In an effort to prepare Hospital and ASC providers to have a smooth transition to the new EAPG-based outpatient method, the Agency, Navigant Healthcare, and DXC invited providers to participate in a series of EAPG webinar sessions. The following questions were received during these EAPG webinar sessions. We hope these answers bring clarity to the questions asked during the EAPG webinar sessions.

### Contents

#### General Questions

- **What version of the EAPG Grouper will the state be implementing?**
- **Will there be a transitional grace period?**
- **Will the Medicaid Managed Care organizations be required to convert to EAPG as well?**
- **What data components are used by the EAPG grouper to arrive at the group code?**
- **What should we do if the EAPG pricing on my remittance advice is different from the EAPG Calculator price?**
- **Will access to the Grouper be available in the same manner as it was for DRG?**
- **Will providers be able to verify EAPG assignment for future claims containing significant/ancillary procedures?**
- **Where can providers obtain the Agency’s recent EAPG fiscal comparison by provider?**
- **How will the health plans’ decision to utilize or not utilize EAPGs be communicated to providers?**
- **Are post-payment cost settlements only for outpatient claims or do ASC claims have post-payment?**
- **How is the EAPG rate calculated? Do we need to put an EAPG code on the claim submission?**
- **When will the updated calculator and rates be available?**
- **Where can we find a list or policy regarding specific carved out services?**
- **Is there a PDF version of the Webinar available for download?**
- **How do we get in touch with a DXC Field Rep?**
- **What about revenue code 0636? Currently, they process and pay for each J code with the NDC number. Will this still be the case?**
- **Is there a crosswalk of EAPG code to CPT code?**
- **Just to clarify, I understand EAPG is based on date of service. I am wondering how this will affect therapy billing. We currently bill therapy monthly. Should we change this to daily to reflect the date of service?**
- **Will there be discussion of the methodology used to complete the Simulations?**
What about Medicaid secondary billing to a TPL where we have to currently break down the TPL payment on each line item in FL 48?
For observation claims now allowed to have span dates, how many days are allowed? Just the two days that span midnight or multiple days?
Is there a list of Managed Care Plans moving to EAPG?
Was the MMIS and Special Feed verified to be correct? The simulation did not match up to our hospitals "actual" line items and encounters billed or the payments we received.
If total charges are less than the EAPG payment, do you pay full EAPG or pay only up to total charges?
What is the expected schedule for base rate updates? (Example: annual or semiannual?)
Is this mandatory to convert to 3M platform or can I continue to use APC model?
Can you clarify if multiple units with a single HCPCS get only 1 EAPG payment?
We bill PT, OT, and ST for peds patients, as well as a facility fee revenue code 0510 with HCPCS code G0463. Will the G0463 be bundled with the therapy or paid separately?

Hospital (PT 01) Specific Questions

Will the EAPG materially affect the coding of outpatient records?
Do EAPGs apply to outpatient behavioral health services?
How will Physical Therapy, Occupational Therapy, and Speech Therapy be reimbursed for outpatient hospital based clinics?
Will we be reimbursed for the facility or the 510 revenue code? If so, what are the billing requirements for this code?
If a patient outpatient services span more than one date of service, do we continue to bill each date of service separately or should the services be billed on a single claim?
Physical therapy, Occupational therapy and Speech therapy are currently billed separately with their own authorization number. How will this change? Will we be able to bill all 3 services on one claim and will there be space for all 3 authorizations?
What does the Annual Total Automatic Rate Enhancement mean and how are we to apply it?
Will we still need to use the Lab Fee Schedule after 07/1/17?
Will the $1,500 outpatient cap still apply and will there continue to be rev code exemptions?
For the Children’s Hospitals, is the 267.82 base rate grossed up by the EAPG Provider Adjustor and then who pays the Per Service Automatic Enhancement Supplemental Payment? The state?
Related to Annual Total Automatic Rate Enhancement, how do we know what facilities are approved for this?
Does revenue code 0636 require a modifier to be paid multiple times?
Do we still need to submit NDC codes with EAPGs?
Has the EAPG payment methodology been approved by CMS?
Regarding units of service: Cost of different chemotherapy doses can vary greatly. Do different doses of a drug pay the same amount?

