Inpatient (IP)/Outpatient (OP) Hospital Specialty Training

Health First Colorado

(Colorado's Medicaid Program)

Navigating This Presentation

- Underlined words or phrases often will link viewers to more information, such as web pages. If you are viewing this presentation in normal mode (not slideshow mode), you may need to press the Ctrl key while you click on the link in order to open it.
- Use color-coded table of contents slides to navigate to specific areas of interest in the presentation.
  - Use back arrows provided in the bottom right corner of some slides to return to table of contents slides.

Agenda

Universal Procedure and Diagnosis Coding

Inpatient

Outpatient

Behavioral Health

Resources

Universal Procedure and Diagnosis Coding

Universal Procedure Coding

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires providers to use universal Current Procedural Terminology (CPT) coding (Level I of the Healthcare Common Procedure Coding System [HCPCS]) guidelines
  - Providers should consult the American Medical Association (AMA) CPT manual definitions for each code submitted for reimbursement
  - Health First Colorado payment policies are based on CPT descriptions

- Level II of the HCPCS is used to identify products, supplies and services not included in the CPT codes, including but not limited to:
  - Ambulance services
  - Durable medical equipment

Universal Procedure Coding

- All outpatient laboratory, occupational therapy, physical therapy, x-ray and hospital-based transportation claims must be billed using both Healthcare Common Procedure Coding System (HCPCS) and revenue codes

- Follow these guidelines for submitting claims for transportation, outpatient laboratory, occupational therapy, physical therapy and radiology:
  - Use most current Current Procedural Terminology (CPT) revision
    - Health First Colorado adds and deletes codes as they are published in annual revisions
  - Use Centers for Medicare & Medicaid Services (CMS) codes only when CPT codes are not available or are not as specific
  - Check fee schedules before billing as not all codes listed in the annual HCPCS code publications are benefits of Health First Colorado

Universal Diagnosis Coding

- Providers must also use International Classifications of Diseases 10th Revision, Clinical Modification diagnosis codes (ICD-10) in order to ensure correct claims processing

- Refer to provider-specific billing manuals located on the Department website for more detailed benefit and billing information
  - For Our Providers → Provider Services → Billing Manuals → Institutional (UB-04)

Inpatient

All-Patient Refined Diagnosis Related Groups

All-Patient Refined Diagnosis Related Groups (APR-DRG) is a patient classification system used by healthcare payers and providers to categorize inpatient hospital stays into clinically meaningful groups that reflect similar resource needs.

These groups are used for reimbursement and analysis.

The APR-DRG system is published and maintained by 3M Health Information Systems.

All-Patient Refined Diagnosis Related Groups

Effective Date Range	All-Patient Refined Diagnosis Related Groups Version
January 1, 2014-September 30, 2015	Version 32
October 1, 2015-September 30, 2024	Version 33
October 1, 2024-Current	Version 40

Pricing Logic

Transfer Payment Logic:

- IF Covered Days is less than Diagnosis Related Group (DRG) Average Length of Stay, THEN pay Per Diem multiplied by Covered Days
- IF Covered Days is greater than or equal to DRG Average Length of Stay, THEN pay DRG Base Payment

Per Diem Calculation:

- Per Diem = DRG Base Payment divided by DRG Average Length of Stay

Outlier Payment Logic:

- Outlier Days = Covered Days beyond DRG Trim Point
- Outlier Payment = Outlier Days multiplied by Per Diem multiplied by 80%

Interim Payments for Long Stays

DRG hospitals may bill interim claims using adjusted claims only when Health First Colorado is the primary payer

Billing Process

1. Submit the first interim claim (type of bill 112) for services from admission date through the billing date with patient status “30: Still a patient”
2. Submit an adjustment claim (type of bill 117) to the first interim claim for services from admission date through the billing date when reimbursement reaches or exceeds an additional $100,000 from first interim claim
   - Patient status should be “30: Still a patient”
3. Continue submitting adjustment claims as reimbursements reach or exceed additional $100,000 from previous interim payments
   - Patient status should be “30: Still a patient”
4. Submit the final interim claim (type of bill 117) for services from admission date through discharge date after the member has been discharged

Combined Stays Under 48-Hour Readmission Policy

Hospitals must bill admissions as a single hospital stay if a member is discharged and then readmitted to the same hospital within 48 hours for symptoms related to, or for evaluation and management of, the prior stay's medical condition.

