DC Medicaid EAPG Training

Provider Training

September 16, 2014

Agenda

- Project overview
- Project goals
- EAPG overview
- Changes in billing & pricing policy
- Remittance advice changes
- New exception codes
- Understanding the three major visit types
- Key data elements
- Bundling techniques
- EAPG payment calculation
- Example claim
- Questions
- Test your understanding!

Disclaimers

- This material is solely the responsibility of the Xerox Corporation, in its capacity as a consultant to DHCF
- The information in this presentation is descriptive of the EAPG grouper version 3.8 released in January 2013
- The EAPG grouper is proprietary computer software created, owned and licensed by the 3M Company. All copyrights in and to the 3MTM Software are owned by 3M. All rights reserved
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Background

Outpatient Hospital Project

- Includes DRG hospitals, non-DRG hospitals (specialty hospitals) and out-of-District hospitals except Maryland
- Currently using very outdated system, dependent in part on ICD-9 codes. Components of current method include:
  - Institutional rate – flat, hospital-specific rate triggered by list of visit codes (mostly E&M codes)
  - Institutional rate with ER add on – Principal diagnoses defined as emergent get a 40% increase
  - Institutional percent – for out-of-District hospitals and National Rehab Hospital
  - Outpatient surgery flat rates – similar to extinct Medicare ASC group methodology
  - HCPCS procedure code pricing – mostly lab & radiology
  - $50 per visit – non-emergent ER visits
- Implementation date is **October 1, 2014**

Background

Outpatient Hospital Project Goals

- Implement a sustainable payment method. Flexibility to accommodate ongoing changes in payment policy and federal regulatory requirements
- Increase fairness. Similar pay for similar care
- Reduce administrative burden. Maintaining the various components of the current payment method presents an administrative burden which will become untenable under ICD-10 in October 2015
- Improve purchasing clarity. The ability to understand how much Medicaid is paying for specific types of outpatient services

EAPG Overview

E - Enhanced

A - Ambulatory

P - Patient

G - Grouping

Introduction

EAPG Overview

- EAPGs are designed by 3M to explain the amount and type of resources used in an ambulatory visit
  - Patients in each EAPG have similar clinical characteristics and similar resource use and cost
- EAPGs developed to represent ambulatory patient across entire patient population, not just Medicare
- Grouping and pricing decisions are at the line level
- Multiple EAPGs may be assigned per visit
- Grouper creates ~ 20 new data elements for each line, which influence or explain the line grouping and pricing
- Evaluates both the CPT/HCPCS codes and the ICD-9 diagnosis codes

EAPG Overview

- The EAPG grouper software includes over 100 different pricing options that allow payer to define payment parameters
  - Discounting levels
  - Modifier pricing
  - Consolidation options
  - Conversion factors
- EAPGs users include:
  - Current Medicaid users: NY, MA, VA, WI, WA, IL
  - Medicaid implementations committed or in process: DC, CO, TX
  - Commercial payers include Oklahoma BlueCross BlueShield, Minnesota BlueCross BlueShield, and Wellmark in Iowa and South Dakota

EAPGs in DC

- DC will implement version 3.8 (January 2013) of the grouper and use version 3.8 of the national EAPG relative weights
- In version 3.8, there are 553 EAPGs
- Hospitals may purchase a DC-specific desktop version of the grouper from 3M; DHCF will process claims with a mainframe version of the grouper
- Grouper software is updated quarterly with code changes and annually with major logic changes
- Conversion factors and rates will be evaluated at least annually
- DC will move to a new version of the EAPG grouper and corresponding relative weights every two years; the January 2015 version will be implemented in October 2016

Observation Services

- DHCF will change its current policy and pay separately for observation services under certain specific conditions
- The new policy requires that observation services must be at least 8 hours and not more than 48 hours.
- The counter for these limits starts at the time that the physician order is written.
- Payment for observation room services will be based on the EAPG relative weight, not on the number of units.
- Observation services are always packaged in the presence of a significant procedure.
- For more detailed information on EAPG observation payment logic, please see the *Information About EAPGs* document posted on the DC Medicaid website at https://www.dc-medicaid.com/dcwebportal/home.

