COLORADO
Department of Health Care Policy & Financing

Colorado Enhanced Ambulatory Grouping Software Implementation Frequently Asked Questions

February 2017

Background

Beginning October 31, 2016, the Department of Health Care Policy and Financing (HCPF) will be paying outpatient hospital services using 3M's Enhanced Ambulatory Patient Grouping (EAPG) methodology. This document is a collection of frequently asked questions regarding the implementation of this new payment system.

Which benefits will be paid using the EAPG methodology?

Beginning October 31, 2016, billing providers enrolled as hospitals will have their outpatient claims paid using the EAPG methodology. These claims are billed with Type of Bill equal to 013X.

We currently bill services using a variety of different Medicaid numbers for different provider types. Will we need to consolidate our claims to bill all services taking place during the single visit and be paid on an inclusive rate?

No. EAPGs will only apply to claims that have been traditionally billed using Type of Bill equal to 013X.
Costs associated with professional services by salaried physicians are included in the hospital's rate structure and cannot be billed separately to the Colorado Medical Assistance Program. Do not bill professional fees (revenue codes 0960-0989) for emergency and outpatient services as an 837 Institutional (837I) electronic transaction or on the UB-04 claim form.
Professional fees for services provided in the emergency room by contract physicians must be billed by the physician as an 837 Professional (837P) electronic transaction or on the CMS 1500 claim form using the appropriate HCPCS codes. The Colorado Medical Assistance Program payment is made to the physician.

How will payment be calculated under the EAPG methodology?

Hospitals will be assigned a hospital-specific base rate. For each detail, payment will be calculated as the assigned EAPG's Adjusted Relative Weight multiplied by the billing

hospital's base rate.

How will claims with multiple dates of service have their payment impacted by the EAPG methodology?

The methodology distinguishes between visits based on line item dates of service. Packaging, consolidation and discounting will only apply to line items taking place on the same date of service. Therefore, the methodology will pay identically for an outpatient claim with multiple visits as it would for multiple claims for each visit, assuming diagnosis information remains the same. The exception is for claims with revenue codes 045x (Emergency Room) or 076x (Specialty Services). In such instances, all line items will be considered part of a single visit and subject to packaging, consolidation and discounting, regardless of date of service.

Are the Colorado EAPG Relative Weights available online?

Yes. The weights are available on the Outpatient Hospital Payment section of HCPF's website.

Will hospitals need to license 3M's EAPG Software in order to be paid by HCPF?

Hospitals are not required to license 3M's software in order to be paid by HCPF. However, it is recommended for hospitals to understand the EAPG methodology in order to anticipate payment and budget accordingly.

How will outpatient hospital claims with service from and thru dates crossing October 31, 2016 be handled?

Claims with services taking place prior to October 31, 2016 will be processed using the percent of charge methodology employed prior to the implementation of EAPGs. Outpatient hospital claims with all dates of service on or after October 31, 2016 will be processed through EAPG.

Is there an online version of the EAPG grouper available?

Currently, no. If 3M makes this offering available then hospitals will be notified.

Is a risk corridor being applied for the implementation period?

Yes. A 10% risk corridor has been built into the hospital-specific base rate setting methodology. Hospitals that will have a projected fiscal impact of magnitude greater than 10% will have their base rate adjusted to mitigate the expected gains or losses to 10%. The basis of the fiscal impacts was calculated by the conversion of state fiscal year 2015 claims charges to 71.6% of costs using the Healthcare Cost Report Information System (HCRIS). These costs were then adjusted for increased caseload to the implementation period. The adjusted costs were compared to the expected EAPG

utilization for hospital, multiplied by their base rate. The EAPG utilization was estimated by processing state fiscal year 2015 claims through the EAPG grouper, then summing the resulting EAPG Adjusted Relative Weights.

When will the risk corridor be removed?

HCPF is working with its hospital providers in the development of a new rate setting methodology for EAPGs. This is an ongoing topic of discussion during its bimonthly meetings with its hospital providers (more information on HCPF's website). There is no timeline for when the new rate methodology will take effect.

Will claims processed under the EAPG methodology be reconciled to a percentage of cost?

