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.

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 outpatient services submitted on a UB-04 (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 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.

MCO requires that hospital UB-04/837I 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)

MCO follows the UB-04 data specifications manual as published by the NUBC.

Not every revenue service line on an 837I/UB-04 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 & pricing.

- Rev 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 NDC code 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.

MCO follows HFS policy and billing guidelines as it relates to Hospital services can be found on the HFS website at below link:

https://www.illinois.gov/hfs/SiteCollectionDocuments/h200.pdf

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

Hospital Psych Type A and Type B Claims-Exhibit 1

IF…	THEN…
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)	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 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
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.

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 REV 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 Rev 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.	• 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 Codes: 99281 or G0380
More than one ED revenue code is billed on the claim	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.

Hospital ED/OBV Billing Scenarios-Exhibit 4

IF…	THEN…
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 emergency room or observation services. All other ancillary services related to the emergency or observation department services are reported on the inpatient claim. 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. For example: Patient presents in the ED on December 1, and is placed in OBV that same day, and is then admitted as an IP on December 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. NOTE: One salaried physician's services may also be billed under the physician's name and NPI. 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)
Patient has ED and/or OBV services on days that precede an inpatient admission as part of the same encounter	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). For example: Patient presents to the ED on December 1, is placed in OBV on December 2, and is admitted as an IP later that same

	day. The patient remains an IP from December 2 through December 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. 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.
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 Observation services that span multiple days, both the G0378 and G0379 HCPCS are required for each dates of service. 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.

The ED or observation claim spans multiple service dates and this is considered one claim, and all service lines reported with an ED or observation revenue code are treated as if they occurred on the first date of service for purposes of EAPG pricing.

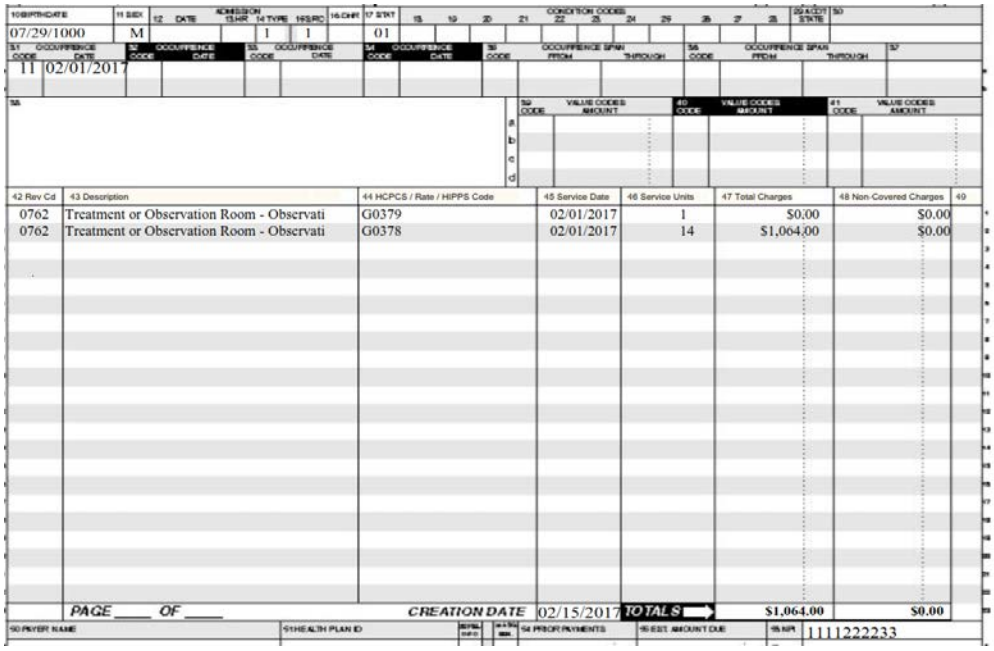
For service dates billed through 12/31/16, Revenue Code 0762 may be billed with one of the following HCPCS codes: 99218, 99219, 99220, 99234, 99235 or 99236.

For service dates billed through December 31, 2016, providers must continue using the Evaluation and Management procedure codes with G0378.

Effective January 1, 2017, for dates of service April 1, 2016 through December 31, 2016, providers have the option to bill the Evaluation and Management codes with G0378, or may bill G0379 with G0378.

Service dates beginning January 1, 2017, all observation claims billed to the MCO must be coded with G0379 and G0378. Providers must continue to identify two revenue lines for observation, with the first Revenue Code 0762 billed with procedure code G0379 representing one (1) unit along with zero dollar ($0.00) charges, and a second Revenue Code 0762 billed with procedure code G0378 representing the number of time based units along with the corresponding charges.

Please see the populated claim example below representing the correct format for Observation services:



10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACCT STATE	30
07/29/1000	M			1	1		01													

31 OCCURRENCE CODE	31 OCCURRENCE DATE	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE SPAN FROM	35 OCCURRENCE SPAN THROUGH	36 CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH	37
11	02/01/2017													

38	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a						
b						
c						
d						

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	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56 NPI	1111222233