- 48 hours is calculated from Discharge Hour on the first claim to Admission Hour on the second claim
- All claims for hospital readmission within 48 hours of discharge will be denied unless the readmission is completely unrelated to the first admission

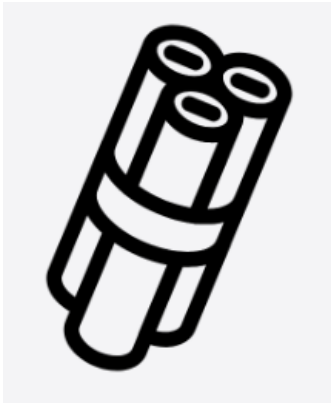
Stays at Transitional Care Units or any other location that is not part of the General Acute Care Hospital are not billable under the hospital's Health First Colorado Provider ID and will be denied.

Bundling

Bundling describes a single reimbursement package for related services.

When applicable, reimbursement for inpatient hospital care includes:

- associated outpatient, laboratory and supply services provided immediately prior to hospital admission and during the hospital stay when billed by the same provider
- prenatal services such as observation stays
- same location emergency department visits provided immediately prior to hospital admission

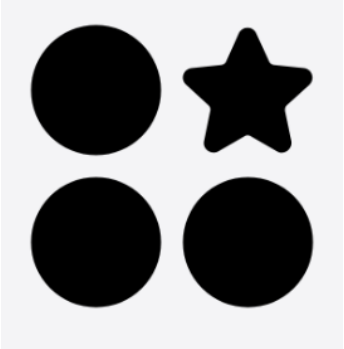


Distinct Part Units (DPUs)

Distinct Part Units (DPUs) are not recognized as separate from the general hospital under which they are licensed.

A single claim should be submitted for a member who is admitted to a general hospital and then transferred to the hospital's DPU.

- Claim should cover the date of admission to the general hospital through the discharge date from the DPU
- The DPU's National Provider Identifier (NPI) should be represented as a service location on the claim



Date of Discharge or Death

- Date of discharge or death is not counted as a covered day **unless**:
  - Discharge or death occur **on** the day of admission
    - Considered day of admission and counts as a full day unit, including if member is discharged or dies after admission but before assignment to a room
    - Charges for ancillary services are covered

Non-Covered Days

Total days are the number of days billed on a claim

- Calculated as the days between admission and To Date of Service (TDOS)

Value codes 80 and 81 should be used to indicate the quantity of covered and non-covered days during an inpatient stay

- The sum of these days should equal the total days on the claim, less the day of discharge

A day on which a member begins a leave of absence is not counted as a covered day

- Occurrence Span Code 74 should be used to report the from and through dates at a non-covered level of care or leave of absence during an otherwise covered stay

Professional Fees

Professional services by salaried physicians are included in the hospital's rate structure and cannot be billed separately.

Professional fees for services provided in an emergency room by contract physicians must be billed by the physician on a CMS 1500 professional claim form

- Payment is made to the physician or physician clinic

Provider Preventable Conditions

Other Provider Preventable Conditions (OPPC) include:

- Surgery performed on the wrong body part
- Surgery performed on the wrong member
- Wrong surgical procedure performed on the member

Hospitals are required to submit claims when:

- any Health Care Acquired Condition (HCAC) or OPPC events occur in an inpatient hospital setting
- when an OPPC event occurs in an outpatient healthcare setting

Provider Preventable Conditions

Inclusion of Present on Admission (POA) indicator responses are required for inpatient claims submitted through the Provider Web Portal.

Indicator responses are used to identify claims with Health Care Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC)

- The Centers for Medicare & Medicaid Services (CMS) does not allow payment of OPPCs or any additional costs arising from HCACs

The Department will collaborate to assure appropriate reimbursement for cases in which a member receives subsequent care for an HCAC or OPPC in a hospital other than the original site in which the event occurred.

