Provider Summary of EAPG Engagement Meeting 10/6/2017

Please Note: There are no Slides for this meeting

Welcome Message and Meeting Etiquette (Time 0:00 – 05:30)

- Staff Introductions
- Created a Known Issues Log

Known Issues Log (Time 05:30 – 01:08:45)

Lower of Pricing (Time 05:44 – 11:43)

- Current EAPG pricing Methodology utilizes a lower of pricing to price a line item at the lower of the line's submitted charges or the EAPG Payment.
- Line charges cannot be accurately compared to EAPG Payment.
- Department has been working with 3M and as of October 12th, this functionality will show in the 3M grouper
- Examples provided of groupings utilizing the Lower of Pricing
- Question about Mass Adjustments from Provider: Department advice depends on situation for 3/1/2017 or 10/31/2017, will discuss further into meeting.

Duplicate Errors (Time 11:43 – 16:10)

- Duplicate claim logic exists to check if the same service has been billed multiple times. Does not currently examine EAPG assigned to claim and is denying the claim line. Evaluating impact if changed to line denial to reviewing the header.
- Actively reviewing better guidelines on how a Duplicate Claim should be determined.
- Examples provided

****Provider Action Item**: Department requesting feedback on if there are situations where client is receiving similar services on the same day?**

- Feedback: Infusion services requires patient to come in two to three times a day for antibiotics

Mass Adjustments (Time 16:10 – 26:13)

- Department is still assessing "lower of" and "duplicate errors" items. Adjustments to begin mid-November
- Confirm "lower of" is performing correctly in system and on 3M
- Still working through proper edits for "duplicate errors"
- Will be a series of Mass Adjustment not a single Adjustment.

Provider Question: Notice duplicate edit misprocessing. Referred question to Jeremy Oat. Currently working on that and aware of the issue. There was a week where the duplicate edit did not work. Any claims that went through were all paid during that week. There will be a reprocessing of all claims that missed the duplicate edit.

- Confirmed Mass Adjustments will be handled mid-November through February, including all claims prior to go live.
- Would like to have all claims processed in new system by the end of the year. Xerox claims may not make it by the end of the year.
- Certain data elements that complicate transferring old claims that need to be adjusted into the new system. Approaching it cautiously. There is a high risk of running into inappropriate denials which will cause a collection of money paid out. The Department is running tests in a testing environment to try to prevent collecting money unintentionally which is why reprocessing old claims is taking time.

****Provider Action Item:** Requesting to send a claim example of Infusion service since this would look like a duplicate even though it is a unique trip each time. **

Medicare Crossover Claims (Time 26:13 – 48:00)

- Received feedback that Crossover claims are not paying due to incompatibility with EAPG methodology.
- After review, Department confirmed that Medicare payment methodology is not similar enough to the EAPG methodology for outpatient hospital services. Solution is to reimburse these at the Medicare coinsurance and deductible.

Provider Question: Critical Access facility – Medicare claims are submitted on an 851 type of bill, Medicaid does not recognize that type of bill. What are options available?

Answer: Department has written a system change request to have interChange allow those types of bills to be billed and receive Medicare coinsurance and deductible.

Provider Question: Will there be a recoup of funds or payment of the increase?

Answer: Fee for service claims, interChange will recoup the previous claims and create a new payment of higher amount. There have been issues lately where it pulls the payment but denying something on the second claim. Department is reviewing that piece with DXC and currently reviewing changing the default to prevent that from occurring and just paying the difference as an additional payment.

- Provider Statement: has HMS coming to look at all debits and credits. Would appreciate and makes it easier business wise to receive credit for difference instead of a debit then credit.
- Provider volunteering to be part of a testing environment to do small batches to also see how it impacts Provider systems. Department advises may slow down timeline but will guarantee a better success of the Mass Adjustments.

Provider Question: Bill types – still being told that 121 bill types have not been uploaded yet. Is there an ETA on this upload?

Answer: Jeremy Oat – Same transmittal piece as 85X, 12X for crossovers.

Provider Question: Can you clarify if we have to resubmit our crossover claims or if there will be a mass reprocess?

Answer: A mass reprocess will be issued to prevent timely filing issue denials on Provider side.

Provider Question: We were being told the Crossover issue was more of an Enrollment Provider ID issue. You are saying it's more of a system issue. Should we wait on making additional enrollment changes?

Answer: Jeremy Oat – Would need to see specifics to the hospital. Some denials could be related to enrollment however, if enrollment is correct then likely linked to discussions we are having today.

Provider Statement/Question: Concerns about the HMS audit of credits since duplicate payments have been received since DXC went live.

