit is not longer available, Will a NOA denial letter be warranted? I believe only if a request comes from the provider does the member get a NOA but we need to ask. - [Per the benefits team there are not currently any changes related to Non-Emergency transaction, at the point at which any changes are considered further direction will be provided.](#)

From transition nurses: Regarding the ETI forms shared to/from health plans. Is there a way to publish the IP days used and ER visits used on the AHCCCS website for all health plans, providers and members to view? Could be more efficient way to share the "days used" data versus forms, and providers/members could also view the information. - [Confirmed that due to member confidentiality considerations broad distribution of this type of data is not feasible.](#)