Long-Term Acute Care and Rehabilitation

All Long-Term Acute Care (LTAC) Hospitals, Rehabilitation Hospitals and Spine/Brain Injury Treatment Specialty Hospitals are reimbursed under a per diem that follows a step-down methodology based on length of stay

LTAC Hospitals

- Tier 1: day 1 through day 21
- Tier 2: day 22 through day 35
- Tier 3: day 36 through day 56
- Tier 4: day 57 through reminder of care

Rehabilitation Hospitals

- Tier 1: day 1 through day 6
- Tier 2: day 7 through day 10
- Tier 3: day 11 through day 14
- Tier 4: day 15 through remainder of care

Spine/Brain Injury Treatment Specialty Hospitals

- Tier 1: day 1 through day 28
- Tier 2: day 29 through day 49
- Tier 3: day 50 through day 77
- Tier 4: day 78 through remainder of care

Newborn Billing

Services for the birthing parent and baby must be billed on separate claims under each member's Member ID.

- If the birthing parent is discharged, and unless identified as medically necessary, charges for a newborn remaining in the hospital are not a benefit (e.g., placement)

Notify the county Department of Human and Social Services to enroll a newborn:

- Infant's full legal name
- Birth date
- Gender
- Birthing parent's Member ID

Anyone can report the birth of a newborn.

- Providers online at the Add-A-Baby Emergent Request Form
- Local Healthy Communities Outreach Coordinators

Newborn Screenings

Costs associated with newborn hearing and metabolic screenings are included in the delivery Diagnosis Related Group (DRG) calculation or birthing center facility payment and may not be billed separately.

Refer to the Audiology Benefit Billing and Policy Manual and the Laboratory Services Billing Manual for more information.

Post-Partum Long-Acting Reversible Contraceptives

Immediate Post-Partum Long-Acting Reversible Contraceptive (IPP-LARC) devices inserted in a Diagnosis Related Group (DRG) hospital may be reimbursed at the fee schedule rate or the amount billed, whichever is less.

- Reimbursement requires submission of both an inpatient and outpatient claim
- No additional revenue or procedure codes can be present on the claims
- Outpatient claim must be submitted after the affiliated inpatient claim is paid

Post-Partum Long-Acting Reversible Contraceptives

The inpatient claim for the DRG payment must:

- group to APR-DRG 540, 542 or 560
- include ICD-10 diagnosis code for LARC insertion: Z30.430 or Z30.018
- include ICD-10 surgical procedure code for either an IUD insertion or a contraceptive implant insertion

The outpatient claim for the IPP-LARC fee schedule payment must include:

- Healthcare Common Procedure Coding System (HCPCS) for the LARC device
- LARC device's affiliated National Drug Code (NDC)
- both the FP and SE modifiers
- Date of service that matches the date of insertion within the inpatient claim’s dates of service

Swing Bed Services

Hospitals certified to provide Skilled Nursing Facility (SNF) services or Intermediate Care Facility (ICF) services to members in swing beds must furnish the medically necessary services, supplies and equipment required within the approved per diem rate.

Swing bed services should be billed using a Swing Bed enrollment (Provider Type 20 Specialty Code 396).

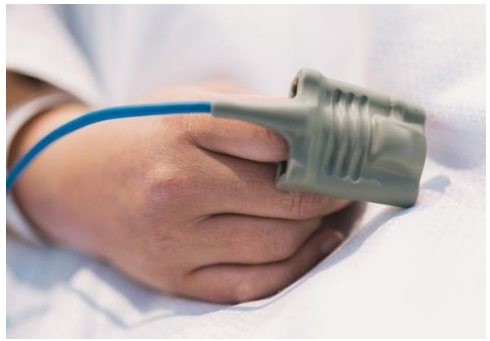
Refer to the Nursing Facility Billing Manual for more information.

Criminal Justice Involved Populations

Inpatient services for criminal justice involved individuals are covered when they meet the following conditions:

- Occur in an inpatient hospital outside of the correctional facility
- Require inpatient hospitalization for at least 24 hours
- Are provided between the time of admission and time of discharge

Health First Colorado cannot cover services that are provided in an outpatient setting or on the premises of the prison, jail or detention center.



Out-of-State Hospitals

- Out-of-State Hospital services are classified as urban or rural
  - Urban: Base rate of 90% of the Colorado urban base rate
  - Rural: Base rate of 90% of the Colorado rural base rate

- Non-emergent out-of-state inpatient services must be prior authorized through the ColoradoPAR Program

- To qualify for Single Case Agreement (SCA), the services must be:
  - Hospital services
  - Not available in Colorado
  - Prior authorized through ColoradoPAR

Outpatient

Enhanced Ambulatory Patient Groups

Enhanced Ambulatory Patient Grouping (EAPG) is a system particularly used in outpatient settings to classify and determine reimbursement for services based on type and quantity of resources used during a visit.