Changes in Billing and Pricing Policy

The Three-Day Payment Window

- Hospital outpatient diagnostic services provided one to three days prior to an inpatient admission at the same hospital are not separately payable and should be billed as part of the inpatient stay.
- Eligible diagnostic services are defined by revenue code, for example, lab 030x and diagnostic radiology 032x
- Non-diagnostic outpatient services may be billed and paid separately
- All hospital outpatient services that occur on the same day as an inpatient admission at the same hospital are also considered part of the inpatient stay and as such are not separately payable. These services should be billed as part of the inpatient stay.
- This policy applies to all providers that DC considers a general acute care hospital, both in-District and out-of-District, including Children's Hospital
  - National Rehabilitation Hospital, Hospital for Sick Children and Maryland hospitals are exempt from this policy

Changes in Billing and Pricing Policy

The Three-Day Payment Window

Diagnostic Revenue Codes for 3-Day Window	Revenue Code Desc
0254 - 0255	Pharmacy
0341, 0343	Nuclear Medicine
0371 - 0372	Anesthesia
0471	Diagnostic audiology
0482 - 0483	Cardiology
0918	Behaviorial health svcs
0300 - 0319	Laboratory
0320 - 0329	Diagnostic radiology
0350 - 0359	CT Scan
0400 - 0409	Other imaging
0460 - 0469	Pulmonary function
0530 - 0539	Osteopathic svcs
0610 - 0619	Magnetic resonance tech
0621 - 0624	Med/surg supplies
0730 - 0739	EKG/ECG
0740	EEG
0920 - 0929	Other dx Services

Changes in Billing and Pricing Policy

Visits Per Claim

- EAPG grouper may define a visit as all services on a claim or may divide the claim into multiple visits based on dates of service.
- A visit cannot be defined by dates of service across different claims.
- DC currently does not allow span billing; that is, separate dates of service do not receive separate payment.
- Hospitals stated that Medicare and other payers allow providers to bill for recurring services in 30 day increments
- DHCF decided to change the current span billing policy so that providers could begin span billing beginning with dates of service in October 2014

Type of Bill 0830-0838

- The DC ASC fee schedule will no longer be used for payment of outpatient hospital surgery services or for chemotherapy/radiation therapy services effective October 1, 2014
- Outpatient hospital surgeries and chemotherapy/radiation therapy services will be paid by EAPG
- The TOB code is a required claim element that provides specific information about the bill for the payer
- Includes 4 digits in the following sequence:
  - 1st – always zero
  - 2nd – type of facility
  - 3rd – bill classification
  - 4th – frequency
- Hospitals should discontinue usage of bill types 0830-0838 for billing outpatient hospital surgery and chemotherapy/radiation therapy services
- TOBs for outpatient hospital services are 0130-0138

Changes in Billing and Pricing Policy

Other Changes

Billing and Payment Policy	Decision
Laboratory Services	Lab services will be paid by EAPG, including consolidation, packaging and discounting logic. Reference billing for lab services will be disallowed under the new payment method. Hospitals should bill for services referred to an outside independent lab on their outpatient hospital claim.
Professional Fees Revenue Codes	Professional fees revenue codes (0960-0989) will be disallowed on outpatient hospital claims (UB-04). These professional services should continue to be billed on professional claims (CMS-1500).
Inpatient Only List	The inpatient-only list is a group of identified procedures that are typically provided only in an inpatient setting and therefore, will not be paid under EAPGs.
Pediatric Policy Adjustor	A pediatric policy adjustor of 25% is applied as percentage increase to EAPG payment on claims for beneficiaries under age 21. On pediatric claims, the payment on every line with a final payment greater than zero will be multiplied by 1.25.