No. One purpose of the EAPG implementation is to shift payment to a Prospective Payment System (PPS), which will facilitate budgeting for both the impacted hospitals and HCPF.

Are any distinctions made for Critical Access Hospitals (CAHs)?

There are no distinctions made for CAHs. As mentioned above, each hospital has been assigned to an Urban, Rural or Pediatric peer group. As the set of Colorado CAHs and the set of Colorado hospitals assigned to the Rural peer group were nearly identical, HCPF opted to use the Urban, Rural and Pediatric peer groups.

It has been previously stated that a procedure code is required for all line items billed. What is considered a "procedure code?"

In this case, a procedure code refers to the CPT/HCPCs code.

It has been previously stated that when anatomical modifiers LT and RT are billed together during the same visit that a line will pay 150% of the EAPG Relative Weight. However, 3M has stated this is not the case. What is the policy that Colorado Medicaid will use?

Colorado has opted not to use anatomical modifiers for the purpose of payment adjustments. In other words, the following modifiers, while recognized by the EAPG methodology, do not influence claim payment: E1-E4, F1-F9, FA, LT, RT, T1-T9, TA, 76, 77, LC, LD, LM, RC and RI. The state has opted to use bilateral modifiers to generate a 150% payment for a line. Eligible procedures will need to be billed with modifier 50 to generate 150% payment.

Not all revenue codes require procedure codes to be billed. How are lines without a procedure code paid?

The costs for such services were considered during the development of the EAPG Relative Weights. While lines without procedure codes will not generate separate

payment on a claim, their payment is included in the other EAPGs assigned during the visit. However, in order to maximize payment, it is encouraged for providers to submit as many CPT/HCPCs on a claim as is reasonable.

How will HCPF pay for Observation Visits?

The Department has opted to use the 8 hours as a minimum requirement for Observation services. For a more technical explanation of how Observation payments will work in the EAPG system:
There are two components that go into Observation EAPG grouping. The first is having an observation visit procedure code that is mapped to EAPG 492 (Encounter/Referral for Observation Indicator). The second component is the presence of procedure code G0378 with a minimum of 8 units during that same visit. When both of these procedure codes and units are present on the claim for that visit, the line mapping to EAPG 492 will map to EAPG 500, 501, or 502 depending on patient diagnosis for payment processing. This line will have a payment associated with it depending on the assigned EAPG. The line with G0378 will map to EAPG 450 (Observation), will be considered ancillary to EAPG 500, 501, or 502 and will be packaged (i.e. pay 0). When one of these components is missing, or G0378 is billed with 7 or less units, the remaining component will group to EAPG 999 (Unassigned) and will not generate payment.
It is possible for EAPG 450 (Observation) to pay on its own. This can occur when G0378 with a minimum of 8 units is billed alongside a Medical Visit EAPG for that visit. In this case, the Medical Visit EAPG (assigned via diagnosis code) will generate payment and the line with G0378 will have a distinct payment from the Medical Visit. However, if G0378 is billed with 7 or less units, EAPG 999 will be assigned to that line and not generate payment. This would not have any impact on the payment for the Medical Visit EAPG.

Are there any high cost drugs/implants that are carved out of the EAPG methodology and handled separately?

No. These line items will be processed through the EAPG grouper.

Will physical therapy, occupational therapy, laboratory or transportation services continue to be paid using a fee schedule?

Physical therapy, occupational therapy and laboratory services will no longer be paid using the fee schedule. These services will be paid using the EAPG methodology. Transportation services will no longer be paid on outpatient hospital claims beginning October 31, 2016. Providers will need to enroll as Transportation providers and bill separately in order to receive payment for these services.

Will Managed Care Organizations be required to pay using the EAPG methodology?

No. The state does not require Managed Care Organizations to use the EAPG payment methodology.

Will there be a "lower of" provision?

Claim details processed through the EAPG methodology will pay the lower of the detail's assigned EAPG Adjusted Relative Weight multiplied by the hospital specific base rate or the billed amount on that detail.

Who can I contact for further information?

For claims reimbursement issues, please contact the Department's Fiscal Agent call support center. For all other issues relating to EAPGs please contact HCPF_HospitalRegulatory@state.co.us.