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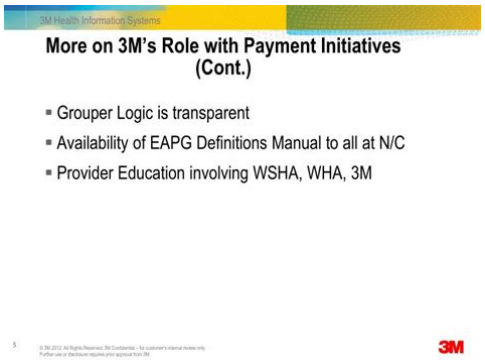

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If you already license 3M APR DRG software you can access the ICD9 and ICD10 definition manual for free on the 3M HIS Support website. If you license 3M APR DRG through a 3M business partner, you will need to pay the licensing fee shown below. If you have questions about your relationship with a 3M business partner, contact 3M before submitting the order form provided below. The EAPG Definitions Manual includes both ICD9 and ICD10 content. This arrangement went into effect on July 1, 2004. NTIS also offers documentation and installation information. Fill out this quick form and we will have one of our experts reach out to you. Please be aware that this information may be stored on a server located in the U.S. If you do not consent to this use of your personal information, please do not use this system. A 3M representative will reach out to you shortly about how you can create a masterpiece using 3M's methodologies. Please try again later. Over 1,000 provider organizations have licensed 3M EAPGs to predict and verify payment as well as analyze and improve their internal operations. In contrast, the CMS APC code assigned to this same visit would be APC 5024Level IV ED Visit. In the 3M EAPG methodology, routine ancillary services like xrays and EKGs are often packaged, so there is no additional payment; procedures that are integral to other procedures are consolidated; and payment for addon procedures is discounted. Efficiency incentives and analytical clarity are stronger under the 3M EAPGs than under APCs, and much stronger than the fee schedule and percentageofcharge approaches. For example, 3M EAPG users may choose among several options for packaging ancillary services, discounting multiple occurrences of the same procedure, and paying or not paying for multiple medical visits in the same day. In addition, 3M EAPGs can address phone contacts, home visits and physician visits.

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These resources include pharmaceuticals, supplies, ancillary tests, equipment, type of room, treatment time, etc. Patients in each 3M EAPG share similar clinical characteristics, resource use and costs.Payers often turn to 3M EAPGs as the basis for an outpatient prospective payment system for analyzing patterns of charges, costs and utilization. Providers combine 3M EAPGs with 3M payerspecific payment prediction software to forecast and verify expected reimbursement. Providers, government agencies and researchers rely on 3M EAPGs to understand outpatient utilization, measure quality and calculate measures of efficiency, such as cost per visit. Implementing a 3M EAPG payment method rewards efficiency, not only because of bundling but also because payment does not depend on providerspecific costs or charges. Such an approach creates incentives for greater access to care, since payment is higher for more costly patients. To see what payerspecific grouping and payment prediction software is available by state, click here. For example, Florida uses 3M EAPGs for comparing volume and charges across hospitals and ASCs. Hospitals, other providers, government agencies, payers and researchers can apply 3M EAPGs to financial measures such as charges, costs and payments to create fair comparisons of utilization and efficiency across providers, attending physicians or service lines. Each payer that uses 3M EAPGs makes its own decisions about prices and payment policies. For hospitals, other providers, health plans and other organizations that seek to understand, predict and verify expected payment, 3M makes available software that emulates payerspecific grouping, pricing and reimbursement policies.

