Frequently Asked Enhanced Ambulatory Patient Grouping Questions and Answers

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General EAPG Questions

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Question: Which ForwardHealth members' claims will be processed through EAPG?

Answer: All hospital claims for outpatient hospital services for members enrolled in BadgerCare Plus, Medicaid, and the Wisconsin Chronic Disease Program will be processed using the EAPG system. The Wisconsin Well Woman Program is excluded from EAPG pricing.

Fee for Service claims price according to EAPG. Effective 1/1/2015, HMO encounters priced by the state will also price EAPG. **NOTE:** There is no correlation between the EAPG priced encounter and what an HMO pays to a provider.

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Question: What providers and services are impacted by EAPG?

Answer: All claims for outpatient hospital services submitted by Medicaid-enrolled hospitals, including critical access and acute care hospitals, will be processed using the EAPG system. Claims from providers who are not Medicaid-enrolled hospitals, such as rural health clinics, federally qualified health centers, home health agencies, hospices, and end-stage renal disease providers, will not be reimbursed using the EAPG system.

Fee for Service claims price according to EAPG. Effective 1/1/2015, HMO encounters priced by the state will also price EAPG. **NOTE:** There is no correlation between the EAPG priced encounter and what an HMO pays to a provider.

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Question: Does a hospital need to purchase the 3M coding module for EAPG billing in order to be paid correctly under EAPG reimbursement?

Answer: No. Hospitals are welcome to purchase the software, but it would be used for reimbursement planning and verification purposes only.

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Question: We have purchased the 3M coding module for EAPG billing. What software version should we be using?

Answer: Please see the EAPG Portal Page for the EAPG software version currently being used by ForwardHealth. EAPG Portal Page is located [HERE](#).

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Question: What schedule setup options should we use to mirror the options selected by ForwardHealth?

Answer: View the Wisconsin Specific EAPG Configuration training module here:
https://www.forwardhealth.wi.gov/wiportal/tab/42/icscontent/html/EAPG/EAPGhome.htm.spage#

The training defines the schedule setup options used by ForwardHealth. The training will be updated to reflect each new iteration of the 3M EAPG software ForwardHealth implements.

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Question: Is there a crosswalk that providers can access on the ForwardHealth Portal to help find the appropriate EAPG number associated with a HCPCS code?

Answer: To receive a listing of all the services (procedure codes) grouped under each EAPG, you will need to contact 3M and complete a form to request a free copy of the 3M EAPG Definitions Manual. You can access the form [HERE](#). Only the first copy of the manual is free. A copy of the form is also available on the EAPG page of the ForwardHealth Portal; however, please contact 3M at 1-800-435-7776 for assistance. If you purchased the provider version of the EAPG software, the EAPG Definitions Manual is included in the purchase price.

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Question: How will the EAPG system treat "not otherwise classified" HCPCS codes?

Answer: The EAPG system will assign an EAPG and group "not otherwise classified" HCPCS procedure codes as it would any other code.

Question: I work for a company that pays claims on behalf of inmates at local jails in Wisconsin. We reprice the claims based on your state's Medicaid rates. Are inmate claims subject to EAPG? If not, where can we find the Wisconsin State Medicaid Rates?

Answer: Inmate claims are not subject to EAPG pricing. Companies that use the Medicaid rate to price inmate claims should use the hospital per-visit Medicaid rates. Medicaid rates can be found by clicking HERE.

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Billing Questions

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Question: Does EAPG pricing impact the way claims are submitted.

Answer: You will continue to bill services on the UB-04 Claim Form or using the 837 Health Care
Claim: Institutional transaction as you have in the past, taking note of what is
considered a "visit" (refer to the October 2012 ForwardHealth Update [2012-55], titled
"Implementation of the Enhanced Ambulatory Patient Groups Reimbursement
Methodology").

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Question: How should we bill multiple visits for a member?

Answer: Update 2012-55 states the following:

- Enter a single DOS per detail line; ForwardHealth recommends avoiding range
dates at the detail level on claims. This may involve splitting a single detail with
range dates into separate, unique details. The EAPG software recognizes only
the first, or "from," DOS at the detail level. The claim may be priced
inappropriately and reimbursement may be less than expected if range dates
are used.