Other Changes

Billing and Payment Policy	Decision
Not Used/Never Pay List	A list of "never-pay" procedure codes will include: • Emergent technology codes or HCPCS ending in "T" • Outcomes codes or HCPCS ending in "F" • DHCF may make additions to this list in the future
Units of service	The national relative weights developed by 3M used total cost as a basis for development. Using total cost means that the weight for each EAPG is based on the average number of units that were billed. The total cost of the EAPG is inclusive of all the procedures with different units of service.
Visit Codes and Institutional Rates	Hospitals are no longer required to bill one of the designated "visit codes" in order to be paid for an outpatient visit. Hospitals should code claims based on national CPT/HCPCS coding guidelines.
Ranking of claim lines	The order in which claim lines or HCPCS procedures are billed on the claim is not relevant for accurate payment. Under certain circumstances the grouper will rank procedures by EAPG weight for discounting or consolidation purposes. This occurs regardless of the order in which lines are billed on the claim
Modifiers and EAPGs	The EAPG grouper recognizes a number of modifiers which may potentially impact payment. Some modifiers are used to increase or decrease the payment amount. Some modifiers are informational and will not affect payment. However, hospitals should continue to bill using standard coding conventions. For a list of the modifiers that impact payment under EAPGs, please see FAQ document posted at https://www.dc-medicaid.com/dcwebportal/home

Remittance Advice – Electronic 835

2110 Loop Service Payment Information:

- REF – Service Identification REF01 = 1S Ambulatory Patient Group (APG) Number, REF02 = EAPG Code

- QTY – Service Supplemental Quantity QTY01 = ZK Federal Medicare/Medicaid Payment Mandate–Cat 1, QTY02 = Full EAPG Weight

- QTY – Service Supplemental Quantity QTY01 = ZL Federal Medicare/Medicaid Payment Mandate–Cat 2, QTY02 = Payment Percentage

MMIS Changes for EAPGs

Remittance Advice – Electronic 835

- Full EAPG weight x the payment percent = the adjusted EAPG weight
- Adjusted EAPG weight x the conversion factor = EAPG payment
- Final claim payment = EAPG payment after any applicable MMIS adjustments

10 X835-SVC-SUBS-UNITS-OF-SVC		438	NS	10.5	0.00000	
05 X835-SVC-DT-SEG(1)		453		11		
10 X835-SVC-DT-CD(1)		453	C	3	472	
10 X835-SVC-DT(1)	456 C 8				20131015	
05 X835-SVC-DT-SEG(2)		464		11		
10 X835-SVC-DT-CD(2)		464	C	3		
10 X835-SVC-DT(2)	467 C 8					
05 X835-SVC-ID-SEG(1)		475		53		
10 X835-SVC-ID-CD(1)		**475**	**C**	**3**	**1S**	
10 X835-SVC-ID(1)	**478 C 50**				**00403**	← **EAPG Payment Code**
05 X835-SVC-LI-CTL-SEG		528		53		
10 X835-SVC-LI-CTL-NUM-QL		528	C	3		
10 X835-SVC-LI-CTL-NUM		531	C	50		
05 X835-SVC-REND-PROV-SEG(1)		581		53		
10 X835-SVC-REND-ID-CD(1)		581	C	3	HPI	
10 X835-SVC-REND-ID(1)		584	C	50	1790785996	
05 X835-SVC-SUPL-INFO-SEG(1)		634		21		
10 X835-SVC-SUPL-AMT-CD(1)		634	C	3	B6	
10 X835-SVC-SUPL-AMT(1)		637	NS	16.2	6.83	
05 X835-SVC-SUPL-QTY-SEG(1)		655		17		
10 X835-SVC-SUPL-QTY-CD(1)		**655**	**C**	**2**	**ZK**	
10 X835-SVC-SUPL-QTY(1)		**657**	**NS**	**10.5**	**0.01910**	← **EAPG Weight**
05 X835-SVC-SUPL-QTY-SEG(2)		672		17		
10 X835-SVC-SUPL-QTY-CD(2)		**672**	**C**	**2**	**ZL**	
10 X835-SVC-SUPL-QTY(2)		**674**	**NS**	**10.5**	**100.00000**	← **EAPG Payment Percentage**