This payment prediction software is available for 16 payers nationwide as of 2018. A common example is 3M EAPG 562 Infections of Upper Respiratory Tract and Otitis Media.http://www.firetac.com.au/userfiles/combatives-fm-3-25_150-complete-manual.xml

For example, 3M EAPG 086 Pacemaker and Other Cardiovascular Device Insertion and Replacement triggers Patient Focused Episode 0860 Pacemaker Insertion and Replacement For example, 3M consultants can help hospitals and clinics implement clinical documentation improvement programs and use the 3M EAPGs to measure and improve their own cost efficiency and quality of care. 3M consultants can also help payers to design payment methods based on the 3M EAPGs and to apply the 3M EAPGs to understanding patterns of utilization, charges, cost and payment. The contract to develop Ambulatory Patient Groups APGs was awarded to 3M. Throughout the 1990s, six major payers implemented payment methods based on APGs. Payment based on Ambulatory Payment Classifications APCs was implemented in August 2000. Because APCs took a feeschedule approach and had a high degree of Medicare specificity, there was demand from other payers and health care organizations for a different approach.If there is a significant procedure present, such as a laparoscopic cholecystectomy, the procedure is assigned to a significant procedure 3M EAPG and related ancillary services would be bundled with it. If there is no significant procedure, then the algorithm checks for a medical visit indicator. If present, a medical visit 3M EAPG is assigned, and related ancillary services are bundled with it. For example, consider an emergency department visit for chest pain. If there is neither a significant procedure nor a medical visit, then the services on the claim are assigned to ancillary 3M EAPGs. An example would be packaging of routine blood tests. For example, when a claim includes both 3M EAPG 3 Level I Skin Incision and Drainage and 3M EAPG 6 Level I Skin Debridement and Destruction, then 3M EAPG 3 is consolidated into 3M EAPG 7. 3M EAPG 3 is shown on the claim but with zero payment. An example would be bilateral myringotomies.

The 3Mproprietary logic is available for licensees to view in an online definitions manual. These statistics include a relative weight for each 3M EAPG. The relative weight reflects the average resource use for a patient in that 3M EAPG relative to the average 3M EAPG. Please note that payers and other users of the 3M EAPG methodology are responsible for using relative weights appropriate for their populations. The 589 3M EAPGs in version 3.14 roll up into 13 3M EAPG types, such as 2—Significant Procedure and 3—Medical Visit. The 3M EAPGs also roll up into 55 categories, such as 15—Radiologic Procedures and 62—Diabetes Mellitus. An example is service line 8 Interventional Cardiology. This categorization allows analysis of charges, cost, payment and utilization by service line to comprise both inpatient and outpatient care. It is updated each quarter with new codes that become effective in April, July or October.They are listed here for the information of readers interested in the various ways that 3M patient classification methodologies have been applied. Also note that listing these references does not imply endorsement of 3M methodologies by individual authors, other organizations or government agencies. Report for the Medicare Payment Advisory Commission. www.medpac.gov. Please try again later. If you do not consent to this use of your personal information, please do not use this system. Under the EAPG system, ForwardHealth reimburses hospital providers for outpatient services based on the quantity and type of services they provide. The new system ensures that both low and highcost services are reimbursed appropriately. We reprice the claims based on your states Medicaid rates. Where might I find the appropriate EAPG number that belongs with a specific CPT code For rate year 2013, companies that use the Medicaid rate to price inmate claims should use the hospital pervisit Medicaid rates available for HMO use.The Wisconsin Well Woman Program is not affected.

http://www.drupalitalia.org/node/67661

Claims from providers who are not Medicaidenrolled hospitals, such as rural health clinics, federally qualified health centers, home health agencies, hospices, and endstage renal disease providers, will

not be reimbursed using the EAPG system. Billing Questions We also have hospitalbased clinics that are designated as rural health clinics. Do we need to send our claims using the new EAPG billing methodology since we are paid per diem rates. If not, do we still need to report the EAPG on our claims I am asking this because the software we would need to do this would be costly. You also do not enter any EAPGrelated information on the claim. ForwardHealth will process and price your claim using the EAPG software and report the EAPG back to you on your 835 remittance. Your claims will process using the EAPG pricing methodology, which uses EAPG rates. Only the first copy of the manual is free. A copy of the form is also available on the EAPG page of the ForwardHealth Portal; however, please contact 3M at 18004357776 for assistance. If you purchased the provider version of the EAPG software, the EAPG Definitions Manual is included in the purchase price. How should this be billed. Billing the services this way helps ensure the provider is reimbursed appropriately, receiving an access payment for each visit. Refer to Update 201255 for more information. ForwardHealth recommends including condition code G0 on the second claim submitted, which allows the system to differentiate one service from another on the same DOS. If these services appear on one or more claim details on an outpatient claim, those details would be denied. If the claim consists only of these services, the entire claim would be denied. If the laboratory services are provided as part of the outpatient hospital visit, the lab services should be included on the outpatient hospital claim and would be reimbursed at the maximum allowable fee.