Solventum (formerly 3M) develops and maintains the EAPG classification system.

Enhanced Ambulatory Patient Groups

Effective Date Range	Enhanced Ambulatory Patient Groups (EAPG) Version
Prior to October 30, 2016	N/A
October 31, 2016-December 31, 2021	Version 3.10
January 1, 2022-Current	Version 3.16

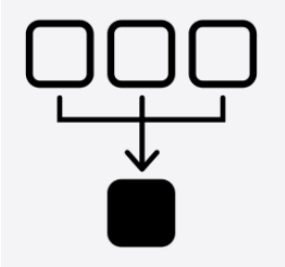
Due to EAPG pricing mechanisms (e.g.,discounting, packaging, consolidation), items will not always pay based on the EAPG weight schedule posted to the Outpatient Hospital Payment web page. The payment formula utilizes the adjusted weight rather than the posted EAPG weights.

Consolidation and Distinct Procedures

The Enhanced Ambulatory Patient Grouping (EAPG) reimbursement methodology groups payment for similar significant procedures so that only the most resource-intensive procedure will be payable per visit .

Claim details may be billed with modifier 59 to indicate that they are distinct procedures for payment to be calculated appropriately for separate and distinct significant procedures occurring during the same visit.

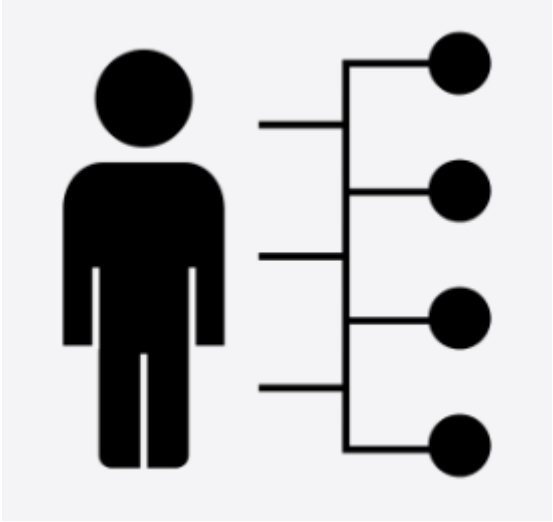
- Modifiers XE, XP, XS and XU may also be used to indicate distinct procedural services



Additional Medical Visits

Modifier 27 may be reported for multiple evaluation and management encounters on the same date.

- Line items may be assigned ancillary EAPG 449 (Additional Undifferentiated Medical Visits/Services) only payable during visits where no significant procedure has taken place



Payment for Other Outpatient Services

Outpatient laboratory, occupational therapy, physical therapy and hospital-based transportation claims are reimbursed based on the Health First Colorado fee schedule.

Outpatient radiology and diagnostic imaging claims are reimbursed based on the hospital cost-to-charge ratio.

- Refer to the Outpatient Imaging and Radiology Billing Manual for more information

Observation Billing

Observation stays are covered when provided by or under the direction of a physician for as many days as determined medically necessary.

- Must have an observation time of eight (8) or more hours
- Observation for more than 24 hours must include appropriate documentation

Observation stays end when the physician orders either inpatient admission or discharge.

Inpatient admissions cannot be converted to observation stay after the member has been discharged.

Multiple Units

Billed units should be summed into a single line for each Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) code and date of service.

- Observation stays that span multiple dates of service must have all units summed and billed on a single line

Exceptions are for:

- required modifiers (e.g., billing two [2] lines for a drug where the discarded portion of the drug must be billed on a separate line with the JW modifier)
- billing drugs with different National Drug Codes (NDCs) but same HCPCS

340B Drug Discount Program

Drugs purchased through the 340B Drug Discount Program must be billed with the UD modifier and at acquisition cost.

- Discarded portions of drugs provided during an outpatient stay must be billed on a separate line with the JW modifier and are not considered payable on an outpatient claim

Hospital Specialty Drug Policy

Certain hospital specialty drugs are carved out of the Enhanced Ambulatory Patient Grouping (EAPG) methodology.