ASC (PT 06) Specific Questions
ASC providers currently receive an allowance of $150.00 for intraocular lens (IOL), which is included into the rate for cataract removal. Will this allowance be made for cataract procedures when reimbursement is calculated by EAPG methodology?
Will the Agency continue to restrict ASC allowable modifiers?
Will modifiers LT and RT affect payment the same way as modifier 50 when both are present with the same CPT/HCPCS code?
For modifier 50, does that have to be billed in the first position, and then modifiers LT and RT in the second modifier position, if used?
Will the new EAPG have a specific crosswalk that clearly indicates a listing of approved ASC Medicaid procedure codes, applicable payment grouper for each specific procedure code, and the expected allowable?
What version of the EAPG Grouper will the state be implementing?
The state is utilizing version 3.12 in order to determine payment.

Will there be a transitional grace period?
There is a prospectively calculated 5% cap on gains and losses in year 1. The EAPG Pricing Session, hosted by Navigant, will provide more in depth information regarding the transitional period.

Will the Medicaid Managed Care organizations be required to convert to EAPG as well?
Health plans are not required to change outpatient reimbursement methods. Some health plans may choose to follow the fee-for-service model and transition to the EAPG payment method. Providers are encouraged to contact the health plans for additional questions regarding their transition.

What data components are used by the EAPG grouper to arrive at the group code?
Detail line procedure codes and modifier, diagnosis codes (for medical visits), patient age, and patient gender are used to arrive at the group code.

What should we do if the EAPG pricing on my remittance advice is different from the EAPG Calculator price?
Providers should defer to the pricing provided on the remittance advice, as the payment information calculated by Florida Medicaid Management Information System (FMMIS) supersedes the EAPG Calculator’s payment calculation.

Will access to the Grouper be available in the same manner as it was for DRG?
Providers can work with 3M on acquiring the new EAPG Grouping Software, if desired.

Will providers be able to verify EAPG assignment for future claims containing significant/ancillary procedures?
Impacted providers will need to purchase 3M software and perform EAPG grouping on their own if they wish to determine exactly which procedures were identified as significant or ancillary by the EAPG grouping software once EAPG pricing is implemented.

Where can providers obtain the Agency’s recent EAPG fiscal comparison by provider?
This information is available on the Agency’s website at http://ahca.myflorida.com/index.shtml.

How will the health plans’ decision to utilize or not utilize EAPGs be communicated to providers?
The health plans are responsible for communicating their decision directly to their providers.
Are post-payment cost settlements only for outpatient claims or do ASC claims have post-payment?
Post-payment cost settlement is only done for hospital outpatient services, not for ASC services. Neither will be done when EAPGs are implemented.

How is the EAPG rate calculated? Do we need to put an EAPG code on the claim submission?
Providers are not required to put an EAPG code on their claim. The Agency will determine initial base rates for active hospitals and ASCs. The rates will be established for the fiscal year 2017/2018 implementation. Base rates can be found on the Agency’s website (http://ahca.myflorida.com) under Institutional Rates.

When will the updated calculator and rates be available?
The updated calculator and rates are now available on the Agency’s website. You may visit the Agency’s website at http://ahca.myflorida.com.

Where can we find a list or policy regarding specific carved out services?
All outpatient services at acute care hospitals and ASCs will be included in the EAPG payment except for services that are included in a transplant global payment. For additional information regarding carved out services, you may contact the Agency for Healthcare Administration by calling 1-877-254-1055, or by visiting their website at http://ahca.myflorida.com.

Is there a PDF version of the Webinar available for download?
This presentation will be made available on the Medicaid Public Web Portal after July 1st. You may also work with a DXC Field Rep if onsite training is required.

How do we get in touch with a DXC Field Rep?
You may contact 1-800-289-7799, option 7, to request to speak to the field representative assigned to your area.

What about revenue code 0636? Currently, they process and pay for each J code with the NDC number. Will this still be the case?
This revenue code will follow standard EAPG grouping and pricing rules including each separate occurrence of revenue code 0636 will be considered for payment. In general, inexpensive drugs may bundle and receive $0 payment while more expensive drugs will tend to receive separate payment, even when multiple occurrences of revenue code 0636 occur on the claim.
Is there a crosswalk of EAPG code to CPT code?
There is within a document produced by 3M called the “EAPG Definitions Manual.” 3M is offering this manual to hospitals in Florida for free for a limited time. The manual will be provided at no cost for orders received by 3M by Sept 30, 2017. After this date, facilities must have a license to the 3M EAPG grouping software to get access to this manual.