When both the RT and LT modifiers are used, they must be listed on separate details. How should the provider handle this A situation like this will require special handling of the claim. If so, do you want a drug under revenue code 250 with no HCPCS procedure code or revenue code 636 with a procedure code National Correct Coding Initiative Questions General information regarding NCCI edits for Medicaid is located at. How will the EAPG system handle Medicare crossover claims with modifier 91 On crossover claims, modifier 91 should not hinder processing of the claim. However, providers may need to resubmit or adjust the claim with modifier 59 in some cases. Rate Questions They are reimbursed at a percent of allowable charge, correct EAPG pricing replaces rateperday pricing and percent of charge. EAPG is a completely different pricing methodology with its own set of weights and provider rates. However, if the most recent audited cost report is more than five years old, providers may appeal the rate and request that ForwardHealth use a more recent unaudited cost report. Current and past provider rates are available on the ForwardHealth Portal. Reimbursement Questions Will Medicare crossover visits be reimbursed using the EAPG reimbursement methodology Am I supposed to times the EAPG by our provider rate. If not, where do I find the weight associated with the EAPG The weight associated with the EAPG can be found in a spreadsheet attached to the EAPG Page on the ForwardHealth Portal. To estimate your payment, multiply the weight associated with the EAPG times your provider rate. This reimbursement method allows Medicaid to pay appropriately and fairly, but is not expected to generate additional revenue for the state. Providers may see a change in reimbursement based on the services they provide. To determine reimbursement for professional services, refer to the maximum fee schedule applicable for the service area in question.

The reimbursement of these codes will depend on the weights assigned. The EAPG Materials posted on this website are for educational and internal purposes only, and are not intended to serve as a substitute for EAPG classification with the 3M EAPG Software. Any use outside of educational purposes including incorporating the 3M EAPG Crosswalk in any other product is expressly prohibited without a license directly with 3M. THIS Agreement is entered into between 3M Health Information Systems, Inc. 3M an operating unit of 3M Company,Please read the Data Subject Rights Guidance. If you wish to download it, please recommend it to your friends in any social system.

Share buttons are a little bit lower. Thank you! Please wait. Patients in each EAPG have similar clinical characteristics and similar resource use and cost. EAPGs were developed to encompass the full range of Ambulatory settings including same day surgery units, hospital emergency rooms, and outpatient clinics. EAPGs can not address nursing home services, inpatient services or miscellaneous services like transportation. EAPGs developed to represent ambulatory care across all payers, not just Medicare. Incentive for efficient use of routine ancillary services is created by significant procedure consolidation and by the packaging of routine ancillaries into base visit payment No incremental payment for routine, low cost ancillaries blood chemistry, chest x ray, ekg, etc. Iowa Medicaid implements the first APGbased OPPS, and other payers follow. APG v2.0 released. New York Medicaid implements the first 3M EAPGbased OPPS. Massachusetts Medicaid implements 3M EAPGbased OPPS. 3M EAPGs are ICD10 ready. CMS implements APCs an APG derivative as the Medicare OPPS. APCs are Medicarefocused and not fully prospective. Payers move to APCbased OPPS. Medical patients are described using the diagnoses of the patient coded in ICD9CM. Users will be able to make modifications to the packaging lists.

