COMMENTS ON Behavioral Health Inpatient Payment Responsibilities
Rec'd as of 01/05/15

Item #	Rule Cite Line #	Comment From and Date rec'd.	Comment	Analysis/ Recommendation
1.		Nathan Jones Northern AZ Regional Behavioral Health Authority (NARBHA) Legal Council 01/05/15 Verbal comments	We are in full support of this rulemaking. We ask for a couple of clarifying points. We are dedicated to following all the rules and laws and contractual expectations of both DBHS and AHCCCS. 1. Clarify statement 8 of the NOPR which refers to this as an existing process consistent with current rules. To our knowledge capitation rates have not been based on this particular interpretation. For example current ACOM 432 states that RBHA's are not responsible for non-behavioral health professional fees related to co morbid conditions such as diabetes, hypertension, asthma, etc. I point this out only to say that this rulemaking does represent a change to existing methodology by making the RBHA responsible for all inpatient hospital services when the principal diagnosis on the claim is a behavioral health diagnosis. Again, NARBHA supports this change and all we want to do is provide the best service that we possibly can, but we would respectfully suggest since it does represent a change to existing methodology that we will need some time to implement. One possible suggestion would be that given the fact that the integrated RBHA contract will be coming into effect on 10/01/15, which would seem a logical implementation timeframe and one we would suggest and support. Given that situations relevant to this rulemaking will often arise with respect to persons who are living with a serious mental illness, for that population come 10/01/15 the acute and behavioral health contractors will be one and the same for that	1. Current ACOM Policy 432, which requires a RBHA to pay claims with a primary diagnosis of behavioral health, has been in effect since July 2012. Therefore, RBHA's were required to comply with this policy as of the effective date of the policy. The economic impact described in section 8 is accurate. Claims for professional fees are filed separately from inpatient facility claims. Payment of professional fees will vary depending on the primary diagnosis on the professional fee claims. Regardless of the principal diagnosis on the inpatient facility claim, payment responsibility for the professional fee is determined by the primary diagnosis on the professional fee claim. For example, if a member has an inpatient stay with a physical health principal diagnosis but the member receives a psych consult during the inpatient stay, that consult is billed separately on a CMS 1500 with a primary diagnosis of behavioral health, which becomes a RBHA financial responsibility.

			population assuming there has not been an opt out. This would enable the RBHA to provide the highest customer service to AHCCCS, DBHS and to the members. We are proposing a possible 10/01/15 implementation date for the agencies consideration.	
			2. Right now NARBHA subjects non-emergent inpatient hospitalization to prior authorization and emergent hospitalizations to retrospective review based on approved criteria pursuant to the AHCCCS Medical Policy Manual. It is anticipated that this rulemaking will be relevant to emergency situations, especially, and as such, NARBHA would suggest some clarification of the impact to non-*inpatient* emergency services, such as the emergency department, ambulances, etc. For example current ACOM 432 states an emergency transportation from the community to the hospital ED is the responsibility of the acute care contractor. Whether the rulemaking will change this aspect, whether the issue of correct diagnosis on claims can be explored and utilization and medical management activities, that is some clarification we would request as well. We are trying to suggest these things are in the states interest and to try and provide the best service we can. An effective	2. This rulemaking is limited to inpatient facility services. Non-*inpatient* services will be addressed in a separate rulemaking. The comments will be referred to the appropriate parties for consideration when drafting rule related to non-inpatient services.

			corporate compliance program, for example, utilization controls, is all parts of the services we provide to the state. These are furthered by RBHA's being able to do things such as, apply authorization and retrospective review criteria with clinical information available, and ensure things such as the diagnosis code on the claim matches the evidence on the chart. 3. Finally, NARBHA would like to note that it has not in the memory of any current staff had a claim dispute concerning allocation of financial responsibility between any two plans and the RBHA that has not been resolved amicably without need for a state fair hearing. We think this is evidence of our positive relationship with our provider network and our coordination with the acute care contractors. Once again as part of our service to the state. We respectfully submit that this change should operate prospectively only so that the RBHA can implement it as quickly as possible without changing the resolution of claims that have already been processed in a manner consistent with the understanding of our provider network. Thank you for the opportunity to comment. We want to emphasize again that we are in full support of this change. We ask only these clarifying points and make a few suggestions in interest of only being helpful with the implementation of this rule.	3. See response in item #1 above.
2.		Julie Bosserman Maricopa Medical Center	We have a few questions. 1. In regards to authorization, NARBHA mentioned that on emergent admissions they do retrospective authorization, in Maricopa County the expectation is	1. In the case of individuals enrolled in managed care, we would like to clarify that by both rule and policy emergency admissions do not require Prior