Answer: Jeremy Oat – requesting clarification if duplicates have still happening? Confirmed still happening. Requesting if receiving duplicate payments to send your information to Andrew Abalos including ICNs.

Provider Answer/Comment: advising attempted to send back additional payments but unable to do so. Other concerns if HMS takes the money back then transmittal goes through and takes money back again. Concerns with staffing being dedicated to HMS for a week.

Provider Questions: Our Crossover claims are pulling the ambulance provider location? How is that happening?

Answer: Jeremy Oat – Please send additional information to Andrew Abalos to pass off. Different issues may cause it such as taxonomy.

Provider Question: We are being told on enrollment issues that we are having denials because we now need to enroll the specific Medicaid Provider ID. We had been told originally that we would enroll with the NPI only. Is that correct?

Answer: Jeremy Oat - Do need to enroll each location to have its own NPI. Not required to have multiple NPI, all locations can be under one but makes billing easier. Should not be a situation where you are enrolling just the Medicaid Provider ID

Provider Question: We also met with Clint at the state last week and were told not to send any refunds back at this time as they would be taking them back down the road.

Answer: Jeremy Oat – Will be reprocessing, do not want multiple claims becoming an issue. Was unaware of the concerns surrounding HMS. Those are being escalated through the Department.

Provider Question: Ambulance claims where they have multiple providers on one address. Called DXC, DXC says to change the zip code.

Answer: Jeremy Oat – They should not be advising to change to incorrect zip. If coming through portal should select information provided. Batch claims, should be separated by location if locations are similar then interChange should be looking at the taxonomy. It is important to include the 4 digits in the zip code. Per Provider DXC advising to change 4 digits to zeros. Prefer not to do that. Provider offered to email information to Jeremy.

BHO Billing with Access Kaiser (Time 48:02 – 54:16)

- EOB 2580 issue specifically with Kaiser – this error was triggering inappropriately for some clients
- Covered under Managed Care shouldn't be allowed under Fee For Service. However, hospitals were getting false denials since those claims are not covered by the Kaiser plan.
- Aware of three different denial reasons. Potential BHO conflict with other codes. The system was not looking at the diagnosis. Resolution for most of these were last week.
- Examples have been shared with Clint Eatmon, Shane Mofford confirmed will follow up with Clint on those.
- Providers commenting that if there are any BHO DX code the claim is denying. Another confirms denial on BHO with diagnosis of alcohol abuse and not mental health. All should now be resolved. May still be awaiting on the technical piece to be completed. Will try to bring specific update and time frame next meeting.

Provider Question: On the 2580 denials should we rebill or will they be mass reprocessed?

Answer: Will be reprocessing on our end. If problematic. Please provide your feedback.

Non-Covered Revenue Codes (Time 54:16 – 55:04)

- EAPG grouper did not reflect non-covered revenue code list in Appendix Q. Department has worked with 3M to integrate this list into the EAPG software which will assign lines to EAPG 999. These lines will no longer be considered when processing a claim through EAPGs. Reflecting interChange MMIS functionality to a greater degree and increase predictability of payments for those that utilize 3M.
- Released 9/27/2017 effective 10/1/2017

Non-Covered Procedure Codes (Time 55:04 – 59:02)

- EAPG grouper does not reflect non-covered procedure codes when billed with certain revenue codes. Best example is Venipuncture billed using laboratory revenue codes which denies in interChange but not in 3M. The Department is evaluating a potential change to this policy and will work with 3M to have EAPG grouper function accordingly.
- No timeline for implementation in 3M software
- Department is trying to make the line items more streamline in the 3M software to interChange logic. Non-covered revenue code update was separate and included in an update to software across the board released 9/27/2017 effective 10/1/2017.
- Updates Department is working with 3M is Colorado specific.

Provider Question: We are receiving denials on Pulmonary Rehab under Rev Code 948. Is this service truly not covered or should we be using a different Rev Code for these services?

Answer: Andrew Abalos – unsure, if could send some ICN examples to Andrew that would be great.

Commented [QE1]: Language format good, please check details are correct

EAPG Grouper Configuration (Time 59:02 – 01:03:56)

- Some schedules were loaded into interChange system without Colorado-specific payor exceptions loaded correctly. This may have resulted in payment variation not reflective of Colorado payment policy.
- Still looking at what claims need to be reprocessed. Should have been resolved mid-July.

Provider Question: We are getting reimbursed the physical therapy (group 271) rates for services provided by occupational therapist (EAPG 270) how do we go about resolving this?

Answer: Andrew Abalos – requesting ICNs to verify the issue and make sure what conflict is occurring in the system.

