District of Columbia Medicaid
A New Outpatient Hospital Payment Method

Frequently Asked Questions

Version Date: October 1, 2015

UPDATE:

The District of Columbia (DC) Department of Health Care Finance (DHCF) submitted state plan amendments (SPAs) for three new hospital payment methods that were effective October 1, 2014. The outpatient SPA was approved by CMS on August 27, 2015. All claims with a first date of service on or after October 1, 2014 have been reprocessed with payment adjustments as necessary under the new payment method.

OVERVIEW

1. What change was made?

The DC Department of Health Care Finance (DHCF) has implemented a new payment method for all outpatient hospital services. The previous payment method was a cost-based method with hospital-specific visit rates. The new method uses Enhanced Ambulatory Patient Groups (EAPGs). EAPGs are a visit-based patient classification system designed by 3M Health Information Systems to characterize the amount and type of resources used in a hospital outpatient visit for patients with similar clinical characteristics. The use of EAPGs results in higher payments for higher intensity services and lower payments for lower intensity services.

2. Why change to a new payment method?

The previous outpatient payment method was based upon hospital-specific costs with an enhanced rate for emergency services, while some services were paid by a fee based on the procedures billed. A flat visit rate of $50 was also paid in certain instances, for example, for emergency room visits considered non-emergent. Outpatient surgery services were paid by flat rates based on groups of HCPCS procedure codes. Based upon this payment methodology, hospitals were reimbursed at 36% of their costs for outpatient services. The previous payment methodology did not take into account the clinical complexity of the patient and the resources needed to appropriately diagnose and treat that patient.

3. What are the goals that DHCF hopes to achieve by implementing a new outpatient payment methodology?

Goals of the new outpatient hospital payment method include:

- ***Implement a sustainable payment method.*** The District needs an outpatient payment method that is sustainable over time, promotes quality of care and is flexible enough to accommodate changes in payment policy and federal regulatory requirements.
- ***Increase fairness.*** Under the previous payment method, different hospitals were often paid very different amounts for the same or very similar care to similar patients based upon historic differences in the cost of providing care. We believe it is fairer to have payment reflect resources currently available and the reasonable costs of providing care based on patient needs rather than the individual hospital's historic experience in providing care.
- ***Reduce administrative burden.*** One component of the previous payment method relied on diagnosis codes defined as emergent for an add-on ER payment. Maintaining this list of emergent diagnosis codes presents an administrative burden after implementation of ICD-10 coding. The EAPG grouper is compliant with ICD-10 coding.
- ***Improve purchasing clarity.*** Under the previous payment method, it was very difficult to understand how much Medicaid was paying for specific types of outpatient services. The District aimed to align its payment methodology with prevailing methodologies used by other Medicaid programs and private payers that improve purchasing clarity and encourage hospital efficiency.

4. Does the implementation of ICD-10 impact the new payment method?

The EAPG grouper is fully compliant with both ICD-9 and ICD-10 codes.

5. What providers and services are affected?

The new payment method will apply to all outpatient hospital services provided by:

- In-District general acute care hospitals and specialty hospitals that offer outpatient hospital services (psychiatric, rehabilitation, and children's hospitals) and
- Out-of-District hospitals, except for Maryland hospitals.

ENHANCED AMBULATORY PATIENT GROUPS (EAPGS)

6. Why were EAPGs chosen? Why not the Ambulatory Payment Classification groups (APCs) that Medicare uses?

The District conducted an assessment of various options available for payment of outpatient hospital services, including Medicare's APCs. EAPGs were chosen because they are more suitable for use with the Medicaid population. Medicare APCs were designed for the Medicare population in support of Medicare policies. EAPGs are designed for an all-patient population. EAPGs reflect the relative intensity of the entire visit allowing providers and payers to more accurately account for resources and for payment. EAPGs reward hospitals for providing efficient access to a wide variety of increasingly clinically complex outpatient hospital services in a more appropriate manner.

As opposed to Medicare's APC mixed fee schedule approach, EAPGs are an outpatient visit grouping system, which places patients and services into clinically coherent groups. EAPGs do rely on the

CPT/HCPCS procedure code but also use diagnosis codes and other clinical and demographic factors to determine appropriate EAPG assignment. And while APCs generate payment based on volume of codes submitted, EAPGs are more clinically driven and are designed to generate payments that reflect the relative resource intensity of the entire visit. Therefore the use of EAPGs will result in higher payments for higher intensity services and lower payments for lower intensity services.

