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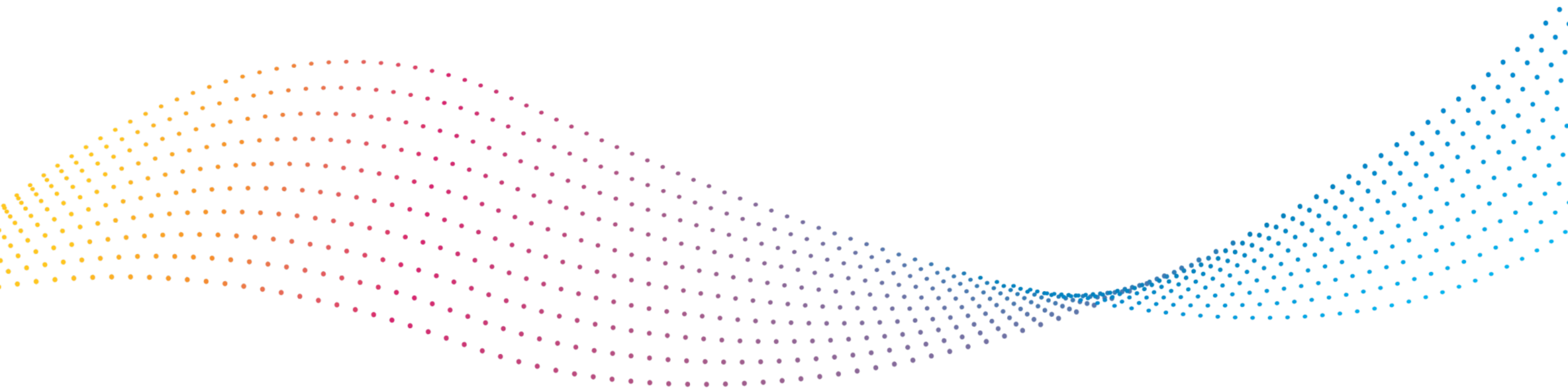
MCO Encounter Error Solutions

837I Billing Guidelines for EAPG pricing



837I Billing Guidelines for EAPG Pricing

- Based on updates to the provider memorandum, we have incorporated the following updates into the corresponding presentation

  - Page 3 - This page was added to further clarify MCO requirements regarding hospital UB-04/837I claims for outpatient services

  - Page 10 - The text following the last two bullet points was modified to include how the G0379 and G0378 procedure codes are represented on the 0762 revenue lines described

  - Page 11 - This page was added to illustrate how the 0762 revenue lines appear on a claim example

  - Page 12 - The last bullet point was added to further clarify guidance on the billing scenario in which the patient has ED and/or OBV services on days that precede an inpatient admission as part of the same encounter

  - Page 13 - This page was also added to clarify guidance on the same billing scenario as the page 12 modification

  - Page 14 - The last bullet point was added to further clarify guidance on the billing scenario in which the patient has ED/OBV services that cross midnight

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837I Billing Guidelines for EAPG Pricing

March 2017

Provider Memorandum-837I Billing Guidelines for EAPG pricing

The Illinois Department of Healthcare and Family Services (HFS) requires Managed Care Organizations (MCO) to meet very specific claim submission standards requiring particular and exact data elements on claims submitted by Hospitals. To facilitate the appropriate application of these rules, Managed Care Organizations are collectively relaying the following billing guidelines in this Provider Memorandum in an effort to improve the acceptance rate of MCO encounter data by HFS and to ensure correct claim submission for services rendered in a hospital outpatient or ambulatory surgical treatment center setting.

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- Effective with dates of service beginning July 1, 2014, all outpatient hospital and Ambulatory Surgical Treatment Centers (ASTC) claims are grouped and priced through 3M™EAPG software or similar MCO grouper software.
- Hospitals are required to follow HFS published guidelines related to claims submission for ancillary services or non APL services
- MCOs require that hospital UB-04/837I claims for outpatient services must include one of the following:
  - One valid Ambulatory Procedure Listing (APL) code from the APL list, which is effective on the date of service OR
  - One Emergency Room (ED) revenue code reported with an allowable HCPCS code OR
  - Observation (OBV) revenue codes reported with an allowable HCPCS code

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- This requirement stands on its own and will be independently edited by MCO 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 MCO rejection of entire claim

- All hospital outpatient service billed that do not meet one of the above three (3) criteria must be billed as FFS on a CMS 1500/837P with the registered professional service NPI.

