Network Notification

Notification Date: October 10, 2017
To: Ohio Medicaid, CareSource MyCare Ohio Health Partners
From: CareSource Health Partner Relations
Subject: Update Regarding Enhanced Ambulatory Patient Group (EAPG) Billing Payment Methodology
Effective Date: October 1, 2017

EAPG Payment Methodology Update

As a follow up to our Aug. 31, 2017, network notification, we are pleased to announce that effective Oct. 1, 2017, CareSource began processing claims with the enhanced ambulatory patient group (EAPG) methodology. This impacts your hospital as follows:

- Any outpatient hospital services claim with a date of service on or after Oct. 1, 2017, will process under the EAPG methodology and should be submitted with covered codes on the EAPG grouper.
- Any outpatient hospital services claim with a date of service prior to Oct. 1, 2017, will be processed under the previous methodology and should be submitted with covered codes on the Ohio Medicaid Fee Schedule.
- Any outpatient hospital services claim with dates of service before and after Oct. 1, 2017, should be submitted with two separate claims – one for dates of service on and after Oct. 1, 2017 and one for dates of service on and before Sept. 30, 2017. Please note that a claim submitted with combined dates of service before and after Oct. 1, 2017 will be denied.

For more information about EAPG, please access the following resources:

- www.ODM.gov
- http://medicaid.ohio.gov/Portals/0/Resources/Publications/Guidance/BillingInstructions/HospitalBillingGuidelines-20170801.pdf

EAPG Claim Processing Defect

A defect currently exists under EAPG methodology where a claim submitted with a non-covered code will result in the denial of all claim lines.

When a non-covered code and certain fee schedule items are submitted on a claim, the fee schedule line will price based on the fee schedule associated with that code, but deny the rest of the claim lines. An example of how the system is currently processing claims is shown below:

How the claim should process:			How the claims pays with the defect:		
Line Items	**Charges**	**Optum Software Response**	**Line Items**	**Charges**	**Optum Software Response**
Normal CPT	$100	Denial	Normal CPT	$100	Claim denial
Non-covered CPT	$100	Denial	Non-covered CPT	$100	Claim denial
VFC fee schedule item	$10	Denial	VFC fee schedule item	$10	$10
Health partner response:	Rebill the claim with only the CPT code to receive payment.		Health partner response:	Rebill the claim with only the CPT code to receive payment.	

If you have received a claim denial due to the defect described above, you may submit a corrected claim with only the covered code on the claim line. A notification will be issued when this defect is fixed. If you have any questions, please contact Health Partner Services at **1-800-488-0134**.

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