Just to clarify. I understand EAPG is based on date of service. I am wondering how this will affect therapy billing. We currently bill therapy monthly. Should we change this to daily to reflect the date of service?
For scenarios in which billing of multiple dates of service is allowed, EAPG pricing will consider each separate date of service to be a separate outpatient visit and will calculate a “full” EAPG payment separately for each outpatient visit. The only exception to this rule is claims billed with an Emergency Department (0450 – 0459) or observation (0760 – 0769) revenue code. If one or more Emergency Department or observation revenue codes exists on the claim, then all services on that claim will be treated as part of one outpatient visit.

Will there be discussion of the methodology used to complete the Simulations?
Twelve months of data with dates of service between 4/1/2015 and 3/31/2016 were used to model the new EAPG payment method and calculate EAPG rates. The claim data was retrieved from the Medicaid Management Information System for recipients in the fee-for-service program and from the “managed care special feed” file for recipients enrolled in managed care plans.

What about Medicaid secondary billing to a TPL where we have to currently break down the TPL payment on each line item in FL 48?
Rules related to billing and processing of Third Party Liability (TPL) payments will not change with the implementation of EAPG pricing.

For observation claims now allowed to have span dates, how many days are allowed?
Just the two days that span midnight or multiple days?
For the purposes of EAPG pricing there is no limit to the number of days included on an observation claim. However, any existing billing and payment rules defined by Florida Medicaid in relation to the length of outpatient visits and inclusion of outpatient services on inpatient claims when a recipient is ultimately admitted will not change with the implementation of EAPG pricing.

Is there a list of Managed Care Plans moving to EAPG?
No list of this type exists that we are aware of. Providers will need to work with their Medicaid managed care plans directly regarding outpatient payment method in upcoming contracts between the provider and the plan.
Was the MMIS and Special Feed verified to be correct? The simulation did not match up to our hospitals "actual" line items and encounters billed or the payments we received. The managed care Special Feed data was verified in aggregate to ensure total managed care plan spend matched similar numbers reported in other financial reports submitted by the Plans to the Agency.

If total charges are less than the EAPG payment, do you pay full EAPG or pay only up to total charges?
In this scenario, full EAPG payment will be applied. Payment will not be capped at total charges.

What is the expected schedule for base rate updates? (Example: annual or semiannual?)
The schedule for base rate updates will be set annually.

Is this mandatory to convert to 3M platform or can I continue to use APC model?
It is not mandatory for plans to convert to the 3M platform.

Can you clarify if multiple units with a single HCPCS get only 1 EAPG payment?
Units are not used under EAPG pricing.

We bill PT, OT, and ST for peds patients, as well as a facility fee revenue code 0510 with HCPCS code G0463. Will the G0463 be bundled with the therapy or paid separately?
G0463 can be bundled with other lines on the claim.
Hospital (PT 01) Specific Questions

**Will the EAPG materially affect the coding of outpatient records?**
Only with the requirement to add procedure-codes.

**Do EAPGs apply to outpatient behavioral health services?**
Yes, EAPGs will apply to outpatient behavioral health services.

**How will Physical Therapy, Occupational Therapy, and Speech Therapy be reimbursed for outpatient hospital based clinics?**
These services will be assigned an EAPG code to determine reimbursed amount based on billed revenue and procedure codes.

**Will we be reimbursed for the facility or the 0510 revenue code? If so, what are the billing requirements for this code?**
Revenue code 0510 will be treated like any other under EAPG pricing. A price will be determined if the service line is billed with a valid HCPCS code and an EAPG code gets assigned. And then, the price will depend on the EAPG’s relative weight and the discounting and bundling that occur, if any.

**If a patient outpatient services span more than one date of service, do we continue to bill each date of service separately or should the services be billed on a single claim?**
Providers will continue to bill each date of service separately as they currently do today. Presently, outpatient claims may only span from one date of service to the next if the admit type is 1 (emergency) or 5 (trauma center), and the detail dates of service fall within the span used at the header.

**Physical therapy, Occupational therapy and Speech therapy are currently billed separately with their own authorization number. How will this change? Will we be able to bill all 3 services on one claim and will there be space for all 3 authorizations?**
Hospitals billing for an outpatient procedure(s) that require a PA will need to include a PA number on the outpatient claim submission. If there are multiple PAs, one PA number must be included on the claim, and any additional PAs will be systematically located. All services for a single outpatient visit must be billed on one claim submission.
What does the Annual Total Automatic Rate Enhancement mean and how are we to apply it?
Automatic rate enhancements are funds that have historically been used to “buy back” budgetary rate cuts. Hospitals are allocated an annual payment amount each year. For some hospitals, that amount is $0. For others, the amount is greater than $0. The allocation for each hospital is determined by the Florida Legislature. For hospitals that do receive automatic rate enhancements, the Agency has calculated a per-payable-service-line payment amount. This amount is added to the EAPG payment on each service line and becomes part of the overall Medicaid allowed amount. Service lines that receive a denied status will not receive the add-on automatic rate enhancement payment. Lines that receive a pay status will get the add-on payment, even if the EAPG discount factor is 0, thus making the EAPG payment $0 for that service line.