7. In general, how will the new payment method impact hospitals?

In general, the new payment method provides rational incentives for the provision of outpatient hospital services:

- There is a more direct link between the level of payment and the complexity of the service provided. Efficiency and cost containment are rewarded. Hospitals that provide similar services are paid similarly.
- Complete and correct coding of claims is more important, and may have an effect on claim payment. It should be noted that CPT/HCPCS codes are not required nor expected on every line of the claim. Some claim lines may be bundled whether or not a procedure code is present. Hospitals should code claims according to national coding guidelines.

8. What other payers use EAPGs?

Medicaid programs currently using EAPGs include: New York, Virginia, Wisconsin, Illinois and Washington for payment; and Massachusetts for service-mix adjustment. Medicaid programs with planned EAPG implementations for outpatient hospital services are: Colorado and Texas. Commercial payers currently using EAPGs include: Oklahoma BlueCross BlueShield, Minnesota BlueCross BlueShield, and Wellmark in Iowa and South Dakota.

9. Is my hospital required to purchase EAPG software in order to receive payment under the new method?

No. The EAPG grouper/pricer specific to DC Medicaid assigns the EAPGs to the claim lines and calculates the payment. The DC Medicaid claims processing system then adjudicates the claim for final pricing. Hospitals may choose to purchase grouping software allowing them to project revenue. For Washington, DC, the 3M sales representative is Robbyn Lessig, Client Relationship Executive, 703-753-0620. Neither DHCF nor Xerox has a financial interest in any 3M product.

10. Does my hospital have to start collecting additional data to use 3M EAPGs?

No. The data elements needed for EAPG grouping include only those hospitals already submit on the paper and electronic standard institutional claim forms. For example, diagnosis codes, CPT/HCPCS procedure codes, revenue codes, line item dates of service, age and gender. Hospitals do not need to add the EAPG to the claim. The EAPG grouper in the DC claims processing system assigns the EAPG.

PAYMENT CALCULATIONS

11. How is EAPG payment calculated?

Each CPT/HCPCS procedure code on a claim line is assigned to the appropriate EAPG at the line level. Each EAPG has an assigned relative weight. This relative weight is adjusted by the various payment mechanisms as applicable such as discounting, packaging and consolidation. The adjusted relative weight is multiplied by a conversion factor or base rate to yield the EAPG payment amount. DC Medicaid has also added a 25% pediatric policy for FY 15, and increased it to 50% for FY 16. This is applied as a percent increase on claims for beneficiaries under the age of 21.

Table 1 **EAPG Payment**
EAPG payment = (Adjusted EAPG relative weight * pediatric policy adjustor) * conversion factor
Adjusted EAPG relative weight = EAPG relative weight *multiple significant procedure discount * bilateral procedure discount * terminated procedure discount * repeat ancillary procedure discount * other discounts

12. What EAPG relative weights are used to calculate EAPG payment?

DC Medicaid uses version 3.8 of the national relative weights available from 3M Health Information Systems. The EAPG national relative weights are calculated by 3M based on Medicare claims data, comprising approximately 55 million claims from FY 2010.

After examining the available options, the District opted to use the national relative weights because statistically valid District-specific relative weights are not feasible due to the District's small volume of Medicaid claims. The national relative weights are updated annually by 3M and use EAPG default settings which align more closely with the District's overall approach and goals. Other Medicaid programs also use or plan to use the national relative weights for their EAPG-based payment method.

13. What conversion factors are used in EAPG payment?

For both FY 2015 and FY 2016, DHCF uses three conversion factors: one for in-District and out-of-District hospitals and one that is 2% higher for United Medical Center (based on its geographic location in an economic disadvantage zone). National Rehabilitation Hospital also has a separate conversion factor because of their significantly different cost structure and more limited array of outpatient services than that of the other hospitals. The values for the final conversion factors effective for Fiscal Year 2015 (October 1, 2014 through September 30, 2015) and Fiscal Year 2016 (October 1, 2015 through September 30, 2016) are shown in the table below.

Conversion Factors	FY 2016	FY 2015
National Rehab Hospital	$205.32	$273.65
United Medical Center	$692.34	$693.71
All Other Hospitals	$678.76	$680.11

14. How were conversion factors calculated?

For both FY 2015 and FY 2016, the conversion factors were configured to achieve overall payments equal to 77% of inflated costs after a 5% coding improvement factor. FY15 costs were estimated using

cost-to-charge ratios (CCRs) from the District's FY 2013 (October 1, 2012-September 30, 2013) hospital cost reports which were inflated forward to FY15 by a 4.14% inflation factor. FY16 costs were estimated using CCRs from the District's FY 2014 (October 1, 2013 through September 30, 2014) hospital cost reports which were inflated forward to FY16 by a 2.52% inflation factor. For both fiscal years, the budget target was reduced by 5% with the expectation that hospitals will improve coding above 77% of inflated costs. Current payments equate to about 36% of estimated costs.