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MMIS Changes for EAPGs

Remittance Advice - Paper

```
==========================================================================
RECIPIENT NAME              MEDICAID ID     TCN            PAT ACCT NUM
DATES OF SERVICE  TOB  SVC PVDR  SERVICE PROVIDER NAME     SUBMITTED AMT   FEE
 LINE EAPG/WGT/PAY PRCT  PROC      TYPE/DESC          M1 M2 M3 M4  REVC
    DATES OF SERV      LINE UNITS   LN SUBM AMOUNT   LN FEE REDUCT AMT
==========================================================================
BRAKE HUBERT                 70460400  11237820000000047 SRN8941773
10/[redacted] 131  03042[redacted]INIA HOSPITAL CENTER      1,317.50
  EXCEPTION CODES: 0127 2532
  EXPLANATION OF BENEFITS CODES (EOB): 0144 2532
  1  00403 0.0191 100   80053     HC/HCPCS/CPT CODE              0301
     10/15/13-10/15/13       1.00        380.10          373.27
  2  00404 0.0487 100   80101     HC/HCPCS/CPT CODE              0301
     10/15/13-10/15/13      10.00        260.00          242.59
  3  00405 0.0300 100   80299     HC/HCPCS/CPT CODE              0301
     10/15/13-10/15/13       1.00         26.00           15.27
  EXCEPTION CODES: 0366
  EXPLANATION OF BENEFITS CODES (EOB): 0366
  4  00400 0.0202   0   82055     HC/HCPCS/CPT CODE              0301
     10/15/13-10/15/13       1.00        199.20          199.20
  5  00408 0.0152   0   85025     HC/HCPCS/CPT CODE              0305
     10/15/13-10/15/13       1.00        123.40          123.40
  6  00826 0.3270 100   99282     HC/HCPCS/CPT CODE    25        0450
     10/15/13-10/15/13       1.00        205.60           88.70
  7  00413 0.0548   0   93005     HC/HCPCS/CPT CODE              0730
     10/15/13-10/15/13       1.00        123.20          123.20
```

- Full EAPG weight x the payment percent = the adjusted EAPG weight
- Adjusted EAPG weight x the conversion factor = EAPG payment
- Final claim payment = EAPG payment after any applicable MMIS adjustments

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MMIS Changes for EAPGs

Web Portal Screenshots

Claim Status Inquiry

Claim Detail	
TCN:	132
Effective Date:	08/06/2014
Recipient ID:	
Recipient Information	
Name:	
Gender:	Male
Date Of Birth:	05/03/2013
Claim Status	
Service Period:	Begin:08/02/2013 End:08/02/2013
Status Category:	F0 - Finalized/Payment -- The claim has been paid.
Status:	O - To be Paid
Institutional Bill Type:	131
DRG Information	
Drg Code:	
DRG Code Weight	0.00000

Web Portal Screenshots

Payment Information

Line Items

Ln#	Service Dates		Product / Service id	Status Category	Status	Modifiers				Line Item Control Number	Revenue Code	Submitted Charges	Submitted Units	Amount Paid:$
	Begin	End				1	2	3	4					
1	08/02/2013	08/02/2013	90471	00087049	A-Allowed Charge						0982	45.00	1.0	0.00
2	08/02/2013	08/02/2013	90472	00087049	A-Allowed Charge						0982	52.00	1.0	0.00
3	08/02/2013	08/02/2013	90473	00087049	D-Denied						0982	41.00	1.0	0.00
4	08/02/2013	08/02/2013	90670	00087049	A-Allowed Charge						0982	147.00	1.0	41.94
5	08/02/2013	08/02/2013	90698	00087049	A-Allowed Charge						0982	103.00	1.0	0.00
6	08/02/2013	08/02/2013	99212	00087049	D-Denied						0982	73.00	1.0	0.00
7	08/02/2013	08/02/2013	99391	00087049	D-Denied						0982	170.00	1.0	0.00
8	01/01/0001	01/01/0001		00087049	-Reimbusement is undetermined						0001	631.00	7.0	0.00