		01/05/15 Verbal comments	that we do prior authorization or notification within the 24 hour or 72 hour based on whether or not the patient is admitted to the ICU or to a floor status. What becomes difficult is when a patient comes in to the medical facility with something to treat medically rather than behavioral health-wise; we are looking to the acute plan for notification, authorization and ongoing concurrent review. It is not until the patient discharges that you actually get the final primary diagnosis. If the patient stays beyond the 24 or 72 hours, and many of ours do, we would exceed the timely notification requirements that are in statute right now. How will this be addressed?	Authorization (PA) and notification cannot be required by the managed care contractor any sooner than the 11th day following admission R9-22-210. In reference to FFS, the notification timeframe is 72 hours from the date of admission as cited under R9-22-210; this would only apply when the principal diagnosis is not a behavioral health diagnosis. In the case of the commenter's example the timely notification obligation would have been met to the acute plan. AHCCCS and ADHS/BHS are developing a process in which the acute contractors can assist the RBHA's with authorizing PA and concurrent review through 09/30/15. Effective 10/01/15 the newly awarded integrated RBHA's will be experienced with PA and concurrent review processes.
			2. This dates back to a time before CRS was integrated; we had similar problems then. We would notify the acute plan and then get a denial for the CRS diagnosis. There was a lot of hand holding where the acute plan would deny and refer to CRS, and CRS would deny and refer back to acute plan. Even when it was integrated where APIPA had both acute and CRS patients, the authorization frequently will be routed into the wrong channel inside United Healthcare. You	2. This rule is intended to clarify for providers as well as stakeholders the appropriate entity to which to submit a claim for payment.

			have a stay where you are providing some medically necessary services and the reimbursement is 0 because it goes here and by the time you get the denial and turn around you miss your timely billing. If you could address somehow those administrative issues with authorization and timely filing of the claim?	
			3. Regarding credentialing, we have taken two of these cases to hearing and one thing that does come up, because we are providing only medical services in the acute facility, is that all our physicians are internist; none of our physicians are behavioral health doctors. My guess is that they are billing with a psychiatric diagnosis and are not credentialed with the RBHA. So you have a whole credentialing issue that will come up and you will have all your psychiatric physicians that you have gone through the credentialing and now you will need to credential all your medical doctors with the RBHA.	3. This rulemaking relates to claims for inpatient hospital services only. Claims for professional fees are filed separately from inpatient facility claims. The professional claim will have no impact on the inpatient facility claim. With respect to those professional claims that have a behavioral health diagnosis, the RBHA is responsible for payment of professional claims. Therefore, those claims should be filed with the RBHA. The acute plan is responsible for payment of professional claims with a physical health diagnosis. Therefore, those claims should be filed with the acute plan.
			4. My understanding is that rather than the APR DRG reimbursement for a hospital stay it is not going to go to a tiered per day based on the ADHS?	4. If the principal diagnosis on the inpatient facility claim is behavioral, then the RBHA's will pay the ADHS per diem rate.
			5. That is currently around $670 per day, the APR DRG is hard to compare since that is paid in a lump sum but previous to 10/01/14 we were paid on a tiered per day	5. Pursuant to rule, ADHS pays the per diem rates. The difference in payment is a fiscal impact of the APR-DRG rule changes.