EAPG Grouper Version (Time 01:03:56 – 01:05:06)

- EAPG grouper has been updated in DXC's system to the most recent version as of October 4th. Accommodate CPT/HCPCS quarterly updates beginning October 1, 2017 back to April 1, 2017

Claims Not Re-Processed for Various Fixes (Time 01:05:06 – 01:06:29)

- Some claims that should have been re-processed due to various system fixes were missed. (Examples Drug Revenue Code, HCPCS Annual Updates, coverage of SUD, members inappropriately assigned to HMOs)
- Department will start analyzing all the claims that should have been re-processed and were not and push them through.

Remittance Advices (Time 01:06:29 – 01:07:38)

- Current remittance advices for EAPG claims do not contain enough information to understand how a claim was processed and priced within the EAPG grouper
- Feedback requested from Providers includes making it clearer on what paid/ didn't pay, detailed reasons for denial and overall more information. Any additional information is requested to help incorporate into a restructure of Remittance Advice.

July 1, 2017 Rate Increases (Time 01:07:38 – 01:08:45)

- As authorized by Senate Bill 17-254, Department will increase all outpatient hospital EAPG rates by 1.4% effective July 1.
- Awaiting final approval of the Medical Services Board (MSB) scheduled for October 13th.
- Pending MSB approval, can then schedule Mass Adjustment for the increase

Open Discussion (01:08:45 – 01:12:47)

Provider Question: How are the adjustments for the corrections going to be addressed? Will you start in March adjust all those claims and move to April? What will that look like?

Answer: Department is looking at different options. Post go live should be easier. Intent is to start in November. We have approximately 1 million claims to reprocess. Looking on how best to prioritize and identify the largest impacts. May prioritize by hospital to work closely together.

Provider Question: Will more recent claims be re-processed or will older claims be handled first then newer ones?

Answer: Open to feedback on how Providers would like to see the claims re-processed. Claims will need to be re-processed through mid-October because of the many changes in August.

Billing Related Issues (Time 01:12:47 – 01:40:34)

UD Modifier – 340B Drugs (Time 01:12:55 – 01:17:04)

- Hospitals are required to bill 340B drugs at acquisition costs and with the UD modifier. This applies a 50% discount to EAPG Adjusted Weight of the 340B drug in EAPGs. Only impacts the drug line, not the weight of the significant procedure it packages into.
- Department has request out to several Hospitals to share their acquisition costs. Department came to this billing policy based on the Federal Register that implemented the program. Need acquisition costs to address additional concerns.
- Department is receiving different feedback that the billing policy is not how program is intended to work or not affectively assisting with reimbursement of drug. Which is why the Department is requesting the acquisition costs of these drugs and/or to set up time with the pharmacy groups to discuss further.

Transportation (Time 01:17:04 – 01:17:47)

- EAPGs cannot accommodate reimbursement for transportation services, hospitals must enroll as transportation providers and bill such services on the 1500. Reimbursement is still based on applicable fee schedule.

CPT to EAPG Crosswalk/Packaging/Consolidation Lists (01:17:47 – 01:25:37)

- 3M does not currently allow for the crosswalk to be posted to Colorado's Website. New York has the option, but was a result of an early contractual agreement for EAPGs. Several legal obstacles exist due to proprietary information. 3M Definitions Manual exists at a discounted rate and has information to the crosswalk and contains packaging/consolidation lists.
- Department is working closely with 3M to have the system be as close to Colorado Payment logic as possible.

Provider Question: Can you please reference where physician billing instruction is coming from. No other processor of medical insurance claims has this instruction or stance. This would be a huge software change and why is this coming up now. Pre EAPG, it was not a problem.

Commented [QE2]: Confirm correct title

Answer: This has been the Department's Billing Manual for years. We are open to having a discussion and possibly reviewing a new format. Would be interested in knowing what other Payers or doing. If all going on one claim or separating the services out on 1500 form. We are showing inconsistencies among how Providers bill for these services.

Provider Answers: Several Providers express that they currently bill on a 1500 for physician services.

Provider Question: Are you advising hospitals to completely change our billing practices?

Answer: Non – salaried physicians should be billed on 1500 form for accurate cost reports

3M Training (Time 01:25:37 – 01:37:35)

- 3M has expressed interest in participating in some of these meetings – what kind of information would be valuable?
- Training doesn't exist with 3M, this is something the Department is developing with them. We can also use this training to better train the DXC Call Center.

****Provider Action Item**: Department is requesting feedback on what information or training would you like to see partnered from 3M?****

Provider Question: We bill on a UB and get several line item denials on the 300s as 0103 paid to another provider? Is that valid?

Answer: Andrew Abalos is requesting ICNs to verify what issue this is reflecting. If it is an EOB related denial or an intended policy denial.