- MCOs follow the UB-04 data specifications manual as published by the NUBC

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- Not every revenue service line on an 837I/UB-04 outpatient claim needs to have an HCPCS/CPT code. But, if one is reported it will be considered and weighted with all the other elements of the claim for EAPG discounting, consolidation, packaging & pricing.

- Revenue codes that do not require HCPCS
  - 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 an NDC code to be billed on the corresponding revenue service line.

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Hospital Psych Type A and Type B claims

The claim contains a psychiatric service (90791-90876, S9480) or regular clinic visit (99201-99215) and that service or visit is billed with a psychiatric revenue code (90X, 91X)

- 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).
  - Psychiatric clinic type A services must be billed with a qualifying APL code in addition to one of the following 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.
  - Psychiatric clinic type B services must be billed with a qualifying APL code in addition to HCPCS code S9480.
    - Intensive outpatient program (IOP) claims must be coded with Revenue code 0913.
    - Partial hospitalization program (PHP) claims must be coded with Revenue Code 0912.

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Hospital Psych Type A and Type B claims (continued)

The 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 claims

The claim is a series bill with multiple dates of service excluding ED and observation.

- There must be a qualifying series billable revenue code 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 must be billed on 837P. If billed on an 837I, the entire claim will be rejected.

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ED/OBV Claims

The claim is for ED/OBV services and billed with the correct revenue code (0450, 0451, 0456, 0762).

- **Emergency Services**
  - 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
  - ED services not billed with one of the above revenue codes will deny for missing / invalid revenue code.

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ED/OBV Claims (continued)

The claim is for ED/OBV services and billed with more than one revenue code

- At least one 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.

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ED/OBV Claims (continued)

- **OBV Services**
  - For service dates billed through 12/31/16, revenue code 0762 must be billed with one of the following HCPCS codes: 99218, 99219, 99220, 99234, 99235 or 99236.
  - **Evaluation and Management Procedure Codes**
    - Effective January 1, 2017, for dates of service April 1, 2016 through December 31, 2016, providers have the option to bill the EM procedure codes with procedure code G0378, or may bill procedure code G0379 with procedure code G0378.
    - For service dates beginning January 1, 2017, all OBV claims billed to the MCO must be coded with G0379 and G0378. Providers must continue to identify two revenue lines for observation.
      - The first line is revenue code 0762 billed with procedure code G0379 representing one (1) unit along with zero dollar ($0.00) charges.
      - The second line is revenue code 0762 billed with procedure code G0378 representing the number of time based units along with the corresponding charges.

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ED/OBV Claims (continued)

- The populated claim example below represents the correct format for OBV services

10 BIRTHDATE	11 SEX	13 HR	14 TYPE	15 SRC	17 STAT
07/29/1000	M		1	1	01

31 OCCURRENCE CODE	DATE
11	02/01/2017

42 Rev Cd	43 Description	44 HCPCS / Rate / HIPPS Code	45 Service Date	46 Service Units	47 Total Charges	48 Non-Covered Charges	49
0762	Treatment or Observation Room - Observati	G0379	02/01/2017	1	$0.00	$0.00	
0762	Treatment or Observation Room - Observati	G0378	02/01/2017	14	$1,064.00	$0.00	
	PAGE ___ OF ___	CREATION DATE	02/15/2017	TOTALS	$1,064.00	$0.00	

50 PAYER NAME	51 HEALTH PLAN ID	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
				1111222233

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Hospital ED/OBV Billing scenarios

Patient receives ED and/or OBV services on the same day as an inpatient admission:

- Hospitals have the option to bill, in addition to the inpatient claim, one outpatient claim containing charges for the use of the ED or OBV services. All other ancillary services related to the ED or OBV department services are reported on the inpatient claim.

Patient has ED and/or OBV services on days that precede an inpatient admission as part of the same encounter:

- The hospital may 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.

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Hospital ED/OBV Billing scenarios (continued)

- 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 December 1 through December 2, and the inpatient claim will have the actual admission date from December 2 through discharge date of December 5 for the inpatient services.

- 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 December 1 and will span through the discharge date of December 5.

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Hospital ED/OBV Billing scenarios

The patient has ED/OBV services that cross midnight:

- This is considered one episode of care, and HFS requires an APL to be present on the UB-04/837I claim on either day 1 or day 2.
- For Outpatient OBV services that span multiple days, both the G0378 and G0379 HCPCS are required for each date of service.