			based on where you're. The ICU day would bring roughly $2,500 and routine floor around $1,000, which is significantly more than the $670 proposed for the tiered per day from ADHS. There will be a significant financial impact to the hospitals making this change if we can get paid and taking a significant cut to the medical reimbursement.	
			6. In rule R9-22-1202 (A) it refers to the mental disorders in the ICD code set. Is it different than the ADHS list that they use, the addendum. Is it different or the same?	6. The requirement of this proposed rule is to utilize the latest ICD code set in use for purposes of identifying the principal diagnosis. This is currently the ICD9 code set. Please refer your question directly to ADHS regarding use of the addendum.
			7. In rule R9-22-1202 (D), in regards to FFS members, is AHCCCS going to be responsible for the FFS members when they have a primary behavioral health diagnosis? What is confusing is where it talks about IHS hospitals or a tribal hospital. What we get is a person who is only eligible for emergency services that come in for withdrawal. I assume the rules applicable would be the same where the RBHAs would be responsible for the emergent service. Would they pay under the APR DRG?	7. We are assuming that the question is related to services provided to Federal Emergency Services (FES) members. FES members are not assigned to a RBHA. AHCCCS is solely responsible for payment of emergent, behavioral and physical health services for FES members. If the member's service qualifies under the emergency service definition, then the AHCCCS Administration will pay APR DRG rates consistent with R9-22-712.61.
3.		Julie Bosserman Maricopa Medical Center 01/05/15	The assignment of financial responsibility by principal diagnosis code has created a lot of confusion because: 1. The ACOM states that the T/RBHA is responsible when the member is **medically stable.** Patients admitted for acute care services are not "medically	1. This is the reason for this rule clarification. ACOM Policy 432 is under revision as well.

		Written comments	stable" and the services provided are medical, not behavioral. For example, acute alcohol withdrawal might require intravenous sedatives to prevent seizures and intubation with mechanical ventilation for airway protection. These patients can be admitted, treated and discharged from an acute hospital **without** receiving any behavioral health services and the principal diagnosis can be behavioral health. **If financial responsibility is going to be assigned by the principal diagnosis, the rule and ACOM must be very clear that the principal diagnosis determines financial responsibility, not the place of service or the services provided. If the principal diagnosis is behavioral, the T/RBHA may be financially responsible for strictly acute care hospitalizations. If the principal diagnosis is medical, an Acute Contractor might be financially responsible for a behavioral health hospitalization.** 2. Admission notification is based on place of service. Acute hospitals notify the acute contractor and behavioral health hospitals notify the T/RBHA. Since the principal diagnosis is not assigned until discharge, facilities are likely to miss the timely notification deadlines if the principal diagnosis does not align with the place of service. **How is the rule going to prevent $0 reimbursement for medically necessary services if the acute plan denies for principal behavioral health diagnosis and the T/RBHA denied for late notification?**	2. See Item #2 (1) above.

			3. It is conceivable that an FES patient can be admitted to an acute care facility with an emergency medical condition related to a principal behavioral health diagnosis. **If AHCCCS is responsible for FES reimbursement, how will FES claims with a principal behavioral health diagnosis be adjudicated?** W**ill AHCCCS adjudicate these claims based on the APR-DRG or tier/day? How will the rule ensure these claims are not denied solely on their principal diagnosis?**	3. See Item #2 (7) above.
			4. **Is credentialing going to be an issue? Our medical doctors are credentialed with the Acute Contractors because they provide acute services. If financial responsibility is going to be assigned by the principal diagnosis, will our medical doctors need to be credentialed with the T/RBHA in order to bill the T/RBHA for acute hospitalizations coded with a principal behavioral health diagnosis?**	4. See Item #2 (3) above.
			5. Current contracts do not address T/RBHA reimbursement for acute stays. **What is the expected tier/day reimbursement from the T/RBHA? If the default is ADHS's rate of $665.33/day, this is significantly less than the $2,667.33/day ICU tier and the $1041.48/day routine tier reimbursement pre-Oct 2014. Depending on the length of stay, this rate will probably be less than the expected APR-DRG payment also. What can be done to ensure hospitals are not significantly underpaid for their services? Will there be an outlier calculation as**	5. T/RBHAs will pay the ADHS per diem rates; there is no outlier provision with those rates.

			there was prior to APR-DRG? Thank-you for your time and consideration.	