EAPG Pricing Details

Ln#	EAPG	Full EAPG Weight	Adj EAPG Weight	Payment Percent	Line Payment	Payment Action
1	00459	0.063200	0.000000	0.000	0.00	04 - PACKAGED
2	00459	0.063200	0.000000	0.000	0.00	04 - PACKAGED
3	00459	0.063200	0.000000	0.000	0.00	04 - PACKAGED
4	00415	0.049500	0.049500	1.000	33.55	01 - FULL PAYMENT
5	00999	0.000000	0.000000	0.000	0.00	05 - NO PAYMENT
6	00877	0.250500	0.250500	1.000	169.80	01 - FULL PAYMENT
7	00491	0.000000	0.000000	0.000	0.00	04 - PACKAGED

Important Note:

- The EAPG Pricing Details window below shows the grouper output *before* any MMIS edits, denials, or adjustments are applied.
- The Line Items Payment Information window above shows final payments by line *after* MMIS processing. See line 6.

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MMIS Changes for EAPGs

Web Portal Screenshots

7	00491	0.000000	0.000000	0.000	0.00	04 - PACKAGED
8		0.000000	0.000000	0.000	0.00	-

Line Items Exception *Move cursor over exception code for more information

Ln item #	Exception Code	Status
3	8500	3-Deny
6	8500	3-Deny
7	8500	3-Deny

New Inquiry

- Line 6 was denied by MMIS edit after passing through the EAPG grouper

MMIS Changes for EAPGs

EAPG New Exception Codes

EAPG Unassigned Code	OmniCaid Exception	Description	Exception Disposition	Resolution
00	N/A	EAPG Assigned	N/A	N/A
01	N/A	User Ignored (Line Action Flag)	N/A	N/A
02	2501	Inpatient Only Procedure reported on Outpatient Claim	Pay & Report	Service is not covered as outpatient procedure
03	2502	Invalid Procedure Code	Pay & Report	
04	N/A	Not Used by APGs	N/A	
05	2503	Invalid Diagnosis Code for Medical Visit	Pay & Report	
06	2504	E-Code Diagnosis for Medical Visit	Pay & Report	
07	2505	Non-covered care or settings	Pay & Report	
08	2506	Invalid or out of range date for the version of EAPG Grouper	Pay & Report	
09	2507	Invalid Procedure (cannot be blank)	Ignore	

While the disposition on many of these exceptions is "Pay & Report", any line with an EAPG of 999 will "pay" zero.

EAPG New Exception Codes

EAPG Unassigned Code	OmniCaid Exception	Description	Exception Disposition	Resolution
10	2508	Direct Per Diem Code without qualifying PDX	Pay & Report	
11	2509	Observation Condition Error	Pay & Report	
12	2510	DAO Condition Error	Pay & Report	
13	2511	Gender unknown or invalid for medical gender specific APG assignment	Pay & Report	
14	2512	Home Management	Pay & Report	
15	2513	User Option for Direct PD Assignment Off	Pay & Report	
16	2514	EAPG Assignment condition not met	Pay & Report	
17	2515	Never Event Modifier Present	Deny	
18	2516	Observation Hour's Condition Error	Pay & Report	
19	2517	Patient Age not reported for preventative Medicine Visit	Pay & Report	
Other	2518	Unknown Return Code	Super Suspend	

While the disposition on many of these exceptions is "Pay & Report", any line with an EAPG of 999 will "pay" zero.