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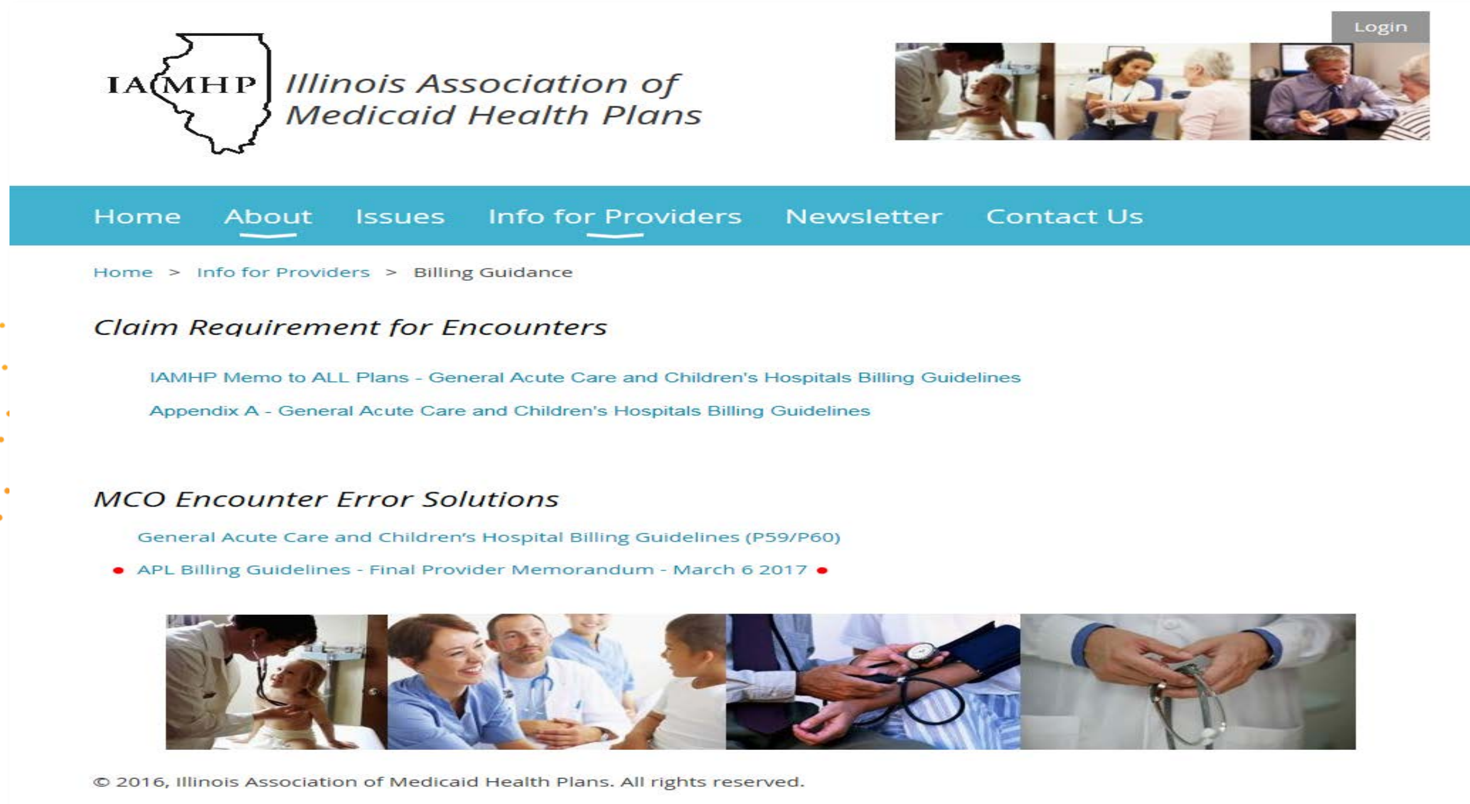
Available Reference Material

- **IAMHP Memo to ALL Plans can be found on the IAMHP website:**
  - http://iamhp.net/page-18098