15. How often will conversion factors be updated?

DHCF will evaluate rates on an annual basis to consider any changes necessary to conversion factors based on budgetary constraints and other factors. DHCF will monitor payment levels closely, especially during the first year of EAPG payment to ensure that payments do not grossly differ from budgeted amounts.

16. What version of the EAPG grouper was implemented?

DHCF will implement version 3.8 of the EAPG grouper, which was released in January 2013.

17. Will there be regular updates to the EAPG Grouper/Pricer software?

Yes. DHCF performs EAPG quarterly updates, which generally involve staying current with CPT/HCPCS coding updates. The grouper version will be updated at a minimum every two years, which may involve changes in grouper logic, enhancements and updates to EAPG settings.

18. Will any outpatient hospital services be paid based on a fee schedule under EAPGs?

No. All outpatient hospital services are paid based on EAPGs. No services have been identified for payment by fee schedule at this time.

19. Will outlier payments be included in the new payment method?

Outlier payment provisions are typically made for cases that are unpredictably expensive. The District's analysis of claims data performed to date does not indicate extreme variation in claim charges or cost, typically associated with outlier cases. An outpatient cost outlier payment policy is not used unless a need is identified in future claims data analyses.

20. Is EAPG payment capped to the lower of the EAPG payment or billed charges?

The previous outpatient hospital payment method limited payment for some services to the lesser of the calculated amount or billed charges. Limiting payment to billed charges is typically used to control costs, particularly when the payment method is based on a percent of charges. EAPGs are a visit-based patient classification system designed to link the level of payment with the complexity of the service provided. When a sophisticated grouping algorithm is used to price claims, such as EAPGs, the result is that a hospital may be paid more than its charge on a specific claim or line and significantly less than its charge for others due to payment bundling techniques (packaged services and discounting). However, on balance

the payment method is expected to be fair. A charge cap to limit payment to billed charges is not imposed.

21. Does this change affect payments from Medicaid managed care plans?

While payments to hospitals from Medicaid managed care plans are outside the scope of this project, the DC Medicaid managed care organizations may opt to move to Medicaid's new fee-for-service payment methods.

22. Does the change affect how Medicare crossover claims are paid?

No. The payment logic for Medicare crossover claims is not affected by EAPGs. DC Medicaid continues to pay the lesser of these two amounts on an outpatient crossover claim:

a. The Medicaid allowed amount minus the Medicare paid amount
b. The Medicare co-insurance amount plus Medicare deductible amount

COVERAGE AND PAYMENT FOR SPECIFIC SERVICES

23. What changes, if any, were made to prior authorization policy?

The Department uses prior authorization to help control inappropriate utilization of services. While there were no changes specifically related to the implementation of EAPGs, changes in the Department's prior authorization policy are made from time to time to address new coverage policies, new technologies or to address areas of potential fraud, waste and abuse.

24. How are laboratory and radiology services paid?

Laboratory and radiology services are processed and paid by EAPG, subject to consolidation, packaging or discounting as applicable.

25. How are physical, occupational, and speech therapy services paid?

Physical therapy, occupational therapy and speech therapy procedures are processed and paid by EAPGs, subject to consolidation, discounting and packaging as applicable.

26. How are dental services provided in an outpatient hospital setting paid?

Outpatient hospital dental services are processed and paid by EAPGs. The procedure codes and payment are for the facility services, not for the professional services provided by the dentist. Professional services provided by dentists (e.g., pediodentist) are not included in the EAPG payment method and will continue to be billed separately and paid by fee schedule.

27. How are payments for pediatric services affected under EAPGs?

For FY 2015, a 25% pediatric policy adjustor applies to claims for beneficiaries under the age of 21. This means that payments for these claims will be 25% higher than the otherwise calculated EAPG payment. For FY 2016, the pediatric policy adjustor will be set to 50%. See FAQ #11 for an illustration of the calculation formula.

28. Are payments for vaccines and vaccine administration codes affected?

DHCF continues its existing policy and makes no payment for vaccines available through the Vaccines for Children (VFC) Program. VFC vaccines are not payable under Medicaid because these vaccines are federally funded and available at no charge to providers for Medicaid eligible children.