EAPG New Exception Codes

Each non-zero condition code will map to a separate MMIS exception code as follows:

Condition Code	OMNICAID Claims Exception	Exception Disposition	Category Description
02	2531	Ignore	NCCI/MUE Exceptions
04	2532	Deny	Data Error Related to Input to EAPG Grouper
06	2533	Ignore	Reserved for future use
08	2534	Suspend	Data Error in Data being passed to EAPG Grouper
10	2535	Ignore	Reserved for future use
12	2536	Super Suspend	Technical Error related to EAPG implementation

Three Major Visit Types Defined

- Significant Procedure - normally scheduled, constitutes the reason for the visit, and consumes the majority of the visit resources
- Ancillary Procedures - ordered by the primary physician to assist in patient diagnosis or treatment
- Medical Visit - must have an evaluation and management (E/M) CPT code and usually do not have a significant procedure
  - ICD diagnosis codes help classify medical visits into clinically appropriate EAPGs

How EAPGs Work

Three Major Visit Types

Primary EAPG Type	Items Included in the Base EAPG Payment	Items for Which Additional Payment is Permitted
Significant procedure or therapy	- Routine ancillaries - Incidental procedures - Supplies - Drugs (except chemo & selected drugs & biologicals - Anesthesia	- Significant unrelated procedures with any applicable discounts - Non-packaged ancillaries - Chemo & selected drugs & biologicals
Medical visit	- Packaged routine ancillaries - Incidental procedures - Supplies - Drugs (except chemo & selected drugs & biologicals	- Non-packaged ancillaries - Chemo & selected drugs & biologicals
Ancillary only		- All "ancillary only" items are paid separately - May be subject to discounting
Source: 3M Health Information Systems, Definitions Manual, Version 3.8.13.1, January 2013		

EAPG Type

- 13 EAPG types; 6 are significant procedure types
  - Types 2, and 21 through 25 are all significant procedure types
- Classifies the EAPG at the line level
- Every HCPCS code maps to an EAPG; every EAPG has a pre-determined EAPG type

Type	Description	No. of EAPGs
1	Per diem	4
2	Significant procedure	*148*
21	Physical therapy & rehab	*10*
22	Mental health & counseling	*15*
23	Dental procedure	*23*
24	Radiologic procedure	*27*
25	Diagnostic significant procedure	*15*
3	Medical visit	190
4	Ancillary	67
5	Incidental	3
6	Drug	23
7	DME	25
8	Unassigned	3

EAPG Payment Action Code

- Describes how the line was handled in the grouper/pricer
- 16 payment action codes
- Some of payment action codes do not apply to the DC grouper

Payment Action Code	Payment Action Code Desc	Payment Action Code	Payment Action Code Desc
00	Not processed	08	Stand alone
01	Full payment	09	Excluded
02	Consolidated	10	Per diem
03	Discounted	11	Low cost outlier
04	Packaged	12	High cost outlier
05	No payment	13	Alternate payment
06	Bilateral	14	Manually priced
07	Discounted bilateral	19	Never pay

EAPG Bundling Techniques - Defined

- Packaging refers to the inclusion of payment for certain services within payment for significant procedures or medical services
- Consolidation refers to the collapsing of multiple-related significant procedure EAPGs into a single EAPG for the purpose of the determination of payment. The rationale is that when one significant procedure is performed, additional significant procedures may require minimal additional time or resources. Multiple unrelated significant procedures performed during the same visit are not consolidated.
  - Packaged or Consolidated services receive no separate payment
- Discounting refers to a reduction in the standard payment rate for an EAPG. Discounting recognizes that the marginal cost of providing a second procedure to a patient during a single visit is less than the cost of providing the procedure by itself.