- For multiple medical visits with different DOS, providers may bill more than one
visit on a claim. The EAPG software treats details with different DOS as separate
visits unless certain revenue codes (e.g. 045X, 0762) are used.

- For multiple unrelated medical visits with the same DOS, ForwardHealth
recommends providers use condition code "G0" and bill the visits on separate
claims. The EAPG software is able to identify separate visits on the same DOS
only when they are submitted on separate claims.

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Question: What is ForwardHealth's definition or criteria for "related" visits?

Answer: When the initial visit matches the primary diagnosis of a subsequent visit(s), these are
referred to as related visits.

Question: When submitting two different claims for unrelated services provided on the same date of service (DOS), how is the primary claim identified?

Answer: A primary claim does not need to be identified.

Question: How should physical therapy, occupational therapy, speech and language pathology, and behavioral health be billed?

Answer: Current ForwardHealth policy states that these services must be billed on a professional transaction (1500 Health Insurance Claim Form or 837 Health Care Claim) in order to be eligible for reimbursement. If these services appear on one or more claim details on an outpatient claim, those details would be denied. If the claim consists only of these services, the entire claim would be denied.

Question: Should we use the 1500 Health Insurance Claim Form when billing for lab services?

Answer: If you are Medicaid-enrolled as an independent lab and are performing services as an independent lab, you should bill on a professional claim. If the laboratory services are provided as part of the outpatient hospital visit, the lab services should be included on the outpatient hospital claim and would be reimbursed at the maximum allowable fee.

Question: When billing a bilateral service, does Medicaid prefer that providers bill the RT/LT modifiers or the 50 modifier?

Answer: Either are accepted. However, the EAPG software may treat claims differently based on the modifier(s) billed.

Question: If a patient has emergency surgery (consider by ForwardHealth as inpatient only) and the patient dies during the surgery (never having been admitted), how should a provider bill for these services?

Answer: For Fee for Service, if this claim denies after a provider has billed for a situation such as the one described, ForwardHealth recommends the provider contact his or her professional representative so the rep can assist with the processing. A situation like this will require special handling of the claim.

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Question: If we bill an infusion code, will ForwardHealth require the presence of a drug on the claim?

Answer: Providers should bill infusion codes according to common billing practices, regardless of the implementation of the EAPG reimbursement methodology.

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Question: Can I bill routine venipuncture (procedure code 36415) separately?

Answer: Topic #51 of the physician handbook, routine venipuncture (service code 36415) is not separately reimbursable. It is included in the lab test rate.

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Question: For members with Medicare and Medicaid eligibility, if a service is provided as an outpatient hospital service but Medicare considers it "inpatient only" while Medicaid does not, what should the provider do?

Answer: The provider should submit the service on a straight Medicaid claim with the appropriate Medicare disclaimer code.

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Question: If a claim is discounted by other insurance but is not reimbursable under Medicaid, should the provider still bill Wisconsin Medicaid?

Answer: All claims for an eligible member on an eligible date of service should be submitted to ForwardHealth.

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National Correct Coding Initiative Questions

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Question: Is Medicare NCCI the same as Medicaid NCCI?

Answer: For outpatient hospital claims, ForwardHealth uses a required subset of the NCCI regulations followed by Medicare. General information regarding NCCI edits for Medicaid is located at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html.

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Question: Is there an appeals process for NCCI?

Answer: Yes, the appeals process for NCCI is outlined in Update 2012-55.

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Question: If a provider receives a denial for a Medically Unlikely Edit, can he or she resubmit using modifier 91? How will the EAPG system handle Medicare crossover claims with modifier 91?

Answer: ForwardHealth does not recognize modifier 91 (repeat clinical diagnostic laboratory test), but will recognize modifier 59 (distinct procedural service). On crossover claims, modifier 91 should not hinder processing of the claim. However, providers may need to resubmit or adjust the claim with modifier 59 in some cases.