Other vaccine and vaccine administration procedure codes currently covered for adults and children are processed through the EAPG grouper. The payment for vaccine administration codes for adults and children are bundled when a significant procedure is billed on the claim.

29. What changes were made to observation room services policy?

DHCF changed its previous policy and now pays separately for observation room services under certain specific conditions. Observation room services begin at the time that the physician writes the order to evaluate the patient.

- The new DHCF policy states that observation services must be at least 8 hours and not more than 48 hours.
- Payment for observation services is based on the EAPG, regardless of the number of units (hours) billed as long as units billed are at least 8. If units are not at least 8, the line will group to EAPG 999 and pay zero.
- Observation room services are always packaged when a significant procedure is also billed.

Under the new payment method, observation room services may be identified by HCPCS code G0378 which groups to EAPG 450. The relative weight for this EAPG reflects the national average units (hours) greater than 8. (For details on the observation logic, please see EAPG Information handout question #11)

30. What changes were made to partial hospitalization program (PHP) services policy?

No change in current policy for partial hospitalization program (PHP) services was made due to the new payment method. Consistent with the District Medicaid State Plan, PHP services are not a covered outpatient hospital service, except as part of waiver services. PHP services are not paid under the new payment method based on EAPGs.

BILLING AND EDITING

31. What billing practices are important for hospitals to follow under EAPGs?

The EAPG grouper relies on revenue codes, procedure and diagnosis codes and patient demographic information to accurately group and price claims. Hospitals are asked to ensure that these fields are coded completely, accurately and defensibly on their outpatient claims based on national coding guidelines.

32. Do hospitals have to submit claim lines in any particular order under EAPGs?

No. After EAPGs were activated in the claims processing system, the order in which claim lines or HCPCS procedures are billed on the claim is not relevant for accurate payment. Under certain circumstances, such as when multiple unrelated significant procedures are billed in the same visit, the

grouper ranks those procedures by weight for discounting purposes. This occurs regardless of the order in which lines are billed on the claim.

33. Do hospitals need to continue using the DC Medicaid visit codes?

Under the previous payment method, hospitals were required to bill outpatient hospital services using one of the District-designated 'visit codes' which included mostly evaluation and management CPT codes. The presence of the visit codes did not interfere with accurate payment of the claims when they were reprocessed under EAPGs. Now that EAPGs are activated in the DC Medicaid system, hospitals no longer have to use the visit codes in order to receive claim payment.

34. When should outpatient services be billed as part of an inpatient claim?

Hospital outpatient diagnostic services provided one to three days prior to an inpatient admission at the same hospital are not separately payable and should be billed as part of the inpatient stay. Diagnostic services are defined by revenue code, see table below. All hospital outpatient services (regardless of revenue code) that occur on the same day as an inpatient admission at the same hospital are also considered part of the inpatient stay and as such are not separately payable.

Diagnostic Revenue Codes for 3-Day Window	Revenue Code Desc
0254 - 0255	Pharmacy
0341, 0343	Nuclear medicine
0371 - 0372	Anesthesia
0471	Diagnostic audiology
0482 - 0483	Cardiology
0918	Behavioral health svcs
0300 - 0319	Laboratory
0320 - 0329	Diagnostic radiology
0350 - 0359	CT Scan
0400 - 0409	Other imaging
0460 - 0469	Pulmonary function
0530 - 0539	Osteopathic svcs
0610 - 0619	Magnetic resonance tech
0621 - 0624	Med/surg supplies
0730 - 0739	EKG/ECG
0740	EEG
0920 - 0929	Other dx services

35. Is there any limit to the number of diagnosis codes, modifiers, CPT or procedures codes that can be submitted per claim?

The DC claims processing system can accept 26 diagnosis codes; however the EAPG grouper only looks at the principal diagnosis and does so only under certain circumstances. The limit on the number of lines per claim that can be accepted by the EAPG grouper is 450. Up to four modifiers may be accepted per line but only certain modifiers impact payment under EAPGs, please see FAQ #44.

36. Should HCPCS/CPT procedure codes be billed on every line of the outpatient claim?

No. HCPCS/CPT codes are not expected on some claim lines, such as certain drugs and supplies. While lines without procedure codes are assigned to EAPG 999 with zero payment, the payment for these items is included in the payment for the significant procedure or medical visit. Some claim lines are packaged or consolidated even if a procedure code is present. Hospitals should note that there is a list of specific revenue codes for which DC Medicaid requires a procedure code. This list is not new nor does it change under EAPGs.