4.		Jason Bezozo Banner Health 01/05/15 Written comments	**The Proposed Regulation Perpetuates Confusion On Payment Responsibility Based On Diagnosis and Should Be Clarified** Banner was an active participant in the APR-DRG work group. We greatly appreciated the opportunity to assist AHCCCS in crafting this important modernizing change to hospital reimbursement. As with any new reimbursement system, however, no agency, consultant, or work group can anticipate each and every operational or financial repercussion of a new system. Once the focus moves beyond the "big picture" to details, there are invariably unanticipated problems. Such a problem now appears to be emerging with regard to inpatient reimbursement for behavioral health services and medical services originating from behavioral health conditions. Specifically, the proposed R9-22-1202 states, in pertinent part: R9-22-1202. ADHS, Contractor, and Administration and CRS Responsibilities A. ADHS responsibilities. ADHS is responsible for payment of behavioral health services provided to members except as specified under subsection (D) [FFS, ALTCS, and CRS]. ADHS' responsibility for payment ***of behavioral health services*** includes claims for inpatient hospital services, which ***may include physical health services***, when the principle diagnosis on the hospital claim is a behavioral health diagnosis. Behavioral health diagnosis are identified as "mental disorders in the latest "ICD code set. . . . C. Contractor responsibilities. A contractor shall: . . .	1. The objective of this rule is to clarify for hospitals, providers, and other stakeholders which AHCCCS managed care contractor (or T/RBHA) is responsible for the payment of inpatient hospitals stays when services are rendered for both physical and behavioral health conditions. We disagree with the commenter that it is less ambiguous to establish a payment rule based on an analysis of the relative degree to which physical health and behavioral health services are described in the detail of the individual claim. As reflected in the proposed rule, the administration has determined that the payment responsibility will be less ambiguous and will result in fewer claim denials if the responsible AHCCCS managed care contractor (or T/RBHA) is identified by the principal diagnosis on the claim for payment. While each inpatient claim can have multiple line-item services provided during a stay (which services can be either physical or behavioral health related), each claim has only one principal diagnosis.

			4. Be responsible for providing inpatient hospital services, which may include behavioral health inpatient hospital services, when the principle diagnosis on the hospital claim is other than a behavioral health diagnosis. (Underlined in original; italic bold added for emphasis). This language corresponds to that appearing in the APR-DRG regulation at R9-22-715.61(B): . . . claims for inpatient services ***that are covered by a RBHA or TRBHA***, where a primary diagnosis is a behavioral health diagnosis, shall be reimbursed as prescribed by ADHS: however, if the primary diagnosis is a medical diagnosis, the claim shall be processed under the DRG methodology. . .. We find this language inherently ambiguous. In discussions with various AHCCCS, RBHA, and acute contractor staff, it appears the agency and its contractors believe AHCCCS now equates the presence of a principal "behavioral health ***diagnosis***" with "behavioral health ***services.***" That is, AHCCCS is assuming any time there is a behavioral health ***diagnosis,*** the patient receives behavioral health ***services***. Indeed, that is what AHCCCS has stated in the Preamble to these Proposed Rules: The Administration is proposing to clarify through its rule, its existing policy that the RBHA is responsible for all inpatient hospital services if the principle diagnosis on the hospital claim is a behavioral health diagnosis. This assumes a false equivalency between ***diagnosis*** and ***services*** that is inconsistent with the statutes and regulations taken as a whole, the practice of medicine, the standard of care, and hospital operations industry wide. The very first sentence of R9-22-1202 begins "ADHS is	

			responsible for payment of ***behavioral health services*** . . ." "Behavioral Health Services" is a defined term in R9-22-1201(2)(h), and is restricted to services "for the evaluation and diagnosis or a mental health or substance abuse condition and the planned care, treatment, and rehabilitation of the member." "Behavioral health services" ***are not*** treatments of medical conditions that arise or originate in a behavioral health diagnosis. Some examples from actual cases are: • An overdose patient in respiratory distress, on a ventilator and in the ICU for 7 days. • A patient who is in withdrawal and comes to the ED, but has multiple seizures, tachycardia, and an extremely high white blood cell count, who undergoes IV antibiotic treatment and Video EEG. • A chronic smoker who has an acute acerbation of COPD due to smoking, whose physician describes his condition as arising from "tobacco abuse." • A patient with confusion and hallucinations, of unknown etiology, whose work up other than initial drug and alcohol screens was entirely neurological, cardiac, renal and infection related, but was ultimately discharged with a diagnosis of "unspecified psychosis."1 1 Conversely, there are patients in psychiatric units or psychiatric hospitals receiving ONLY behavioral health services who have a principal diagnosis that is not in the "behavioral range" and for whom the RBHA will not pay. Key among these are patients being treated for postpartum depression (code 648.44). This is a recognized behavioral condition, treated as such, and one for which AHCCCS has an explicit clinical policy. Yet the RBHAs will not pay for the	