Significant procedure consolidation refers to the collapsing of multiple related significant procedure APGs into a single EAPG for the purpose determining the payment. Example If both a simple incision and an complex incision are coded on a patient bill, only the complex skin incision will be used in the EAPG payment computation. Observation Logic MVI assigned medical EAPG based on primary dx code; HCPCS G0378 assigned to EAPG 450 and paid separately, based on packaging logic HCPCS G0378 Present on claim. Sign Px or PerDiem EAPG present.Discounting refers to a reduction in the standard payment rate for an EAPG. Discounting recognizes that the marginal cost of providing a second procedure to a patient during a single visit is less than the cost of providing the procedure by itself. Multiple Visit Processing Multiple visit claims claims with different from and through dates Most claims treated as multiple claims Determined by the line item dates of service A single claim may include services provided on two or more days Ex surgical work up and then a same day surgery a few days later Series services, such as therapies, or wound care For payment purposes services provided on a single day based on line item dates of service are treated a logic visits Packaging and discounting performed based on the visit and not the claim Multiple Visit Processing Cont. Single visit claims episodes All services reported on a claim are treated as a single visit for payment purposes Claims when the from and through date are equal, and When specific revenue codes are present regardless if the from and through dates are equal For example revenue codes 450, 451, 452, 456, 459, 762 Packaging and discounting performed for the entire claim The views presented here are those. To use this website, you must agree to our Privacy Policy, including cookie policy. To experience the easy yet powerful Coding platform, talk to us. No Hardware.

Simply Web ezEncoder Features CodeBook Click Here to Know More Learn more about our other AIbased midrevenue cycle management solutions. ComputerAssisted CDI Software Computer Assisted Quality Measures ComputerAssisted Coding Compliance Contact Us. The OCE will perform three major functions It is the users responsibility to organize all applicable services into a single claim record, and pass them as a unit to the OCE. The OCE only functions on a single claim and does not have any cross claim capabilities. The OCE will accept up to 450 line items per claim. The OCE software is responsible for ordering line items by date of service. In order to accommodate this functionality, the OCE is structured to return lists of edit numbers. This structure facilitates the linkage between the actions being taken, the reasons for the actions and the information on the claim e.g., a specific diagnosis that caused the action. Since these coding systems are complex and annually updated, the centralization of the direct reference to these codes and modifiers in a single program will reduce effort and reduce the chance of inconsistent processing. However, with the

integrated OCE, line items on claims from nonOPPS hospitals will be assigned specific edit numbers and dispositions, where in the past; this type of detail was not provided. Reproduced by CMS with permission. No portion of the American Hospital Association AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 3128936816. CMS and its products and services are not endorsed by the AHA or any of its affiliates. Inpatient stays are reimbursed by APRDRG methodology.

Any questions regarding No Fault, including payment of Ambulatory Surgery Bills, should be directed to the Department of Financial Services. Stakeholders may calculate payments either through the use of the 3M Grouper software, or manually.The transition to EAPG is expected to result in a slight net increase in payments. Can billers purchase the software. How much does it cost Any organization that processes healthcare claims may purchase the software. It is available for many reimbursement systems including Medicare, Medicaid, Tricare and NYS Workers Compensation Ambulatory Surgery bills. For information on pricing, please contact 3M directly. It should be noted that the 3M product is not required to make the necessary calculations. Alternate products may be available and the calculations can be done manually as well. The software is not required; facility bills can be manually calculated. Facility payment is due within 45 days. The Medical Directors Office can provide assistance and guidance but since the 3M software is available it is no longer repricing bills. The vendor that produces Encoder Pro should be contacted regarding the specifics of that products packaging and consolidation rules. The same base rates are used for services provided in a hospital as well as an ambulatory surgery center. However, the capital addon values differ for hospitals and ambulatory surgery centers. Additionally At present, code 1401 is for hospital outpatient surgery services and 1408 is for ambulatory surgery centers when using EAPG methodology. Rate code 1416 is used for ambulatory surgery performed at an outofstate hospital. The Board does not authorize ambulatory surgery centers or hospitals.If a facilityspecific value is not present, the rate should be calculated generically using the following guidance or by creating a generic table within the 3M Core Grouper software. Are they a required part of the bill.