37. How do the National Correct Coding Initiative edits apply under the new payment method?

DHCF continues to identify and edit claims where coding methods do not adhere to these federal guidelines under the new EAPG payment method. The National Correct Coding Initiative is a federal requirement for all Medicaid programs under the Affordable Healthcare Act.

38. How are payments for professional revenue codes affected?

Effective October 1, 2014, professional fees revenue codes are not eligible for payment under the EAPG payment method when billed on outpatient hospital claims (UB-04). These professional services should continue to be billed on professional claims (CMS-1500).

39. What type of bill (TOB) should be used for billing outpatient hospital surgery services?

Under the previous payment method, hospitals were required to use bill types 0830-0838 to bill for outpatient hospital surgery services and some chemotherapy services. Now that EAPGs are activated in the DC Medicaid claims processing system, outpatient surgical services should no longer be billed with bill types 0830-0838 because these bill types are designated for ambulatory surgery centers. Outpatient hospital services should be billed with bill types 0130-0138.

40. How is an outpatient hospital visit defined under EAPGs?

Under EAPGs, an outpatient hospital visit is defined as services on a single claim billed with the same date of service. A given claim may contain multiple visits if the dates of service are different. However, a single visit cannot cross different claims.

The ability to recognize multiple visits for payment on a single claim is a functionality that is built into the EAPG grouper software. Under the previous payment method, multiple dates of service on a single claim were not recognized for separate payment. Under EAPGs, each date of service on a claim is processed and paid as a separate visit.

41. How are medical visits paid under EAPGs?

Lines billed with HCPCS/CPT codes that are designated by the EAPG grouper as a medical visit indicator EAPGs are packaged in the presence of a significant procedure. If a claim is billed with a medical visit HCPCS/CPT code and no significant procedure is present, then the EAPG for that line is assigned based on the principal diagnosis. Most of the HCPCS/CPT codes designated as medical visit indicator codes are evaluation and management codes.

42. Has DC Medicaid implemented an inpatient-only list? Is the list the same as that maintained by Medicare for APCs?

Yes. The EAPG list of inpatient-only services applies under the new payment method. The list of procedures is similar but less restrictive than the Medicare list.

43. What bundling or packaging methods did DHCF implement with EAPGs?

Bundling or packaging refers to grouping different services provided into a single payment unit. A bundled or packaged service receives no separate payment. DHCF will implement the following bundling methods with EAPG payment:

Packaging/Bundling	Description
Packaged Services	• A standard list of packaged EAPGs is built into the grouper. • Packaging occurs in the presence of significant procedure visits or medical visits. • Packaging applies only to procedures that group to ancillary, drug and DME EAPGs. • If a significant procedure or medical visit is not present on the visit, items on the standard packaging list *may* be paid separately.

Significant Procedure Consolidation	• Consolidation refers to the collapsing of significant procedures into a single EAPG - when one significant procedure is performed, additional significant procedures may require minimal additional time or resources.
	• The procedures are ranked based on the relative weight of the EAPG.
	• There are two types:
	  • Same significant procedure, which applies to procedures that group to the same EAPG.
	  • Clinically related significant procedure, which applies to related EAPGs.

Discounting Multiple Significant Procedures	• This type of discounting refers to a reduction in the payment for an EAPG – when an unrelated significant procedure is performed multiple times during the same visit. • Multiple significant procedure discounting is applied to procedures within the same EAPG type and across EAPG types. • The procedures are ranked based on the relative weight of the EAPG. • Discounting level percentages are applied: 100, 50 and 25 percent for the first, second, third and subsequent procedures.
Discounting Repeat Ancillary/Drug/DME Procedures	• This type of discounting refers to a reduction in the payment for an EAPG – when non-routine ancillary procedures are repeated on the same visit. • Discounting is applied to repeat procedures for ancillary, drug and DME procedures within the same EAPG. • Discounting level percentages are applied: 100 percent for the first non-routine ancillary, 50 for the first repeated ancillary and 25 percent for the second, third and subsequent repeated non-packaged procedures, respectively.

Packaging/Bundling	Description
Notes: 1. There are six EAPG significant procedure types subject to consolidation and discounting: significant procedure, physical therapy and rehabilitation, mental health and counseling, dental procedure, radiologic procedure, and other diagnostic procedure. 2. 3M Health Information Systems, *Definitions Manual*, Version 3.8.13.1, January 2013	

44. What modifiers impact payment under EAPGs?

The EAPG grouper recognizes a number of modifiers which may potentially impact payment. Some modifiers are used to increase or decrease the payment amount. Some modifiers are informational and will not affect payment. Hospitals should continue to use standard coding conventions in the assignment of modifiers.