			services because the code "is not within the behavioral range." A.A.C. R9-22-1202 should be revised to be consistent with the clear intent of the definitions as well as actual medical practice and standards in the community – patients who receive ***medical*** treatment for conditions or effects of their behavioral health principal diagnosis are the payment responsibility of the payer/contractor responsible for acute medical services. We certainly understand that in this electronic and data driven world, the Administration is seeking a "code based" mechanism to streamline financial operations and data collection. But the Administration should not let its desire for simplicity ignore the realities of patient care or create a "black hole" of unpaid claims. And while we understand that the acute contractors have been told they can override diagnosis code denials or recoupments in the claim dispute process after medical review confirms the medical nature of services, this exception process has not been formalized or made public, and we do not know if it is intended to apply to post October 1 claims. We also do not believe the ADHS and the RBHAs have been given the same permission; we certainly have not seen it in operation. **We recommend and request the following changes:** 1. The regulation should expressly require that any claim submitted to a payer (ADHS/TRBHA or acute contractor) that denies for improper principal diagnosis code for the payer type be automatically sent for medical review and exception processing based on actual services provided (subject to medical necessity, of course). 2. In addition, we ask that the Administration consider establishing a condition code (similar to the "61" used for outliers) that would flag a claim for medical review and	

			exception processing, which could then be documented in the encounter process. **Authorization Problems Created by The Rules Need to Be Addressed.** Diagnosis codes are established after the patient is discharged, not at admission. Indeed the very definition of a "principal diagnosis" is: "[T]he condition established ***after study*** to be chiefly responsible for the admission. Even though another diagnosis may be more severe than the principal diagnosis, the principal diagnosis, as defined above, is [entered on the UB]. CMS Medicare Claims Processing Manual (100-04), Ch. 23 § 10.2 The process of assigning diagnosis codes starts with the physician notes and other information in the medical records. After discharge, the record goes through a coding system (software and human validation) that matches the medical record to industry-standard coding requirements, and generates the diagnosis and procedure coding for the claim. This process can take several days, depending on the complexity of the claim and claim type. The Administration's rules require that hospitals notify the responsible plan within a specified time for emergencies and seek authorization. The regulations also permit a plan to deny payment of non-emergency claims for failure to obtain authorization. As currently contemplated, however, the responsible plan is determined by information only available after discharge. Even if limited clinical information about the patient is communicated to admitting staff during the admission process, the coding of that information would not be available, and the information may change at discharge.	

			It is inconsistent with the program goal of "cost containment" and efficiency to promulgate rules which require a hospital to notify two plans for every admission or risk losing the ability to be paid due to failure to notify the "right" payer. In most cases, and absent very obvious circumstances, the hospital will notify the acute contractor. For inpatient admissions, the notified plan has opportunity to concurrently review the stay and can refer the case to the alternate contractor if it believes such a referral is appropriate. We believe that **R9-22-1202(C) and (E)** should be amended to state that if a hospital notifies or receives authorization from either the acute contractor or ADHS/TRBHA, but subsequently bills the claim to a different AHCCCS payer type based on the principal diagnosis code or subsequent instructions from the authorizing plan, the claim cannot be denied for failure to notify or secure authorization. Put more simply, AHCCCS regulations and policies should presume that notice and authorization information is shared by all AHCCCS payers responsible for the patient. This approach will not only protect the hospital from unfair denials for failure to notify or secure authorization, but will encourage closer communication by the AHCCCS constituent contractors, moving the system closer to an integrated model for all members. **Adequacy of Behavioral Per Diem for Medical Cases** Finally, we must comment on what we believe will be inadequate rates for medical cases with behavioral principal diagnosis codes if these cases remain an ADHS/TRBHA responsibility. As you are aware, ADHS and its TRBHAs historically have not been responsible for patients being treated medically, even if the principal diagnosis code was "behavioral." Instead, the ADHS/TRBHA payment responsibility was limited to circumstances in which the patient had a behavioral health principal diagnosis ***and*** was receiving	

