

Hospital Outpatient EAPG

Billing and Payment Questions

Q1 – What are the new codes that replace procedure code 92506?

A1 – Procedure code 92506 has been deleted effective December 31, 2013. Providers should use 92521, 92522, 92523, 92524 to report services previously covered by 92506. Only one code per visit should be reported on the revenue line.

Q2 – What should we expect in terms of payment for emergency department visits? [The facility] submitted a claim for 99284 (level 4 emergency department visit) and was expecting a payment of ~\$150. The claim returned with only \$20 in payment.

A2 – Under EAPG, the payment is dependent on the diagnosis codes and the procedure codes submitted. DMAS advises providers to code as completely as possible.

All services with applicable procedure codes provided during the visit must be submitted on the claim, including drugs. All providers, including those not participating in the 340B drug discount program, must continue to submit NDC codes and applicable HCPCS/CPT codes for each drug submitted.

Q3 – Is there a spreadsheet available to show how to price a claim?

A3 – The EAPG methodology uses a facility base rate along with an EAPG-specific weight for each revenue line. It is necessary to purchase the 3M software to determine the weights assigned for each procedure based on the 3M software logic and DMAS reimbursement scheme settings. The processed claim will have the EAPG weight assigned to each line on the remittance advice. The sum of the EAPG weights times the facility-specific base rate determines the payment. There is no spreadsheet available for pricing claims.

Q4 – Do the facility base rates take into account the Medicare wage index and the 5% increase for children’s hospitals?

A4 – The facility base rate reflects regional differences but not all hospitals in a region will have the same rate. The base rate is a blend of the percent of charges (cost) rate and the full EAPG rate. A 5-percent differential applies to children’s hospitals and was factored into the calculation of the base rate for children’s hospitals.

Q5 – Are medical records for emergency department visits no longer required?

A5 – For emergency department visits with a date of service on or after January 1, 2014, medical records will no longer be required for payment of hospital outpatient services. Hospitals may be required to send records for physician emergency department services.

Q6 – Has the billing manual been updated to reflect EAPG implementation? Has the provider manual been updated?

A6 – The billing and the provider manuals are in the process of being updated. The provider manual will be updated and is available from the DMAS web portal:

<https://www.viriniamedicaid.dmas.virginia.gov/wps/portal>

Q7 – How will payment be handled if a claim audit shows that a procedure is not supported by medical records? Will the claim be run through the grouper a second time without the procedure?

A7 – The post-payment audit procedures have not changed with the implementation of EAPG. Providers will receive a letter with an explanation of what the claim would have paid. Hospitals will be expected to adjust their claims accordingly.

Q8 – What are the discounting rules?

A8 – The discounting rules are similar to before EAPG implementation. Multiple unconsolidated significant procedures and multiple unpackaged ancillaries are discounted.

Q9 – Does EAPG support DME?

A9 – Providers should continue to bill DME as before. Although payment will not appear on the DME revenue line, DME payment will be included on other procedures. Providers should bill for DME (and supplies) even if they see zero payment.

Q10 – What is the transition period for EAPG?

A10 – Because implementation began January 1, 2014, the EAPG transition period will be for 3½ years in 25-percent increments. The transition rate for each hospital will be a blend of cost-based reimbursement and EAPG reimbursement. DMAS shall also calculate a budget neutrality adjustment every six months during the first six years of implementation beginning January 1, 2015.

Q11 – Will Virginia be reporting episodes and visit claims?

A11 – Virginia will not be reporting episodes and visit claims.

Q12 – Are separate payments for capital included?

A12 – Capital payments are included in the EAPG base rate. The base rate is inclusive of operating and capital expenses.

Q13 – Who is the best point of contact at DMAS for EAPG questions?

A13 – Providers should contact the provider helpline with questions. If your question is not resolved by the provider helpline, you may send questions related to payment policies to the email address: HospitalEAPG@dmas.virginia.gov. Questions will be routed to appropriate DMAS staff for answers.

Q14 – If we include the “UD” modifier with the pharmacy revenue lines, will those drugs continue to be reimbursed? It appears that the drugs are bundled with other procedures.

A14 – You will continue to be reimbursed for those drugs but providers participating in the 340B drug discount program must report the “UD” modifier. The “UD” modifier indicates that the drug was provided through 340B and should be discounted consistent with reporting of the lowest acquisition costs. Drugs for all providers, whether participating in 340B or not, may not be paid separately. Providers should continue to report the drugs and the appropriate charges on the claims consistent with the current billing policies.

Q15 – What claims data are used to group a claim into a specific EAPG?

A15 – The HCPCS/CPT codes as well as the diagnosis codes are used to group a procedure to a specific EAPG. The patient’s demographics including sex and age also determine the EAPG assignment.

Q16 – How do we determine how many authorized visits a patient has left? Is this different from when we determined the authorized units before EAPG?

A16 – The process for determining the number of authorized visits did not change after the implementation of EAPG. Providers can call the DMAS help line or use the utilization review (UR) screen in the Automated Response System (ARS) through the DMAS web portal.

Q17 – On the Outpatient Percentages spreadsheet, what is the difference between the last activity date and the rate begin date?

A17 – The hospital outpatient percent of charge spreadsheet is available from: http://www.dmas.virginia.gov/Content_atchs/pr/pr-outptnt_prcnt.pdf. The rate begin date is the effective date of the rate and the last activity date was the date that the rate was entered into the system at cost settlement. Effective January 1, 2014, this report will be updated on a quarterly basis as all outpatient hospital claims will be reimbursed through EAPG.