More on EAPG Bundling Techniques

Ancillary Packaging

- Standard list of packaged EAPGs are built into the grouper which can be modified by user – packaging occurs only in significant procedure visits or medical visits
- Applies only to routine ancillary services and drugs
- List of incidental EAPGs contained in the grouper cannot be modified

Consolidation – ranks by EAPG weight

- Significant Procedures only
  - Same significant procedure – applies to same EAPG
  - Clinically related significant procedure – applies to related EAPG

Discounting

- Repeated Ancillary Procedure – applies to same EAPG
- Significant Procedure – applies to those unrelated – ranks each significant procedure line by EAPG weight for discounting

EAPG Payment

- HCPCS codes on each line of the claim are assigned with an EAPG
- Claim lines without a HCPCS procedure code group to unassigned EAPG
- Each EAPG has a relative weight
  - Full EAPG weight – national weights developed by 3M
  - Adjusted EAPG weight = the full EAPG weight after the claim passes through the grouper and is adjusted by discounting, packaging and consolidation
- The grouper assigns a series of flags and other action indicators that influence the pricing of each line
  - Those assignments may depend on attributes of the other lines on the claim
- Consolidated, packaged or unassigned lines are always “paid” zero

How EAPGs Work

Calculating EAPG Payment

FY15 EAPG Conversion Factors	
National Rehabilitation Hospital	$273.65
United Medical Center	$693.71
All other hospitals	$680.11

EAPG Payment for each line =

Adjusted EAPG weight x conversion factor

EAPG Payment for the visit =

Sum of the EAPG payment on each line

Final claim payment =

EAPG payment adjusted by any applicable MMIS edits, denials, and/or adjustments (including the pediatric policy adjustor)

EAPG Example Claim

CPT Code	EAPG Assigned	Payment Element	Payment Action	Applied EAPG Discount
31545	063 - Level II Endoscopy of Upper Airway	Significant Procedure	Full Payment	100%
31515	062 - Level I Endoscopy of Upper Airway	Related Procedure	Consolidated	0%
42405	252 - Level I Facial & ENT Procedures	Unrelated Procedure	Discounted	50%
88331	390 - Level I Pathology	Routine Ancillary	Packaged	0%
82435	402 - Basic Chemistry Tests	Routine Ancillary	Packaged	0%
93000	413 - Cardiogram	Routine Ancillary	Packaged	0%
00322	380 - Anesthesia	Routine Ancillary	Packaged	0%
84233	399 - Level II Endocrinology Tests	Non Routine Ancillary	Full Payment	100%
Source: 3M Health Information Systems, Definitions Manual, Version 3.8.13.1, January 2013				

Questions??

Test Your Understanding!

Please Also See…

Posted at https://www.dc-medicaid.com/dcwebportal/home

- Items under “What’s Hot” banner

FAQ	This FAQ document which provides DC Medicaid policy, payment and billing information about the new outpatient hospital payment method. FAQs are periodically updated and distributed to hospitals.
Information About EAPGs	A separate document which provides general information about EAPGs.

Acronyms

Acronym	Description
ASC	Ambulatory Surgical Centers
CCR	Cost-to-charge ratio
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DHCF	Department of Health Care Finance
DC	District of Columbia
EAPG	Enhanced Ambulatory Patient Groups
EOB	Explanation of benefits
ER	Emergency room
E/M	Evaluation and Management, refers to CPT procedure codes
FAQ	Frequently Asked Questions
FFS	Fee-for-service
HCPCS	Healthcare Common Procedure Coding System
ICD-9-CM	International Classification of Diseases, 9th Edition, Clinical Modification
ICD-10-CM	International Classification of Diseases, 10th Edition, Clinical Modification
ICD-10-PCS	International Classification of Diseases, 10th Edition, Procedure Coding System
MMIS	Medicaid Management Information System
NCCI	National Correct Coding Initiative
OPPS	Outpatient Prospective Payment System
PA	Prior authorization
TOB	Type of bill
UB-04	Centers for Medicare and Medicaid Services Uniform Billing Form
VFC	Vaccines for Children

For Further Information

For more information on Medicaid payment methods, please go to www.xerox.com/Medicaid

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