			"***behavioral health services***." The assigned "behavioral" per diem for FY 2014-2015 is $678.64 per day for all levels of acuity in a general acute care hospital. This rate is consistent with prior ADHS/TRBHA rates for ***behavioral health services*** and far below the final AHCCCS tiered per diem rates for hospitals. At the end of FY 2013-2014, the psychiatric tier was approximately $820 to $860 per day for Banner hospitals. The ADHS behavioral per diem of $678.64 is obviously lower than this final psychiatric tier. But more important to this discussion of ***medical*** treatment, the ADHS rate is only 2/3 of the final routine tier rate (approximately $1000 per day), and only 1/4 of the final ICU tier rate (approximately $2500 per day). We know from our experience that a significant number of patients admitted for withdrawal, suicide attempts, and overdoses are initially admitted to the intensive care unit due to respiratory distress, seizures, cardiac complications, organ failure, fluid or electrolyte imbalances, or other medical complications. Patients are transferred to telemetry or medical floors as their ***medical*** condition improves, while still requiring medical treatment. Medical treatment remains the predominant focus until the patient is medically stable and can be discharged to outpatient behavioral treatment or moved to a psychiatric unit or behavioral facility. The cost to Banner for caring for these patients is identical to the cost of caring for any similar medical patient in a general acute care hospital. A per diem based on providing traditional "behavioral health services" is inadequate to cover those costs. To the best of our knowledge, there has been no effort by ADHS or AHCCCS to re-evaluate the behavioral per diem in light of the increase patient acuity that will result from the addition of medical cases to the historic ADHS/TRBHA case mix. We certainly have not been asked to review relevant Banner "principal diagnosis code" claims and encounter data	

			generated by AHCCCS as is typical when the Administration engages in rate setting. If AHCCCS and ADHS are going to persist in using principal behavioral diagnosis code as the determining factor in payer responsibility, the rates should be revisited and, for general acute care hospitals, made commensurate with the final year of the per diems. Thank you again for the opportunity to submit these comments and your consideration. We look forward to continuing to work with AHCCCS and ADHS on the further development of the integrated delivery and payment system through both rule making and policy development. If you have any questions, please contact Jason Bezozo, System Director, Government Relations, at 602-747-8138 or at jason.bezozo@bannerhealth.com.	
5.		Kim Aguirre Northern Cochise Community Hospital 11/21/14 Written comments	We welcome a clear rule to the claim process as we go back and forth trying to obtain payment right now primarily with our Emergency Room claims. Please consider this as you finalize the inpatient process.	1. Although this rule delineates fiscal responsibility for inpatient stays, AHCCCS has published AHCCCS Contractor Operations Manual (ACOM) Policy 432 which addresses the emergency room claim issue.
6.		Julie Bosserman Maricopa Medical Center 11/21/14 Written comments	1. While MIHS appreciates the attempts of this proposed rule to clarify the responsible payer for an inpatient stay, the proposed rule should also clarify that the RHBA is responsible for payment even in situations where the patient was admitted for acute medical services, the Acute Contractor was notified but not the RBHA, and the principal diagnosis on discharge was behavioral health. Conversely, the proposed rule should also clarify that the Acute Contractor is responsible for payment even in situations where the patient was	1. See Item #2 (1) above.

			admitted for behavioral health services, the RBHA was notified but not the Acute Contractor, and the principal diagnosis on discharge was medical.	
			2. Currently, the acute contractor is notified when a patient is admitted to MMC for medical services and the RBHA is notified when a patient is admitted to Desert Vista or the Behavioral Health Annex for behavioral health services. Since the principal diagnosis is the condition, after study, which occasioned the admission to the hospital, it may not represent the majority of services provided during the hospitalization. The ambiguity arises when the principal diagnosis assigned at discharge changes the responsible payer and the responsible payer has not received timely notification of the admission.	2. See Item #2 (1) above.
			3. Under the proposed rule, the Contractor/RBHA authorizing inpatient services can be prevented from paying a claim secondary to the principal diagnosis on discharge and the claim can be denied by the Contractor/RBHA for lack of notification/prior authorization. It is unclear under the proposed rule where the financial responsibility lies in these circumstances. Is it the RBHA because the principle diagnosis is a behavioral health, even in the absence of prior notification? Or, is it the Contractor as a default payer because the RBHA has denied payment for lack of notification? The proposed rule must make that clear.	3. See Item #2 (1) above.