

Provider Memorandum

Enhanced Ambulatory Patient Grouping System (EAPG) Billing Guidelines

Effective immediately, Molina Healthcare of Illinois (Molina) will implement the below revised billing guidelines for services rendered in a hospital outpatient or ambulatory surgical treatment center (ASTC) required by the Illinois Department of Healthcare and Family Services (HFS).

Effective with dates of service beginning July 1, 2014, all outpatient hospital and ASTC claims are grouped and priced through 3M™ Enhanced Ambulatory Patient Grouping System (EAPG) software.

Hospitals are required to follow HFS published guidelines related to claims submission for ancillary services or non APL services.

Molina requires that hospital outpatient services submitted via 837I include one of the following:

- Ambulatory Procedure Listing (APL) procedure code OR
- Emergency room (ED) revenue code OR
- Observation (OBV) revenue code

This requirement stands on its own and will be independently edited by Molina as it relates to EAPG pricing. Each component of the above requirements will be individually evaluated when processing on an 837I – Institutional outpatient claim. Failure to have an APL code, Healthcare Common Procedure Coding System (HCPCS), ED revenue code, and/or OBV revenue code on the 837I will result in the rejection of entire claim.

All hospital outpatient service billed that do not meet one of the above three (3) criteria must be billed as fee-for-service (FFS) via 837P with the registered professional service NPI.

Molina requires that hospital 837I claims for outpatient services must include one of the following:

- One valid APL code from the APL list, which is effective on the date of service OR
- One ER revenue code reported with an allowable HCPCS code (see Exhibit 3) OR
- OBV revenue codes reported with an allowable HCPCS code (see Exhibit 3)

Molina follows the 837I data specifications manual as published by the National Uniform Billing Committee (NUBC).

Not every revenue service line on an 837I outpatient claim needs to have an HCPCS/CPT code. But, if the one is reported it will be considered and weighted with all the other elements of the claim for EAPG discounting, consolidation, packaging and pricing.

- Revenue codes that do not require HCPC

- Pharmacy 0250-0259
- M&S Supplies and device 0270-0273, 0275-0279
- Anesthesia 0370-0379
- Supplies 0620-0622
- Recovery Room 0710, 0719

Accordingly, general pharmacies (e.g. revenue code 250) do not require the National Drug Code (NDC) to be billed on the corresponding revenue service line.

Effective with dates of service on and after July 1, 2014 hospitals are required to identify the NDCs in FL 43 for all outpatient drugs billed.

For “through” dates of service prior to July 1, 2014, providers are required to detail revenue code line reporting when billing for more than one NDC per HCPCS code in conjunction with revenue codes 0634, 0635, and 0636. Duplicate revenue codes identifying the same HCPCS code but different NDCs on the same claim are not to have the HCPCS Units and charges rolled into the first Revenue Code line. Each Revenue Code line must contain detailed reporting.

Effective with “through” dates of service July 1, 2014 and after, providers are required to detail revenue code line reporting when billing for more than one NDC per HCPCS code in conjunction with any revenue code. Duplicate revenue codes identifying the same HCPCS code but different NDCs on the same claim are not to have the HCPCS Units and charges rolled into the first Revenue Code line. Each revenue code line must contain detailed reporting.

Molina follows HFS policy and billing guidelines as it relates to hospital services can be found on the HFS website at: <https://www.illinois.gov/hfs/SiteCollectionDocuments/h200.pdf>

APL code listing can be found on the HFS website at: <https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/AmbulatoryProceduresListing.aspx>

Hospital Psych Type A and Type B Claims-Exhibit 1

IF...	THEN...
<p>A claim contains a psychiatric service (90791-90876, S9480) or regular clinic visit (99201-99215) listed and that service or visit is billed with a psychiatric revenue code (90X, 91X).</p>	<p>That visit is paid under the EAPGs, and no other APL code is needed (unless the claim has multiple service dates, in which case, the other dates would require an APL code).</p> <p>Psychiatric clinic type A services must be billed with a qualifying APL code in addition to one of the following Healthcare HCPCS codes: 90791, 90792, 90832, 90833,90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90849, 90853, 90870, 90875, 90876, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, or 99215.</p> <p>Psychiatric Clinic Type B intensive outpatient program (IOP) claims must be coded with revenue code 0913. Partial hospitalization program (PHP) claims must be coded with revenue code 0912. Psychiatric clinic type B services must be billed with a qualifying APL codes in addition to the following HCPCS code: S9480.</p>

A claim contains a psychiatric service (90791-90876, S9480) or regular clinic visit (99201-99215), and that visit is billed with a regular clinic revenue code (51X).	The entire claim will be denied for payment, because hospital clinical visits should not be billed on the institutional claim form and are not included in the EAPG payment system for Illinois Medicaid program.
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Series Bill-Exhibit 2

IF...	THEN...
The claim is a series bill with multiple dates of service excluding ED and observation.	There must be a qualifying series billable revenue and HCPCS/APL on each covered service date of the series bill.
Any covered service date(s) on a series bill that do not have an APL procedure.	Claim must be billed on 837P. If billed on an 837I, entire claim will be rejected.