Will we still need to use the Lab Fee Schedule after 07/1/17?
The Lab Fee Schedule will no longer be used for reimbursement of acute care hospitals after 7/1/2017. However, the Lab Fee Schedule will continue to be used for other types of providers, including free-standing laboratories.

Will the $1,500 outpatient cap still apply and will there continue to be rev code exemptions?
Yes, the rules for the $1,500 hospital outpatient benefit limit will remain unchanged, including the existence of revenue code exemptions.

For the Children’s Hospitals, is the 267.82 base rate grossed up by the EAPG Provider Adjustor and then who pays the Per Service Automatic Enhancement Supplemental Payment? The state?
Technically, the EAPG provider policy adjustor is applied separately from the EAPG base rate. However, the policy adjustor is applied to every claim, so it has the same effect as increasing the EAPG base rate. The Agency only has direct control of payment rates for fee-for-recipients. Individual rates negotiated between hospitals and Medicaid managed care plans are determined between those two entities. The Automatic Rate Enhancement portion of the outpatient payment is built into (is included in) the capitation rates paid by the Agency to the Medicaid managed care plans.
Related to Annual Total Automatic Rate Enhancement, how do we know what facilities are approved for this?
The following URL is an address to the Agency hospital reimbursement web pages: http://ahca.myflorida.com/medicaid/cost_reim/hospital_rates.shtml. From this Web page, there is a link to a spreadsheet called “Provider EAPG Rate Worksheet FY 2017-18” which lists the annual automatic rate enhancement allocations for individual hospitals.

Does revenue code 0636 require a modifier to be paid multiple times?
This revenue code will follow standard EAPG grouping and pricing rules, including each separate occurrence of revenue code 0636 will be considered for payment. In general, inexpensive drugs may bundle and receive $0 payment, while more expensive drugs will tend to receive separate payment, even when multiple occurrences of revenue code 0636 occur on the claim.

Do we still need to submit NDC codes with EAPGs?
Yes, NDC codes still have to be submitted with EAPGs.

Has the EAPG payment methodology been approved by CMS?
Yes, CMS has approved the EAPG payment methodology.

Regarding units of service: Cost of different chemotherapy doses can vary greatly. Do different doses of a drug pay the same amount?
Yes, different doses of a drug are paid the same amount.
ASC providers currently receive an allowance of $150.00 for intraocular lens (IOL), which is included into the rate for cataract removal. Will this allowance be made for cataract procedures when reimbursement is calculated by EAPG methodology?
No, this allowance will not be for claims that reimburse using EAPG.

Will the Agency continue to restrict ASC allowable modifiers?
Yes, Florida Medicaid will restrict the allowable modifiers, only accepting modifiers 50, 73, and 74.

Will modifiers LT and RT affect payment the same way as modifier 50 when both are present with the same CPT/HCPCS code?
No. Under EAPG, only modifier 50 (not LT/RT) will affect payment. We recommend you register for the EAPG Pricing and Q&A Session webinar that will be presented by Navigant to see specific examples of this.

For modifier 50, does that have to be billed in the first position, and then modifiers LT and RT in the second modifier position, if used?
No, modifier 50 does not have to be submitted as the first modifier to be used in EAPG payment processing.

Will the new EAPG have a specific crosswalk that clearly indicates a listing of approved ASC Medicaid procedure codes, applicable payment grouper for each specific procedure code, and the expected allowable?
There is within a document produced by 3M titled, “EAPG Definitions Manual.” 3M is offering this manual to hospitals in Florida for free for a limited time. 3M is providing this manual at no cost for orders received by September 30, 2017. Facilities must have a license to the 3M EAPG grouping software to get access to this manual after September 30th. Visit the 3M Health Information Systems Support website, [http://www.3m.com/3M/en_US/health-information-systems-us/support/](http://www.3m.com/3M/en_US/health-information-systems-us/support/), to contact 3M on how to obtain the EAPG Definitions Manual.
For More Information

Agency for Health Care Administration
For more information regarding EAPG and related policies, visit the Agency website at http://ahca.myflorida.com/medicaid/Finance/finance/institutional/hoppps.shtml.

DXC Technology