District of Columbia Medicaid Outpatient Hospital Payment Method EAPG

Frequently Asked Questions

Version Date: October 1, 2026

DHCF will continue to use three conversion factors for Enhanced Ambulatory Patient Groups (EAPGs): one for in-District and out-of-District hospitals, one for Cedar Hill Regional Medical Center, and a separate one for National Rehabilitation Hospital (NRH) because of their significantly different cost structure and more limited array of outpatient services than that of the other hospitals. The final values for the conversion factors effective for District fiscal year 2027 (October 1, 2026 through September 30, 2027) are $1,680.07 for Cedar Hill Regional Medical Center, $585.74 for NRH and $1,199.49 for all other hospitals.

For FY 2027 rates, the pediatric policy adjustor remains unchanged at 1.25, based on results of FY 2027 simulated payment levels for adults and children. The District will remain on version 3.18 of the EAPG grouper for FY 2027.

Please note that the EAPG payment method uses the claim header level first date of service to determine which year's rates are paid.

OVERVIEW

1. What change was made?

The DC Department of Health Care Finance (DHCF) implemented a new payment method for all outpatient hospital services effective October 1, 2014. 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 Solventum 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 less intensive services.

2. Why change to the EAPG 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 a fee based on the procedures billed. A flat visit rate of $50 was also paid in certain instances (e.g., emergency room (ER) visits considered non-emergent). Outpatient surgery services were paid by flat rates based on groups of Healthcare Common Procedure Coding System (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 account for the clinical complexity of the patient, or the resources needed to appropriately diagnose and treat that patient.

3. What were the goals that DHCF hoped to achieve by implementing EAPGs?

Goals of the EAPG payment method included:

- ***Implement a sustainable payment method.*** The District needed 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 presented an administrative burden after implementation of International Classification of Diseases, 10th Revision, Clinical Modification (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 EAPG grouper recognize ICD-10 codes on hospital claims?

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

5. What providers and services are affected?

The EAPG payment method applies 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
- Outpatient hospital services provided by 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 assessed 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 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 less intensive services.

7. How do EAPGs impact hospitals?

In general, EAPGs provide 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 impact 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?

Several Medicaid programs currently use EAPGs for payment. Maryland uses EAPGs for reporting and payment adjustment purposes. Additionally, several commercial payers currently use EAPGs.

9. Is my hospital required to purchase EAPG software 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 hospitals interested in learning more about EAPGs, information is available at https://www.solventum.com/en-us/home/health-information-technology/support/. DHCF does not have a financial interest in any Solventum 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 that 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 to yield the EAPG payment amount. DC Medicaid also has a 1.25 pediatric policy adjustor for FY 2027. This is applied as a percent increase on claims for beneficiaries under the age of 21.

EAPG Payment Calculation
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?

For FY 2027, DC Medicaid will use version 3.18 of the national relative weights updated in 2024 with DC specific weights for EAPGs 269 (0.256330) and 493 (0.180232). The DC-specific weights for these EAPGs are higher than the national weights. EAPG national relative weights are calculated by Solventum Health Information Systems based on Medicare claims data.

During the design of the EAPG payment method, DHCF examined other options for relative weights. After review, the District opted to use the national relative weights because statistically valid District-specific relative weights are not feasible due to the small volume of Medicaid claims. The national relative weights are updated annually by Solventum 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?

DHCF uses one conversion factor for in-District and out-of-District hospitals, a separate one for National Rehabilitation Hospital because of their significantly different cost structure and more limited array of outpatient services than that of the other hospitals and a separate one for Cedar Hill Regional Medical Center (based on its geographic location in an economic disadvantage zone[i]). The values for the final conversion factors effective for fiscal years 2026 and 2027 are shown in the table below.

Conversion Factors	FY 2027	FY 2026
National Rehab Hospital	$585.74	$574.82
Cedar Hill Regional Medical Center	$1,680.07	$1,640.69
All Other Hospitals	$1,199.49	$1,193.52

14. How were conversion factors calculated?

In previous years, conversion factors have been configured to achieve overall payments equal to the District's budget target of 77% of inflated costs. For FY 2022, the budget target was increased to 100% of inflated cost to offset the discontinuation of the outpatient hospital supplemental payment in FY 2021. FY 2027 costs were estimated using cost-to-charge ratios (CCRs) from the District's FY 2025 (October 1, 2024 through September 30, 2025) hospital cost reports which were inflated forward, by two years, to FY 2027 by using a 5.06% inflation factor. The inflation factors are from the Medicare Inpatient Prospective Payment System (IPPS) rules for FY 2026 (final rule) and FY 2027 (proposed rule).

15. How often will conversion factors be updated?

DHCF evaluates rates on an annual basis to consider any changes necessary to conversion factors based on budgetary constraints and other factors.