If the EAPG codes are not submitted with a bill, should it be rejected Bills should not be rejected if the EAPGs codes are not listed. Are prior year or deleted CPT codes included EAPGs codes cover all current CPT codes. There is a crosswalk available on the Boards website to assist stakeholders in mapping prior year or deleted CPT codes to current CPT codes.Only preop testing occurring on the same day as the procedure by the facility performing the procedure would be included in the EAPG reimbursement. However, payment can be calculated generically without an NPI or OpCert number to cover Workers Compensation reimbursements. Directions for creating a generic table within the 3M Core Grouper are available on the Boards website. The Board does not authorize ambulatory surgery centers or hospitals.If a facilityspecific value is not present, the rate should be calculated generically using the following guidance or by creating a generic table within the 3M Core Grouper software. Certain EAPGs include the cost of capital and would not result in an additional capital addon payment. However, these EAPGs would receive a 150% increase over Medicaid using the Workers Compensation specific base rate. It is a set fixed dollar amount. There can be payment for the services, derived from the EAPG grouping, even if the capital addon amount is zero. Normally, the capital addon amount is not zero, but there are a few exceptions where there is no capital addon for certain services.The payer has the right to raise legal or valuation issues in a timely manner on the appropriate form. Implants are reimbursed, but not as an addon. EAPG payment is based on the severity of an episode of care. The 2015 EAPG fee schedule has a Workers Compensation specific base rate that pays 150% of Medicaid hospital rates for upstate and downstate regions and includes the cost of implants in the relative weight of the procedure.

Reference documents including helpful links to the Department of Healths APG reference materials are on the EAPG Ambulatory Surgery Fee Schedule page on the Boards website. By failing to keep pace with the cost of care and medical advances, the current ambulatory care rates do not appropriately pay providers who deliver evidencedbased, state of the art care. Background 3 Office of Health Insurance ProgramsOffice of Health Insurance Programs New Yorks growing budget deficit will require significant gap closing measures. Ambulatory investments are made possible only through the reallocation of funds drawn from inpatient reform and rebasing. Payment restructuring coupled with targeted primary care enhancements are central to Medicaid reform. Invest in ambulatory care to provide more adequate reimbursement. Develop a new payment system to pay more for higher cost services and less for lower cost services. Improved clarity and transparency of payment structure and methodology. Frequent payment updates to recognize medical advances and changes in cost of service delivery. Uses standard HIPAAcompliant code sets HCPCS and ICD9 codesUses current HIPAA compliant claim formats.Greater clarity and transparency of payment structure and methodology. Features more frequent payment updates to Better acknowledge the impact of medical advances, and Accommodate changes in service delivery patterns. Office of Health Insurance Programs APCs vs. Specifically, in the CY 2003 OPPS, there were 569 APCs, but by CY 2007, the number of APCs had grown to 862, a 51 percent increase in 4 years.

Office of Health Insurance ProgramsOffice of Health Insurance Programs Packaging and bundling payment for multiple interrelated services into a single payment creates incentives for providers to furnish services in the most efficient way by enabling hospitals to manage their resources with maximum flexibilityIn many situations, the final payment rate for a package of services may do a better job of balancing variability in the relative costs of component services compared to individual rates covering a smaller unit of service without packaging and bundling.CMSs new Composite APCs will bundle and package more services it would be more appropriate to establish a composite APC under which we would pay a single rate for the service reported with a combination of HCPCS codes on the same date of service than to continue to pay for these individual services under service specific APCs. Patient Groups Payments for Duplicate. APG claims are reimbursed. Ambulatory Patient Groups Payments for Duplicate Claims and Services in Documents Clips60 Apg Documents white paper BIOMEDICAL DEVICE INTEGRATION.