Modifier	Description	Effect on EAPG Payment
Therapy modifiers GN (speech and language), GO (occupational), GP (physical)	Identify whether the therapy services were for speech, occupational or physical therapy services.	• Claim lines billed with therapy modifiers will not be exempt from significant procedure consolidation.
Anatomical modifiers and other select modifiers (E1–E4, F1–F9, FA, LT, RT T1–T9, TA, 76, 77, 91, RC, LC, LD)	Used to report procedures performed on paired organs or specific sides of the body, (e.g., eyelids, fingers, toes, arteries, kidneys, lungs, right, left) or to report the same procedure was performed more than once by the same or different physicians.	• Claim lines billed with these modifiers will not be exempt from significant procedure consolidation.
Modifier 25 Distinct service	Used to report significant, separately identifiable evaluation and management (E/M) service by the same physician on the same day as a significant procedure or other service.	• Medical visits are payable with a significant procedure in the presence of this modifier.
Modifier 27 Multiple outpatient hospital E/M encounters	Used to report multiple outpatient hospital E/M and emergency room visits on the same day to indicate that the E/M service is a separate and distinct E/M encounter.	• Lines billed with this modifier may be payable unless a significant procedure is present on the visit.
Modifier 59 Distinct procedural service	Used to report procedures not normally reported together and are distinct or independent from other services performed on the same day.	• Lines billed with this modifier will not be subject to same significant procedure consolidation.
Distinct Procedure Modifier Option	Used to report procedures not normally reported together and are distinct or independent from other services performed on the same day. Distinct procedure modifiers are: XE: Separate encounter XP: Separate practitioner XS: Separate structure XU: Unusual non-overlapping service	• Lines billed with these modifiers will not be subject to same significant procedure consolidation

Modifier	Description	Effect on EAPG Payment
Modifiers 73 and 52 Terminated procedures	Used to report that the procedures or services were not completed so that the service provided was less than usually required for the procedure as defined by the CPT/HCPCS code.	• Lines billed with these modifiers will be discounted by 50% • If the line is subject to both multiple significant procedures discounts and modifiers 73/52 discount, the modifier discount will be based on the adjusted weight that results after the significant procedure discount is applied.
Modifier 50 Bilateral procedure	Used to report any bilateral procedures that are performed on both sides at the same operative session as a single line item (except when 'unilateral' or 'bilateral' is in the CPT/HCPCS description).	• Lines appropriately billed with this modifier will be paid at 150%. Certain procedures that are identified as independent bilateral procedures and will be paid at 200%. • If the line is subject to both multiple significant procedure discounts and a modifier 50 discount, the modifier discount will be based on the adjusted weight that results after the significant procedure discount is applied.
Modifier 57 Option	Determines if the option to use modifier -57 is applied to allow the separate assignment of a medical visit reported with modifier -57 when present with a significant procedure.	• Claim lines billed with these modifiers will not be payable in the of a significant procedure
Never Events modifiers PA (wrong body part), PB (wrong patient) or PC (wrong surgery)	Used to report erroneous surgical or invasive procedures.	• DC current policy continues for non-payment of never event procedures and related services, as required by federal law.
Note The list of bilateral procedure codes subject to discounting are identified in the Medicare Physician Fee Schedule.		

OTHER

45. How will hospitals be kept informed and involved as changes occur to the prospective payment system?

FAQ	This FAQ document which provides DC Medicaid policy, payment and billing information about the new outpatient hospital payment method. FAQs are periodically updated and distributed to hospitals.
EAPG Information	A separate document which provides general information about EAPGs.
Provider information sessions	Held periodically to keep providers informed of data, decisions and the progress of the project.
Training sessions	Outpatient trainings were held on August 27th, 2014 and September 16th, 2014.

46. Who can I contact for more information?

Policy questions contact	Sharon Augenbaum, Reimbursement Analyst, Office of Rates, Reimbursement and Financial Analysis Department of Health Care Finance Tel: 202-442-6082 ● Email: Sharon.augenbaum@dc.gov
Technical questions contact	Connie Courts, Xerox State Healthcare Senior Consultant, Payment Method Development Tel: 859-312-2040 ● Email: Connie.Courts@xerox.com