ED/Observation Claims-Exhibit 3

IF...	THEN...
Any ED or observation service is not billed with the correct revenue codes (0450, 0451, 0456 or 0762).	The entire claim will deny for missing/invalid revenue code.
The ED or observation services are billed with the correct revenue codes (0450, 0451, 0456 or 0762).	Another APL code is not needed.
An ED revenue code is billed on the claim, it must have at least one line with the right HCPCS code combination listed in next column, though the other ED revenue code can be billed with valid APL not from below list.	<ul style="list-style-type: none"> Revenue Code 0450 must be billed with one of the following HCPCS Codes: 99284, 99285, 99291, G0383, or G0384. Revenue Code 0456 must be billed with one of the following HCPCS Codes: 99282, 99283, G0381, or G0382. Revenue Code 0451 must be billed with the following HCPCS Code: 99281 or G0380.
More than one ED revenue code is billed on the claim.	At least one (1) of the revenue codes must be billed with an allowable HCPCS as described above. The other ED revenue codes may be billed with any valid APL not from the above list.

Hospital ER/OBV Billing Scenarios- Exhibit 4

IF...	THEN...
Patient receives ED and/or OBV services on the same day as an inpatient admission.	<p>Hospitals have the option to bill, in addition to the inpatient claim, one outpatient claim containing charges for the use of the emergency room or observation services. All other ancillary services related to the emergency or observation department services are reported on the inpatient claim.</p> <p>On OP bill only the emergency room charge or the observation service may be billed on the outpatient claim. It is up to the hospital to determine which outpatient service will provide greater reimbursement. Charges incurred as a result of services provided by other outpatient departments prior to the patient's admission, such as laboratory or radiology services, are to be shown on the Inpatient claim.</p>

	<p>For example: Patient presents in the ED on Dec. 1, and is placed in OBV that same day, and is then admitted as an IP on Dec. 1. The hospital bills the ED (E&M code) or OBV charge on an OP claim, and rolls into the IP claim all other ancillary services provided in the OP setting.</p> <p>NOTE: One salaried physician's services may also be billed under the physician's name and NPI.</p> <p>NOTE: The hospital may also be reporting non-E&M ED services identified with an ED revenue code on the inpatient claim (e.g. an APL procedure performed in the ED that is something other than the E&M).</p>
<p>Patient has ED and/or OBV services on days that precede an inpatient admission as part of the same encounter.</p>	<p>The hospital is allowed to submit two claims, with all of the OP charges on one claim and all IP charges on a second claim. Hospitals are allowed to seek reimbursement for ED and/or OBV for each day outpatient services are rendered (ED on day 1 and OBV on day 2, or vice versa, whichever reimburses higher).</p> <p>For example: Patient presents to the ED on Dec. 1, is placed in OBV on Dec. 2, and is admitted as an IP later that same day. The patient remains an IP from Dec. 2 through Dec. 5, when he is discharged home. The hospital bills all the Outpatient charges related to an ED/OBV on an Outpatient claim. Separately, the Hospital bills all the Inpatient changes related to inpatient admission on an Inpatient claim.</p> <p>If hospitals are submitting two claims (outpatient and inpatient), the initial outpatient claim will have the respective dates of service for ED and/or OBV from Dec. 1 through Dec. 2, and the inpatient claim will have the actual admission date from Dec. 2 through discharge date of Dec. 5 for the inpatient services.</p> <p>If hospitals are submitting one inpatient claim for all services, the admission date will reflect the date that the patient presents to the ED from Dec. 1 and will span through the discharge date of Dec. 5.</p>
<p>The patient has ED/OBV services that cross midnight.</p>	<p>This is considered one episode of care, and HFS requires an APL to be present on the 837I claim on either day 1 or day 2.</p> <p>For Outpatient Observation services that span multiple days, both the G0378 and G0379 HCPCS are required for each dates of service.</p> <p>For example: Patient presents in ED on Day 1, but is not discharged from Outpatient services until Day 2. In this case, the hospital may report APL HCPCS for ED services on either Day 1 or Day 2.</p>

