

June 26, 2020

**ILLINOIS HEALTH AND HOSPITAL ASSOCIATION  
M E M O R A N D U M**

**SUBJECT: Update #1: Medicaid Hospital Outpatient FFS Billing Transition to Institutional Billing – Eff. July 1, 2020**

As previously communicated in an [IHA memo](#) (June 3, 2020), **all hospital outpatient services billed to the Illinois Department of Healthcare and Family Services (HFS) and the Medicaid Managed Care Organizations (MCOs) must be billed uniformly on an institutional claim (UB-04/837I) and will be reimbursed under the EAPG methodology, effective for claims with “From” dates of service (DOS) on or after July 1, 2020.** In other words, HFS will require all hospital outpatient services currently billed on a professional claim (HFS 2360/837P) and paid under the Practitioner Fee Schedule (PFS) to be billed on an institutional claim (UB-04/837I) and paid under the EAPG methodology. The Ambulatory Procedures Listing (APL) will be eliminated and all hospital outpatient services must be billed under the hospital’s institutional NPI. These changes also apply to hospital outpatient services submitted on the professional claim form (CMS 1500/837P) to the Medicaid MCOs.

**Background and Financial Impact**

As a reminder, this change was authorized under legislation ([Senate Bill 2541](#)) passed by the General Assembly on June 17, 2020 to implement the hospital assessment program. SB2541 adds a new section to the Public Aid Code (305 ILCS 5/5A-12.7) that requires HFS to “...*incorporate into the EAPG system for outpatient services those services performed by hospitals currently billed through the Non-Institutional Provider billing system.*” Additional information on the hospital assessment legislation may be found in a May 23, 2020 IHA memo.

Several members have asked about the financial impacts of moving claims paid under the Practitioner Fee Schedule to the EAPG methodology. According to a [Public Notice](#) (June 12, 2020), HFS estimates that this change will increase the total annual spending for outpatient services by approximately \$113 million. In May 2020, IHA provided hospital leaders estimated impact reports, prepared by HFS, showing in total a net positive revenue outcome from the conversion to this methodology. If members require “line-item” detail on specific CPT/HCPCS payment, they may obtain this information by processing claims data through the respective EAPG grouper/pricer software (i.e., 3M/Optum) that reflects the current version of HFS’ EAPG payment methodology.

**Implementation**

HFS initially announced the transition to hospitals in a June 2, 2020 [provider notice](#), which generated a number of technical questions from member hospitals and health systems. IHA subsequently submitted these questions to HFS for feedback and/or validation to ensure hospitals had the information to support the system changes needed to comply with HFS’ direction. As a result, HFS issued an [FAQ](#) on June 11 and additional technical details in a June 24 [provider notice](#).

In the June 24 provider notice, HFS reiterated that the effective date remains July 1, 2020, but indicated that **hospital outpatient claims (excluding renal dialysis) for DOS beginning July 1, 2020 may be placed on a temporary hold until all system requirements have been fully tested and approved.** IHA has also

been in discussions with the MCOs regarding implementation of the system changes needed to effectuate this change. It is our understanding that, similar to the current process for the annual EAPG grouper updates, the MCOs will accept, process, and pay all claims submitted on the UB-04/837I, including those formerly billed on the CMS-1500/837P, under the current pricer. Once their systems have been updated, they will automatically adjust any service lines that were formerly billed on the professional side, as needed, to reflect accurate payment. **We are, however, awaiting confirmation that all MCOs will adopt this approach**, which will ensure hospitals continue to have cash flow while the system changes are being finalized. We are meeting with the MCOs again on Monday, and will share additional details as soon as possible.

### **Key Billing Considerations**

Below please find a summary of the guidance HFS has released to date on the transition, as well as some additional details shared directly with IHA. These changes apply to claims billed to traditional Medicaid and the MCOs and are effective for DOS on or after July 1, 2020.

- The requirement that all EAPG priced outpatient claims contain an APL code is eliminated. All hospital outpatient claims must be billed on the UB-04/837I, including:
  - Chemotherapy Administration (for cancer treatment);
  - Chemotherapy Agents (for cancer treatment);
  - Non-Chemotherapy Drugs administered for side effects of cancer treatment (ICD-10 code for cancer diagnosis must be present on the claim);
  - Drug Administration (Baclofen, Lupron, RhoGAM, Tysabri);
  - Outside Reference Laboratory Services;
  - Laboratory Services (on-site);
  - Radiology Services;
  - Durable Medical Equipment and Supplies (Note – Hospitals will no longer need to get prior approval for DME for clients covered under FFS Medicaid. These items will be inclusive in the EAPG grouper);
  - Speech, Physical, and Occupational Therapy (Note – Hospitals will no longer need prior approval and all modifiers (GP, GO, GN) will continue to be necessary on institutional claims);
  - Audiology Services;
  - OB Triage Services (Billed with CPT 99211 – TH Modifier);
  - EKG Tracing (Technical Component CPT 93005); and
  - Telemedicine Originating Site Only (Note – Hospitals must use Revenue Code 0780 to denote the originating site).
- National Drug Codes (NDCs) are still required on all outpatient drugs billed on the UB-04/837I. Hospitals must also identify all 340B-acquired drugs with modifier –UD in the first position after the HCPCS code on the claim.
- The list of series-billable revenue codes is eliminated.
- Hospitals must bill all outpatient services under the NPI assigned for institutional services and **STOP** using their professional services NPI for dates of service on or after July 1, 2020.
- No changes will be made to the current billing instructions for emergency department and/or observation services. Revenue codes 450, 456, and 451 must continue to be billed with the corresponding CPT/HCPCS codes, as currently listed on the APL.
- Hospitals will be required to split claims with multiple service dates that cross July 1, 2020 during this transition; however, an exclusion applies to emergency department and observation claims.

- No changes will be made to current billing instructions for psychiatric Type A and Type B services.
- Long Acting Reversible Contraception (LARC) after delivery performed in the inpatient setting must be billed on the UB-04/837I, but an add-on payment to the EAPG rate will be made (Note – The following HCPCS codes will prompt the add-on payment: J7296, J7297, J7298, J7300, J7301, and J7307).
- Physician professional fees are still reported under the current billing requirements, using the name, and NPI of the rendering provider. This also applies to provider-based departments that bill both a facility and professional fee; these services should not be billed under the hospital NPI.
- Claims billed on the UB-04/837I do not require a –TC modifier as all are considered technical fees of the hospital.

### **Next Steps**

We are pleased HFS has released this additional guidance, but are continuing to press HFS to answer additional operational and technical questions as soon as possible as we know hospitals need this information to move forward with making changes to their billing systems. Additionally, IHA is working collaboratively with the Illinois Association of Medicaid Health Plans (IAMHP) on updating the *MCO Comprehensive Billing Manual* to reflect the changes to the non-APL services section.

If you have any other questions, please [contact IHA](#).