16. What version of the EAPG grouper was implemented?

Effective October 1, 2014, DHCF implemented version 3.8 of the EAPG grouper, which was released in January 2013. For October 1, 2016, DHCF implemented version 3.11 (released in January 2016). For October 1, 2018, DHCF implemented version 3.13. For October 1, 2020, DHCF implemented version 3.15 (released in January 2020). For October 1, 2022, the District implemented version 3.17 (released in January 2022). For October 1, 2024, the District implemented version 3.18 (released in January 2024). For October 1, 2026, the District implemented version 3.18 (released in January 2026).

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

Yes. DHCF performs EAPG quarterly updates, which requires 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 EAPG 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 percentage 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 such as EAPGs is used to price claims, 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 considered fair. A charge cap to limit payment to billed charges is not imposed.

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

DC Medicaid managed care plans are required to use the same hospital payment methodologies as are used for the Medicaid fee-for-service program. However, managed care hospital-specific rates are the result of negotiations between the plans and the hospitals.

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; or
b. The Medicare co-insurance amount plus Medicare deductible amount.

COVERAGE AND PAYMENT FOR SPECIFIC SERVICES

23. What changes, if any, were made to the 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 are not included in the EAPG payment method and continue to be billed separately on a professional claim form and paid by fee schedule.

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

The pediatric policy adjustor remains unchanged at 1.25 in FY 2027. The 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. 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 that are 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 and are not federally funded, 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 the observation room services policy?

Under EAPGs, observation room services may be separately payable under specific conditions. Observation room services begin at the time that the physician writes the order to evaluate the patient.

- The 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 if units billed are at least 8. If units are less than 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 EAPG payment method, observation room services may be identified by HCPCS code G0378 which groups to EAPG 450 under certain circumstances. 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 EAPG 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 EAPGs.

BILLING AND EDITING

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

The EAPG grouper relies on 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?

Before the implementation of EAPGs, hospitals were required to bill outpatient hospital services using one of the District-designated 'visit codes' which included mostly evaluation and management CPT codes. Now that EAPGs are activated in the DC Medicaid system, hospitals no longer need to use the visit codes 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
0300 - 0319	Laboratory
0320 - 0329	Diagnostic radiology
0341, 0343	Nuclear medicine
0350 - 0359	CT Scan
0371 - 0372	Anesthesia
0400 - 0409	Other imaging
0460 - 0469	Pulmonary function
0471	Diagnostic audiology
0481, 0489	Cardiology with specific CPT codes
0482 – 0483	Cardiology
0530 - 0539	Osteopathic svcs
0610 - 0619	Magnetic resonance tech
0621 - 0624	Med/surg supplies
0730 - 0739	EKG/ECG

Diagnostic Revenue Codes for 3-Day Window	Revenue Code Desc
0740	EEG
0918	Behavioral health svcs
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 up to 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 EAPGs payment method?

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

Before the implementation of EAPGs, 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 group to medical visit 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?

The inpatient-only list was eliminated in FY 2023.

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 implemented the bundling methods described below 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.
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.

Packaging/Bundling	Description
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.

Notes:

1. There are six EAPG significant procedure types subject to consolidation and discounting: significant procedure, physical therapy and rehabilitation, behavioral health and counseling, dental procedure, radiologic procedure, and diagnostic or therapeutic procedure EAPGs.
2. Solventum Health Information Systems, *Definitions Manual*, Version 3.18

44. What modifiers impact payment under EAPGs?

The EAPG grouper recognizes several 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, RC, LC, LD, LM and RI)	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.

Modifier	Description	Effect on EAPG Payment
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.
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 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 separately payable in the presence 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.
Modifier JW	Used to report the amount of drug or biological that is discarded and eligible for payment under Medicare's discarded drug policy. The modifier can only be used for drugs in single dose or single use packaging.	• DC currently does not have a discarded policy; this modifier will be ignored by the grouper.

Note:
1. 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 provides DC Medicaid policy, payment, and billing information about the EAPGs payment method. FAQs are periodically updated and distributed to hospitals. They are published at least annually on the following website: https://dhcf.dc.gov/page/rates-and-reimbursements
EAPG Information	A separate document which provides general information about EAPGs.

46. Who can I contact for more information?

Sharon Augenbaum, Reimbursement Analyst, Office of Rates, Reimbursement and Financial Analysis
Department of Health Care Finance
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[i] District government defines the DZE designation as follows: “Enterprise Zones and Economic Development Zones are both areas in the District designated by law to provide special initiatives that stimulate economic growth and job development. Programs include taxable and tax-exempt revenue bonds to finance the acquisition, construction, and renovation of a wide array of capital projects owned by private enterprises and nonprofit institutions; wage credits and additional expensing allowance; a zero federal capital-gains tax rate on certain investments; and tax-exempt bond financing. Businesses that are located within either of these zones and have received a "DZE" certification from DSLBD will also be eligible for two preference points and a two-percent price reduction for proposals and bids.