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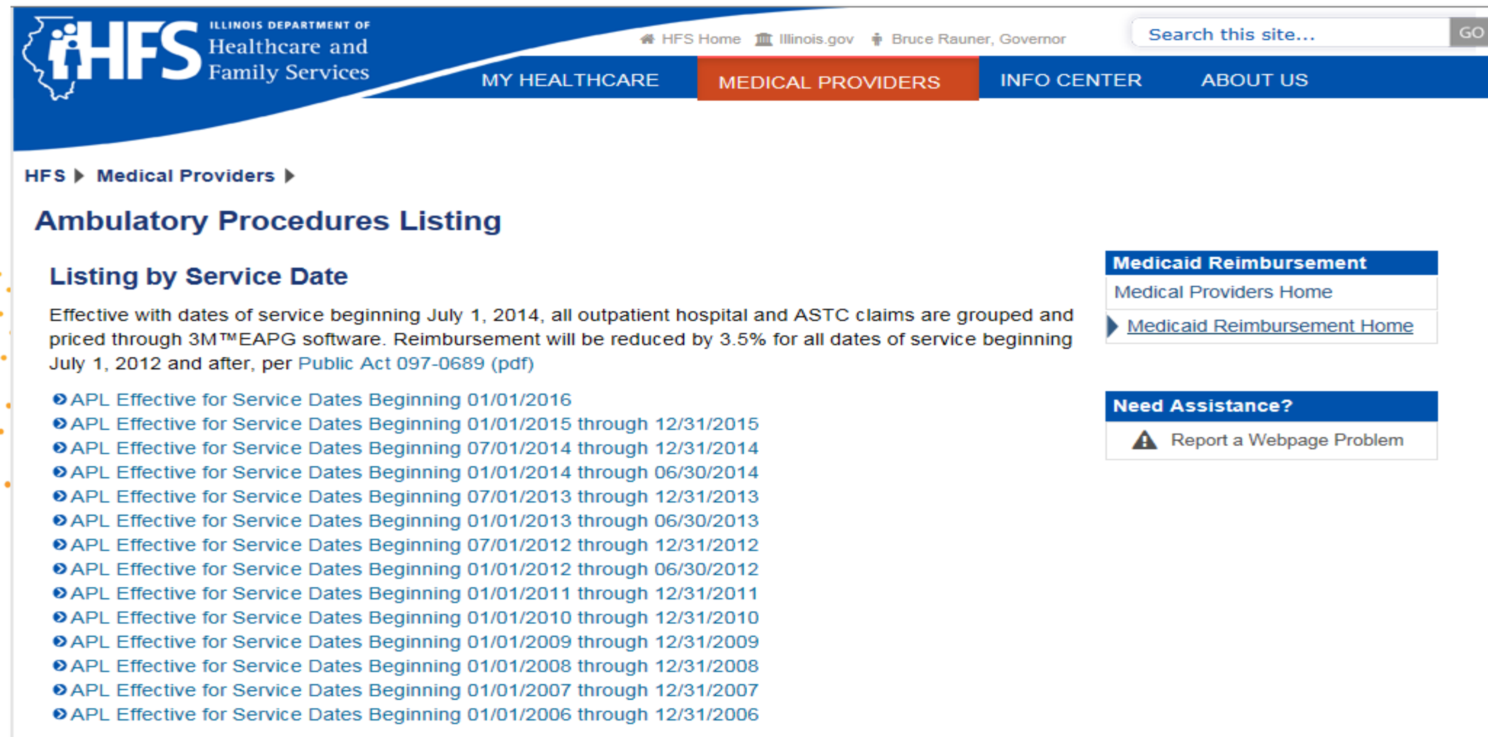
Available Reference Material

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



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Available Reference Material

- **HFS policy and billing guidelines related to Hospital services can be found on the HFS website:**
  - ➢ https://www.illinois.gov/hfs/SiteCollectionDocuments/h200.pdf
- **Series Billable Revenue Codes can be found on pp. 5 and 6 of Appendix H3 on the HFS website:**
  - ➢ https://www.illinois.gov/hfs/SiteCollectionDocuments/h200a.pdf

Handbook for Providers of
Hospital Services

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837I Billing Guidelines for EAPG Pricing

MCO Actions

Verify APL code listings:

- APL codes are date sensitive.

Claims Configuration logic:

- Claims configuration logic should be periodically updated to accurately reflect allowable APL codes for given dates of service in accordance with HFS published guidelines. ED/OBV Claims submitted with invalid revenue or APL codes should deny. Providers need to re-submit these claims with correct revenue and/or APL codes.

Rejected Encounters:

- ED/OBV Claims that are paid with invalid revenue or APL codes that are not caught by configuration edits often reject with encounter error codes such as A39, U31, U32, etc… These dollars should be recouped. Providers need to re-submit these claims with correct revenue and/or APL codes