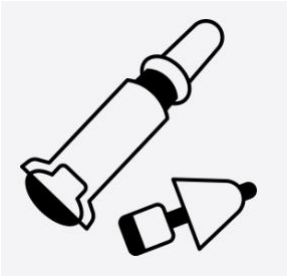
- May be administered in the inpatient setting, reimbursed outside of the All-Patient Refined Diagnosis Related Group (APR-DRG) when billed on outpatient claim
- Must be prior authorized

Refer to Appendix Z and the Physician-Administered Drugs web page on the Department website.

Take-Home Naloxone

Payment for take-home Naloxone (opioid antagonist) dispensed by a hospital upon discharge to members deemed at risk of opioid-related overdoses will be paid according to the Physician-Administered Drugs (PADs) payment methodology.

- Reimbursement requires submission of both an inpatient and outpatient claim
- No additional revenue or procedure codes can be present on the outpatient claim
- Outpatient claim must be submitted after the affiliated inpatient claim is paid



Take-Home Naloxone

The outpatient claim for the take-home Naloxone fee schedule payment must include:

- Healthcare Common Procedure Coding System (HCPCS) code for take-home Naloxone *(Attach invoice if G2215 is used)*
- Take-home Naloxone's affiliated National Drug Code (NDC)
- SE modifier
- Date of service that matches the dispense date within the inpatient claim's dates of service

Unbundled Durable Medical Equipment

Unbundled Durable Medical Equipment (DME) is carved out from outpatient claims.

- Must be billed on the CMS-1500 professional claim form

Refer to Appendix G on the Department website for a listing of the Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes that are unbundled from the Enhanced Ambulatory Patient Grouping (EAPG) methodology.

Never Events and Terminated Procedures

Never Event Reporting

Modifiers for never events must be reported when appropriate.

- PA: Surgery, wrong body part
- PB: Surgery, wrong patient
- PC: Wrong surgery on patient

Not considered payable on an outpatient claim

Terminated Procedure Reporting

Terminated procedures must be reported with modifiers 52 (reduced services) or 73 (discontinued services prior to anesthesia administration).

Span and Split Billing

Span billing is allowed for outpatient hospitals, rural health clinics and dialysis centers.

- Billed services must appear on one (1) claim
- Enter the beginning and ending dates of service
- Enter the date of service for each line item submitted
- Each date of service must be shown with a revenue code, procedure code, unit(s) and charge

Claims that cross over from one (1) calendar year to the next should be split billed by year to accommodate any rate changes.

Third-Party Payment Prorating

Providers should prorate third-party lump sum payments for multiple services billed to Health First Colorado on separate claim forms (e.g., outpatient, transportation).

Each Health First Colorado claim must include a copy of the third party's Explanation of Benefits or check with notation that the payment has been applied to multiple claims.

Third-Party Payment Prorating

How to Prorate Third-Party Payment

- Divide each individual billed service by the total billed amount to determine what percentage of the total billed amount is represented by each service
  - Example:
    $800 billed for outpatient services ÷ $1,000 (total billed amount) = 80%
    $200 billed for transportation services ÷ $1,000 = 20%
- Multiply the percentages by the amount received from the third party to determine how much of the third-party's payment went to each service
    80% for outpatient services x $700 (amount received from third party) = $560 20% for transportation services x $700 = $140
- Enter the difference between the total billed amount and the third-party prorated amount in the field for Estimated Amount Due
    $800 (billed for outpatient services) - $560 (amount received from third party) = $ 240 on the outpatient claim
    $200 (billed for transportation services) - $140 (amount received from third party) = $ 60 on the transportation claim

Behavioral Health

Behavioral Health

- The **primary diagnosis** determines when claims are submitted fee-for-service or to the Regional Accountable Entities (RAEs)
  - If a RAE-covered diagnosis, the claim is submitted to the RAE
  - If not a RAE-covered diagnosis or the member is not attributed to a RAE, the claim is submitted fee-for-service to Gainwell Technologies

- Split billing is not allowed
- Refer to the State Behavioral Health Services Billing Manual for more resources, including RAE-covered diagnoses
- Contact HCPF_BHCoding@state.co.us for behavioral health billing questions

Psychiatric Hospitals

Inpatient hospital psychiatric services are a benefit for members under the age of 21 when provided as a service of in-state hospitals.