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Rate Questions

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Question: Will EAPG affect out-of-state hospital outpatient payment rates? They are reimbursed at a percent of allowable charge, correct?

Answer: EAPG pricing applies to all hospitals and institutes for mental disease, regardless of the provider being in-state, border status, or out of state. EAPG pricing replaces rate-per-day pricing and percent of charge. EAPG is a completely different pricing methodology with its own set of weights and provider rates.

   The rates calculated for in-state, border status, and out-of-state providers for EAPG claim pricing will be different from the rates that were calculated and used for rate-per-day and percent-of-charge pricing.

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Question: Which Medicare audited cost reports are used to calculate base rates?

Answer: The most recent 12 month audited cost reports are used to make these calculations. However, if the most recent audited cost report is more than five years old, providers may appeal the rate within 60 days of receiving notification and request that ForwardHealth use a more recent unaudited cost report.

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Question: Will every hospital have the same outpatient rate?

Answer: Critical access hospitals (CAHs) and Medicaid high-volume hospitals receive different, hospital-unique EAPG Base Rates. Other hospitals including out-of-state hospitals and Medicaid low-volume hospitals receive a standard EAPG Base Rate. Hospitals with identical EAPG Base Rates may nevertheless receive different Medicaid EAPG reimbursement, i.e., if they serve a different patient case-mix population. [Current and past provider rates](#) are available on the ForwardHealth Portal.

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Reimbursement Questions

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Question: Will Medicare crossover visits be reimbursed using the EAPG reimbursement methodology?

Answer: Medicare crossovers are subject to the EAPG reimbursement methodology, but only for claims billed from provider type 01 (hospitals) and 58 (institutes for mental disease).

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Question: When I look up a CPT code in the EAPG Definitions Manual it shows the EAPG number. Am I supposed to multiply the EAPG by our provider rate? If not, where do I find the weight associated with the EAPG?

Answer: The EAPG is just a code under which similar services are grouped. The weight associated with the EAPG can be found in a spreadsheet attached to the EAPG Page on the ForwardHealth Portal or by clicking [HERE](). To estimate your payment, multiply the weight associated with the EAPG times your provider rate.

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Question: Is reimbursement handled differently for services submitted on a professional claim (e.g., 1500 Health Insurance Claim Form or 837 Health Care Claim: Professional transaction)?

Answer: Yes. EAPG only applies to outpatient hospital claims and does not apply to professional billing. To determine reimbursement for professional services, refer to the maximum fee schedule applicable for the service area in question.

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Question: How is pay for performance (P4P) affected by EAPG?

Answer: EAPG will have no independent impact on P4P withholding; ForwardHealth will continue to withhold funds for P4P. This answer pertains to Fee for Service claims.

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Question: Is there reimbursement for revenue codes that are exempt from requiring a procedure code?

Answer: A detail billed with a revenue code only will receive EAPG 999 and pay $0.

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Question: Is there reimbursement for exempt revenue codes?

Answer: Although exempt revenue codes may not be separately reimbursed, the costs are included for purposes of rate setting, so it's important these services are billed.

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Question: When a detail pays $0, how does a provider know whether it's packaged or invalid?

Answer: Denied details will receive an EOB that explains why the detail is invalid. Paid details will receive an EAPG priced EOB, even if the detail pays $0. Details that bill incidental, packaged or unassigned services may reimburse $0.

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Question: Will "not otherwise classified" codes have a lower reimbursement?

Answer: Reimbursement is determined by taking the provider-specific base rate and multiplying it by the EAPG-assigned weight. The reimbursement of these codes will depend on the weights assigned.

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Question: How are hospice and home health services affected by EAPG?

Answer: There is no change to hospice and home health services reimbursement because they are not outpatient hospital services.

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Question: What are some reasons an entire claim would deny?

Answer: Common reasons for an entire claim to deny include:

- The main reason for the visit denies. With the implementation of EAPG pricing, if the significant procedure or medical visit is denied, then all associated services for that visit will also be denied.
- The claim sets an error at the header level which results in the entire claim being denied.