Provider Question: Regarding Physician services billed on the UB – how would those be reimbursed or would they be bundled under the EAPG methodology?

Answer: This is dependent on the billed services and the revenue codes billed.

Provider Question: One of the challenges I am having is we have the 3M EAPG product and for example it shows that on Rev Code 300 HCPC 36415 we show we should receive a payment but Medicaid is not paying the charge. Without a crosswalk or published list I have no way to verify that we should get payment. What do you suggest for how we can confirm if payment is correct or not?

Answer: We currently have a list of codes that can be attached to 300 and 301 to ensure lab codes are being associated with lab revenue codes. Current issue is HCPC 36415 for venipuncture is not being included in that list and not reflected in the 3M grouper. Department will work on getting a list out to Providers.

Provider Question: Can you tell me which billing manual this is in, I am trying to find it.

Answer: Couple of different resources for billing codes/practices and physician billing. For physician billing is under the UB billing manual which should be located under Outpatient/Inpatient External pages. Also review Appendix Q non-covered revenue codes.

Commented [QE3]: Language set, double check HCPC and Rev Codes are correct in reference

Updated Billing Manual (Time 01:37:35 – 01:38:15)

- Department is currently working on updating its Billing manual for all hospital services, which will include more information on EAPGs.
- Goal to have it posted in the next month or so and will communicate when available.

DXC Unable to Answer EAPG Questions (Time 01:38:15 – 01:38:48)

- What would be valuable for the call center to know and be able to communicate?

Distinct Procedure Modifiers (Time 01:38:48 – 01:40:34)

- EAPG grouper only recognizes Modifier 59 for distinct procedures and not XE, XP, XS & XU

Provider Question: Is that specific for Critical Access Hospitals for the 9XX exclusions?

Commented [QE4]: Verify correct abbreviation

Answer: Currently the Department does not have any billing exceptions made for Critical Access Care Hospitals.

Miscellaneous (Time 01:40:34 – 01:44:48)

Cost Settlements (Time 01:40:34 – 01:43:49)

- Comment provided through past survey: "I think we need more of an explanation as to why the cost settlements would impact patient cash? Typically, the cost settlements are paid out by the providers, so if we have paid you back, how are you going to calculate the payment differences?"
- The old methodology worked by paying an interim payment until cost reports became available. At that time cost settlements were released to settle up the differences. Cost reports were audited by Medicare. If there was a large settlement then initially the Provider was overpaid. The Department wanted to try to avoid this with the new EAPG methodology.
- The new methodology pays prospectively so there is no overpayment up front. This prevents recoupment down the line.

Timely Filing (Time 01:43:49 – 01:44:10)

- With Department initiated mass adjustments, timely filing will not be an issue. Providers can also mass adjust and valid timely filing is waived so long as the Department is within federal timely filing. If mass adjustment is not related to a Department corrected issue, Providers are still responsible for ensuring claims are within timely filing.

Reconsiderations (Time 01:44:10 – 01:44:48)

- Several questions have come up regarding the proper method for reconsiderations or disputing payment variances.

Department Requests More Information (Time 01:44:48 – 01:56:06)

1. Physical Therapy vs Occupational Therapy – requesting ICNs
2. High Cost Drugs – Department is currently trying to address regarding costly drugs recently approved by the FDA. These drugs are not part of cost reports and difficult to find information for reimbursement purposes.
3. Payment Calculations – Requesting more clarity or has this been addressed with today's meeting
4. Split Billing/ Recurring Therapy Visit – Requesting ICNs
5. Recurring Payment - requesting ICNs
6. Injection Services/Drug Infusion/ Packaging - requesting ICNs
7. System/Portal Errors – Error number and claim number to further investigate. If receiving a technical error please take screen shot and send to Jeremy Oat.
8. Observation Reimbursement – requesting
9. Unlisted CPT Code Reimbursement – more clarity or examples
10. Multiple Procedures – more clarity or examples

11. Clinically Distinct Services - requesting ICNs
12. Suspended Claims – multiple surgery edit posting on physician side. Logic wasn't brought over from Xerox and is drastically reducing the claims in suspense. If there are still claims concerns then we are requesting ICNs
13. Emergency Medicaid Eligibility - requesting ICNs
14. Error Messages for Claims >1 year old - requesting ICNs
15. Hydration and ED – Already addressed earlier in our talk.

Provider Question: We regularly meet with the State couple times a week. Do those questions and concerns get back to you?

Answer: Our Department does work closely with Systems and other Sections on resolving issues. While we do communicate, what other teams may be looking for and asking of in claim examples may not be the same as what our Department reviews. To be safe send information that is specifically requested by our team to us for review.