- Services must involve active treatment which a team of physicians and other qualified personnel has determined is necessary on an inpatient basis
- Services must reasonably be expected to improve the condition or prevent further regression so that the services are no longer needed
- Services can continue to be provided to members who attain age 21 while receiving services and may be provided until the member attains age 22, if necessary

Outpatient services are not a benefit in psychiatric hospitals.

Psychiatric Hospitals

Inpatient services provided in psychiatric hospitals are reimbursed on a per diem basis:

- Step 1 (Revenue Code 114): day 1 through day 7
- Step 2 (Revenue Codes 124 and 134): day 8 through remainder of care at acute level

Psychiatric hospitals may bill on an interim basis for services.

- A new claim should be submitted for each span of time billed with:
  - the admission date representing the original date of admission
  - the From Date of Service representing the first date of service on the claim the To Date of Service representing the last date of service on the claim

Substance Use Disorders
Psychiatric Hospitals

Inpatient Substance Use Disorder (SUD) services are a benefit for members ages 21 to 64 with a primary SUD diagnosis when medically necessary as determined by the American Society for Addiction Medicine (ASAM) Criteria.

Reimbursement is on a per diem basis and rate are identified based on revenue code.

- Revenue code 1000 - ASAM Level 3.7: Medically Monitored Intensive Inpatient Treatment
- Revenue code 1002 - ASAM Level 3.7WM: Medically Monitored Inpatient Withdrawal Management

Members under the age of 21 may access these services through Early and Periodic Screening, Diagnostic and Treatment (EPSDT) in facilities that attest to having rehabilitation components required by the Department.

Substance Use Disorders

Reimbursement for inpatient SUD services include behavioral health treatment, medical treatment and room and board.

Refer to the Provider Manual for Resident and Inpatient Substance Use Disorder (SUD) Services located on the Ensuring Full Continuum SUD Benefits - Providers web page.

Hospitals must maintain an accurate count of all beds in their facility (regardless of whether they are utilized for psychiatric or SUD stays) in the Provider Web Portal.

Substance Use Disorders
Non-Psychiatric Hospitals

Inpatient Substance Use Disorder (SUD) services are a benefit for members of all ages with a primary SUD diagnosis when medically necessary as determined by the American Society for Addiction Medicine (ASAM) Criteria.

Inpatient SUD services should be billed using the following accommodation revenue codes:

- Revenue code 1000 - ASAM Level 3.7: Medically Monitored Intensive Inpatient Treatment
- Revenue code 1002 - ASAM Level 3.7WM: Medically Monitored Inpatient Withdrawal Management

Resources

Resources

For Our Providers web pages: https://hcpf.colorado.gov/our-providers

The **General Provider Information Manual** is an overview of the program, including billing and policy information.

The **Inpatient/Outpatient (IP/OP) Billing Manual** provides specific guidance for the inpatient and outpatient hospital benefits.

Inpatient Hospital Payment web page
Outpatient Hospital Payment web page
Ordering, Prescribing and Referring (OPR) Provider web page

Provider Contacts web page **Provider Training** web page

Provider Web Portal Quick Guides web page

hcpf.colorado.gov/our-providers

Where can I find…?

For Our Providers

- Enrollment forms
- Revalidation dates spreadsheet
- National Provider Identifier (NPI) information
- Provider types

- Fee schedules
- General Provider Information manual
- Billing manuals & appendices
- Forms
  - Prior Authorization Requests (PARs)
  - Load letters
  - Request to use paper claim form

- Newsletters
- What's New?

Where can I

- Check member eligibility
- Submit claims
- Review Prior Authorization Requests (PARs)
- Receive Remittance Advices (RAs)
- Complete provider maintenance requests

- Quick Guides for Web Portal
- Known issues
- EDI Support
- Training registration
- Information about
  - Accountable Care Collaborative & RAEs
  - Co-Pays
  - EVV

Why should you become a provider?	Provider enrollment	Provider services: Forms, rates, & billing manuals	What's new: Bulletins, updates & emails
CBMS: CO Benefits Management System	Long-Term Services and Supports	Web portal	
Revalidation	Provider contacts: Who to call for help	Provider resources: Quick guides, known issues, EDI, & training	

COLORADO
Department of Health Care Policy & Financing

COVID-19 Provider Information	Resources for HCBS Providers		
SAVE System	ColoradoPAR	DDDWeb	Value Based Payments

Thank you!